

THEMATIC SEGMENT

ZERO DISCRIMINATION IN

HEALTH CARE SETTINGS

COUNTRY SUBMISSIONS

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INTRODUCTION

The Thematic Segment of the 41st UNAIDS Programme Coordinating Board (PCB) meeting will be held on the 14th December 2017 and will focus on “zero discrimination in health-care settings”.

In the preparation for the Thematic Segment, UNAIDS issued a call for submission of examples of interventions that have contributed to reducing discrimination in health-care settings (good practices). A total of 52 good practice submissions were received, showcasing the wide range of efforts at all levels to end discrimination in health-care settings from African States, from Asian States, from Eastern European 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, civil society, United Nations and international organizations, as well as collaborative efforts. The case studies highlight different approaches to reducing discrimination in health-care settings, ranging from measuring the levels of discrimination to information campaigns and to training of health care workers, and from HIV-related legal services to specific measures to increase discrimination-free access to HIV and other health services.

I. AFRICAN STATES

1. ALGERIA: Elimination de toute forme de discrimination en milieu de soins.

TITLE OF THE PROGRAMME: Elimination de toute forme de discrimination en milieu de soins.

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- **Le programme est en place depuis :** 2016
- **Partie/Parties responsable(s) :** Gouvernement, Société civile, ONU, PVVIH
- **Groupe(s) de populations bénéficiaires :** Personnes vivant avec le VIH, Hommes ayant des rapports sexuels avec des hommes, Personnes qui s'injectent des drogues, Travailleurs/euses du sexe, Femmes, Filles
- **Est-ce que le programme a été évalué/analysé ?** Non
- **Est-ce que le programme fait partie de la stratégie nationale sur le sida ?** Oui
- **Est-ce que le programme fait partie d'un plan national autre que la stratégie nationale sur le sida ?** Non

INFORMATIONS DE BASE : *

Dès le début de l'épidémie de l'infection VIH/Sida en Algérie, l'Etat s'est investi dans la riposte au sida à travers notamment un engagement politique exprimé et régulièrement réaffirmé au plus haut niveau et le maintien du recours à un financement conséquent avec plus de 95% du budget alloué sur le seul budget de l'Etat.

Cela a permis grâce à l'approche participative et multisectorielle qui a impliqué tous les acteurs gouvernementaux, la société civile, les PVVIH et les partenaires au développement d'assurer à titre gratuit et universel toutes les prestations de santé y compris le traitement ARV pour tous, de porter le taux de couverture antirétrovirale à plus de 80 % et de stabiliser le nombre de nouveaux cas d'infection VIH à moins de 1000 par an.

Le profil épidémiologique du VIH en Algérie a toujours été celui d'une épidémie de type peu active, avec une prévalence dans la population générale inférieure à 0.1% mais concentrée dans les groupes de populations clés les professionnelles du sexe (PS 5.5%), les hommes ayant des relations sexuelles avec d'autres hommes (HSH 4.4 %) et les consommateurs de drogues injectables (CDI 4.5 %) (Source : Rapport de la riposte Algérie-MSPRH-ONUSIDA 2016)

Selon les estimations de ONUSIDA 2016, calculées sur la base des données du Laboratoire National de Référence du VIH/sida (LNR):

- Le nombre de personnes vivant avec le VIH (PVVIH) est estimé à 13 000 personnes dont 350 enfants de moins de 15 ans ;
- Le nombre de nouvelles infections avoisinerait les 1000 cas pour les adultes de plus de 15 ans et moins de 100 cas de moins de 15 ans.

En termes de prévalence et de nombre cumulé de cas :

- Au 30 Septembre 2017, et depuis le début de l'épidémie (1985), un total cumulé de 11385 personnes (6347 hommes et 5038 femmes) ont été diagnostiquées séropositives pour le VIH selon le LNR.

En termes de nouvelles infections :

- Entre le 1er janvier au 30 septembre 2017, 723 nouveaux diagnostics d'infection VIH (379 hommes et 344 femmes) ont été recensés.
- Les groupes d'âge les plus touchés sont les 25-29, les 30-34 ans et les 35-39 ans avec respectivement 15%, 18 % et 15% des cas. Le groupe d'âge de 0-14 ans représente 6 % des nouveaux diagnostics ce qui montre la proportion moindre de la transmission chez les enfants.

BÉNÉFICIAIRES ET RESPONSABLES DE LA MISE EN ŒUVRE : *

Les PVVIH ont été identifiées comme groupe prioritaire au même titre que les populations clé et vulnérables dans le PNS 2016-2020.

L'étude Stigma Index de 2015(Source : Index de stigmatisation et de discrimination des PVVIH -MSPRH-AIDS Algérie-EI Hayet-ONUSIDA-IDLO 2015), a démontré que malgré l'accès de toutes les PVVIH au traitement ARV, il en ressort que les structures de santé restent le premier lieu de discrimination des PVVIH (53 % des répondants 170-320) ont déclaré avoir été victime au moins une fois d'un refus d'accès aux soins de santé, y compris des soins dentaires, en raison de leur statut sérologique.

Les organisations de la société civile dont l'association des PVVIH sont parties prenantes de la mise en œuvre du Plan National Stratégique 2016-2020.

Leurs interventions se réaliseront dans la cadre d'un plan d'action en étroite collaboration avec le Ministère de la Santé et d'autres partenaires dont ONUSIDA, qui identifiera non seulement les champs de compétences de chaque association, mais également les zones d'intervention à travers le territoire national.

Pour jouer pleinement leur rôle, les associations et l'association des PVVIH bénéficient d'un appui institutionnel en ressources humaines, financières et matérielles ainsi que dans le domaine de la formation, du renforcement des capacités managériales, de gestion de projets.

EMPLACEMENT GÉOGRAPHIQUE ET COUVERTURE PROGRAMMATIQUE : *

Le programme s'inscrit dans le cadre de la mise en œuvre de riposte nationale au sida, s'appuie sur le renforcement du système de santé, articulé autour des 15 centres de référence de traitement (CDR) au niveau national.

Le cadre juridique défini dans la circulaire N°3 du ministère de la santé de 2010, a déjà établi la liste des services médicaux de prise en charge des soins spécialisés autres que ceux prodigués par les CDR.

Toutes les PVVIH suivies dans les CDR, 10 200 (juin 2017) y compris les populations clés, bénéficieront de l'aide des associations et de l'association des PVVIH, par le renforcement des programmes d'éducation thérapeutique, la coordination avec les CDR de l'approche multidisciplinaire (continuum de soins), l'accompagnement des PVVIH aux différents services de soins ainsi que le plaidoyer, la mobilisation communautaire, signalement des dépassements et la fourniture de l'aide juridique aux PVVIH et leurs familles.

FINANCEMENT ET PÉRENNITÉ: *

La mise sous ARV avec suivi biologique conformément aux nouvelles directives de prise en charge représente 12,6% du budget du PNS (\$157 millions), ce qui aura un double impact à la fois sur la mortalité due au VIH et sur la prévention de la transmission.

L'appui du FM aux côtés de l'engagement du gouvernement constitue une contribution financière 200 000 \$ couvrant les domaines de ce programme. La mise en œuvre sera inscrite au titre du programme Fonds mondial Algérie « appui à la mise en œuvre du Plan National Stratégique 2016-2020 » coordonnée par le CCM.

Un processus de transition est en cours d'élaboration pour assurer la continuité des activités à travers la mobilisation de ressources additionnelles au niveau national et international.

DESCRIPTION: *

Les personnes dépistées séropositives pour le VIH seront orientées et accompagnées par les médiateurs associatifs vers les centres de traitement (CDR) pour une prise en charge médicale et psychosociale entièrement financée par le budget du gouvernement algérien.

Cette approche globale permet d'établir des liens entre les associations et les structures de santé dans une démarche complémentaire comme le montre (la figure 1) pour faire face aux besoins et répondre aux questions complexes concernant la prévention, le traitement et la gestion du VIH/sida.

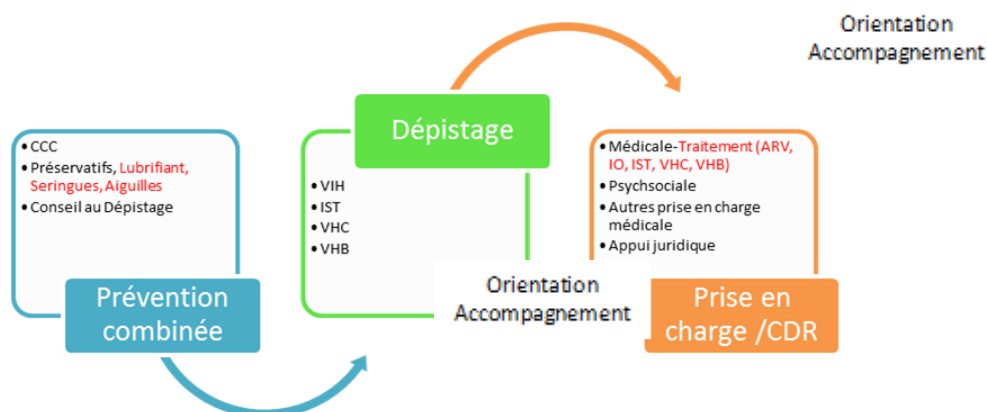


Figure 1: Processus de mise en œuvre des interventions

RÉSULTATS DU PROGRAMME : *

Le programme est à sa première phase, depuis son lancement 70 PVVIH ont bénéficiées de différentes formes d'appui au niveau de trois (03) régions du pays (centre, ouest et sud), il est prévu d'accélérer la mise en œuvre au niveau national pour les deux prochaines années.

RÉPERCUSSIONS ET IMPACT DU PROGRAMME : *

Malgré l'existence d'un arsenal juridique en faveur de l'élimination de la discrimination dans les structures de santé, il faut noter toutefois que les situations de discrimination enregistrées en milieu de soins ont mobiliser plusieurs acteurs institutionnels et communautaires ainsi que les médias pour conjuguer leurs efforts dans le cadre de la mise en œuvre du PNS afin d'atteindre l'objectif zéro discrimination dans les structures de santé en Algérie.

Plusieurs demandes ont été formulées pour renforcer les connaissances des professionnels de santé en particulier pour qu'ils adoptent des comportements respectueux des droits humains, excluant les différentes formes de discrimination, dans tous les contextes.

La célébration nationale de la journée mondiale du SIDA sous le slogan droit à la santé a été un catalyseur pour le renforcement de la mise en œuvre du programme.

SUIVI ET ÉVALUATION/VALIDATION DE L'IMPACT: *

Le plan de suivi & évaluation du programme est en cours de finalisation, il est intégré dans le plan de S&E du programme Fonds Mondial et le PNS Algérie.

Les données seront disponibles à la fin du 1^{er} semestre 2018, ce qui permettra de dresser une analyse situationnelle de la discrimination dans les structures de santé dans le pays.

ENSEIGNEMENTS TIRÉS ET RECOMMANDATIONS: *

Les principales recommandations du programme dans sa première phase sont comme suit :

- Plaidoyer pour la lutte contre la discrimination des PVVIH en milieu de soins à travers :
 - ✓ La société civile en particulier l'association des PVVIH;
 - ✓ Les leaders politiques et religieux ;
- Renforcer les connaissances et les capacités des professionnels de santé en matière de lutte contre la stigmatisation, la discrimination et la protection des droits à la santé des PVVIH et populations clés ;
- Elaborer des textes d'application des lois existantes pour le signalement et la prise en charge des cas de discrimination des PVVIH dans les milieux de soins;
- Permettre et encourager les associations et les PVVIH à se constituer partie civile.

CONCLUSIONS : *

Les droits des PVVIH, sont une réalité dans les textes (ils sont nombreux) et en pratique sur le terrain, il persiste encore des insuffisances, et des dérapages que les PVVIH et leurs associations rapportent.

Cependant, il faut rester vigilants, veiller avec le concours de tous, notamment la société civile, au respect de ces droits.

ANNEXES/RESSOURCES SUPPLÉMENTAIRES : *

Ci-dessous deux liens vers deux vidéos produites en 2013 et 2015 qui ont été à l'origine de l'élaboration du programme actuel :

- <https://youtu.be/yvj8YdJ3rhA>
- <https://youtu.be/cJA1ccaHo8I>

2. EGYPT: Strengthening and expanding HIV-related legal services and rights

TITLE OF THE PROGRAMME: Strengthening and expanding HIV-related legal services and rights

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- **Start date of the programme:** April 01, 2009
- **End date of the programme:** December 31, 2018
- **Responsible parties:** Civil Society, UN or other international organizations
- **Populations reached:** Health workers, people living with HIV, women, girls, gay men and other men who have sex with men, people who inject drugs, sex workers
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND

The Arab Republic of Egypt has experienced a national epidemic concentrated in two populations - people who inject drugs and men who have sex with men - in a setting of overall low prevalence among the general population. According to UNAIDS Data 2017 Report, the number of people living with HIV in Egypt in 2016 was 11,000, which is less than 0.1 per cent or less of Egypt's population.

Source: http://www.unaids.org/sites/default/files/media_asset/2017_data-book_en.pdf

The Egyptian health care system through the Ministry of Health currently offers voluntary counselling and testing, provider-initiated testing and counselling, laboratory services, and care, support and treatment for people found to be living with HIV. Most prevention services are delivered by non-governmental organizations, while most care, support and treatment services are delivered by governmental providers.

Key populations

People who inject drugs

According to an urban population estimate of people who inject drugs undertaken in 2015, there were an estimated 30,000 people who inject drugs in Greater Cairo and Alexandria, and a further 1,000 in Menia. There is no official national population estimate for people who inject drugs. HIV prevalence among people who inject drugs has most recently been estimated at 7.7 per cent in Cairo and 6.7 per cent in Alexandria. About ten per cent of men who inject drugs also have sex with men.

Men who have sex with men

According to an urban population estimate of men who have sex with men undertaken in 2015, a best national estimate of about 43,000 was determined. The best estimate of men who have sex with men in Greater Cairo and Alexandria is about 18,000. In 2015, HIV prevalence in Egypt among men who have sex with men was estimated at 5.4 per cent in Cairo and 6.9 per cent in Alexandria. About ten per cent of men who have sex with men also inject drugs.

Female sex workers

Female sex workers in Egypt mostly work on the streets, in small food and drink and entertainment venues, in hair salons, or through contacts made through mobile phones. According to a recent urban population estimate, Egypt has about 23,000 female sex workers, with Greater Cairo and Alexandria accounting for about 10,000. Making a population estimate, conducting bio behavioural surveys among them, and implementing HIV prevention programmes are all challenges.

Source: National HIV Programme Situation and Gap Analysis, Egypt, 2015
http://www.unaids.org/sites/default/files/country/documents/EGY_narrative_report_2015.pdf

BENEFICIARIES

- People living with HIV (men and women)
- Men who have sex with men
- People who inject drugs
- Sex workers

IMPLEMENTERS (NATIONAL / LOCAL CIVIL SOCIETY ORGANIZATIONS)

- Al-Shehab Foundation for Comprehensive Development (Cairo)
- Caritas Egypt and Woman and Development Association (Alexandria and Behira)
- Friends Association – Al Menya, Egypt and Ayadena Comprehensive Development Association (Menia and Banisouif)
- Magar Center for Development and Legal Services and Comprehensive Social Services Association (Alexandria and Luxor)
- The National Council for Justice and Social Peace (MAAN) and Egyptian Center for Civil & Legislative Reform (ECRCL) (Giza and Fayoum)
- Windows of Blessings Charity (freedom from drugs program) and New Generation Organization (Cairo)

Each of the implementing organizations engages in different ways with the beneficiaries in the design of the activities supported by IDLO. Further, representatives of people living with HIV and key affected populations participated in all of the national and regional consultations organized under the programme. The following is a sample of the recent national and regional consultations with legal service providers, civil society representatives of people living with HIV, and key populations.

Meetings and Consultations 2015-2017

- First Egyptian National Networking & Training HIV-related Legal Services & Rights, 22-23 April 2015, Cairo, Egypt. A national training with all the implementers in Egypt in partnership with UNAIDS-Egypt and the National AIDS Program.
- 6th Regional Consultation on HIV-related Legal Services and Rights, 2-3 February 2016, Hurgada, Egypt.

- A regional meeting with all implementers from Egypt in addition to non-governmental organizations from Tunisia, Morocco, Algeria, Lebanon and Jordan in partnership with several UN organizations and the National AIDS Program.
- Regional workshop on the establishment of the MENA Network for AIDS and Law, 25-26 April 2016, Tunis, Tunisia.
- A regional meeting with representation of civil society organizations involved in the HIV related legal services and rights from Egypt, Tunisia, Morocco, Algeria, Lebanon and Jordan to establish their own sustainable regional network.
- Capacity building Meeting of HIV-related Legal Services Providers in Middle East and North Africa Region, 18-20 October 2016, Amman, Jordan
- A three-day regional capacity development workshop for the MENA Network for AIDS and Law to assist the newly established network in partnership with UNDP.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The program supported legal services for PLHIV and KPs across the MENA region and in Latin America. This submission focuses on results in Egypt in the period 2015-2017.

- Egypt: Alexandria, Banisouif, Behira, Cairo, Fayoum, Gharbia, Giza, Luxor, Menia (Mynia)

FINANCING AND SUSTAINABILITY

Programme funders: OPEC Fund for International Development (OFID) 2009-2012 Ford Foundation 2010-2017

Sustainability: Memoranda of Understanding have been agreed to continue providing legal services to people living with HIV and key populations after the end of the programme. The Magar Center for Development and Legal Services and Comprehensive Social Services Association (Alexandria and Luxor) has signed multiple agreements between the Center and the National AIDS Program, other non-governmental organizations and other networks. Magar continues to provide legal services after the conclusion of their project for those who cannot pay, and with minimal fees to those who can. Al-Shehab Foundation for Comprehensive Development in Cairo has mainstreamed HIV-related legal services into other funded projects related to gender, refugees and other humanitarian funding. A regional network for HIV-related legal service providers in the MENA region has been established, including Egypt. One task will be to share experiences in resource mobilization, and to seek regional resources to support national activities.

DESCRIPTION

The program supported legal services for people living with HIV and key populations across the MENA region and in Latin America. The program was renewed in phases during the period 2009 - 2017. This submission focuses on results in Egypt in the period 2015 – 2017. The program aims to strengthen HIV-related legal services to address discrimination faced by people living with HIV and key affected populations. The program includes strengthening regional collaboration to improve the quality and sustainability of HIV-related legal services and rights, as well as building the capacity of partners to advocate for an improved legal and policy environment for HIV prevention and treatment. The program design included ‘twinning’ pairs of human/legal rights organizations with health advocacy organizations, so that each could learn from the other. The legal rights groups learned about HIV- related issues and the health advocacy organizations learned about options for legal action to enforce health rights. Planned program outcomes in the current period include:

- Strengthened legal services capacity, mechanisms and opportunities to effectively address inequalities faced by people living with HIV and key affected populations;
- Strengthened regional network and partnerships between legal services and relevant actors for legal responses to address discrimination and inequality related to HIV in the context of the 2030 Agenda for Sustainable Development; and
- Strengthened appreciation and understanding of the advocacy actions on the intersection of HIV and rights issues at regional and global levels to promote an enabling legal and institutional environment.

The program also focused on the nexus between law and health care, by training hospital managers on the legal rights of people living with HIV and access to health care, and providing free-of-charge, stigma-free and competent legal services and consultations, especially in health care settings.

RESULTS OF THE PROGRAMME

The following results include all HIV-related legal complaints, and are not limited to health care services:

Since 2015, participating civil society partners reported: 500+ people living with HIV and key affected populations were provided with direct HIV legal information Hotline and Facebook page for communication of HIV related legal information were created for virtual information dissemination. 150+ court cases were filed in the Egyptian judicial system 500+ legal consultations were provided to people living with HIV and key populations. Approximately 60 incidents in the period 2014-2016 were reported to the National AIDS Program regarding failure to provide satisfactory health services to people living with HIV. All complaints (except one) raised in this way were resolved to the satisfaction of the complainant. (One complaint resulted in court action.)

OUTCOMES AND IMPACT OF THE PROGRAMME

A key outcome was the establishment of a national protocol with the National AIDS Program for addressing HIV-related discrimination in health care. The protocol includes the following steps:

- If a person living with HIV attends a hospital and does not get satisfactory health care, the participating NGOs can send a lawyer to the hospital with him/her to negotiate the provision of services.
- If a satisfactory result is not obtained, the NGO will send an email to the National AIDS Program Manager, copying the UNAIDS country office and the IDLO field officer.
- The UNAIDS country office and / or the IDLO field officer will then discuss the case with the National AIDS Program Manager to explore how to resolve the complaint.
- Other key results included:
- Local civil society advocacy and engagement led to inclusion of the 'legal environment' reference in the Ministry of Health National Strategic Plan.
- In the Upper Egypt Governorate of Menia, a committee was formed to oversee the project, consisting of different governmental stakeholders, civil society and people living with HIV. The participants include the Deputy Minister of Health and the chair of the ambulance services, among others. This assisted in responding swiftly to incidences of discrimination in accessing health care services in that Governorate.
- In 2016, an Egyptian court ruled that HIV infection is not a valid ground for termination of employment.

LESSONS LEARNED AND RECOMMENDATIONS

Success factors:

- IDLO's position as an intergovernmental organization, with Egypt as a Member Party, helped mediate relations between the government and the civil society organizations;
- Continuous involvement of people living with HIV and key populations in all consultations and meetings;
- Regional and interregional dialogue between Egyptian partners, MENA partners, and Latin American civil society organizations undertaking related work.

Challenges:

- The rapid and ever-changing political environment in Egypt 2009-2017;
- Declined overall funding in the HIV domain;
- Stigma and discrimination among the public and health care providers;
- Overall decreased spending in the prevention domain after the Egyptian grant application to the Global Fund was declined, increasing the load on IDLO's implementers;
- Uncertainty regarding the autonomy of non-governmental and civil society organizations after the implementation of the newly adopted legislation on civil society organizations.

Recommendations:

- The engagement of both human rights and health rights organizations working jointly on these issues was productive. The human rights-based approach and legal obligations to provide quality care should continue to be a cornerstone of future programs.
- Training of medical personnel alone is insufficient to ensure delivery of quality services. The protocol for addressing complaints around health care service delivery to people living with HIV was more effective than legal action against the government hospitals. Such alternatives to legal action should always be explored.
- Ethical obligations to provide medical care people living with HIV and key affected populations should be included or strengthened in professional training.
- Future initiatives should strengthen the engagement of professional medical associations and peer accountability systems in the issue.

CONCLUSIONS

This program was the first of its kind to utilize legal services as a means to achieve better access to health care services for people living with HIV in Egypt. The legal component proved to be extremely effective in building trust between civil society organizations and people living with HIV and key populations, increasing the number of individuals reached through outreach, and helping retain them in direct contact with the civil society organizations. There were numerous interventions where access to health services was improved after emphasizing the rule of law and the individual's rights to medical treatment under both Egyptian and international law.

Dr El-Helw's report notes:

Before the project, PLHIVs did not know their rights and due to stigma did not want to disclose their HIV status. Thus, they used to endure violations in silence without going to court. IDLO Program raised capacity of PLHIVs to know and request their rights. It was thus

able to transform PLHIVs' silence into readiness to take legal action. After winning several legal cases, PLHIVs/MARPs are now optimistic, have more confidence in themselves and ability to face stigma and discrimination. PLHIVs/MARPs psychological state improved, as they are now able to pursue and demand their rights through provided legal support. This sometimes positively affected their willingness to go for Voluntary Counselling and Testing (VCT) conform to AIDS medication and protect themselves and others from infection. Empowerment of PLHIVs is a prominent outcome of IDLO Program.

The committee of trained PLHIVs in Mynia was influential in convincing PLHIVs to seek their rights through legal action. In addition, they found that when problems are presented to the decision-makers committee, action is taken to resolve issues or lawyers would take legal action.

Project interventions took place in collaboration with the NAP and/or under-secretaries of health to enable PLHIVs to access needed health care. When this failed, legal interventions were used 1) after the death of a PLHIV and 2) to save the PLHIV's life. IPs were also able to intervene and allow access of PLHIVs to needed services through threatening or actually filing complaints in the police station against physicians who refused to operate. Access to health services was vital to PLHIVs health and lives.

As for IDLO Program objective two, IPs [implementing partners] were able to include a third pillar, the "enabling environment", to the national strategic framework with its strategic objective "action will be taken to reduce discrimination and legal barriers while vulnerability is being addressed through legal support", which represents the overall objective of all IDLO Program projects.

This is an unplanned/unintended result, which represents a positive change to the legal and policy environment for HIV prevention and treatment. The strategy now addresses needs of PLHIVs for legal services, preserves their human rights and combats stigma and discrimination in important entities where PLHIVs go for services such as health care, Ministry of Social Solidarity (MOSS), police stations and courts. The addition of the new pillar will have positive implications on availability of future funds for IDLO and IPs to continue their work.

There were also changes in NAP procedures due to feedback meetings with PLHIVs. Dispensing HIV drugs no longer takes place only in Cairo but is now done in governorates. The NAP also modified its procedures in dispensing drugs according to PLHIVs' concerns. In addition, the NAP has increased the number of days for taking laboratory specimens. Due to legal action, the Minister of Health reissued a decree and distributed it to some MOH hospitals stating that PLHIVs have the right to receive services without stigma and discrimination and that physicians have no right to refuse providing needed services.

ANNEXES/ADDITIONAL RESOURCES

- Toolkit: Scaling Up HIV-related Legal Services (IDLO, UNAIDS, UNDP) available in Arabic, Chinese, English, French, Russian, Spanish
http://data.unaids.org/pub/manual/2010/20100308revisedhivrelatedlegalservicetoolkitwebversion_en.pdf
- 'Ten Reasons why legal services must be central to a rights-based response to HIV' Factsheet, English, also available in Arabic, Chinese, English, French, Russian, Spanish
<http://www.idlo.int/sites/default/files/pdfs/events/IDLO-AIDS2016-TenReasons.pdf>

3. GHANA: HIV prevention and BCC to reduce HIV new infections, stigma and increased PMTCT in the West Mamprusi district, northern region Ghana

TITLE OF THE PROGRAMME: HIV prevention and BCC to reduce HIV new infections, stigma and increased PMTCT in the West Mamprusi district, northern region Ghana

CONTACT PERSON

Name: Abdul -Mumin Yussif

Title: Executive Director

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- **Start date of the Programme:** April 01, 2014
- **End date of the Programme:** June 30, 2014
- **Responsible parties:** Civil society, Government, Faith based organizations
- **Population group(s) reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Indigenous people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes. National MARP Strategy

BACKGROUND INFORMATION

PROJECT GOAL

- The project goal is to reduce new infections in the general population

PROJECT OBJECTIVES

- To promote safer sexual practices in the general population especially among vulnerable groups

SUB PROJECT OBJECTIVES

- Reduction of sexual transmission of HIV
- Increase the proportion of women and infants completing PMTCT programme (the role of the CSO is to generate demand for services at the community level)

ACTIVITIES CARRIED OUT

- Selection of peer educators
- Training of peer educators
- Peer educator activities and education
- Engagement with organized groups
- Conducting HIV testing and counselling
- Monthly review meetings with peer educators
- Referrals
- Monitoring and Evaluation Activities

- United Force for Development (UFFD) selected peer educators from communities in the West Mamprusi District of the Northern Region of Ghana. The peer educators are to send down
- Information and vital messages of HIV and AIDS among their community members and the general population. The West Mamprusi District of the Northern Region recorded a total of 565 new HIV positive cases this year as against 589 cases before the project, making the district the highest
- HIV/AIDS prevalence area in the Northern Region. (Ghana AIDS Commission (GAC) in collaboration with Social Accountability Monitoring Committee (SAMC)).

BENEFICIARIES AND IMPLEMENTERS

- Youth
- Communities
- Faith based organisations
- Barbers associations and hair dressers associations
- Persons living with HIV
- Peer educators and staff
- Health care workers,
- Key populations and women and girls

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Ghana
- Northern Region
- West Mamprusi district
- Number of youth reached with HIV prevention interventions -1000 (961 reached)
- Number of adult reached with HIV prevention interventions -1080 (779 reached)
- Number of People reached with HIV prevention interventions through one-on-one and small groups - 1400 (1740 reached)
- Number of people reached with Stigma Reduction activities -600 (561 reached)
- Number of people received HIV Testing and Counselling (HTC) and know their results – 392 (100 reached)
- Number of condoms distributed- 12000
- Male -3086
- Female -47
- Total-3133
- Number of review meetings held-3 (3 meetings held)

FINANCING AND SUSTAINABILITY

The programme is managed and coordinated by United force for Development (UFFD) with funding from Ghana AIDS Commission.

DESCRIPTION

PROJECT GOAL

- The project goal is to reduce new infections in the general population

PROJECT OBJECTIVES

- To promote safer sexual practices in the general population especially among vulnerable groups

SUB PROJECT OBJECTIVES

- Reduction of sexual transmission of HIV
- Increase the proportion of women and infants completing PMTCT programme (the role of the CSO is to generate demand for services at the community level)

ACTIVITIES CARRIED OUT DURING THE PERIOD

- Selection of peer educators
- Training of peer educators
- Peer educator activities and education
- Engagement with organized groups
- Conducting HIV testing and counselling
- SSR'S monthly review meetings with peer educators
- Referrals
- Monitoring and Evaluation report

UFFD selected seven peer educators from communities in the West Mamprusi district. The peer educators are to send down information and vital messages of HIV and AIDS among their community members and the general population

TRAINING OF PEER EDUCATORS AND PROJECT STAFF ENGAGEMENT WITH ORGANIZED GROUPS CONDUCTING HIV TESTING AND COUNSELING REVIEW MEETING WITH PEER EDUCATORS MONITORING AND EVALUATION REFERRALS

RESULTS OF THE PROGRAMME

- Number of youth reached with HIV prevention interventions -961reached
- Number of adult reached with HIV prevention interventions -779 reached)
- Number of People reached with HIV prevention interventions through one-on-one and small groups - (1740 reached)
- Number of people reached with Stigma Reduction activities - (561 reached)
- Number of people received HIV Testing and Counselling (HTC) and know their results - (100 reached)
- Number of condoms distributed-
- Male -3086
- Female -47
- Total-3133
- Number of review meetings held-3 meetings held

OUTCOMES AND IMPACT OF THE PROGRAMME

- Number of youth reached with HIV prevention interventions - 961reached
- Number of adult reached with HIV prevention interventions -779 reached)
- Number of People reached with HIV prevention interventions through one-on-one and small groups - (1740 reached)
- Number of people reached with Stigma Reduction activities - (561 reached)
- Number of people received HIV Testing and Counselling (HTC) and know their results - (100 reached)
- Number of condoms distributed-
- Male -3086
- Female -47
- Total-3133
- Number of review meetings held-3 meetings held

Though we did not have a reactive client during our outreaches, our peer educators referred seven people for HTC and STI's/STD's during their house to house, one on one and through small groups.

Three (3) were referred for HTC service and four (4) people referred for STI's and STD's. The training programme really impacted more knowledge on to all peer educators and they could not have found it anywhere.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Regular Monthly and quarterly monitoring and supervision were conducted by a joint team of United force for Development, GHANA AIDS COMMISSION and THE DISTRICT HIV FOCAL UNIT OF DISTRICT HEALTH MANAGEMENT TEAM

LESSONS LEARNED AND RECOMMENDATIONS

CONSTRAINTS AND CHALLENGES

- Not much HIV test kits for our outreached programme (HTC)
- Means of transport
- Some Faith group's leaders rejected promoting of condoms during our outreaches.
- Condoms sales very difficult after device means

LESSONS LEARNT

- BP checking of groups before testing and counselling brought a high turnout.
- Follow-ups to clinics after the HTC reveal that most of the people tested had their blood pressure to be high and they were referred to government hospital
- Ability to send down messages to community members thus, community conversations techniques, entry process and approaching difficult and controversial people.
- The training programme at really impacted more knowledge on to all peer educators and they could not have found it anywhere.

RECOMMENDATIONS

- We recommend that Pastors and Imams should be given training on the HIV issues and encourage them to at least allocate some minutes of their preaching time to talk on it.
- We recommend also that Sexuality Education component should be added to the components of HIV so that we can educate young people, the youth and their parents.
- We recommend again that Ghana AIDS Commission should re-integrate HIV education among in school youth as this will help curb the menace.

CONCLUSIONS

REFERRALS

Though we did not have a reactive client during our outreaches, our peer educators referred seven people for HTC and STI's/STD's during their house to house, one on one and through small groups. Three (3) were referred for HTC service and four (4) people referred for STI's and STD's

CONCLUSION

The groups we met in our activities could not have found these opportunities anywhere in their lives if not because of this project. They hope that the project will continue and more scale-up programmes to meet ever community in the districts.

The project ended on the 30th of June 2014 with a lot of supervision by the lead NGO United Force for Development (UFFD) and the Ghana Aids Commission and the District HIV Focal Unit.

ANNEXES/ADDITIONAL RESOURCES

- HIV Prevention and Care Training Manual and Tools
- Peer education and HIV/AIDS: Concepts, uses and challenge

4.1 KENYA: Improving access to integrated sexual and reproductive health services to female sex workers in Kilifi County

TITLE OF THE PROGRAMME: Improving access to integrated sexual and reproductive health services to female sex workers in Kilifi County

CONTACT PERSON

Name: Dan Okoro, Lilian Langat

Title: Programme Specialist - SRHR/Maternal Health, Programme Analyst - HIV Prevention

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- **Start Date of the Programme:** Feb 01, 2013
- **Responsible Parties:** Government, NGO
- **Population Group(s):** Women, Girls, Sex Workers, Clients of female sex workers
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

The HIV epidemic in Kenya is mixed being concentrated in female sex workers (FSW), men who have sex with men (MSM) and Persons who inject drugs (PWID) and generalized in the rest of the populations. The national HIV prevalence is 6% but varies across counties, gender and age groups. Among the three key population groups, female sex workers have the highest prevalence at 29.3% followed by PWID and MSM at 18.3% and 18.2% respectively.

There is an enabling policy environment for the prevention of HIV among Key populations and programme guidelines are in place. However, sex workers face challenges of stigmatization and occasional discrimination when seeking SRH services in health facilities especially when their profession is revealed. In some instances the negative attitudes and low capacity among health providers make these services inaccessible, not client centred or low quality. The programme seeks to contribute towards improving access to SRH including HIV prevention services, at first in small scale in Kilifi County and subsequent scaling it up.

Mtwapa in Kilifi County (Coastal part of Kenya) is a vibrant business town known for high sex work activities – known as a 24hour town. UNFPA Country office through International Centre for Reproductive Health, established the Drop In Centres to enable the female sex workers access SRH services such as HIV screening, female and male condom, cervical cancer screening, family planning, screening and treatment of sexually transmitted infections, counselling and psychosocial support among others.

The National Ministry of Health and Kilifi County Health department acknowledges and provide support to this programme.

BENEFICIARIES AND IMPLEMENTERS

The programme is being implemented by a non-governmental organization, International Centre for Reproductive Health - Kenya. This is an implementing partner to UNFPA CO whose main activities is in the coastal towns of Kenya. It was selected by CO in consultation with the government by virtue of its comparative advantage of its programmes among sex workers and other HIV prevention interventions. In consultation with CO, ICRH develops annual work plans with priority activities agreed upon in every annual programme review meetings attended by stakeholders from government and other partners.

The Ministry of Health provides technical support as well as HIV test kits, condoms, contraceptives and other supplies as may be needed. The Kilifi County Health department also provides local oversight role, supervisory and technical support.

The key beneficiaries include female sex workers and their male clients. Those diagnosed or are living with HIV and AIDS are linked to care. Among the female sex workers are adolescent girls, some of whom dropped out of school due to poverty/lack of school fees. Other beneficiaries include health workers through capacity building on service provision to key populations with particular reference to FSW.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The main programme is being implemented in Mtwapa town, Kilifi County, coastal region of Kenya. Other centres in Kilifi county were in Kilifi and Malindi towns - these two have been closed this year, 2017 due to funds cut.

FINANCING AND SUSTAINABILITY

The programme is under direct management of ICRH, which is majorly funded by UNFPA. However, due to severe reduction of funds (US withdrawal of funds to UNFPA) this year, there has been a great drop in the activities - closed 3 drop-in-centres (DISC). The two main DISCs in Kilifi town and Mtwapa could serve over 12,000 FSW and 8200 males in a year. The fund cut was abrupt- however, it demonstrated the gap in sustainability plans beyond UNFPA support.

There is current initiative to have these services integrated within the established health facilities, although the FSW/clients are resisting this - stating unsuitable/unfriendly environment due to stigma. Sustainability can be ensured when the services are integrated in the MOH or other private not-for profit facilities. The latter has challenge of cost of services. Capacity of the health facilities should be strengthened to address the needs of these clients.

DESCRIPTION

In summary, the program activities implemented aimed at increasing: uptake of integrated SRH services (FP/HIV/STI/ cervical cancer screening); demand for and scaled up access to SRH information and commodities, HIV prevention interventions for key populations and youth, capacity building of service providers and community stakeholders to prevent and respond to SGBV.

Focus:

Provision of integrated SRH/HIV services to female sex workers and their clients as well as capacity building of peer educators on risk reduction.

Service delivery model:

Services are provided in a stand-alone facility dedicated to female sex workers and their clients with monthly outreaches to hard-to-reach areas and referral for services not available at the centre. Mobilisation is conducted through peer educators.

RESULTS OF THE PROGRAMME

In 2014 and 2015: FSW Drop-In Service Centers in Mtwapa & Kilifi provided HTC services to 8,785 males and 12,247 Females, 4,865 clients received FP services, 7271 clients received STI treatment and 3,350 clients were screened for cervical cancer. A total of 10,651,010 male condoms and 96,923 female condoms distributed to FSW peers, clients and hotspots.

In 2016: Four thousand five hundred and forty-one (4,541) female sex workers and 506 clients of FSW received various SRH and HIV services through the in reach and outreach approaches. In the reporting period, 48 FSW and 2 clients of FSW tested HIV positive. Seven hundred and twenty-eight (728) and 47 FSW and clients of FSW respectively were treated for STIs; 623 FSW received Family Planning (FP) services. Sixty-one (61) FSW tested positive for cervical cancer during the cervical cancer screening and were referred for further services. Over one million (1,089,334) male condoms, 9,853 female condoms and 14,105 lubricants were distributed.

OUTCOMES AND IMPACT OF THE PROGRAMME

Although the programme has not been independently evaluated, the interventions have been shared and replicated in other parts of the country by some organizations. These may not be to the scale of what is at Mtwapa, Kilifi County but some aspects such as moonlight HIV testing and linkage to care for those testing positive. It also enabled identification of the gap (stigma) in service delivery to this population in health facilities.

During the implementation period, last year, the FSW demanded to have ARV to be provided at the centre - to enhance linkage to care and treatment instead of being referred to health facilities. This was granted by the County health team.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The programme is monitored by ICRH using a reporting tool. ICRH in consultation with CO agrees on targets of the year and the progress measured and reported on through quarterly reports.

Internally (at ICRH), the Peer educators and leaders (FSW) meet every month (and sometimes every two weeks) to review their activities and share reports. Some of the peer educators support documentation and coordination of the programme.

There is need to conduct a comprehensive independent evaluation of the programme.

LESSONS LEARNED AND RECOMMENDATIONS

Some of the factors that led to the success of the programme include:

1. Availability of resources (funds) - as mentioned above, due to the sudden cut of UNFPA funds, the activities drastically dropped - closed some DISCs.
2. Location of DISC: they are within the town centres where most activities are. They can access services any time and any day including late evening- especially for moonlight services - HIV testing, PEP and EC.
3. Participation/Engagement of the FSW - this enhanced ownership
4. Government support: made available commodities and supplies, including technical support.
5. Policy environment - the national strategy and guidelines which outlines programming for Key population. These have also been used to sensitize the local authorities and law enforcement to prevent harassment of the FSW and their clients.

RECOMMENDATIONS

Conduct an independent evaluation which also includes cost-benefit analysis.

Consider an equivalent model in health facilities to enhance sustainability.

DISC is an innovative model that can improve access to integrated SRH including HIV services - can be scaled up

CONCLUSIONS

The DISC model of service delivery creates a platform for provision of friendly, client centred, integrated non-stigmatized package of services to FSW, their clients and possibly other key populations leading to increased uptake of integrated SRH services. It enhances support for risk reduction. During field monitoring visits, one sees the love of the programme among the FSW - them describing the empowerment gained through this initiative - risk reduction/ 100% condom use, prevention of unintended pregnancies, negotiation for safe sex, demand for linkage to care and treatment among those living with HIV.

ANNEXES/ADDITIONAL RESOURCES

- Poster presentation made at the last ICASA (2015) sent separately

4.2 KENYA: Promoting Zero Discrimination at Health Care Settings, Nakuru, Kenya

TITLE OF THE PROGRAMME: Promoting Zero Discrimination at Health Care Settings, Nakuru, Kenya

CONTACT PERSON

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Title: Board Member

Organization: AFROCAB

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- **Start Date for the Programme:** Sep 18, 2016
- **Responsible Parties:** Government, Civil society, Private sector, Faith based organizations, People living with HIV
- **Population group(s) reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Sex workers, TB Survivors
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Despite massive investment and commitment by the government, civil society, private sector and people living with HIV, the number of new HIV infections reported continue to increase and most vulnerable populations include adolescent girls and boys, (45%) women (35%), children, sex workers and injection drug users, long distance truck drivers. Report from the National AIDS Control Council (NACC) indicate stigma and discrimination remains a critical barrier to reaching the prevention and 90-90- 90 targets and majority of health care workers suffer from stigma hence discriminate patients seeking treatment services hence compromising prevention and ART uptake.

However, patients' rights charter has been placed in most of the public hospitals as an education campaign strategy for all health care workers and patients to be informed on rights of patients and treatment access. and encourage health care workers infected with HIV to seek treatment and live openly /positively with the disease so as to access care services from the health managers.

BENEFICIARIES AND IMPLEMENTERS

The programme aimed at reaching the nurses, clinicians both in public and private hospitals, people living with HIV especially women and adolescents who comprise over 79%, NGOs linked to grassroots organizations of people living with HIV providing care services, MOH, NACC, and NTP., HIV Tribunal members

The selection criteria was based on their expertise, professionalism, experience on matters related to HIV, prevention, treatment and care and role in development of the National HIV Prevention Strategy. and legal knowledge on rights of patients.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

NAKURU COUNTY, KENYA

- Targeting 320,000 beneficiaries

FINANCING AND SUSTAINABILITY

Managed by health manager, county government, HIV positive people and coordinated by Ambassadors of Change NGO an organization focused on promotion of gender -equality, patient centered approach to treatment, and access to quality, non-discriminatory treatment and care.

To sustain the programme issues related to cultural attitudes, values and taboos, gender, HIV are prioritized to reduce barriers in reducing HIV transmission and enhance PMTCT uptake by pregnant women.

DESCRIPTION

The main objective is to encourage health workers to freely test for HIV, disclose their HIV status to enhance their ART uptake at less costs at their place of work and care services and interact freely with people living with HIV to share experiences and support in advocacy for better policies, improved drugs and working conditions, and legal reforms to protect rights of patients.

The program implementation has been facing problems due to time available for health workers due to their assignments at the hospital and most of the activities take place over weekends. or lunch hour at the hospital. Costs of travel have been a challenge coupled with co-infections and regular visits to clinics by patients.

RESULTS OF THE PROGRAMME

Number reached so far is estimated at 25,000 covering 3 sub-counties in the county with a population of 4 million people.

OUTCOMES AND IMPACT OF THE PROGRAMME

Through the traditional leaders and rights advocates and people living with HIV, stigma on HIV has reduced though TB remains a challenge due to the deeply rooted cultural attitudes and taboos associated with the disease. Need exist for education campaigns on, patients' rights and the existing laws to make the community aware and seek justice. Due to lack of funds, quality care services remain poor especially on adequate nutrition, costs of travel to access treatment and lack of community health workers and drug shortages/stock outs.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Questionnaires were developed aimed at gathering information on factors that promote stigma and discrimination, gender dimensions of HIV, and treatment access and challenges. Consultative meetings by stakeholders to share stories, personal experiences and lessons learned and recommendations.

LESSONS LEARNED AND RECOMMENDATIONS

- The success of the programme is attributable to openness, non-discriminatory language use in communication and emphasis on human rights.
- Biggest challenges include financing, and stigma which is still rife, diverse cultural backgrounds, gender in a male dominated society.
- County government in collaboration with FBOs have been supportive in creating a friendly policy environment.
- Engagement of local leaders and people living with HIV is critical as agents of change.

CONCLUSIONS

Expected outcomes of the programme include reduced stigma and discrimination at on HIV at all levels including among health care workers, increased treatment uptake, reduced drug resistant HIV, increase of pregnant women on PMTC and delivering in hospital and less infants born HIV positive and most importantly reducing the barriers to reaching the prevention and 90-90-90 targets.

4.3 KENYA: Case study: Reducing stigma and discrimination in healthcare settings, Kenya

TITLE OF THE PROGRAMME: Case study: Reducing stigma and discrimination in healthcare settings, Kenya

CONTACT PERSON

Name: Kofi Amekudzi

Title:

Organisation: ILO

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- **Responsible party/parties:** Civil society / UN or another inter-governmental organisation
- **Populations group(s) reached:** health care workers, key population

BACKGROUND INFORMATION

According to the Kenya Modes of Transmission Report of 2008, 2.5% of new HIV infections are health facility-related. Stigma and discrimination are still a barrier for People Living with HIV (PLHIV) seeking healthcare. This is primarily attributable to the fact that healthcare providers fear getting infected with HIV, through occupational exposure. This fear links to the lack of adequate personal protective equipment (PPE) for health workers to carry out their routine tasks when in contact with blood or other body fluids from patients. As at 2016, Kenya had 172,706 registered medical personnel (Kenya Economic Survey, 2017), stigma and discrimination is a barrier to these Healthcare workers seeking health care services especially for highly stigmatized conditions such as HIV and TB. As a consequence, to ensure good access to healthcare services as well as non-discrimination from health sector workforce with relation to PLHIV, it is critical to improve the occupational safety and health of health workers in terms of HIV prevention. It is also important to eliminate stigma related to accessing medical services for health care workers particularly in relation to HIV and TB which is a critically important aspect in the Recommendation No. 200.

The Occupational Safety and Health Act of 2007 (OSHA) obligates the employer to ensure that the workplace is safe and obligates the employee to follow workplace health and safety rules laid down by the employer. In addition to this the Work Injury Benefits Act, No. 15 of 2007 provides for compensation to employees for work related injuries and diseases contracted in the course of their employment. These laws are enforced by the Directorate of Occupational Safety and Health Services (DOSHS) which is under the Ministry of East Africa Community, Labour and Social Protection.

This highlighted the need for action to improve occupational safety and health of service providers in health care settings. Kenya used “HealthWISE” – Work Improvement in Health Services - a tool developed by the International Labour Organization (ILO) and the World Health Organisation (WHO). HealthWISE approaches a health facility as a workplace. HealthWISE includes a specific biological hazard module to guide actions to improving health workers’ access to HIV, Hepatitis and TB prevention, treatment, care and support services. HealthWISE is based on the ILO WISE methodology (Work Improvement in Small Enterprises), which has been successfully applied for more than 20 years in 45 countries and adapted to several economic sectors. HealthWISE was designed to guide action especially in

the implementation of ILO Recommendation No. 200 concerning HIV and AIDS and the world of work (2010) and the Joint WHO-ILO-UNAIDS policy guidelines on improving health workers' access to HIV and TB prevention, treatment, care and support services. The aim of the programme was to enhance women and men health workers' occupational safety and health relating to HIV/TB and reduce stigma and discrimination within health care settings.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Through this initiative, a health facility was identified in Nairobi for application of HealthWISE and additional coaching conducted to follow-up with actual on-site implementation. Awareness on stigma and discrimination was also done as part of the modules in HealthWISE.

DESCRIPTION

The Directorate of Occupational Safety and Health Services (DOSH in collaboration and with the support of the ILO, through an OFID funded programme, partnered with the St. Mary's Mission Hospital (SMMH) and Emergency Life Support Group LTD (ELSG) to model the implementation of HealthWISE in its hospital, with a focus on HIV and TB.

A workplace OSH assessment, based on the HealthWISE checklist, was conducted to identify and prioritize areas of OSH needing improvement so as to reduce HIV, hepatitis and TB transmission.

An OSH committee was established and orientation on HealthWISE was provided to the hospital management and workers (doctors, nurses, laboratory technicians as well as support staff).

An action plan was developed to address the risks and make improvements in the facility in the short, medium and longer terms.

An OSH protocol was developed which included revision of the Infection Prevention and Control guidelines (IPC), PEP protocol, HIV workplace policy and TB protocol.

Hospital management and workers were also sensitized to reduce stigma and discrimination towards PLHIV and towards other health workers seeking care.

RESULTS OF THE PROGRAMME

An OHS protocol for SMMH focusing on biological hazard safety of its health workers was developed. The protocol takes into account the revised IPC guidelines, PEP protocol and HIV policy and will guide the implementation of occupational health and safety of the health workers at the hospital

Visual improvements were noted on follow up assessment to include;

1. Uniform labelling of all sharp boxes and appropriate placement of sharp containers according to the IPC guidelines had been done;
2. Radiation-monitoring badges had been issued to the radiographers;
3. New TB isolation room had been set up with 4 beds, open windows with no curtains and the windows shared with the regular medical ward had been sealed;
4. Proper waste segregation according to the IPC guidelines;

5. Dental unit changed from using micro-tip to use of capped needles (blue). This is because the micro-tip do not have caps, and previously, the doctor and nurses in the dental unit were concerned about sharps injury;
6. Reorganization had been done in the laboratory making it neater with less clattering;
7. The negative fume cupboard was repaired;
8. Two (2) fans were installed on opposite sides of the lab, at the windows, to facilitate movement of air;
9. PEP protocol was put up on the notice boards in different wards.
10. Orientation on HealthWISE was conducted for the Nurses Union and more recently with the
11. Doctor's union

LESSONS LEARNED AND RECOMMENDATIONS

- HealthWISE is a simple, low-cost, pragmatic model in enhancing health workers' occupational safety and health related to HIV, Hepatitis and TB as well as other biological hazards.
- Conscious and systematic planning for health workers OSH is key to improving service delivery for PLHIV.
- Refresher courses for staff on IPC/OSH helps keep the staff mindful in maintaining a safe working environment and promote adherence to universal precautions which in turn, enhances the quality of service delivery.
- The commitment of hospital management to improving the OSH and working conditions for their workers is key.
- Flexible training programmes are key to accommodate the schedules of health workers

5.1 MALAWI: Campaign on Awareness of health care users, health workers' rights and responsibilities

TITLE OF THE PROGRAMME: Campaign on Awareness of health care users, health workers' rights and responsibilities

CONTACT PERSON

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- **Start Date of the Programme:** January 10, 2013
- **End Date of the Programme:** April 30, 2014
- **Responsible Parties:** Government, UN or other inter-governmental organization, National Aids Commission
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Gay men and other men who have sex with men, Prisoners and other populations in closed settings, Sex workers, Migrants (documented and undocumented), refugees or internally displaced populations, People living in humanitarian emergency settings, Indigenous people, Leaders, Member of Parliament, Chiefs, Councillors
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

The program was implemented in an environment where there is a political will from the government to ensure equal access to care, it was in line with the Medical Council of Malawi mandate to protect the patients and the public. In addition, Medical Council receives complaints against practitioners and health facilities on abuse of patients and malpractices hence out of 27 districts, over 5 districts there were no complaints lodged. The assumption was that there was lack of awareness on patients' rights and responsibilities. Furthermore, Council received reports of health workers selling ARVs illegally, HIV test kits hence inadvertently denying patients access to health care.

Therefore, a campaign to educate leaders, Traditional chiefs, Members of Parliament, Councillors was embarked with the aim to empower the gate keepers with the information on the roles of the Medical Council of Malawi and how they can engage in reporting unprofessional conduct and breach of duty of care.

BENEFICIARIES AND IMPLEMENTERS

The beneficiaries were the health workers, Traditional Chiefs, Traditional Authorities, the Village Leaders, Members of Parliament, Ward Councillors, Health Centre Committee

Representatives, and The District Commissioners. These were provided with information to disseminate to the public under their areas, institutions and constituencies.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

This was a country wide programme, all 27 districts were reached. Information during the interface was provided to the representatives and information was further relayed through the TV interviews and radios, newspapers accorded during the program hence targeting not only leaders and health workers as mentioned but the entire population of Malawi around 16 million.

FINANCING AND SUSTAINABILITY

The program was managed properly and was funded by National AIDS Commission, also using resources from Medical Council of Malawi such as human resources, vehicles, and paper work.

This is a continuous program for Medical Council however sometimes faces financial support. Currently, it has embarked on sensitization awareness on patients' rights and responsibilities and health workers rights, assessment of the level of stigma and discrimination among health workers and airing of radio jingles on Zodiak Radio Station and Malawi Broadcasting Corporation courtesy of the funding from UNAIDS Malawi. The current activities cost K15,000,000.00

DESCRIPTION

Campaign on promotion of patients' rights and responsibilities, health workers rights and responsibilities, the primary focus is the health care user since the rural population have low level of education hence continuous education is key so that they start to query certain behaviors from unprofessional practitioners. Hence, they are provided with telephone numbers, toll free number, the address where they can report more of informing them of the complaints mechanisms against any discrimination and stigma, abuse and malpractices in health facilities. In addition, targeting the proprietors of the health facilities to avoid creating policies that are discriminatory against certain population. The program could not continue in the second year due to funding.

RESULTS OF THE PROGRAMME

Almost all Traditional Authorities, Chiefs, Ward Counsellors, in Malawi in all 27 districts and the entire population through radio and TV interviews.

OUTCOMES AND IMPACT OF THE PROGRAMME

Increased awareness among health care users evidenced by increase in number of complaints lodged to Councils Secretariat on any malpractices, increased number of membership of practitioners providing health care as it is a legal requirement, advocated for improving content of the curriculum in training medical ethics, human rights issues, and health law, improved content on the same during Continuous Professional Development activities. Though there are increased antagonisms between practitioners and health users on whose rights prevails.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

No proper evaluation was done, however the increased number of people lodging complaints to our office and through the media. People are able to get recourse if they have been harmed or injured when accessing care at the health facility.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learned includes continuous engagement with the public and the stakeholders is key in reducing stigma and discrimination, Policy reviews needed, The Medical Practitioners and Dentists Act No 17 of 1987 have to be reviewed to accommodate changes in medical practice which is being challenged with rise of human rights, the rise in medical technologies, the rise of social media which can expose the public to abuse of their rights such as privacy and confidentiality. The balance between patients' rights and health workers rights very important.

CONCLUSIONS

Traditional Authorities in the three regions testified that this was their first interface to be briefed about abuses in health facilities face to face and the issue of bringing the District Health Officers interface with the community Leaders was a rare moment as they were able to inform them the problems they face when accessing health care and the DHOs were able to respond and advise them on what to do next time they face similar problems and they provided them with contacts so that they can assisted if one of their wards faces problems in the health facilities.

ANNEXES/ADDITIONAL RESOURCES

- Reports were produced and sent to National AIDS Commission Secretariat.

5.2 MALAWI: Ending child marriage in Malawi

TITLE OF THE PROGRAMME: Ending child marriage in Malawi

CONTACT PERSON

Name: Nazneen Damji

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- **Start Date of the Programme:** January 01, 2014
- **End Date of the Programme:** October 6, 2017
- **Responsible Parties:** Government, Civil society, UN or other inter-governmental organization
- **Population Group(s) Reached:** Women, Girls, Young people/adolescents
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Gender inequality, violence, lack of information about HIV and discriminatory social norms put young women and adolescent girls at particular risk for HIV infection. According to UNAIDS, 59 per cent of new HIV infections among young persons aged 15-24 in 2016 occurred among adolescent girls and young women. In sub-Saharan Africa, young women aged 15-24 made up 67% of new infections among young people. UNAIDS data from seven longitudinal studies across Eastern and Southern Africa show that young women of 15-19 years accounted for three quarters (74%) of new infections in eastern Africa and nearly all of the new infections (91%) in Southern Africa.

Violence disproportionately affects women and girls and their ability to confront HIV. Child marriage is a manifestation of that violence against young women and adolescent girls. 15 million girls a year are married before the age of 18. It is very difficult for child brides to negotiate safe sex - if they even know what it is – and they are especially vulnerable to early pregnancy, HIV, and other sexually transmitted infections. Ending child marriage is essential to reducing HIV vulnerability and risk among young women and adolescent girls.

BENEFICIARIES AND IMPLEMENTERS

Efforts by UN Women included lobbying and training parliamentarians, engaging with traditional leaders and mobilizing civil society and young women and adolescent girls, including those living with HIV, to advocate for elimination of a practice of child marriage.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- The efforts have targeted rural areas of Malawi.

FINANCING AND SUSTAINABILITY

The initiative was implemented involving a range of partners at different stages of implementation, including the national parliament, the Ministry of Gender, Children and Social Welfare, the Ministry of Justice & Constitutional Affairs, Women and Law in Southern Africa (WLSA), the Paramount Chiefs, UN partners, women's organizations, faith-based organizations, youth-led movements, international organizations, etc. to ensure the sustainability of the efforts.

DESCRIPTION

In Malawi in 2012, one in every two girls was married before the age of 18 and according to the UN Population Fund; it has one of the highest rates of child marriage in the world, ranked 8th out of 20 countries considered to have the highest rates.

UN Women and other partners focused their efforts on the local and national level legislative frameworks to remove the provisions related to the legal age of marriage that put girls under the risk of child marriage.

RESULTS OF THE PROGRAMME

In 2014 UN Women supported the follow-up and the implementation of the High-Level Task Force Declaration of Commitment to HIV and AIDS signed by the Paramount Chiefs in addressing key issues such as girl's education, gender based violence, sexual and HIV and AIDS issues. UN Women has facilitated an agreement by Paramount and Senior Chiefs to develop an action plan for implementation of customary by-laws on ending violence against women and girls, with focus on keeping girls in school and ending child marriages. The Chiefs have a big role to play in community development in influencing, enforcing and monitoring human rights and women rights at local level.

In 2015, UN Women has launched paralegals in partnership with the Chiefs to support prevention and response to GBV cases. In 2015, Malawi's Senior Chief Inkosi Kachindamoto annulled 330 customary marriages – of which 175 were girl wives and 155 were boy fathers – in Dedza district, in the Central Region of Malawi. The objective was to encourage these youths to return to school, and continue a healthy childhood.

Chief Kachindamoto's decision was initially met with resistance from other community and opinion leaders, young couples and their parents—especially in marriages where a dowry had been involved—but she continued door-to-door campaigning in the community with mothers' groups, members of the Village Development Committee, faith-based leaders and NGOs-- lobbying, sensitizing and even annulling marriages.

Chief Kachindamoto also suspended village heads that had consented to child marriages, as the community's bylaws forbade it, even before the new Marriage Act. Now that Chiefs have been recognized for their role in the new Act, it makes it easier for the suspensions to be regulated under this law.

Efforts by UN Women included lobbying and training parliamentarians, engaging with traditional leaders and mobilizing civil society to advocate for the enactment of a law. More than 12 years in the making, Malawi's Marriage, Divorce and Family Relations Act, was passed by Parliament in February and enacted in April 2015. It raises the minimum age of marriage without parental consent to 18.

In February 2017, with support from UN Women and partners, the Parliament unanimously adopted a constitutional amendment that raises the minimum age of marriage from 15 to 18

years. The amendment aligns the Constitution with the 2015 Marriage, Divorce and Family Relations Act.

OUTCOMES AND IMPACT OF THE PROGRAMME

- 330 customary marriages were annulled by Malawi's Senior Chief Inkosi Kachindamoto in 2015.
- The Marriage, Divorce and Family Relations Bill was adopted in 2015, which raises the minimum age of marriage to 18 years.
- In February 2017, the Parliament unanimously adopted a constitutional amendment that raises the minimum age of marriage from 15 to 18 years.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

UN Women story: From where I stand - Elizabeth Chatuwa

<http://www.unwomen.org/en/news/stories/2016/10/from-where-i-stand-elizabeth-chatuwa>
UN Women video: Ending child marriage in Malawi: <https://youtu.be/eiVPKib8Ctk>

LESSONS LEARNED AND RECOMMENDATIONS

In Malawi, from village chiefs to lawmakers in the capital, attitudes are shifting; but turning the tide on child marriage needs sustained advocacy within communities, in schools and in homes. More efforts are required to repeal unequal gender norms and gender-based discrimination and violence to ensure that girls can protect themselves from HVI and mitigate its impact.

CONCLUSIONS

UN Women will continue to support traditional leaders, as well as the Ministry of Gender, Children and Social Welfare to ensure that the recent changes in marital law are fully understood and implemented, and that the Ministry is able to move forward with future work on gender equality.

UN Women will continue to partner with civil society networks to change discriminatory attitudes among both lawmakers and the public to ensure effective implementation of the new law. UN Women will also support the Ministry of Gender and Justice to harmonize the new Constitutional Amendment Bill and the various pieces of discriminatory legislation against women and girls.

ANNEXES/ADDITIONAL RESOURCES

UN Women articles on the issue:

- <http://www.unwomen.org/en/news/stories/2017/2/news-malawi-parliament-adopts-amendment-to-end-child-marriage>
- <http://www.unwomen.org/en/news/stories/2017/3/news-malawi-chief-receives-vital-voices-award>
- <http://www.unwomen.org/en/news/stories/2015/9/malawi-chief-annuls-330-child-marriages>
- UN Women video:
- Ending child marriage in Malawi: <https://youtu.be/eiVPKib8Ctk>
- UN Women story: From where I stand: Elizabeth Chatuwa: <http://www.unwomen.org/en/news/stories/2016/10/from-where-i-stand-elizabeth-chatuwa>

5.3 MALAWI: Umunthu Workshops for Health Care Workers

TITLE OF THE PROGRAMME: Umunthu Workshops for Health Care Workers

CONTACT PERSON

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- **Start Date of the Programme:** December 01, 2015
- **End Date of the Programme:** December 01, 2020
- **Responsible Parties:** Government, Civil society, Academic institution
- **Population Group(s) Reached:** Health care workers, Gay men and other men who have sex with men, Sex workers, Transgender people
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

LGBTI acts are criminalized in Malawi. While arrests are not currently taking place, there is great confusion in health delivery, affecting the country's ability to reduce the prevalence and transmission of HIV/AIDS, and manage further conditions. Few LGBTI persons are comfortable disclosing to health workers. Some health workers report fears that treating LGBTI persons may contravene laws. With the government apparently unwilling to review legislation. Malawi has a complicated human rights history. After a period of economic gains during Bingu wa Mutharika's presidency, the human rights situation deteriorated significantly in 2011, marked by political unrest, aggressive government responses to peaceful demonstrations, and attempts to restrict media reporting. The country has since made strides towards greater awareness and protection of human rights. However, a number of issues affecting minority groups in Malawi remain unresolved (e.g. increasing reports of homophobia, legally restricted access to abortions, and the prevalence of child marriages).

LGBTI Rights

The ambiguous political and legal context leaves the public with conflicting views on the matter of LGBTI rights. One of the problems with the current debate in Malawi is that it has become politicized, and has come to signify north-south relations. For many Africans, the West is seen as imposing its ideals of human rights, while same sex acts are viewed as "un-African".

Malawi stopped arresting individuals engaged in same-sex relationships due to an ongoing case in the constitutional courts which questions the constitutionality of the law that criminalizes same sex practices. The current president, Peter Mutharika, has not taken an official stance on the issue of LGBTI rights. However, parliament recently approved a marriage bill that states that marriage can only take place between a man and a woman.

Moratorium on the arrest of LGBTI persons is in force but the general public is very homophobic with religious and traditional leaders in the fore front. Access to health for LGBTI persons is difficult because of attitudes, beliefs and perceptions of health service providers based on religion, law, politics and culture. With some health service providers citing the illegality of the practice as treating them might be contravening the law.

Despite all that homophobic acts and practices, Malawi has made strides in making sure that LGBTI people are protected and are able to access health care services but that is not communicated to the frontline health service providers. National frameworks such as the draft HIV and AIDS (Prevention and Management) Bill and the National HIV and AIDS Policy and the National Strategic Plan (NSP) for HIV and AIDS all recognise the role of protective laws and policies in national responses to HIV. The NAC and MHRC advocate for law reform and access to justice in the context of HIV and AIDS.

In Malawi, adult HIV prevalence remains high, with pronounced social and economic inequalities in accessing HIV prevention, testing and care services. According to the Malawi Population Based HIV Impact Assessment (MPHIA), the prevalence of HIV among persons aged between 15 and 64 years is 10.6%. The MPHIA estimates the prevalence rate among females at 12.8% and 8.2% amongst males. Prevalence is even higher among key populations, specifically female sex workers and gay men and men who have sex with men, due to various factors including their high risk of HIV exposure and low uptake of HIV testing. According to the National Strategic Plan female sex workers remain “the highest at risk” population, notwithstanding that they represent a small segment of the general population. The prevalence of HIV among female sex workers is estimated at 62.7 %. A number of influential studies reveal that HIV prevalence in men who have sex with men is higher than in the general population. A 2013-2014 study of selected districts across the three regions of Malawi estimated HIV prevalence among men who have sex with men ranging from a low of 5.4% to a high of 24.9%.⁸

These developments put the public at the forefront of the direction the country will take. Malawian courts, politicians and public will either move Malawi further down the path of intolerance, following Uganda and Nigeria, or towards tolerance of LGBTI persons, possibly decriminalizing same sex acts through the courts or through a gradual shift of political and elite opinion. These shifts – both towards LGBTI rights and other issues impacting marginalized groups – can improve Malawi’s overall human rights situation.

- Human Rights Watch. (January 2012). Country Summary: Malawi. Retrieved from <http://www.hrw.org/africa/malawi>.
- Temba, F. (2014, October 15). Reports show increasing homophobia in Malawi. The Nyasa Times. Retrieved from <http://www.nyasatimes.com/2014/10/15/report-shows-increasing-homophobia-in-malawi/>
- Chauwa, A. (2014, September 17). Women’s caucus back reform of abortion laws in Malawi. The Nyasa Times. Retrieved from <http://www.nyasatimes.com/2014/09/17/womens-caucus-back-reform-of-abortion-laws-in-malawi/>.
- Human Rights Watch. (March 2014). I’ve Never Experienced Happiness: Child Marriage in Malawi. Retrieved from <http://www.hrw.org/reports/2014/03/06/ive-never-experienced-happiness>

BENEFICIARIES AND IMPLEMENTERS

Curriculum Development Workshop

We brought together experts, practitioners and technicians from different fields to develop the curriculum and content for Umunthu health care workers workshops. The retreat brought together participants from the legal, medical, programming, facilitation, mental health, research, social science, theatre for development, psychology, academia and LGBTI population.

The 3 days workshop was aimed at developing content, practices and methodology of the Umunthu health care workers with input from all parties concerned for psycho- social development, legal support and overall wellbeing of LGBTI populations and other discriminated groups. At the end of three days, participants came up with the content, methodology and the draft curriculum.

Notable quotes from the curriculum development workshop were:

- “The all-inclusive curriculum development retreat, will give an opportunity for all perspectives to be represented and incorporated and so have a comprehensive curriculum which will, if well implemented surpass in achieving the given objectives. I applaud AGHCA for coming up with the initiative of inviting experts in different fields to come together and bang heads on the best way of putting the message across to health service providers to have key population access health services freely.” a participant, Dr Enock Changamire.
- “Many thanks for inviting me to the curriculum development retreat. The training was well-organised, and I am glad to report that it exceeded my expectations. It was highly enriching and engaging. Believe you me, the curriculum, once finalised, will be a watershed in reaching out to health-workers on sexual minorities and their access to health. Looking forward to more engagements and interactions”. Fletcher Simwaka – Center for Human Rights and Rehabilitation Programmes Manager.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Umunthu Workshops for Health Care Workers will train 1450 frontline health service providers in 8 districts in Malawi for a period starting February 2017 to January 2020

FINANCING AND SUSTAINABILITY

Umunthu workshops for Health Care Workers are managed by Umunthu Programs Officer under Art and Global Health Center Africa. The Umunthu Workshops for Health Care workers got the endorsement for Ministry of Health in Malawi and works hand in hand with Malawi College of Medicines, National AIDS Commission, District Executive Committees, District Health Management Teams and like-minded grassroots Civil Society Organisation implementing access to health programs in districts. The Program is currently being financed by US state Department DRL program up to 2020.

The printed resources (Umunthu DVDs and educational resources) will allow for continued viewership and discussions of LGBTI issues beyond the initial film screenings. Distribution of the materials within institutions of higher education will increase the likelihood that these resources will continue to be used as part of ongoing teaching and learning in these institutions. By having the DVD ready for dissemination, the opportunity for thoughtful conversations to develop will increase substantially.

Expanding our program activities into the public sector through Umunthu workshops will institutionalize improvement of access to and quality of services for LGBTI persons across various sectors. Incorporating Umunthu activities in the curricula and trainings carried out by colleges, ministries and other NGOs will have a ripple effect on the overall attitudes towards and treatment of LGBTI persons in Malawi.

At the organizational level, we will be implementing a strategic fundraising plan to ensure long-term funding for our programs. As part of this plan, we seek to diversify funding by expanding our reach to international, individual donors. Additionally, we will be working with a local organization to establish a robust evaluation plan, which will help guide further developments in our program to ensure we meet our goals.

DESCRIPTION

The Umunthu Program (UP) brings voice to marginalized communities by utilizing art as a catalyst for discussion, providing a platform to address contentious human rights issues, which have implications on health, through the lens of “Umunthu.” Umunthu is a Pan-African philosophical concept of humanity, often defined in the phrase, “I am because we are.” Umunthu respects and celebrates the interconnectedness and interdependence of humanity with emphasis on tolerance, togetherness, diversity, co-existence, and unity. The program uses this philosophy to instil a local approach to advocacy.

The goal of the Umunthu Program is to provide a platform for thoughtful public discourse on contentious human rights issues in Malawi through the lens of ‘Umunthu.’ Specifically, the program advocates for LGBTI rights by improving the attitudes and behaviours of public servants towards the LGBTI community.

The objectives of the Umunthu Health Worker project are as follows:

- Objective 1: Malawian Health Workers consider and better understand LGBTI persons through the local perspective of Umunthu. They appreciate and act on their responsibilities towards discriminated persons, particularly LGBTI persons.
- Objective 2: Members of civil society and community leaders engage with healthcare workers to discuss ways to tackle health access disparities of LGBTI and other key marginalized communities.
- Objective 3: The workshop activities will be integrated into civil society, educational institutions or government curricula and trainings.

Implementation and activities

This project delivers an interactive workshop program targeted at health service workers, who directly impact the quality of services and treatment provided to LGBTI persons. The Umunthu Program workshop is an intervention designed to apply Umunthu philosophy in order to address the underlying attitudes and behaviours in society that are disadvantageous to the psychosocial wellbeing, health, legal and economic development of LGBTI people. Umunthu respects and celebrates the interconnectedness and interdependence of humanity with emphasis on tolerance, togetherness, diversity, co-existence, and unity. The workshop program transforms Umunthu from a philosophy to a way of life by tackling real-life issues and situations through participatory, artistic methods.

The Umunthu Health Workers Project utilises an interactive, discursive methodology based on a Malawian philosophy to allow health workers and select members of local communities to gain a personal understanding of the situation of LGBTI and other discriminated persons, and their responsibilities towards them, then take action to improve health delivery for discriminated persons.

The workshops engage health workers and people training as health workers at training institutions, including the College of Medicine, in a series of interactive and creative activities over a period of three days. Using process theatre, film, story narration and role-playing, participants critically explore and reflect on their attitudes and roles in providing culturally competent care to marginalized people and encouraging an environment that enables LGBTI persons to access quality healthcare. In addition, three guest speakers – an LGBTI community representative, a medical professional and a legal professional – fill the gaps in knowledge and understanding of the particular needs and challenges of this population, and address questions and sources of anxiety that the health professionals have. By the end of the workshop, participants develop an action plan to challenge discrimination, particularly against LGBTI persons, in their work environment and individual practice. Part of the workshop also involves developing a visual sign or poster displaying participants' pledge on anti-discrimination to display at the host health centers.

A one-day follow-up will take place 3-6 months later to give participants an opportunity to reflect on how they have applied the learning from the initial workshop and implemented their action plan, brainstorm ways to overcome any challenges, and develop further steps to address challenges and expand their response.

RESULTS OF THE PROGRAMME

The Umunthu Workshops for Health Care workers has conducted three workshops so far and has trained 120 health care workers and community leaders. In addition, the project has engaged 60 district health management team members in 6 districts and managed to have the project endorsed in their districts, in addition the project has also engaged 256 district executive members and have had the project approved in 5 districts.

OUTCOMES AND IMPACT OF THE PROGRAMME

The LGBTI led organisations have registered a rise in LGBTI persons seeking and disclosing in confidence and getting health services without facing negative attitudes, ridicule, stigma or discrimination from the health service providers we have trained.

Out of the pilot workshops we have conducted, we have seen tremendous shift of attitude as some of the participants had this to say;

Highlights

- 100% turn out of participants from the onset to the end of the workshop, active participation and lively discussions that culminated to formulation of community action plans to be followed up through established structures in the health centers
- Positive comments from the participants about the facilitation and the artistic participatory activities, e.g. "this is the best workshop that I have been to, games and activities were great alongside the learning, keep it up" said one of the participants.
- The inclusion of the LGBTI speaker that saw the deconstruction of many of the social and religious constructs that informed attitudes of a good number of participants, and led them to discriminate against LGBTI people.
- The cooperation and assistance rendered by the District Health Management Team coordinator and the Civil Society Organisations Network secretariat
- The mood of the workshop room as one guest speaker, Dr Delroy White had this to say and I quote "I didn't believe the lively and warm mood in the workshop room when I walk in, I have spoken in other workshops of similar nature but this workshop is different, I think your approach is the best way of impacting on attitude, believe you me, those participants are no longer the same"

- On recapping of previous day's learning, one participant who was expressly very negative against inclusion of LGBTI persons had this to say and I quote "I have learnt that LGBTI people are born and that they are humans like anybody else, all along I believed they choose, and now I know that we shouldn't discriminate against them"

MONITORING AND EVALUATION/VALIDATION OF IMPACT

We have engaged an external Monitoring and evaluation consultant who is yet to come up with the initial report.

But for project delivery internal monitoring we administer pre-workshop surveys before the start of the workshop and post workshop surveys at the end of each workshop, the is tremendous shift of attitudes but we are yet to come up with analysed data reports.

LESSONS LEARNED AND RECOMMENDATIONS

One of the reasons why most Africans in general and Malawians in particular discriminate against minority groups and socially exclude others that are different is on the basis of religion and culture. Most religions, if not all, conforms perfectly to the teachings and principles of umunthu and so is culture, traditional norms, where most behavioral dynamics, in all their complexity and splendor, beliefs and practices are rooted. Traditional values, perspectives and beliefs mostly stems out of umunthu governing principles and way of life, it is this reason why umunthu becomes non-negotiable tool for tolerance.

Why a participatory approach?

A participatory approach encourages people to think for themselves. Participants actively contribute to teaching and learning, rather than passively receiving information from outside experts, who may not understand the local context of the subject. The approach encourages people to share information, learn from one other, and work together to explore issues and propose solutions.

Using participatory arts-based activities reaches hearts and minds in ways that reading a pamphlet or listening to a speech may not. What happens to the characters in a performance and the emotions one feels while engaged in role-play, for example, strike people in a unique way and will likely be remembered long after the activities end. The characters and the dramatic situations are discussed and remembered long after the workshop; it is not rare that a character becomes a prototype in the common conversation of the group.

CONCLUSIONS

African culture and philosophy is diverse, evolving and subject to interpretation. It is possible to use African belief systems- specifically those focusing on interdependence and tolerance- to invoke reflection and encourage greater tolerance of LGBTI people. Confrontational approaches can lead to a backlash which entrenches people more firmly in their beliefs. Creative participatory approaches that work with participants' familiar values and ideologies, and facilitate exploration of underlying basis of discrimination, could be an effective way of impacting on popular thinking and achieve positive shift of attitude towards LGBTI people.

ANNEXES/ADDITIONAL RESOURCES

- Select Pictures from the curriculum development workshop
- Experts, practitioners and technicians from different fields converged in Boadzulu resort, Mangochi, to develop the curriculum and content for Umunthu health care workers workshop. The retreat brought together participants from the Legal, medical, programming, facilitation, research, social science, psychology, academia and key population.
- Figure 1: group work, looking at some presentation techniques
- Figure 2: Medical group, Dr Changamire stressing a point
- Figure 3: The AGHCA Executive Director delivering opening remarks
- Figure 4: developing the methodology, brainstorming with experts
- Select pictures from the Umunthu health care workers pilot
- Figure 5 Pairs game, a participant illustrating how it feels to be different.
- Figure 6 participants gearing up to play balloon stomp game acknowledge how detrimental are bad intentions to not only the victim and the perpetrator and the society as a whole
- Figure 7 listening to storytelling, we can only become the best we can be if everyone become the best they can be!
- Figure 8 learning through visual, touch, movements, stories, creativity and sounds is what makes Umunthu workshop entertaining and effective!
- Figure 9 Participants really grasped the concept of umunthu, of non-discrimination, tolerance, co-existence and togetherness in accommodating LGBTI persons in health service provision as shown through the pavilions and subsequent presentations
- Figure 10 after all has been said and done, health care workers happily commit to provide health care services to all without discrimination!

Umunthu Health Care Workshop Draft Curriculum

Program objectives

The Umunthu Health Care Workers Workshops

Specific Program Objectives:

1. Malawian Health Workers (including Health Worker students) consider and better understand LGBTI persons through the local perspective of the Umunthu Program. They appreciate and act on their responsibilities towards discriminated persons, particularly LGBTI persons.
2. Members of civil society and community leaders engage with healthcare workers to discuss ways to tackle health access disparities in communities.
3. The workshop activities will be integrated into civil society, educational institutions or government curricula and trainings.

These workshops will be largely targeting objectives 1 and 3

Learning objectives/ outcomes

By the end of the sessions participants will:

- Have an understanding of the concept of Umunthu, and how it relates to stigma and discrimination in society and reflected on their personal experiences of discrimination, both as a victim and as a perpetrator

- Have explored ways that situations of stigma and discrimination can be changed/ reversed and linked more general understanding of stigma and discrimination to the experiences of LGBTI people.
- Have (Health care workers) explored ways of making health facilities accommodative and friendly to minority groups including LGBTI people.
- Have (Health care workers) engaged with community leaders to address health care provision disparities against minority groups including LGBTI people.
- Have increased knowledge and hands on experiences of LGBTI people from social, medical and legal perspectives.
- Have (Health care workers and community leaders) developed an action plan to tackle stigma and discrimination against minority groups including LGBTI people.

Day 1

Time	Activity	Lead Person	Objective	Remarks
8:00 to 8:30	Venue set up (stationary; pen, folder, note pad, papers and pre-survey placed on every desk) mild music playing in the background	Facilitator	To create an ambience of easiness and at the same time adeptness	Make sure that the seats are arranged in a C shaped layout around a reasonable space (avoid custom or classroom-like layout that could create we and the outlook.
8:30 to 8:45	Bingo game	Facilitator	Ice Breaker	To create a warm, friendly and open and atmosphere through interactions and laughter, also to assign ID number for pre and post surveys Participants have to move around and about asking others questions on their bingo cards, those who have all boxes ticked get ID numbers
8:45 to 9:00	Umunthu baseline survey	AGHCA team Survey questionnaire administration	To collect baseline data	Participants to use ID numbers

				given not their real names for confidentiality and openness
9:00 to 9:15	Introduction of AGHCA and programs, Welcoming of participants, setting of ground rules, communication of workshop objectives and any other issues that could be necessary in the context	AGHCA representative/Facilitator	Plenary talk and discussions to make participants take ownership of the workshop by being guided by their own rules.	AGHCA's mission, vision and programs presented and umunthu program and broad overview of health workers project introduced.
9:15 to 9:30	Songs and Dance	Facilitator	Warm up and pace setter	To break ice and set the open and participative mood
9:30 to 10:15	Find your partner	Facilitator	Introduction and umunthu activities entry point To introduce the other as oneself and explore the "who" and "what" we are question	Find Your Partner Famous People. Each member is given a slip of paper with a name on it. Each name has a corresponding name on another slip of paper.
10:15 to 10:30	Tea Break			
10:30 to 10:45	What does Umunthu mean to you?	Facilitator	Drawing of pictures that depict umunthu from a personal perspective to assess the participants own understanding of Umunthu and also to act as a baseline on the level of understanding of Umunthu philosophy	Distribute sheet of paper, let participant draw whatever represent Umunthu to them.

10:45 to 11:45	Interpreting the pictures	Group activity led by facilitator	Plenary discussion to critically explore the levels of knowledge and understanding of umunthu concept from personal and group understanding	Participants swap the pictures and try to figure out what it means to them as far as umunthu is concerned
11:45 to 12:00	Umunthu Talk	facilitator	Participatory presentation	To fill the information gap and expound on umunthu philosophy and concept for in-depth understanding
12:00 to 13:00	Lunch			
13:00 to 13:20	Songs and dance	facilitator	Energizer and mood realignment to reset the mood after the long lunch break	Could start with an energy activity to a mind game
13:20 to 13:50	Balloon stomp game	facilitator	Mind Game to explore how we spend our energies and intentions and also how we also respond to such	Participants dangle a balloon a foot away from their foot, they stomp on the other's balloon while they protect their own, those whose balloon is stomped on are eliminated
13:50 to 14:10	The balloon stomp talk and reflection	facilitator	Discussion to reflect on the balloon stomp as it relates to real life	Lead discussions wrapped by the rat trap story
14:10 to 14:30	Group Game, silent lines	facilitator	To allocate participants in different focus groups creatively.	Participants to line up according to their month of birth without conferring
14:30 to 15:00	Group discussions	facilitator	To share real life experiences where they witnessed,	Participants to appreciate the extensiveness

			perpetrated or victimized by discrimination	of discrimination
15:00 to 15:15	Tea Break			
15:15 to 15:40	Role play	groups	To explore the depth of discrimination from the perpetrators, the witness's and victim's perspective	Participants to choose one touching story from the group sharing and role play it.
15:40 to 16:00	Group discussions	facilitator	Coming up with other areas of discrimination to expand the list of discriminated areas or groups in the society	
16:00 to 16:15	First day closing activity and logistics	facilitator		

Day 2

8:30 to 9:00	Songs and dance and previous day's recap	facilitator	Energizer and reminder to lead participants into the workshop end point of the previous day	After energizer, participants to ball game for recapping
9:00 to 10:00	SOGI Talk	facilitator	Plenary presentation to fill the information gap about sexual orientation and gender identity and sexuality	Build up on discussion about areas of discrimination to sexual orientation
10:00 to 10:15	Tea Break			
10:15 to 10:45	Pandora Box	facilitator	Anonymous view expression to let participants write the underlying beliefs, perceptions and attitudes discourages them from treating LGBTI people	Papers are distributed and participants write anything they feel is a reason why they could treat or not treat an LGBTI person
10:45 to 11:30	Plenary discussions of pandoras and grouping	facilitator	Sharing the pandoras and reading them to the group to share the	Pandoras are shared among the participants

	into thematic areas		underlying reasons without revealing the identity of the writer	and each read and group them into thematic areas
11:30 to 12:00	Energizer and Birthing game and life interrelatedness story sharing	facilitator	Game and empathy provoking activity	To give participants a balancing perspective
12:00 to 13:00	Lunch			
13:00 to 13:30	Energizer and storytelling	facilitator		
13:30 to 14:00	Legal Presentation	Legal Guest Speaker	Presentation	
14:00 to 14:30	Legal presentation Q&A	Legal Guest Speaker	Plenary questions and answers to allow participants to ask questions and get clarity on issues they need deeper understanding	
14:30 to 15:00	Medical Presentation			
15:00 to 15:15	Tea Break			
15:15 to 15:30	Medical Presentation Q&A			
15:30 to 15:40	Please stand up if - activity	facilitator	Intro activity	To set up ground for LGBTI speaker
15:40 to 16:10	LGBTI presentation, Q&As	LGBTI guest speaker		
16:10	Closing activity			

Day 3

8:30 to 9:30	Community Leaders briefing	facilitator	Energizer and activities sampling to let community leaders have an idea of what transpired in the previous two days of workshop with HCW	
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9:30 to 9:50	Songs and dance and recapping	facilitator	Community leaders and HCW come together to blend the two groups together	
9:50 to 10:00	Introductions			
10:00 to 10:15	Tea break			
10:15 to 10:20	The numbers game	facilitator	Energizer and The grouping activity	To group participants into 3 groups with at least a good representatio n of different participants
10:20 to 10:50	Pavilions creations	facilitator	Creative expression of the umunthu/health provision learning to make participants express themselves creatively what an umunthu health facility could be like	An outside activity. Participants to collect anything they could find and together in a group build something that could represent or depict an umunthu health facility.
10:50 to 11:30	Pavilions tour	facilitator	Participants visit pavilion by pavilion and listen to presentations from group leaders to hear expressions and ask questions about umunthu health facility	
11:30 to 12:00	Community action plans	facilitator	What could be our role to achieve the umunthu health facility that we have talked about to make actionable commitments towards achieving the umunthu health facility	

Closing game	<p>Imaginary gifts.</p> <p>Everyone stands in a circle, each person goes to another participant and mimes a 'gift' for them, and states something they appreciated in their contribution to the workshop</p>			
Closing remarks				

5.4 MALAWI: Promoting Social Inclusion and Access to Health Care Services for LGBTIQA's

TITLE OF THE PROGRAMME: Promoting Social Inclusion and Access to Health Care Services for LGBTIQA's

CONTACT PERSON

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Title: Miss

Organization: The Centre for Human Rights Education, Advice and Assistance

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- **Start Date of the Programme:** July 02, 2017
- **End Date of the Programme:** July 02, 2018
- **Responsible Parties:** Civil society
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Gay men and other men who have sex with men, Sex workers, Transgender people
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Malawi is a deeply religious and culturally motivated country thus people tend to be resistant to anybody who is deemed to be going against those values. Members of the LGBTI community have found themselves at odds with their local communities, facing abuse, violence and discrimination. Further, the courts in Malawi have been reluctant to commit to creating precedents that will result in removal of laws that police sexual expression. The discrimination that LGBTI's face is often very apparent in the health sector as health workers will call the police or refuse to treat LGBTI persons. The majority of LGBTI's prefer to remain anonymous, those who are brave enough to come out in the open are ostracised, leaving them isolated. These issues are exacerbated by the fact that most LGBTI activists lack basic training in human rights law, advocacy, and documentation thus they are ill equipped to assist fellow LGBTI's.

BENEFICIARIES AND IMPLEMENTERS

Intended beneficiaries are people from the LGBTI community and because the project focuses on healthcare workers, it will also benefit sex workers as they have similar issues of access to treatment.

When CHREAA was planning this project, we had meeting with members of the LGBTI community and sex workers to determine what issues they were facing in the healthcare setting. In the implementation of the project, we invited members of the LGBTI community to give us their priority areas and members of the LGBTI community lead every meeting and advocacy efforts under the project.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The project is being implemented in Malawi, in the Southern Region of Blantyre. We are targeting four areas within the district that have high reports of abuse against LGBTBI's namely, Bangwe, Chilomoni, Ndirande and Machinjiri. 500 traditional chiefs, religious leaders and members of local communities trained. 60 health service providers, trainee doctors and nurses trained. 60 police officers and judiciary members trained. The LGBTBI community in Blantyre to become empowered and incapacitated to fight for their rights.

FINANCING AND SUSTAINABILITY

1. The programme is managed by a Project Coordinator who is assisted by two paralegals and members of the LGBTBI community.
2. CHREAA addressed the financial sustainability aspect by applying for an extension of the grant with the donor
3. The programme is training members of the judiciary, religious leaders, cultural leaders, The project is funded by the other foundation.

CHREAA came up with the following tools and systems to ensure that activities are implemented in accordance with time-frames, and achieve results in line the campaign goals.

- Work plan: This details a specific period through which each activity will be undertaken and concluded. The tool includes specific officers assigned to undertake each of the specific activity. This assists CHREAA to timely and effectively track the implementation of activities.
- Activity debriefs and progress discussant meetings: Upon implementation of each activity and at intervals, the project team holds debriefing meetings to discuss outcomes of the activity to see if the activities have achieved the intended results. This helps proper adjustments of the activities where and when need be.
- Physical project site monitoring and constant feedback hearing from beneficiaries: Throughout the project period CHREAA will conduct regular project site monitoring i.e. Community sensitisation meetings. This will assist in verifying and ensuring that, officers indeed get on ground campaign delivering only planned messages as outlined by the concept. CHREAA will as well encourage and enhance feedbacks from beneficiaries. This will again help adoption of lessons learnt underway into the campaign or preserve them for incorporation to other future similar campaigns.
- End of project external evaluation: To examine whether the project will indeed have achieved its goals at the end, CHREAA shall hire an independent external consultant who will evaluate the project and come up with an independent opinion and recommendation on its results on whether the project has achieved its goals or not.

DESCRIPTION

The project aims to create an inclusive environment where members of the LGBTBI community are free to express themselves including accessing healthcare without fearing arrest or discrimination.

CHREAA will hold several meetings and human rights trainings that will target traditional chiefs, religious leaders, health service providers, trainee doctors and nurses, the police, the judiciary and members of the LGBTBI community.

CHREAA will create a three-part documentary that will document the human rights violations face by the LGBTBI community, CHREAA will use the media both TV and print to disseminate information and raise awareness of LGBTBI rights.

CHREAA will engage leaders and activists within the LGBTI community and will assist them to form diverse support groups; the support group will be accessible anonymously on an online platform and group meetings for areas with no WIFI.

The outcomes will be increased awareness of human rights challenges and LGBTI issues by local communities at grassroots levels. Increased knowledge and awareness by health service providers of the LGBTI issues resulting in less discrimination towards LGBTI's. Increased support of LGBTI rights from the judiciary coinciding with a decrease in arrests of LGBTI persons.

RESULTS OF THE PROGRAMME

The project so far has reached 30 healthcare workers, 30 members of the judiciary and 170 community members. The project covers Blantyre city which is in the southern part of Malawi.

OUTCOMES AND IMPACT OF THE PROGRAMME

The programme has been successful in creating a safe environment for LGTBIs to interact with each other. The programme has improved the attitudes of healthcare workers towards LGBTIs as they have a better understanding of LGBTIs issues. The judiciary are also more open minded, and they have stated that they have gained sufficient knowledge to be ably assist LGBTIs who appear before the courts.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

As I previously mentioned CHREAA, hold activity debriefs and progress discussant meetings after each activity. This is in addition to physical project site monitoring and constant feedback from beneficiaries. Through these mechanisms, CHREAA is able to monitor the impact of the project, these debriefing also include feedback from the beneficiaries and the people receiving the training.

LESSONS LEARNED AND RECOMMENDATIONS

The factors that contributed to the success of the project thus far is the involvement of the LGBTI community. Currently, we are also receiving technological support from M-Hub which hosts an online platform that facilitates the reporting of human rights violations by LGBTIs and other key populations. The biggest challenge is working with community, religious and traditional leaders due to the fact that they are very opposed to having conversations around LGBTI especially with the LGBTI community. CHREAA has addressed this by combining the community sensitisation with the healthcare and judiciary meetings so that there is diversity in our discussions.

CONCLUSIONS

The project is not yet midway but has made a huge impact. CHREAA has seen a large influx of complaints from the LGBTI community who are becoming more confident to report abuses against them. Through this, project members the LGBTI community have approached CHREAA requesting that we partner with them on future projects.

6 SENEGAL: HIV Prevention 2.0 (HP2): Achieving an AIDS-Free Generation in Senegal

TITLE OF THE PROGRAMME: HIV Prevention 2.0 (HP2): Achieving an AIDS-Free Generation in Senegal

CONTACT PERSON

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- **Responsible Parties**: Government
- **Populations Group(s) Reached**: People Living with HIV, key population

BACKGROUND INFORMATION

Potential Causal Pathway for Stigma and HIV-Risks

Structural Equation Model:

- Indirect effect of stigma in health system on sexual risk practices
- 527 MSM from Lesotho *p=0.072; **p<0.01
- Stigma as upstream determinant of HIV risk
- Opportunity - Target stigma to improve HIV risk

A systematic review of interventions to reduce HIV-related stigma and discrimination

Results:

Domains and levels targeted and approaches employed in the 48 studies

- Multiple intervention strategies
- Target multiple stigma domains
- Target multiple socioecological levels

BENEFICIARIES AND IMPLEMENTERS

- Study population: female sex workers, men who have sex with men

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Senegal – Dakar, Mbour, Theis

DESCRIPTION

Objective

Develop and Evaluate Integrated Stigma Mitigation Interventions

- Specific Aim 1: Systematically review the literature for existing stigma metrics that have been used for MSM and FSW.
- Specific Aim 2: Use mixed methods approaches to characterize unbiased estimates of the current coverage of HIV prevention and treatment services as well as barriers and facilitators to the uptake of these services among MSM and FSW in Dakar, Mbour, and Thies, Senegal.
- Specific Aim 3: Use a prospective cohort of MSM and FSW in Senegal followed for 24 months to evaluate non-randomized Integrated Stigma Mitigation Interventions (ISMI) including peer, clinic, and web-based components.

Study design

- Longitudinal cohort

Pre-Clinical/Community Intervention

Aim: Reduction of perceived and anticipated stigma

- Training MSM / FSW peer educators to provide community interventions that strengthen social cohesion and individual resilience.
- Peer educators paired with 2 groups of 10 participants each
- Modules delivered on a quarterly basis
- Curriculum development based on existing trainings, international guidelines, and best practices
- Adapted to local context through collaboration with ENDA and other local partners

Modules

1. HIV prevention and transmission
2. Reproductive health
3. Human rights
4. Stigma and discrimination
5. Living with HIV

Clinical Intervention

Aim: Reduction of experiences of stigma at the health clinical level.

- Training of health clinic personnel
- Creation of a network of trained and sensitized clinical providers within a community
- Curriculum based on “Promoting the Health of Men who have sex with Men worldwide : A training curriculum for providers” (MSMGF/JHU) and “Understanding and challenging stigma ” toolkits (ICRW)

Modules:

1. Key Populations
2. Stigma and discrimination
3. Barriers to health and HIV
4. Health and sexuality / Human Rights
5. Mental health / Use of drugs and alcohol
6. Creating a friendlier environment
7. Action planning

Web Intervention

Aim: Reduction of individual stigma

- Peer-to-peer referral system
- Creating an anonymous reference system for health services and prevention information between peers
- Facebook Platform

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- Abbreviated questionnaires (months 3,9,15, 21)
- Full assessment (Baseline, 6, 12, 18, 24)

LESSONS LEARNED AND RECOMMENDATIONS

- Female Sex Workers
 - Reduction was observed in anticipated, perceived, and enacted health care stigma
 - Engagement in ART was above 90% at baseline for female sex workers, and maintained over 15 months
 - Viral suppression among female sex workers was high at baseline, with no significant change in the first 6 months
- Men who have sex with Men
 - Results showed increase resiliency in men who have with men with reductions in anticipated stigma despite increase in enacted health care stigma
 - Significant increase in engagement in ART and viral suppression among men who have sex with men

CONCLUSIONS

- There is a disconnect between the potential and actual measured impact of current interventions to address enacted stigmas in health care settings
- Baseline and follow up data suggested the potential utility of the multicomponent integrated stigma mitigation intervention
- Results reinforce the need for stigma mitigation interventions to be combined with HIV prevention and treatment interventions for key populations

7.1 UGANDA: Link Up: Better sexual and reproductive health and rights for young people living with and most affected by HIV

TITLE OF THE PROGRAMME: Link Up: Better sexual and reproductive health and rights for young people living with and most affected by HIV

CONTACT PERSON

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- **Start Date of the Programme:** January 01, 2013
- **End Date of the Programme:** June 30, 2016
- **Responsible Parties:** Civil Society, Government
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Gay men and other men who have sex with men, Sex workers, Transgender people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

The HIV epidemic in Uganda is generalized, and national prevalence is estimated at 7.3% (UNAIDS. 2014. "The gap report." Geneva, Switzerland: Joint United Nations Programme on HIV/AIDS). HIV disproportionately affects adolescent and young people: of the 1.5 million PLHIV in Uganda, 170,000 are between the ages of 15-24 (Uganda Bureau of Statistics and ICF International. 2012. "Uganda Demographic and Health Survey 2011." Kampala, Uganda and Calverton, Maryland: Uganda Bureau of Statistics and ICF International.)

The Link Up project (2013-2016) aimed to advance the sexual and reproductive health and rights (SRHR) of young people most affected by HIV in five countries including Uganda. As well as material and legal barriers, a Link Up consultation with young people identified social factors stopping young people from accessing and using SRHR services across these five countries. These included negative attitudes and taboos around sexuality (particularly for young people living with HIV); a lack of knowledge on sexual and reproductive health including the range of contraceptives available and the use of them; and gender inequality, which can make young women unable to negotiate condom use or to access contraception. Young people living with HIV face additional barriers to achieving their SRHR, including stigma and discrimination at the community and health service level.

Additionally, a 2014 Link Up baseline survey conducted by the Population Council in Luweero and Nakasongola (https://www.popcouncil.org/uploads/pdfs/2015HIV_UgandaPLHIVBrief.pdf) showed that young people living with HIV had a low enrolment rate onto antiretroviral care, and lacked integrated SRHR information and services, both issues being partly caused by their experience of stigma and discrimination.

The survey showed that 29.8% of 473 young people living with HIV had been diagnosed with HIV in the past 12 months. However, almost a third of them had not enrolled on antiretroviral therapy because they were afraid and did not have support to take the next steps after receiving their HIV results. Additionally, data from different health facilities in two districts suggests children born with HIV receive healthcare until they are adolescents, after which they stop visiting health facilities. As they grow older, they stop following

instructions from their parents about accessing care and instead focus on their relationships with peers. The reality of HIV-related stigma subsequently causes them to drop out of care. The baseline survey of young people living with HIV further demonstrates low knowledge of HIV prevention. Of those surveyed, 31.1% believed mosquitoes could transmit HIV and 45% said they had not used condoms with an HIV-negative partner. A significant percentage did not know how to use male condoms and had never seen or used female condoms. Around a third (33%) of women in Uganda of reproductive age have unmet family planning needs, yet few public facilities provide youth friendly and integrated SRHR and HIV services.

Experiences of internal and external stigma are a reality amongst young people living with HIV. Half (50%) of those questioned in the baseline study said people's attitudes towards HIV made them feel worse, and 37.2% described themselves as not feeling as good as others due to their HIV status. More than a third (34.5%) had experienced verbal violence as a result of their HIV status. There is a double stigma for young people living with HIV who sell sex, or for HIV positive MSM. The anti-homosexuality bill has forced many MSM into hiding for fear of being judged by health workers or even imprisoned. A consultation (see section below) with young people living with and affected by HIV confirmed that stigma and discrimination, including from service providers, hindered young people's access to SRHR services. Key issues and priorities identified in the consultation included: "Fear of stigma and discrimination"; "Sex work is highly stigmatised and a criminal offence"; "Young persons suspected of doing sex work or belonging to LGBTI communities can be detained and imprisoned without charge, and forced to pay bribes for their release"; "Lack of acceptance of sexuality by friends, family and community"; "Lack of confidentiality (perceived or actual) within health services, especially for young women"; "Discrimination against lesbians, sex workers and single mothers, who are expected to present with a male partner to access some services"; "Judgemental attitudes of service providers towards sex workers."

BENEFICIARIES AND IMPLEMENTERS

In Uganda, Link Up supported young people aged 10 to 24, including young people living with HIV, young people who sell sex, young MSM, and young people who are particularly vulnerable to HIV, including truck drivers, boda boda (motorbike taxi) drivers and fisher folk. Link Up put young people at the heart of programme design and implementation. A consultation was held in 2013 in Uganda with young people living with and affected by HIV, to find out their views and experiences of accessing HIV and sexual and reproductive health (SRH) services. Focus group discussions and community dialogues took place in and around Kampala with the help of the Girls Awake Foundation, the International Community of Women Living with HIV and AIDS Eastern Africa (ICWEA), Uganda Health Science and Press Association, Uganda Harm Reduction Network (UHRN) and the Uganda Network of Young People Living with HIV. Key issues and priorities that were identified by young people in Uganda highlighted the need for integration of HIV and SRH services for young people living with HIV, young sex workers, young people who use drugs, and young people from LGBTI communities. Participants of community dialogues in Uganda were young women living with HIV who are mothers (65); young people who use drugs (15); young people who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) (21); young people who engage in sex work (22); young people living with HIV (40 participants); and young people who chose not to identify with any one group (25). For more information on this consultative process, read the brief: *Voices, visions and priorities: Key issues of young people living with*

and affected by HIV in Uganda (http://www.aidsalliance.org/assets/000/001/076/Link-Up-voicesvisions_uganda_original.pdf?1416928837). Peer educators were also at the heart of all the programme's interventions. Over the course of the programme, 649 young people living with HIV were trained as peer educators on a range of SRHR and HIV issues and then play a critical role in empowering their peers, reaching out to other young people with information, counselling and commodities and linking them to necessary services. The project's implementing partners identified peer educators through health facilities and support groups.

In Uganda, Link Up was implemented by a consortium of partners including Community Health Alliance Uganda (CHAU), Marie Stopes International Uganda (MSIU), Uganda Youth Coalition on Adolescent Sexual Reproductive Health and Rights and HIV/AIDS (CYRSA-Uganda), the International Community of Women Living with HIV in Eastern Africa (ICWEA), the Ugandan Network of Young People Living with HIV (UNYPA) and the Population Council. CHAU delivered its community and facility-based activities through the following implementing partners: Integrated Community Based Initiatives (ICOBIs), Mildmay, Family Life Education Program (FLEP), Uganda Youth Development Link (UYDEL), Naguru Teenage Health and Information Centre, and the Most At Risk Populations Initiative (MARPI).

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Link Up worked in 11 Ugandan districts: Kampala, Wakiso, Luwero, Nakasongola, Mukono, Kayunga, Mayuge, Iganga, Kamuli, Bugiri and Namutumba. It focused on young people most affected by HIV aged 10 to 24, with a focus on young people living with HIV, young people who sell sex, young men who have sex with men, the fishing community and young truck and boda boda [motorbike taxi] drivers who are usually young men.

Through Link Up in Uganda, 296,047 young people were reached in a community or home-based setting (target was 275,000) and 98,099 were reached in a facility setting (target was 30,000)

FINANCING AND SUSTAINABILITY

Link Up was a multi country programme implemented between 2013 and 2016 by a consortium led by the International HIV/AIDS Alliance. It was funded by the Ministry of Foreign Affairs of the Government of the Netherlands.

The International HIV/AIDS Alliance (the Alliance) is ensuring sustainability of the programme through its continuing investment in Link Up's implementing partners and their adolescent SRHR programming and advocacy activities. With its READY Teens programme (<https://www.aidsalliance.org/our-priorities/current-projects/886-ready-teens>), the Alliance is committing some of its strategic funding to supporting adolescents aged 10-19 in Uganda, Ethiopia and Burundi to realise their SRHR, building on Link Up's legacy. READY Teens' total budget for 2017 was \$450,000, of which \$113,000 was onward granted to implementing partners in Uganda.

DESCRIPTION

In many countries including Uganda and other Link Up countries, attitudes and norms around 'appropriate' behaviour marginalise young people most affected by HIV, preventing them from accessing sexual and reproductive health services and information and realising their right to sexual health.

The goal of the Link Up programme was: To contribute to reduced unintended pregnancies, HIV transmission and HIV-related maternal mortality amongst young people affected by HIV

(aged 10-24). The purpose was: To increase health seeking behaviours and uptake of quality integrated maternal health, family planning and HIV information, services and commodities amongst young people affected by HIV and uphold their sexual and reproductive rights in generalised epidemics in five countries including Uganda.

Link Up put young people at the heart of programme design and delivery, enabling them to make healthier choices regarding their sexuality, and abler to advocate for their sexual and reproductive health and rights.

The following activities were implemented by Link Up Uganda to increase young people's knowledge of SRHR and HIV and their access and uptake of these services and reduce stigma and discrimination in the community and among healthcare workers.

Training peer educators: At the heart of Link Up's interventions were peer educators: young people living with HIV who were trained on a range of SRHR and HIV issues. 649 young people living with HIV were trained as peer educators by Link Up in Uganda. Each attended a three-day training course where issues to do with growing up, body changes, relationships, sex, sexuality, pregnancy, STIs, HIV and sexual and gender based violence were explored. Peer educators also learned strategies on how to talk to their peers about SRHR issues and what to do if they could not answer a question. Building a strong team of peer educators who were visible and proud of their work was the foundation for community mobilisation and service provision in the project.

Supporting peer outreach: Peer educators played an important role in reaching out to other young people with information, counselling and commodities (e.g. male and female condoms, information materials), referring peers for services, and conducting follow-up visits.

Supporting Y+ clubs and support groups: Support groups, sometimes referred to as 'Y+ clubs' provide an important space for people living with HIV to meet, discuss their challenges, and give each other practical guidance and emotional support. Yet support groups emerge and often fade away. In Link Up, support groups of young people living with HIV were assisted to organise themselves and to create a space where they were comfortable learning and sharing together.

Training health providers: People living with HIV in Uganda report experiencing discrimination at health facilities (PLHIV Stigma Index Uganda 2013). Healthcare providers are part of their communities and are influenced by cultural and social norms, which include the expectation that young people will not be having sex before and outside of marriage; the same service providers – like other community members -- sometimes view living with HIV as a result of misbehaviour. Interrogating these cultural and social norms and inspiring change is a long-term process. For this reason, training health providers on the specific needs and experiences of young people living with HIV – including why they may or may not be currently accessing services, what kinds of services to offer and, most importantly, how best to offer these services – was essential to the project's success. A key part of this trainings focused on how to communicate effectively with young people living with HIV, including the importance of listening, giving non-judgemental responses, recognising their sexual and reproductive rights, helping them think through their own solutions and inviting them back for additional services should they want them. To challenge the deeply ingrained attitudes of some health providers, young people living with HIV were invited along to provider training sessions to either co-facilitate or share their experiences. Listening to these young people share their experiences in this setting gave participants the space and time to listen.

In their day-to-day work, health providers are often under pressure to see the next client and do not have the time to listen to a client's views. A number of resources were developed by Link Up to facilitate workshops and trainings, including a Workshop Guide on Safeguarding the Rights of Children and Young People and a SRHR 101 Workshop Guide

Community dialogues: Community dialogues with gatekeepers such as police workers and brothel owners proved helpful in making these stakeholders more knowledgeable about key populations and HIV. Some police workers are beginning to improve how they handle issues of gender-based violence against sex workers as a result.

Promoting youth friendly spaces in health facilities: This was found to be an effective strategy for challenging young people's perceptions of facilities and encouraging them to attend. Some youth-friendly spaces constituted simply a corner or a table, dedicated to displaying SRHR information, others included free condoms, indoor games and television. Youth-friendly corners were staffed at specific times by a peer educator who is able to help young people feel comfortable at the health facility, as well as letting them know where to go and what to do.

Linking young people with health facilities: Peer educators deployed three main strategies to encourage the young people they met in the community to visit a health facility:

- Referral slips: These clearly displayed the Link Up logo. When a young person visited a health facility using a slip, it ensured they were given the time and services suitable to their needs.
- Vouchers: Peer educators could also refer young people to private BlueStar health facilities, which are part of a social franchise supported by Marie Stopes Uganda and thereby operate to specific standards. Under Link Up, peer educators could provide young people with a voucher that enabled them to access HIV, STI and family planning services for free from these clinics. BlueStar clinics were aware of Link Up and were trained to provide tailored, appropriate and friendly services to young people referred through the project.
- Accompaniment: As some young people are afraid of going to health facilities, peer educators were given a budget to accompany them.

Taking services to young people through clinical outreach: In order to reach young people who did not want to go to health facilities, implementing partners took SRHR and HIV services to places where young people living with HIV already meet. An example is the tuk-tuk service, which was operated by a nurse and two peer counsellors who used the tuk-tuk to provide clinical services at selected spots. The tuk-tuks carried a range of commodities such as short and long-term contraceptives, HIV test kits and STI medication as well as a tent to create space for young people to seek services confidentially.

RESULTS OF THE PROGRAMME

In Uganda, Link Up 296,047 reached young people in a community or home-based setting and 98,099 in facility setting, across 11 districts (Kampala, Wakiso, Luwero, Nakasongola, Mukono, Kayunga, Mayuge, Iganga, Kamuli, Bugiri and Namutumba). Young people were reached with an integrated package of HIV and SRHR services. The most 'popular' integrated service packages accessed by young people in Uganda were:

- Safer sex /basic HIV and SRH counselling with family planning (134,558 young people reached)
- Voluntary counselling and testing with family planning (102,909 young people reached), and
- Safer sex /basic HIV and SRH counselling with gender and sexuality counselling (83,744 young people reached)

OUTCOMES AND IMPACT OF THE PROGRAMME

The end line study showed:

- Significant improvements in comprehensive knowledge of HIV, self-efficacy, HIV disclosure, and condom use at last sex amongst young people
- Significant increases in the uptake of clinical HIV, STI, and FP services, including utilization of STI testing and screening, ART uptake, ART adherence, routine CD4 count testing, and use of modern contraceptives amongst young people
- Involvement of peer educators in running Y+ clubs and in ensuring linkages between young clients in the community and facility contributed to retention of young people in care

The project trained 548 health care workers in Uganda, three (3) times the target number, for the provision of quality integrated HIV and SRHR services for young people. The Link Up providers' trainings were a key intervention, which contributed to improving clients' experiences in the healthcare setting and to increasing their knowledge, uptake of services and retention in care. Further, 3,060 young people were supported to participate in youth-friendly programming and planning, which included facilitating or contributing to provider training sessions.

Ministry of Health trainers who supported and/or co-facilitated the Link Up trainings fed back that the materials and methodologies used in the trainings were engaging and challenged healthcare providers at an individual level.

Providers who took part in the trainings reported greater integration of services, and the establishment of youth corners in their facilities. One partner reported that at the start of the project only 3 out of the 23 health facilities they worked with had youth friendly corner. By the end of the project 19 of the 23 facilities had established a youth corner; those that had not were not able to due to lack of space.

In addition, the over three quarters (76.9%) of surveyed participants reported having received friendly and non-judgemental treatment from service providers, including young people from key affected populations. 63% of young women selling sex, 75% of young people living with HIV, and 64% of boda-boda drivers said they were handled in a friendly manner by service providers when seeking treatment for STIs,

Other practices instigated by facilities included the use of Youth Charters, to guide behaviour towards young people, and the separation of clinic hours so that young people could be received at different times from older adults, to create a youth-friendly environment. Providers reported positive changes in attitude towards young people from facility staff, and greater uptake of SRHR services among young people.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

As the research partner for Link Up, the Population Council conducted activities to understand the needs of young people living with HIV (baseline: https://www.popcouncil.org/uploads/pdfs/2015HIV_UgandaPLHIVBrief.pdf) and demonstrate the impact of programmes designed to meet those needs (endline: https://www.popcouncil.org/uploads/pdfs/2016HIV_LinkUp_UgandaEndlineBrief.pdf)

Both the baseline and end line surveys were implemented by the Population Council, in collaboration with project implementers, including Community Health Alliance Uganda, Marie Stopes International Uganda and the Ugandan Network of Young People Living with HIV (UNYPA). While the project was implemented in 11 sites, it was evaluated in two sites (Luwero and Nakasongola). Project partners worked together to design and implement the interventions. As a youth-led network, UNYPA played a critical role in recruiting young people to the Y+ clubs, training them as peer educators, co-facilitating the healthcare provider trainings, monitoring activities on the ground (through the use of SyREX, a management information system) and providing guidance to the Population Council in their research activities.

LESSONS LEARNED AND RECOMMENDATIONS

Successful approaches: Role of young people in service provision: The role of young people living with HIV in service provision enhances the quality of programming. They speak the same language as their peers, and other young people do not feel intimidated to ask them questions. They also work closely with healthcare workers and generate ideas for healthcare providers about how to make services more attractive and accessible to their peers.

Partnership with youth organisations and networks: Meaningful collaboration with youth organisations and networks is key to the success of interventions aimed at young people. Youth organisations and networks play a critical role in promoting health to young people. They know their members, how to reach them, what they need and how to engage them in an effective way. Part of 'meaningful collaboration' means ensuring young people have a budget to lead interventions (e.g. development of IEC materials, exit client surveys, 1-2-1 counselling), trusting young people to be successful in implementing initiatives, inviting them to collaborate on all health-facility related activities (e.g. health provider trainings, health days) and providing support when needed.

Positive and innovative messaging: A health promotion campaign called 'Stay on top of your game, be safe' sought to reach young people with messages about growing up, relationships, safer sex, the use of modern contraceptives, stigma, discrimination, living with HIV, sexual violence and the prevention of HIV and other STIs. Information leaflets and a radio song were produced to support the campaign. The campaign was bright, colourful and positive in design. It was developed in collaboration with young people who gave their perspectives on different messages and images. The campaign's materials were really useful as they gave peer educators information to refer to if they were unsure of something. These materials also included information about where to access services and what to expect of services, which is important when trying to link young people and to encourage them to access services.

Interactive health worker trainings: The health worker trainings focused on 'how' to deliver a service, rather than on the 'what'. The Link Up trainings involved a range of interactive exercises, which provoked personal and group reflection on sensitive topics, such as gender roles, sexuality, safe abortion and post-abortion care, violence. The exercises involved a range of methodologies – case studies, role play, agree/disagree, story-telling, drawings – in order to maintain the attention and interest of healthcare providers.

Working in close partnership with Ministry of Health: The Ministry of Health has existing training materials for healthcare workers on the provision of adolescent-friendly health services. Partnership with the Ministry of Health, in some cases as observers and in other cases as co-facilitators, was key in order to effectively combine existing Ministry of Health material with Link Up training tools.

Lessons learned and constraints: Collaboration between young people and health providers: Changing attitudes takes time. As such, ongoing mentoring from implementing partners is critical in reminding providers about the needs and rights of young people living with HIV. Joint activities between young people living with HIV and health providers is one way to break down barriers and encourage communication. For example, a sports event was organised by a youth organisation and health facility around World AIDS Day.

Investment in young people to monitor quality of services and retain young people in care: The value of young people living with HIV accompanying their peers for services, monitoring the quality of services (through client exit surveys and mystery client surveys) and in co-facilitating health provider trainings cannot be underestimated. This requires a budget to cover peer educators' time and costs. Without these services, young people may want to visit a health facility but fear of the unknown, or fear from what others have told them about health facilities, may prevent them from doing so.

Health providers: Ongoing exploration and learning: The healthcare provider trainings took place over 5 days, with annual refresher trainings. Participants often felt the five days were just right. However, the training raised many questions at an individual and group level that required ongoing thought and exploration. As such, the mentoring of health providers through monthly visits was critical, so they had someone to discuss any issues with – issues from the trainings or new issues that had arisen since the trainings. Short and open mentoring sessions by programme implementing partners in-between the trainings were critical in ensuring health providers felt comfortable to provide services in new ways.

CONCLUSIONS

The Link Up programme in Uganda was successful in reaching young people who would not otherwise be reached by services, for fear of stigma and discrimination they might experience in health facilities. Young people living with and most affected by HIV have shared different stories of how they have been treated in health facilities and how this has prevented them from coming back to access services they need.

The training of healthcare providers and their collaboration with youth networks and organisations was critical in making health facilities a space that young people were more comfortable being in. The Link Up training provoked self-reflection and encouraged group debate amongst health providers on challenging and sensitive issues in society. As such, the trainings were useful in addressing attitudes, behaviours and language that put young people off accessing the care they need. Health providers themselves reported greater satisfaction from being able to meet the needs of their clients more holistically. Involving young people directly in those trainings – as well as supporting their activities in communities around the health facilities – has been critical in ensuring that young people are directly informing, designing and implementing the programme with healthcare providers.

ANNEXES/ADDITIONAL RESOURCES

- Breaking down barriers: Empowering young people living with HIV in Uganda:
http://www.aidsalliance.org/assets/000/002/147/2015_Alliance_Case_Study_Link_Up_Uganda_YPLHIV_Full_online_original.pdf?1453290806
- Voices, visions and priorities: Key issues of young people living with and affected by HIV in Uganda: http://www.aidsalliance.org/assets/000/001/076/Link-Up-voicesvisions_uganda_original.pdf?1416928837
- Project Overview (multi-country):
http://www.aidsalliance.org/assets/000/002/660/LinkUpOverviewJULY16_original.pdf?1468604285
- Project summary (multi country):
http://www.aidsalliance.org/assets/000/002/802/link_up_newsletter_interactive_final_low-res_original.pdf?1474977190
- Link Up website: <http://www.aidsalliance.org/our-impact/link-up>
- SRHR 101 Workshop Guide:
http://www.aidsalliance.org/assets/000/002/588/Sexual_and_reproductive_health_and_rights_and_HIV_101_workshop_guide_v2_original.pdf?1464867192
- Workshop guide: Safeguarding the rights of children and young people:
<http://www.aidsalliance.org/resources/480-safeguarding-the-rights-of-children-and-young-people>
- Aiming High: Strategies for Meaningful Youth Engagement:
<http://www.aidsalliance.org/resources/744-aiming-high-10-strategies-for-meaningful-youth-engagement>
- Mentoring toolkit: Step Up, Link Up, Speak Up:
<http://www.aidsalliance.org/resources/745-step-up-link-up-speak-up-mentoring-toolkit>
- Journal of Adolescent Health Supplement: Integrating Rights into HIV and Sexual and Reproductive Health: Evidence and Experiences from the Link Up Project:
[http://www.jahonline.org/issue/S1054-139X\(16\)X0007-9](http://www.jahonline.org/issue/S1054-139X(16)X0007-9)
- Baseline study brief:
https://www.popcouncil.org/uploads/pdfs/2015HIV_UgandaPLHIVBrief.pdf
- Endline study brief:
http://www.popcouncil.org/uploads/pdfs/2016HIV_LinkUp_UgandaEndlineBrief.pdf

7.2 UGANDA: Developing of Standard Operating Procedures (SOP) for implementing of Needle and Syringe Program (NSP) and Medically Assisted Therapy (MAT) as an essential program to prevent the prevalence of HIV among People Who Use and Inject Drugs (PWUID)

TITLE OF THE PROGRAMME: Developing of Standard Operating Procedures (SOP) for implementing of Needle and Syringe Program (NSP) and Medically Assisted Therapy (MAT) as an essential program to prevent the prevalence of HIV among People Who Use and Inject Drugs (PWUID)

CONTACT PERSON

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- **Start Date of the Programme:** September 03, 2017
- **End Date of the Programme:** October 2, 2018
- **Responsible Parties:** Civil Society, Government, GFATM
- **Population Group(s) Reached:** People who inject drugs
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

In Uganda about 30% of the new HIV infections occur among members of the key population groups and their partners and one of the most at risk group is people who inject drugs. In this group there is high risk of HIV spread as a result of use of syringes or other injecting instruments by more than one person, particularly as a method of administration of drugs. The recent studies conducted by UHRN and CHAU with support from Global Fund indicated that Sharing of needles and syringes in police or prison detention was reported by 15.5% of those who had ever been detained by a drug-related offence. NSP is an essential program that is scientifically proven to be an organized service that allows injecting drug users to exchange their used needles and syringes for new ones at little or no cost in order to reduce the risks associated with re-use and sharing of contaminated needles and syringes.

BENEFICIARIES AND IMPLEMENTERS

People Who Inject Drugs (PWID), this group was selected through UHRN programs including outreach, referral and community engagement meetings program, also the rapid assessment and population size estimate studies that were conducted by UHRN exposed as to majority of PWUID who concentrated on sharing equipment in the processes of sharing drugs.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The program is to benefit four districts of Uganda including Kampala, Gulu, Mbarara and Mbale where the HIV and Harm Regional Project under Global Fund is being implemented

FINANCING AND SUSTAINABILITY

The programme is affiliated/ hosted by already established public health centres in Uganda, being in public health centres it guarantees its sustainability even after donor funding

DESCRIPTION

The MoH acknowledged that NSP and MAT are two most critical HIV prevention interventions that have been lacking among our intervention, yet it is among the 9 core harm reduction intervention as per the WHO guidelines. In line with strengthening Uganda's HIV response and accelerating progress towards achieving the 909090 targets and ending AIDS by 2030, it also acknowledged that is timely and highly a welcome initiative since it has been proven to scientifically to reducing HIV infections and Hepatitis B and C infections among people who use drugs. The NSP will be implemented in MARPI Mulago, Butabika National Referral Hospital, Mbarara regional referral, Mbale regional referral hospital and Gulu regional referral hospital. The MoH, STD/AIDS control program will provide oversight and supervisory role during the program implementation.

RESULTS OF THE PROGRAMME

- The program is targeting 250 people who inject drugs

OUTCOMES AND IMPACT OF THE PROGRAMME

Increased uptake of HIV services (MAT and NSP services) among people who inject drugs
Strengthened community systems for a sustained HIV response among people who inject drugs in East Africa

MONITORING AND EVALUATION/VALIDATION OF IMPACT

UHRN has an overall framework for monitoring and evaluation of MAT and NSP programme outcomes and core indicators. At the start of the programme, rapid assessment and population size estimates was conducted. A project monitoring framework and basic tools for collecting data will be produced with support from the M&E Manager. The M&E Manager will work closely with partners from various centres where the programme will be implemented. Partners will be trained on the use of both existing and new monitoring forms, data collection tools and reporting forms. The MoH AIDS control will provide oversight and supervisory role. Routine monthly, quarterly and annual reports will be compiled by UHRN and submitted to MoH. The findings and lessons learned will be shared at partner stakeholders' meetings to which other members of the communities in which the programme is implemented will be invited to attend. The findings and lessons learned are also expected to be shared with nesting partners and other UHRN supported programmes in and outside Uganda as well as at national and international meetings and forums.

LESSONS LEARNED AND RECOMMENDATIONS

- The approach used by UHRN was key in effecting demonstration of MAT and NSP program in the public health facilities in Uganda.
- Use of high level dialogues was a key to bringing together parties to discuss on the essential program and the importance of demonstrating NSP and MAT in Uganda
- Stakeholder engagements with key influential parties at the ministry and CSOs was key to educating key influential parties on the importance of NSP and MAT in Uganda.
- Lobbying and advocacy was another key influential approach to bring key people on board to advocate for the implementation of NSP and OST program

CONCLUSIONS

The NSP programmes is organized service that allows injecting drug users to exchange their used needles and syringes for new ones at little or no cost in order to reduce the risks associated with re-use and sharing of contaminated needles and syringes. NSP is based on the philosophy of harm reduction that attempts to reduce the risk factors for diseases such as HIV&AIDS and Hepatitis (B & C).

ANNEXES/ADDITIONAL RESOURCES

- UHRN Annual Report 2016, can be accessed at;
<https://ugandaharmreduction.wordpress.com/2017/05/03/uhrn-annual-report-2016-2/>
- Activity pictures, posters and banners can be accessed at;
<https://twitter.com/uhruganda>

II. ASIAN STATES

8. CAMBODIA: Promoting Access to Care, Treatment and Psycho-social Support for People Living by HIV

TITLE OF THE PROGRAMME: Promoting Access to Care, Treatment and Psycho-social Support for People Living by HIV

CONTACT PERSON

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- **Start Date of the Programme**: January 1, 2004
- **End Date of the Programme**: December 31, 2018
- **Responsible Parties**: Civil Society
- **Population Group(s) Reached**: Health care workers, People living with HIV, Young people/adolescents, Gay men and other men who have sex with men, People who inject drugs, Prisoners and other populations in closed settings, Sex workers, Transgender people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

AUA is a non-profit association comprised of PLHIV using ART. AUA was founded in January 2002 with the cooperation of Médecins Sans Frontières – France, and registered with the Cambodian Ministry of Interior in December 2003. In the beginning, AUA provided a unique opportunity for mutual support, understanding, and advice between PLHIV in Phnom Penh and was facilitated on a voluntary basis with no formal structures or administrative support.

AUA has grown rapidly in the last 11 years, implementing best-practice governance and management structures to expand its programs in Phnom Penh and Kampong Cham, covering Pre-ART/ART clinics in 1 national hospital and 6 referral hospitals. AUA also covers Correction Center 1 (CC1) and Correction Center 2 (CC2) in Phnom Penh. Through a USAID grant in 2015, AUA expanded its services to clinics in 6 additional provinces (Ratanakiri, Kep, Mondulakiri, Battambang, Kampong Cham and Thbong Khmum). Today, AUA plays an important role in HIV/AIDS treatment and care in Cambodia by providing patient education and peer support. AUA is aware of the need for more advocacy to reduce stigma and discrimination against PLHIV – especially in the areas of provision of services, education and employment.

BENEFICIARIES AND IMPLEMENTERS

This project targets people living with HIV who are receiving pre- ART/ART treatment at supported sites in Phnom Penh and Kampong Cham. The number of direct beneficiaries is 7318.

Other partner organizations that work in the same local context as AUA include:

- KHANA: Provides technical assistance, capacity building for AUA staff and funding to AUA.
- Health Family International (FHI360): Provides ongoing technical support to AUA and also former AUA donor.
- HIV/AIDS Coordinating Committee (HACC): is umbrella organization representing local NGOs. AUA is an active member and member of technical working group.
- Cambodian People Living with HIV Network (CPN+): Provides home based care to PLHIV in communities and organize self-help groups for PLHIV. AUA partners with home based care organization to minimize missed appointments and lost-to-follow up cases.
- Maryknoll: Provides home based care, provides support during hospitalization including food, money, hygiene supplies. AUA works at level health facilities and collaborates with Maryknoll to care for patients. Maryknoll provides AUA with caregivers when AUA has a shortage.
- Korsang: Provides services to drug users in Phnom Penh and advocates for drug users. AUA and Korsang refer beneficiaries to each other depending on their needs.
- Family Health Development (FHD): AUA works as collaboration with FHD to interview new patients and re-interview previous patients with expired Health Equity Fund Cards. AUA is responsible for interview and issue Health Equity Fund Card to PLHIV.
- FoNPAMS: Network of key populations who meet regularly to advocate for rights of key populations and PLHIV, convened by UNAIDS. AUA is an active member of FoNPAMS representative of PLHIV.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

AUA is a unique NGO, works at level health facility in one national hospital, six referral hospitals and two correctional facilities in Phnom Penh and Kampong Cham province. 7318 beneficiaries are under supported by AUA.

FINANCING AND SUSTAINABILITY

AUA received Funding from USAID through KHANA. The funding is confirmed until 2018. The total cost is 173,396.00\$/ year.

DESCRIPTION

The program objectives

- 8.1 a) To provide direct support to at least 7318 active HIV patients to access care, treatment and psychosocial support through AUA's 2018 clinical sites.
- 8.2 b) To provide effective onsite care for TB and HIV prisoners in Correctional Centers 1 and 2, Prey Sor Prison, Phnom Penh.
- 8.3 To increase the number of active AUA members in order to encourage mutual support, treatment adherence and advocacy for quality of care within the PLHIV community.

8.4 To strengthen AUA's management system and partnerships so that activities can be implemented effectively and efficiently.

Targeted population

- People living with HIV receiving ART treatment at supported sites in Phnom Penh and Kampong Cham.

RESULTS OF THE PROGRAMME

- 7318 PLHIV under supported by AUA

OUTCOMES AND IMPACT OF THE PROGRAMME

1. Provide minimum package support to 7151 patients at health facilities: Objective: Improve service quality and patient health outcomes at nine Pre-ART/ART sites. In 2016, a AUA facilitated a total of 7151 active patients in nine Pre-ART/ART clinics. AUA was responsible for patient appointments, maintaining patient files, transferring information between departments, and directing patients to get other services. Triage staff worked with AUA's Social Workers and home-based care organizations to track patients who did not attend their appointment or were lost to follow-up and encourage them to return to treatment.
2. AUA staff identify poor patients and provide them with financial support for transportation, consultation fees and lab tests: Objective: Improve treatment adherence, reduce missed appointments, and reduce debt for poor patients. In 2016, AUA provided financial assistance for transportation and lab tests to patients in need at its Pre-ART/ART sites. Assistance was given to greatest-need patients (very poor patients, orphans, new patients, pregnant women, disabled patients and patients without family support). In 2016, 2181 cases received transportation support to encourage patients to access Pre-ART/ART regularly. AUA also reimbursed consultation fees in 69 cases when poor patients did not hold a Health Equity Fund Card, and supported 419 cases of lab test service charges.
3. Increase number of people who attend HIV/AIDS testing and counselling (HTC) at point-of-care: Objective: Improve diagnosis and treatment outcomes for partners of PLHIV and key populations. In 2016, AUA staff identified and referred partners of PLHIV of unknown HIV status to attend HTC. AUA's Case Management Supporter worked closely with service providers to assist in detection, tracking and management of partners. From January to December 2016, 672 partners of PLHIV of unknown status were identified. 280 of 672 were referred to HTC and 33 tested positive. AUA also collaborated with prevention NGO partners to identify key populations within the Pre-ART/ART cohort and improve education packages for men who have sex with men (MSM), entertainment workers (EW), people who use drugs (PWUD), and people who inject drugs (PWID). There are 56 KPs in AUA's cohort.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Through the evaluation: Patients' answers to questions relating to Quality, Efficiency, Effectiveness and Respect show that they are largely satisfied with the services at the clinics.

- Quality – AUA staff: Good (75%) and Average (15%)
- Quality -OI/ART staff: Good (75%), Average (5%) and other (20%)
- Quality – doctors: Good (70%), Average (20%) and other (10%)
- Efficiency- AUA: Good (95%) and Average (5%)
- Effectiveness (usefulness)- AUA: Good (100%)
- Respect –AUA: Good (80%), Average (20%)
- Respect –OI/ART staff: Good (75%) and Average (5%) and other (20%)
- Respect – Doctors: Good (80%) and Average (20%)
- 80% of patients are able to access quality service.

LESSONS LEARNED AND RECOMMENDATIONS

- AUA needs to raise its profile and increase advocacy with the general public and external stakeholders.
- AUA should review their goals and activities at least annually. M&E to include hospital admissions/readmissions/length of stay AUA needs to review and improve treatment adherence to reduce tracing and tracking of missed appointments by delivering appointment reminders. AUA to lobby other organizations to extend Poor ID Card services to needy PLHIV. AUA should provide more internal and external training and refresher training for AUA staff in a broad range of topics to ensure best practice. Management should develop and implement a regular and comprehensive performance appraisal system to provide a formal mechanism for feedback between staff and management.
- Management and Board should review staff salaries to ensure that high quality; committed staff are recruited and retained.
- Management should improve turnover time for feedback and communication from staff.
- Management should conduct more site visits to build relationships.
- AUA to improve communication with donors, supporters, partners and collaborators: AUA to source a long-term donor.

CONCLUSIONS

AUA is a community-based organization in Cambodia that works directly alongside healthcare providers in response HIV/AIDS in Cambodia. The below is a testimony from or story about a project beneficiary:

- AUA staff member: “AUA is good for the patients but also good for myself... AUA patients know that AUA staff members have HIV. They can share experiences on how to maintain good health.”
- Patient 1: “AUA staff helped me when I had problems with my life. When I had the blood test, I was sad and said that I did not want to live. Staff told me that they also had HIV and showed me that is was still possible to have a good life. They told me to take care of myself and I should take care of my health. I have and my life is improving.”

- Patient 2: “My life was difficult - it was difficult to find money for family. I didn’t have land or a house or money for children to go to school. AUA told me about Mary Knoll that could support my children to
- go school. My child was supported by Mary Knoll and was able to complete year 12.”
- Patient 3: “Now is better than before. AUA helped me contact HABITAT. I have a new life because I have a house. I am happy now even though we don’t always have enough for food, but we have a house. My husband has a job in construction (he had this previously) and I work in a factory. Before we got the house I was always sick, now I am well enough to work in the factory.”

ANNEXES/ADDITIONAL RESOURCES

- Evaluation report
- Agreement/ MoU
- Pictures
- Website: [www. auacambodia.org](http://www.auacambodia.org)
- Facebook: ARV Users Association

9. CHINA: Case Study: Reducing Stigma and Discrimination in Healthcare Settings

TITLE OF THE PROGRAMME: Case Study: Reducing Stigma and Discrimination in Healthcare Settings

CONTACT PERSON

Name: Kofi Amekudzi

Title:

Organisation: ILO

Address:

Tel:

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- **Responsible Parties:** United Nations and other inter-governmental organizations
- **Populations Group(s) Reached:** People Living with HIV, Health care workers

BACKGROUND INFORMATION

Health services are workplaces which must be safe for all the workers in the health sector. Decent working conditions in the health sector must take into account workers' health and wellbeing, since the quality of care provided by health workers is partly linked to the quality of the work environment. If decent working conditions are not promoted, health sector workplaces can be unsafe for the workers working in the sector and this could lead to elevated levels of stigma and discrimination towards people living with HIV.

Decent working conditions will be achieved through a combination of institutional and individual factors. Individual and institutional factors such as the HIV-related knowledge levels of health providers, the access to preventive measures such as sterile rubber gloves, working autoclaves, and access to free HIV testing for providers, the general level of equipment in the healthcare setting as well as the perceived institutional support from the hospital management all contribute towards the levels of stigma and discrimination towards people living with HIV. In China as in many countries, stigma and discrimination towards people living with HIV persists in some health services. The level of care (in China), at which services are provided presents quite different challenges for providers. The Chinese health care system is organized in a very hierarchical manner: provincial, city, county, township, and village. Health care professionals in a village, township clinic, or county hospital typically have the most intimate relationships with patients at the local level, yet they have the least amount of medical training. Addressing stigma and discrimination in healthcare settings is critical because, when present, it reduces access to and uptake of health services by people living with HIV. This means, even when health services are physically present, access by people living with HIV will be impeded.

BENEFICIARIES AND IMPLEMENTERS

- The ILO and WHO have worked jointly to address working conditions in the healthcare sector.
- HealthWISE is a joint ILO/WHO tool which is a practical, participatory methodology for improving the quality of health facilities. To strengthen the institutional and individual capacities of healthcare facilities and workers, the ILO, the China Center of Disease Control (CDC), the China Labour Institute of MOHRSS, the China HIV and STD Prevention and Control Association and civil society organizations applied the HealthWISE toolkit to launch a HIV/OSH programme covering 20 hospitals and reaching 31,000 healthcare workers.

DESCRIPTION

A 2-pronged approach was used. The first prong focused on the health services and the establishment of strong Occupational Safety and Health and HIV structures. Building the capacity of the health workers and the institutions to reduce stigma and discriminated towards people living with HIV. The specific actions included: mobilization and advocacy of 20 hospitals on HIV/OSH issues; establishment of steering committees with representation from people living with HIV; establishment of HIV/OSH task forces in each hospital; created HIV and OSH Management Systems in each hospital; development and implementation guidelines on Management of Occupational Exposure to Blood Borne Pathogens; and the organization of a tripartite workshop to remove a discriminatory clause within the Medical Standard of Recruitment of Civil Servants in China. The second prong focused on empowering people living with HIV and giving them a voice. Capacity was built in Non-Governmental Organizations (NGOs) partners in particular the He'rbutong Training and Education Center, and the National Women's Network against AIDS to expand the provision of legal services to people living with HIV. Information education and communication materials were developed to encourage people living with HIV to seek legal services. A handbook on the 100 frequently asked questions was developed and disseminated widely. People living with HIV were encouraged to have a voice and know their rights for Decent Work and Social Protection.

RESULTS OF THE PROGRAMME

- NGO partners expanded their legal support services which offer legal protections to people living with HIV. Communication materials on the legal rights of people living with HIV were developed and disseminated
- In each of the 20 hospitals, bipartite HIV and OSH task forces were established to create policies and programmes which strengthen HIV and OSH Management systems in-line with ILO Standards
- OSH Committees were established in each of the 20 hospitals to improve upon the working conditions of all healthcare workers
- To reduce the levels of stigma and discrimination towards people living with HIV, Guidelines on the Management of Occupational Exposure to Blood borne pathogens in China were developed and adopted by the hospitals. These guidelines were based on the ILO/WHO Joint Guidelines on HIV/AIDS and Health Services
- ILO, MOHRSS and the China CDC built the capacity of healthcare workers in the 20 health facilities to facilitate a reduction in HIV discrimination and prevent occupational exposure to blood borne diseases

LESSONS LEARNED AND RECOMMENDATIONS

- An effective approach to addressing stigma and discrimination in healthcare settings must involve engaging the health facility and engaging the communities, including people living with HIV
- Making people living with HIV aware of their rights and encouraging them to have a voice strengthens the approach towards reducing stigma and discrimination
- Supporting health services to build their institutional capacities is a critical element in ensuring a conducive and enabling environment for the reduction of stigma and discrimination. Developing and applying evidence informed guidelines is critical to achieving sustainable outcomes.
- Strengthening the capacity of communities, as part of community systems strengthening is key to achieving sustainable outcomes
- Periodic monitoring of cases of discrimination is key to assessing the progress of each hospital in ensuring a safe and non-discriminatory environment
- A strong partnership with national stakeholders from the public and private sectors as well as civil society is key to providing a comprehensive and holistic approach to reducing stigma and discrimination in healthcare settings.

10.1 INDIA: Samarth Community Clinics: Health and HIV Testing for MSM, Transgenders and Hijras in India

TITLE OF THE PROGRAMME: Samarth Community Clinics: Health and HIV Testing for MSM, Transgenders and Hijras in India

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- **Start Date of the Programme:** January 06, 2016
- **End Date of the Programme:** March 01, 2019
- **Responsible Parties:** Government, Civil Society, Private sector and Academic institution
- **Population Group(s) Reached:** Gay men and other men who have sex with men, Transgender people
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

HIV prevalence among Key Population in India is in stark contrast with country's infection rate in general population. In 2014, India reported record low prevalence of 0.27% in general population, while in the same year infection rate in Men who have Sex with Men (MSM) and Transgender (TG) population are reported as high as 4.34% and 8.83%

India HIV/AIDS Alliance's Pehchan (a five-year Global Fund-supported programme building MSM and TG community capacity for HIV prevention in 18 states of India) programme supported government's HIV prevention response to scale up with 68% (240,000) MSM and 25% (13,200) TG representation. Despite of this increase coverage, the programme witnessed testing level for both the population to remain at around 60%. While India boasts 16,300 number of dedicated government facilities for HIV testing, various factors contribute negatively to reach the desired situation. It was also explored these factors ranges from social stigma, discrimination, punitive laws, lack of sensitized workers, and unresponsive service hours and locations.

Following the global 90-90-90, India's stand in advance of rapid HIV testing processes and encourage HIV testing among previously untested MSM and TG, India HIV/AIDS Alliance developed an innovative community testing model through an initiative called 'Samarth' ('empowered' in Hindi). Samarth aimed to establish community group / organization implemented clinic promote community friendly HIV testing services for 10,800 MSM and TGs and link newly diagnosed clients to treatment in six priority states of India.

BENEFICIARIES AND IMPLEMENTERS

Samarth programme is developed as per requirement of MSM and TG population. National level key community experts are involved from concept designing to proposal submission. All seven sites were selected through prior experiences from Pehchan programme in relation of density of MSM and TG people, state prevalence rate and presence of capable MSM-TG group / organization.

At national level the programme is managed by a dedicated team of programme, data and finance expert with regular support from senior management team of India HIV/AIDS Alliance. The programme lead is as known MSM community representatives and is involve from beginning of Samarth

At field level every Samarth clinic is managed by Clinic Manager, who is supported by clinical and non-clinical staffs. Every clinic is also monitored by the local community group or organization.

Each of these clinics also has one Clinic Advisory Board (CAB) comprised of stakeholder and clinic beneficiaries to ensure quality.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Samarth has established six community clinics in one major city each of six priority states including- Noida – Delhi National Capital Region, Jalandhar – Punjab, Vadodara – Gujarat, Pune – Maharashtra, Hyderabad – Telengana and Hooghly – West Bengal. Following programme achievement within one year and strong demand from both government and community stakeholders Seventh Community Clinic was established in Hasssan city of Karnataka. Overall Samarth programme has targeted to provide HIV screening test to 10,800 MSM and TG people and retain at least 70% of them through repeat testing.

FINANCING AND SUSTAINABILITY

Samarth Programme is funded by Elton John AIDS Foundation (EJAF) for a period of three years from June 2016 to May 2019. This programme is developed in line of providing effective model for government programme to mitigate gaps in HIV response. Samarth able to demonstrate effective community involvement in bridging testing gap and also able to leverage government support in procuring HIV screening test kits. The programme also creates mile stone in expanding to one more clinic within the given resources

DESCRIPTION

Samarth Community Clinics aims on creating safe spaces for MSM and TG to expand HIV testing in seven priority states (Delhi, Gujarat, Maharashtra, Punjab, West Bengal, Telangana and Karnataka) with high HIV prevalence. The programme works towards increasing the capacity of community groups and organization to run clinical services and to increase community based safe testing opportunities to help in reducing testing gaps. Similarly, the programme focuses on the certain segment of MSM and TG population who have not received support in HIV prevention programme. Moreover, Samarth serves as a pilot programme on community testing for MSM and TGs in India and to influence government for HIV strategies in future.

With an intention to ensure that no one is left behind, Samarth Community Clinics emphasizes on accompanied referral and linkages to increase uptake of HIV testing and help in driving early treatment and reduce HIV transmission among MSM and TG. The programme works on mitigating service gaps, increasing health access and reducing the

structural barriers to health access for MSM and TG through regular sensitization meetings with stakeholders. A special focus is given in the programme to cover TG and Hijras leveraging our recently awarded grant from Amplify Change in support of the Wajood program, which focuses on community mobilization/empowerment, prevention of violence, and access to sexual health services and social schemes for TGH.

Samarth provides essential evidence to support expansion of India's community testing efforts. NACO's recent "Community Based Testing" (CBT) further established Samarth vision on service expansion through community empowerment. It is expected that evidence from Samarth will help in strengthening initiatives such as care cascade for MSM and TG populations.

RESULTS OF THE PROGRAMME

Since the first HIV screening test in September 20, 2016 to August 30, 2017 Samarth programme has screened 5435 MSM and TG people. In this short period the programme showed 1.81% and 5.20% prevalence rate among MSM and TG respectively compare to TI programme prevalence rate of 0.21% and 0.58% for both the population.

OUTCOMES AND IMPACT OF THE PROGRAMME

Samarth programme has specifically proved impact of systematic community empowerment and community system strengthening to create positive difference. 77.5% of the total clients in Samarth have reported to have undergone HIV screening for the first time in their life. Similarly, effective mobilization brings back 840 clients under HIV prevention cascade, those who have opted out of HIV prevention services for a year or more.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Samarth programme has specific data management system with dedicated registers. All the data collection tools are created with core value of simplicity to avoid human error. Additionally, primary data of testing and referrals are collected and reported daily at a central management system (google drive) to minimize data loss. The national team regularly visit each clinic for evaluation and handholding support for improvement

LESSONS LEARNED AND RECOMMENDATIONS

The programme is at a low risk category having established community systems, trust, services and mobilisation approaches. Government stakeholder and other partners are on board and we witness ownership of the project. One clear risk arising is that provision of only prevention messaging and HIV screening facilities will not continuously attract the target population groups and we do need to innovative other mobilisation approaches.

CONCLUSIONS

Case Study: Sheena (name changed) a male to female TG reluctantly visited Samarth Jalandhar clinic in early May after months long insistence from her friend Parma (name changed) who is also working as a mobilizer at the same clinic. Parma knows that Sheena earns mainly from sex work and often perform with multiple partner at same time for higher income. However, Sheena denies such facts and insisted that she had HIV test done from a reputed hospital a year back.

After two days of repetitive counselling by the counsellor, Sheena agreed to undergo HIV screening test and identified reactive. She showed an emotional outburst while requested for confirmation test at ICTC and denied to accept the result as the blood has been drawn from her finger not from her arm. She went on to become aggressive but the counsellor able to calm her with help of Parma and supported her over next few days over personal visit and phone counselling. Currently, Sheena has undergone confirmation test and linked with ART

ANNEXES/ADDITIONAL RESOURCES

- <https://we.tl/NBKw4eYGzQ> (Samarth National Consultation Meeting Minute)

10.2 INDIA: Vihaan Care and Support

TITLE OF THE PROGRAMME: Vihaan Care and Support

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- **Start Date of the Programme:** April 01, 2013
- **End Date of the Programme:** December 31, 2017
- **Responsible Parties:** Government, Civil Society, UN or other inter-governmental organization, GFATM and Academic institution
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Gay men and other men who have sex with men, People who inject drugs, Sex workers, Transgender people, Migrants (documented and undocumented), refugees or internally displaced populations, TB and Hep C affected
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Vihaan is the only care and support program implemented throughout the country, almost 80% implementing partners and staff are PLHIV CBO's. Program is working very closely with National AIDS control program's free ARV through ART centers. A strong quarterly feedback, technical support and co-working system is in place at National level, through National Oversight Committee, at state level State Oversight committee and at district level monthly ARTC and Vihaan CSC coordination meeting mechanism.

BENEFICIARIES AND IMPLEMENTERS

All the PLHIV registered at the ART centers (1.2 million) and their family members are the direct beneficiaries through the program. Almost 80% implementing partners 19 Sub recipient and 350 Sub Recipients are PLHIV CBO's and few are MSM and IDU CBO's. PLHIV community is involved from day one in designing the Care and Support Centers guideline to every Technical resource group of ART, PPTCT, TB-HIV and ethics.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Throughout country through 350 CSC's attached with 530 ART centers

FINANCING AND SUSTAINABILITY

Program is supported by Global Fund and India HIV/AIDS Alliance is a PR and PLHIV CBO's are SR and SSR. Financial sustainability is a big question mark as most of the CBO's are advocacy organisations and no government invest and support to advocacy organisations. Investment in Community system strengthening is also only on paper. And no direct support to CBO's.

DESCRIPTION

Goal - To improve the survival and the quality of life of People living with HIV/AIDS

The specific objectives of Vihaan include:

1. Early linkages of PLHIV to Care, Support and treatment services
2. Improved treatment adherence and education for PLHIV
3. Expanded positive prevention activities
4. Improved social protection and wellbeing of PLHIV
5. Strengthened community systems and reduced stigma and discrimination

In the second phase as per GF suggestion TB-HIV component is also included in the project and ICF at field level is also added as the 6th objective from 2015

RESULTS OF THE PROGRAMME

Out of 1.2 million, 1.14 million are reached through 358 CSC's (350 by GFATM + 7 CSC through national Health mission and + 1 is through corporate social responsibility almost covering all 530 ARTC. 358 direct and remaining through Outreach reach

OUTCOMES AND IMPACT OF THE PROGRAMME

The biggest outcome is increased retention in care, support and treatment cascade. Almost more than 100,000 loss to follow up has been tracked backed and more than 300,000 contacted. Through constant peer counselling PLHIV has been motivated for partner testing and positive partners were 100% linked with care as early linkage strategy. Positive living and positive prevention is the key strategy of PLHIV CBO's which is directly contributing to 90:90:90 and End AIDS by 2030.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

PR, National and State AIDS control Organsiation, CCM oversight committee, LFA and OIG do regular monitoring of the program.

LESSONS LEARNED AND RECOMMENDATIONS

Strengths:

Peer led intervention, psychosocial support, constant advocacy with all stake holders and at each level are the strength of the project.

Challenges

Since Care and support is closely linked with ARV treatment, frequent stock outs of ARV and other commodities like breakdown of CD-4, Limited availability of Viral Load testing is affecting the quality of life and increasing LFU's and reducing outreach efforts of PLHIV community.

CONCLUSIONS

Role of PLHIV in retention cascade is very crucial, investment in CSS and PLHIV CBO's to sustain GF investment in HIV and TB program. PLHIV must be considered as key prevention partner and not just beneficiaries and pill receivers and other prevention donors like PEPFAR and world bank start investing in PLHIV CBO's along with GF.

Best practice and model by PLHIV CBO which is also discussed as one of the best differentiated care model of, for by PLHIV.

TAAL community pharmacy is an initiative and one stop shop for PLHIV, Hepatitis and Cancer patient, which provides costly medicines at 40 to 60% subsidized cost along with peer counselling, treatment education and linking with other unmet needs. TAAL community pharmacy is also supporting countries free HIV treatment program during crisis situation of ARV stock outs by giving free donations and subsidized cost for those who can afford.

This initiative has not only provided medication at subsidized cost and reduced financial burden on individuals and family, but also helped to gain self-confidence, treatment adherence/literacy, overcome self-stigma, promoting positive prevention, boost self-esteem, through peer counselling and constant motivation.

ANNEXES/ADDITIONAL RESOURCES

Most of the reports are available with PR at India HIV/AIDS Alliance website. Where few initiatives like TB-HIV campaign, Positive Leadership and Treatment @ 10 events were uploaded. Few treatment literacy videos in local language are shared through Facebook and whats up within the PLHIV advocacy group.

11. THAILAND: Tackling HIV-related Stigma and Discrimination reduction in Health Care Settings in Thailand

TITLE OF THE PROGRAMME: Tackling HIV-related Stigma and Discrimination reduction in Health Care Settings in Thailand

CONTACT PERSON

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- **Start Date of the Programme:** January 10, 2014
- **End Date of the Programme:** December 31, 2020
- **Responsible Parties:** Government, Civil society, Private sector, UN or other inter-governmental organization, Academic institution
- **Population Group(s) Reached:** Health care workers, people living with HIV
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Thailand was one of the first countries to offer free HIV testing and treatment under universal health coverage schemes. As of October 2014, antiretroviral treatment became available to all people living with HIV, including migrant workers from 4 neighbour countries, regardless of CD4 level. Thailand acknowledges that stigma and discrimination are key impediments to access to HIV testing, prevention and treatment service, with about 60 per cent of people living with HIV were coming to know of their diagnosis very late. In response, Thailand prioritized stigma reduction and committed itself to reduce by half HIV-related stigma and set mechanisms to protect the rights of people living with HIV and key populations by 2019. To reduce discrimination, especially in health care settings, Ministry of Public Health joined force and resources with multi-stakeholders such as civil society, people living with HIV and key population networks, academia, UN and US Government to develop a simple and practical tool (survey) to measure stigma and discrimination in healthcare setting and pilot in 2 provinces (Bangkok and Chiang Mai). National AIDS Committee endorsed the use of stigma measurement tool as a routine monitoring instrument and the national survey will be conducted every two years. At present, the implementation of the tool rolled out to 22 provinces. The Ministry of Public Health is rolling out an accelerated system-wide stigma reduction programme, with civil society and concerned communities committed and fully engaged. In-person HIV related stigma and discrimination reduction training for health care staff is implemented in four Thai priority provinces (Bangkok, Chiang Mai, Chon Buri, and Songkhla), and will be expanded to more than 10 provinces in 2017. E-learning system is also being developed, to complement the in-person training and make sure that all health care staffs, at all levels, receive training and necessary support. Thailand's experience is showing that stigma and discrimination in healthcare can be and should be measured routinely, and addressed systematically.

BENEFICIARIES AND IMPLEMENTERS

- International Health Policy Program (IHPP)
- The Research Institute of Health Sciences (RIHES); Faculty of Medicine, Chiang Mai University; Chiang Mai Provincial Health
- Bureau of AIDS, Tuberculosis (TB), and Sexually Transmitted Infections (STIs);
- Bangkok Metropolitan Administration (BMA);
- Thai Network of Persons Living with HIV (PLHIV)/AIDS (TNP+),
- Non-governmental organizations (NGOs).

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- 15 provinces and 43 hospitals

FINANCING AND SUSTAINABILITY

USAID (under the U.S. President's Emergency Plan for AIDS Relief – PEPFAR), ILO, UNAIDS, UNDP, UNFPA, UNICEF and Ministry of Public Health, Thailand

DESCRIPTION

Thailand was one of the first countries to offer free HIV testing and treatment under universal health coverage schemes. As of October 2014, antiretroviral treatment became available to all people living with HIV, including migrant workers from 4 neighbour countries, regardless of CD4 level. Thailand acknowledges that stigma and discrimination are key impediments to access to HIV testing, prevention and treatment service, with about 60 per cent of people living with HIV were coming to know of their diagnosis very late. In response, Thailand prioritized stigma reduction and committed itself to reduce by half HIV-related stigma and set mechanisms to protect the rights of people living with HIV and key populations by 2019. In 2014, collaborators from a range of organizations adapted globally designed tools to measure HIV-related stigma and discrimination and applied them in Thailand. The measurement of stigma and discrimination was a critical first step for establishing a baseline against which to measure progress towards mitigating stigma and discrimination. Importantly, the process also enabled stakeholders to better understand how stigma and discrimination limit access to health services, particularly for key populations [defined as men who have sex with men, transgender women, sex workers and people who inject drugs] and migrants. To reduce discrimination, especially in health care settings, Ministry of Public Health joined force and resources with multi-stakeholders such as civil society, people living with HIV and key population networks, academia, UN and US Government to develop a simple and practical tool (survey) to measure stigma and discrimination in healthcare setting and pilot in 2 provinces (Bangkok and Chiang Mai). National AIDS Committee endorsed the use of stigma measurement tool as a routine monitoring instrument and the national survey will be conducted every two years. At present, the implementation of the tool rolled out to 22 provinces. The Ministry of Public Health is rolling out an accelerated system-wide stigma reduction programme, with civil society and concerned communities committed and fully engaged. In-person HIV related stigma and discrimination reduction training for health care staff is implemented in four Thai priority provinces (Bangkok, Chiang Mai, Chon Buri, and Songkhla), and will be expanded to more than 10 provinces in 2017. E-learning system is also being developed, to complement the in-person training and make sure that all health care staffs, at all levels, receive training and necessary support. Thailand's experience is showing that stigma and discrimination in healthcare can be and should be measured routinely, and addressed systematically.

In Thailand we address Stigma and discrimination in systematic manner.

1. S&D tool to measure and understand S&D situation (survey) in health care settings in two pilot provinces and expand to other provinces)
2. Stigma and Discrimination reduction packages are tailored to the evidence from the survey. We have now expanded the program to cover half of the 76 provinces, and will soon cover all provinces.

The S&D tool covers multiple domains that capture observed and perceived or enacted (i.e., experienced or manifested) stigma, as well as what drives stigma within health facilities. The core measures of stigma and discrimination in health facilities are:

- Health care worker fear of work-place HIV transmission;
- Negative or hostile attitudes towards clients who are living with HIV or are from key populations;
- Policies and protocols that shape a stigma-free health facility environment, including anti-discrimination policies and their enforcement; and
- Presence of standards of practice and resources to keep health care workers safe from workplace exposure to HIV.

Between January and March 2014, the tool was field tested in 32 public and private hospitals in two provinces.

The Stigma and Discrimination Curriculum for health care providers was developed.

RESULTS OF THE PROGRAMME

HIV-related stigma and discrimination in health care settings are common even in a country with a mature epidemic and response. Thai health care workers in the pilot provinces display high levels of stigma and discrimination towards people living with HIV and key populations. Reports of experienced stigma from people living with HIV are therefore corroborated and based on both personal and collective experience that cannot be ignored. This finding is crucial, as it exposes a significant and previously unmeasured obstacle to an effective HIV response

- 36.4% of health care providers who fear of contracting HIV.
- 33.4% of health care providers taking unnecessary precautions.

OUTCOMES AND IMPACT OF THE PROGRAMME

Measuring stigma and discrimination provides a platform for data collection, analysis, and routine monitoring of HIV stigma and discrimination in the health system. These data will enable policy makers, HIV programmers, people living with HIV, and key populations to design and implement evidence based stigma and discrimination-reduction activities and programs. The process of demonstrating the feasibility of measuring stigma and discrimination and generating baseline measures provided evidence to the national program, which has allowed stakeholders to establish stigma and discrimination reduction targets and a process for monitoring change overtime

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Data collection took place following institutional review board approvals. The questionnaire was self-administered and data were collected from all staff levels (i.e., medical and non-medical). No identifying information was collected on the questionnaires and the signed consent forms were delinked from the questionnaires, thereby protecting client confidentiality. Tools for evaluation as follows;

1. Comprehensive Health Facility Staff Questionnaire (14 questions; 24 baselines and 25 end line items (includes an additional question about participation in S&D-reduction activities)).
2. A brief Health Facility Staff Questionnaire (7 questions; 10 items).

LESSONS LEARNED AND RECOMMENDATIONS

The data yielded by pilot-testing Thailand's new stigma measurement tool confirm the need for increased monitoring and better-targeted action. The evidence from the pilot study triggered accelerated health system-wide action. The Ministry of Public Health, in partnership with civil society and international partners, has developed a draft package of stigma and discrimination interventions for health care settings that is currently being tested in facilities in four provinces. The interventions aim to reach all health care workers, both those who provide direct clinical services, as well as those who do not (e.g. cleaners, receptionists etc.) Improving the attitude of health care workers is not only key to providing better care to people living with HIV but also has wider social benefits, as health care workers are highly regarded and seen as social role models. The pilot also confirmed that stigma and discrimination within health care settings can be routinely measured and the data can serve as a basis for managing action plans and results evaluation. In 2015, the measurement tool was used by the national monitoring system in six more provinces and an additional 15 provinces have begun voluntarily applying it with their own resources, which demonstrates that the measurement tool is not only adaptable but also fiscally sustainable.

CONCLUSIONS

- i. The most important one concrete action is to shift the paradigm for all leaders in society, starting from health professionals, political leaders, celebrities, community and all social leaders.
- ii. The imperative involvement of key stakeholders able to contribute expert knowledge of local manifestations of HIV stigma and discrimination shaped the relevance of the questionnaire to the Thai context.
- iii. The S&D reduction was carried out with strong collaboration among key stakeholders from both academic and operational research institutions at national and local levels, including government and non-government sectors, research institutes, and PLHIV.
- iv. Health staff are role models within the communities and held in high regards.
- v. The practice in health settings and their behaviors has influenced other sectors and community.
- vi. The commitment from these leaders, with the new paradigm will remove all social, economic and legal barriers and enable us to eliminate stigma and discrimination.

ANNEXES/ADDITIONAL RESOURCES

- Thailand eliminates mother-to-child transmission of HIV and syphilis at <https://www.youtube.com/watch?v=WcvuLRLAXTM>
- Thailand launches initiative to prevent stigma in health settings at https://www.youtube.com/watch?v=0_46wuyRTql&index=27&list=LLMowAyAi9jgv37hz4yKAe1A&t=251s

12. VIETNAM: Pilot initiative of Reducing HIV- related stigma and discrimination in care setting in Ho Chi Minh City (Fast Track city)

TITLE OF THE PROGRAMME: Pilot initiative of Reducing HIV- related stigma and discrimination in care setting in Ho Chi Minh City (Fast Track city)

CONTACT PERSON

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- **Start Date of the Programme:** September 28, 2016
- **Responsible Parties:** Government, UN or other inter-governmental organization
- **Population Group(s) Reached:** Health care workers, People living with HIV
- **Has the programme been evaluated / assessed?** No
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Viet Nam has committed to the new testing and treatment targets of 90-90-90 by 2020 and the global target of ending AIDS by 2030. However, the Stigma Index, which was conducted by the Viet Nam National Network of People living with HIV (VNP+) in 2014, revealed important barriers to the achievement of these ambitious targets. Many PLHIV in Viet Nam continue to face S&D in their families, communities, and institutions. Stigma and discrimination exist in all settings and in various forms such as the denial of schooling and exclusion from health care services. The Stigma Index results showed that HIV service delivery can be unfriendly and sometimes unethical. Among recently diagnosed PLHIV, 7.7% said that they had been forced to take an HIV test. In addition, over one third of all respondents (37.5%), and nearly half of the PWID respondents said that their HIV status had been disclosed to the others without their consent.

Furthermore, due to Viet Nam's relatively new status as a middle-income country, funding for development has been reduced sharply, especially for the national HIV response. Therefore, the Government of Viet Nam and its partners are exploring more sustainable approaches to dealing with HIV. While the HIV response is being integrated in to the general health care system, the strengthening of capacity for health care workers in the area of S&D will be necessary. A UNAIDS "fast track" effort was launched in 2015, with an emphasis on innovative interventions in big cities; Ho Chi Minh City (HCMC) was included as one of the world's large cities meriting special "fast track" attention. This pilot effort to reduce S&D in the health care setting is envisaged as part of this special approach.

Global and regional initiatives for the elimination of HIV-related S&D in health care settings have been launched. Survey tools, trainer's guide and practical experience from countries in the region (such as Thailand) were found useful to adapt to Viet Nam's context. As a first step, UNAIDS in close collaboration with Vietnam Administration for HIV/AIDS control (VAAC) supported Ho Chi Minh City (HCMC) Provincial AIDS Center (PAC) to adapt the survey tools and use the adapted survey tools to assess the HIV related stigma and

discrimination in selected health care setting in HCMC in late 2016. The survey results were then used to inform development of the training manuals and the training for health care workers in those health care facilities in HCMC.

BENEFICIARIES AND IMPLEMENTERS

- People living with HIV and key populations
- Health care workers and health professionals in the three selected health facilities
- Implementing partner: Ho Chi Minh City Provincial AIDS Center (PAC)

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Location

- Ho Chi Minh City, Viet Nam

Programmatic coverage

- 252 Health Care Workers in the three selected health facilities were trained on reducing S&D in health care setting.
- Nearly 2300 PLHIV who are currently receiving HIV care and treatment services in the selected facilities are expected to receive less HIV stigma and discrimination services after the training provided for health care workers

FINANCING AND SUSTAINABILITY

The programme was managed by HCMC PAC in close guidance of UNAIDS Viet Nam and Viet Nam Authority of HIV/AIDS Control (VACC). The pilot programme was funded by UNAIDS Viet Nam, using externally mobilized financial resources. The programme was to build capacity for VAAC officials, HCMC PAC staff, VNP+ members and a development partner as trainers on reducing S&D in health care. The trainer's guide was adapted to Vietnam's context and piloted in Ho Chi Minh city and is available for use in various trainings for health care workers nationwide. A shorter version of the trainer's guide has also been developed so that it is easily integrated into training curriculum for health care workers who provide HIV services for PLHIVs. The trainer's guide, both long and short versions are being institutionalized and will be disseminated nationwide as attachment of a directive on further strengthening HIV related S&D reduction approaches in health care setting.

DESCRIPTION

Project objectives

- To adapt and pilot a tool of measurement of stigma and discrimination in health care setting in HCMC
- To adapt and pilot interventions for reducing HIV related stigma and discrimination in health care settings in HCMC.

Activities

Component 1: Pilot survey of HIV related S&D in health care setting (conducted in 2016)

1. Workshop to adjust the questionnaires used in Thailand and Laos to suit with local contexts using previous tools as primers.
2. Pilot-test the questionnaires in a health facility with 15 HCWs and 10 HIV patients
3. Review the questionnaires for finalization

4. Conduct training for HCMC PAC and VNP+ members on data collection and interview techniques and data entry
5. Conduct data collection in the pilot sites
6. Do data analysis, using REDCap software
7. Organize a validation workshop with health care workers in the selected health facilities, and representatives of VNP+ to finalize and gain understanding of the results

Component 2: Adapt the training material and build capacity of HCWs in the 3 selected health care facilities (ongoing in 2017)

1. Adapting trainer's guide, which was used in Thailand and other existing training manuals
2. Conduct a training of trainers on reducing HIV related stigma and discrimination in health care setting, for 25 people, who are VAAC official, HCMC PAC, leaders and staff of the health facilities
3. Conduct training for 252 health care workers in the three pilot health care facilities
4. Undertake regular monitoring of the service provision performance at the piloted health facilities and provide feedbacks to the service quality with engagement of VNP focal points.
5. Conduct an end-line survey to measure any changes of HIV stigma and discrimination free service provision after trainings for HCWs.
6. Organize a validation workshop of the survey results
7. Organize a final review meeting with the participating health facilities, HCMC PAC, Department of Health, VAAC and other provincial partners who are going to replicate this model in the coming times.

RESULTS OF THE PROGRAMME

- Existing survey tools used in Thailand adapted to suit with the local context, in terms of languages and categories
- 18 people from HCMC PAC, network of PLHIV and KAP trained on data collection and data entry
- A baseline survey results of HIV related stigma and discrimination with 345 health staff of the 3 selected facilities voluntarily engaged in self-administration of the questionnaires and 338 PLHIV who visited the selected facilities for HIV care and treatment voluntarily participated in structured questionnaire interviews about their experiences of HIV related S&D
- Existing trainers' guides used in Thailand and other training manuals adapted for use in Ho Chi Minh City
- 32 people from VAAC, HCMC PAC, leaders/managers and staff in charge in the three selected health facilities and network of PLHIV and KAP trained as trainers of reducing HIV related S&D in health care settings.
- 252 HCWs in the three selected health facilities trained on providing stigma free services for PLHIV.
- A standard procedure and practice for HWs to follow in these selected health facilities reinforced.

OUTCOMES AND IMPACT OF THE PROGRAMME

This is an ongoing project. An end-line survey is planned to measure any changes of attitude, behaviours and practices of health care workers in providing HIV services to PLHIV. Great involvement of PLHIV and KAP networks members in the capacity building sessions for health workers was found an important factor to create a positive change among HCWs in the pilot health facilities.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

UNAIDS Stigma and discrimination/ Access to Justice specialist under guidance from UCD worked closely with the implementing partner in consultation with VAAC and VNP+ to implement these activities. VNP+ members participated in all activities of the project. The project has regular monitoring and oversight visits by both UNAIDS, HCMC PAC in close collaboration with VNP+ members in the selected health facilities. Observations and feedback from VNP+ focal points in the selected health facilities on the services and also attitude and behaviors of health care workers toward PLHIV showed more friendly health services for the patients, including PLHIV and KAPs when they visited the health facilities.

LESSONS LEARNED AND RECOMMENDATIONS

- Commitment and support from Central and Provincial authority leadership
- Commitment and support from the participating health facilities
- A strong focal point/champion identified in each of the health facilities
- Measurement of S&D in health care is not to blame or point out any wrongdoings in health facility, but better understand the situation so as to design appropriate interventions for improvement of the service quality.
- Major survey results helped develop appropriate training contents for HCWs and interventions for PLHIVs
- Great participation of the community, especially VNP+ and other network members in all of the process, especially in training for health care workers led to a major change.
- A team of trainers at facility training must include trained health care workers and trained members of PLHIV/KP networks
- Important characteristics of the trainers: time commitment, facilitation skills, no stigmatizing toward PLHIV/KP
- Participatory training approach is really important for creating S&D reduction behaviour change. 100% of the participants rated highest score for the training methodology, showed their strong interest in these trainings.
- Mixed HCWs from different departments in a training.
- Setting training schedule for health care workers should take into account their tight working schedule. There are two options for facility training schedule, either two full days (6 hours per day for two days) or three half days (4 hours per day for three days). Due to tight working timetable, the health facilities selected the option 2 with three half days per training. One facility did it two times per week, taking one and half a week to complete a training. One did it only once per week, taking 3 weeks to complete a training session.

CONCLUSIONS

The project showed its feasibility and acceptability. Its impacts have not been evaluated yet, but its usefulness can be affirmed via testimony by health care workers in interviews. In the meantime, the pilot project in HCMC already led to discussion and development of the nation action plan led by VAAC with engagement from various partners and their interest of replication and scaling up of the model.

An interview with Vice Director of Pham Ngoc Thach Hospital, one of the three participating health facilities, Dr Le Tien Dung

“The survey results of HIV related stigma and discrimination in health care conducted in my hospital reported that S&D remains prevalent among health care workers in my facility. With a wish to create a friendly and safe environment for people living with HIV, I thought that it is necessary to participate in the project of reducing HIV related stigma and discrimination in health care via conducting capacity building activities and development of a code of practice

for my hospital. Their discriminatory acts and practices come from limited awareness and knowledge of HIV, HIV transmission, universal precautions among my health care workers. Participatory trainings with story- telling session by VNP+ members for health care workers were proved appropriate and brought initial good results. Apart from the training, we developed a code of practice for our own hospital, which guides the health care workers the acts and health service provision for patients living with HIV. I do hope that it will help minimize S&D towards PLHIV among HCW in my facility”.

An interview with a health care worker of Pham Ngoc Thach hospital, who joined a training of trainers of reducing HIV- related S&D in health care and became a facilitator at facility training sessions, Ms. Sam Nhu Ha Vu, a lead nurse

“Through trainings for health care workers in my facility, I realized that many of them did not have full understanding of HIV and HIV transmission, and then they were afraid of HIV infection while providing health care services for PLHIV in my facility. So the training helped better improve their understanding of these issues. Development of code of practices for my facility came from proposed actions by health care workers during the trainings on reducing S&D in health care, then I think the code of practice would be very easily implemented and translated into their routine practices in my facility. Success of the programme I think comes from a strong commitment and support of my leaders, trainings for health care workers with appropriate approaches and great engagement of VNP+ members, and consensus of newly developed code of practices.

ANNEXES/ADDITIONAL RESOURCES

- Feature story posted on the UN Vietnam Website: <http://www.un.org.vn/en/feature-articles-press-centre-submenu-252/4363-viet-nam-embraces-zero-hiv-related-discrimination-in-health-care.html>
- Video clip posted on Facebook of RST AP: <https://www.facebook.com/unaid.s.asiapacific/videos/1406716999399346/>
- A baseline survey report
- A training manual
- Pictures of TOT of reducing S&D in health care
- Audio documents, which recorded interviews with Pham Ngoc Thach Health care workers
- Code of practice by Pham Ngoc Thach hospital

III. EASTERN EUROPEAN STATES

13. UKRAINE: Reducing HIV-related Stigma and Discrimination for Most-At-Risk Populations in Health Care Facilities in Ukraine (RESPECT)

TITLE OF THE PROGRAMME: Reducing HIV-related Stigma and Discrimination for Most-At-Risk Populations in Health Care Facilities in Ukraine (RESPECT)

CONTACT PERSON

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- **Start Date of the Programme:** Sep 18, 2013
- **End Date of the Programme:** October 01, 2017
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Gay men and other men who have sex with men, People who inject drugs, Prisoners and other populations in closed settings, Sex workers, Migrants (documented and undocumented), refugees or internally displaced populations, People living in humanitarian emergency settings
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Ukraine has one of the fastest-growing HIV epidemics in the world, with significant numbers of new infections and AIDS death registered annually. The epidemic mostly affects key populations (KPs), such as People Who Inject Drugs (PWID), Men who Have Sex with Men (MSM), Commercial Sex Workers (CSWs), and prisoners. The prevalence of HIV/AIDS in Ukraine remains high despite efforts undertaken by the Government. Low access to HIV testing for KPs, inadequate coverage of Antiretroviral Therapy (ART), insufficient access to treatment for People Living with HIV (PLWH), and lack of adequate prevention and OST programs are the main challenges to epidemic control.

Since 1987, a total of 84,045 cases of AIDS have been reported and 38,457 deaths were attributed to AIDS. According to the Ukrainian Center for Social Disease Control of the Ministry of Health of Ukraine (UCDC) data, the current estimated number of PLWH in Ukraine is 238,000 as of January 1, 2017. Only 58% (126, 604) know their HIV-positive status. Out of this group, 98,325 (45%) are linked to care, with ART coverage 68, 455 (31%). Stigma and discrimination towards PLWH in Ukraine remains one of the main barriers to timely HIV testing and treatment. According to the Stigma Index research results (2013), PLWH experience stigma and discrimination (S&D) from the health care providers (HCP) throughout the entire cascade of services, which directly affects their access to medical services and adherence to treatment. According to the research results:

- 24% of PLWH were tested without counselling; 7% of PLWH were tested without their knowledge, and 10% were forcibly tested.
- Health care professionals (HCP) demonstrate the lowest level of support after discovering the HIV status of PLWH: 25% of PLWH felt discriminatory attitude from HCP when they have shared their HIV-positive status (versus 5% from friends and 8% from husband/wife/partner).
- 11% of PLWH people experienced S&D caused by their HIV status in healthcare facilities and were denied access to medical care due to their HIV status.
- 23% of PLWH stated that medical workers told other people about their HIV-status without their consent.
- 62% of PLWH made self-discrimination decisions including avoiding visits to outpatient clinics (21%) and avoiding hospitalization when they needed it (18%).

BENEFICIARIES AND IMPLEMENTERS

The program has been implemented in close cooperation with the Ministry of Health of Ukraine (City/Region Health Care Departments), AIDS Centers and the other healthcare facilities in six high burden regions of Ukraine. The Project was focused on changing policies, knowledge base and practices of the HCPs working in the mainly visited by PLWH and KPs HCFs.

In order to enhance HIV testing, and avoid losses between HIV testing and linking patients to medical care at the AIDS centers, the program worked with main three types of HCFs – “points of entry” of potential clients, such as TB clinics, STI clinics, and Drug Rehabilitation clinics. In order to decrease stigma and discrimination and ensure access to general medical treatment, also enhance provider initiated HCT, the project worked with other types of HCFs (ex. primary healthcare settings, policlinics, general in-patient clinics/units, Obstetrics/Gynaecology facilities etc.).

In total, 63 healthcare facilities were covered by the program interventions.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Activities took place in six regions (both City and Regional level) of Ukraine – Dnipropetrovsk, Cherkasy, Lviv, Kyiv, Kirovograd, Mykolaiv.

FINANCING AND SUSTAINABILITY

The program was implemented by the Ukrainian Network of People Living with HIV/AIDS (Network) and financed by USAID. Significant efforts were made to ensure the sustainability of the proposed interventions by strengthening the knowledge and practices of HCPs who work with KPs by providing special post-graduate training, as well as by implemented KPs- and PLWH-friendly policies on HIV/AIDS care and management at health care facilities. Sustainability of the proposed interventions was ensured by recognition (by the regional HCDs) and institutionalization of the developed policies and practices (CITT and CBTM) at the local level.

Post-graduate training for family doctors “Managing HIV-positive patient by family doctor” became a part of the pilot Medical Universities’ training curricula and was supported by local budgets. 4 cycles of thematic improvement were conducted by budget costs. Emphasis was also made on building the capacity of Network to Institutionalize and scale-up efforts to reduce HIV-related S&D towards KPs among HCP. Project developments were shared with the other stakeholders and partner projects funded by different donors.

DESCRIPTION

The Project goal was to increase access to HIV testing and treatment by reducing HIV-related stigma and discrimination towards representatives of key populations and PLWH by health care providers. This was achieved within the three Project objectives:

- Objective 1: By decreasing S&D, increase the number of patients on ART through implementation of Client's Involvement-to-Testing-and-Treatment (CITT) and a Community-Based HIV Testing model (CBTM) in four project pilot regions.
- Objective 2: Pilot medical universities, at the expense of local budgets, carry-out a post-graduate training program for family doctors/general practitioners on management of HIV-positive patients.
- Objective 3: Enhance the capacity of Network and its RAs to address HIV-associated S&D towards KPs/PLWH and increase the number of people receiving HIV testing & treatment.

An integrated approach is the key to success: during the preparation for the project it became clear that it is necessary to work simultaneously in two directions: to increase the knowledge and skills of both medical workers and patients themselves.

In this purpose Stigma reducing activities within the Client's Involvement-to-Testing-and-Treatment intervention (CITT) developed and piloted by the Project proved to be an effective response to the needs of the country in reaching of UNAIDS' 90-90-90 goals and ensuring the continuum of medical-social services for PLWH. CITT Model includes:

- Assessment of stigma level among health care providers of the pilot HCFs
- Approval by the chief doctors and implementation by the medical staff of the PLWH/KPs friendly policy including a client referral system; compilation of Ukrainian legislation on universal precautions (UP) for prevention of HIV infection in the workplace; post-exposure prophylaxis (PEP) of medical staff; waste management (WM) instructions
- Trainings for HCPs on HIV, S&D, UP, PEP, WM and client referral to HIV testing, treatment, care and support programs
- Development, approval and implementation of the algorithms of client involvement into HIV testing and treatment
- Legal support of PLWH in S&D cases in HCFs
- Psycho-social support of PLWH with focus on decreasing of internalized stigma.

First of all, it was necessary to change the attitude of medical personnel to HIV-infected patients. The majority of stigma and discrimination cases were due to the lack of knowledge among health professionals on the topic of HIV. Many of them were not sufficiently acquainted with the legislation in the field of HIV, which entailed making wrong decisions. Lack of general knowledge about the epidemiological situation with HIV led to the fact that health professionals did not understand their importance in the prevention and treatment chain.

Another factor that led to the violation of the rights of PLHIV/key population was that there were no policies in the medical institutions for dealing with such patients. Ignorance of the algorithm of their actions by medical personnel led to conflicts with patients.

To solve these problems, training modules for medical personnel have been developed for all necessary issues. After that, trainings were conducted for the staff of all the pilot medical institutions that participated in the project. And as a result, it became possible to develop PLHIV/key population-friendly policies in each HCF.

On the other hand, work was done with the clients themselves. This work included gathering information about violations of the rights in order to work with a client in a multidisciplinary team consisting of a social worker, a psychologist and lawyer. Each of the team's specialists was directed to the solution of their task. As a result, social support was provided to the project clients, as well protection of their legal rights, informing and training how to protect the rights, as well as work with self-stigma and improvement of the psychological state.

In addition, the Project gave significant input into the post-graduate education of family doctors who play the role of "entry point" into the healthcare system and can potentially identify patients in need of HIV testing and treatment. Thus, through the project's efforts, a 5-day curriculum on "Managing HIV-positive patient by family doctor" was developed and approved by the leading Medical Universities of Ukraine. After the respective manual for trainers was published, academics from the five Medical Universities were fully prepared to train family doctors.

RESULTS OF THE PROGRAMME

- 6,223 health workers took part in 270 training events in stigma and discrimination reduction
- 63 health facility policies were developed implementing:
 - PLHIV/key population-friendly policies
 - Universal prevention and post-exposure prophylaxis
 - Medical waste disposal
- 8 information/visual materials were designed and disseminated at pilot medical facilities
- 3031 client received services within the Project:
 - medical and social support of a social worker;
 - provision of services to reduce clients' internal stigma;
 - providing legal protection in cases of HIV-related discrimination in the HF.
- Within Pre-service training at 10 medical universities and colleges:
 - 1382 nurses trained in reducing stigma and discrimination against PLWH and Key Populations
 - 1094 doctors trained in reducing stigma and discrimination against PLWH within Epidemiology Course
- 327 family doctors are trained within the post-graduate training course "Management of HIV+ patient by family doctor"

(The data as of July 31, 2017)

OUTCOMES AND IMPACT OF THE PROGRAMME

Due to the implementation of CITT Model:

- Comparative analyses of the stigma level assessments conducted in the project's pilot health care facilities (HCFs) before and after the project interventions show significant improvement, demonstrating the effectiveness of the piloted models: the level of knowledge about HIV transmission changes from 56% to 66%. Level of stigma caused by fear of being infected changed from 20% to 7%. Decreased number of HCP who believe that PLWH should be treated separately from others to protect the general population from infection (from 40% to 16%) and who say that if the HCP is afraid of infection from the patient, he may refuse to treat him (from 12% to 10%). The positive dynamic is observed in the practice of disclosure of HIV status of the client without his/her consent – from 42% to 21%.

- Within the project in pilot HF 3610 clients were referred to HIV Testing Services (HTS) and tested. 730 of them had a HIV-positive result and 493 of these clients were registered at the AIDS-centers to receive appropriate ARV treatment.

Due to the implementation the curriculum and program cycle of thematic improvement "Management of Patients with HIV/AIDS by Family Doctor":

- Results of studies show that the general level of knowledge of family doctors after training increased from 58% to 77%. In addition, as a result of the training, the level of communication and cooperation at regional level between family doctors, representatives of NGOs and specialized medical facilities increased. Therewith, the number of patients referred to the HIV testing counselling centers and to the second level of health care services provision increased too (in 4,5 times in average) as a result of changing family doctors attitude to HIV-positive people and willingness to share gained knowledge among other medical staff of HCFs.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The project has established a strong Monitoring and evaluation (M&E) system and used appropriate data collection and analysis methods to determine whether program activities are achieving the targets and expected outcomes and are effective and replicable. M&E project activities helped evaluate the effectiveness of undertaken S&D reduction interventions, identified the most effective set of interventions for scale-up, and determined any unintended consequences of the proposed interventions.

The M&E activities took place in accordance with the Network's guidelines and using a results-based management approach. The monitoring activities were carried out by the assigned personnel. The program personnel and implementing partners were responsible for ensuring the adequacy, consistency and regularity of M&E activities, as well as their operational implementation. All program activities were supported by primary documentation to the extent possible.

The M&E tools were used by Network to track the progress of program implementation and measure its results included the following:

- Establishing and tracking of indicators;
- Field monitoring visits and respective reports and checklists;
- Submission of progress reports to donor;
- Submission of regular financial reports to donor;
- Annual reviews of the program implementation;
- Submission of final report to donor.

Also, implementation of the Project model was accompanied by a study of its effectiveness.

LESSONS LEARNED AND RECOMMENDATIONS

Non-governmental organizations can and should build effective interaction with medical settings to achieve effective work with different categories of patients. It is also necessary to conduct consistent work with the clients themselves in order to teach them to defend their rights, believes in themselves and their strength. And at the same time, medical structures, educational institutions and the state as a whole should not stand aside from all described processes, but go through institutionalization of the processes of training medical personnel with the knowledge and skills they need. It is necessary to expand training programs at the national level to train qualified specialists in accordance with the requirements of the time.

CONCLUSIONS

During the implementation of the project it became evident that the chosen approach is effective both in working with patients and in working with medical personnel. Moreover, this line of work is claimed and brings positive results both in terms of improving access to treatment, and in reducing the level of stigma and discrimination towards PLHIV/key population.

ANNEXES/ADDITIONAL RESOURCES

- PROJECT RESPECT: REDUCING HIV-RELATED STIGMA AND DISCRIMINATION FOR MOST AT RISK POPULATIONS IN HEALTH CARE FACILITIES
<http://network.org.ua/en/projects/proekt-respect-zmenshennya-stigmi-ta-diskriminatsiyi-povyazanoyi-z-vil-shhodo-predstavnikiv-grup-najvishhogo-riziku-v-medichnih-zakladah-ukrayini/>
- Manual "Management of Patients with HIV/AIDS by Family Doctor"
<http://network.org.ua/wp-content/uploads/2017/03/31cb3aa0d526dca74a922a8b458575b7.pdf>

IV. LATIN AMERICAN AND CARIBBEAN STATES

14.1 ARGENTINA: Programa de recepción y resolución de consultas para la respuesta al VIH en sistemas de salud

TITLE OF THE PROGRAMME: Programa de recepción y resolución de consultas para la respuesta al VIH en sistemas de salud

CONTACT PERSON

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- **Start Date of the Programme:** April 10, 2013
- **Responsible Parties:** Government
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescent, Gay men and other men who have sex with men, People who inject drugs, Prisoners and other populations in closed settings, Sex workers, Transgender people, Migrants (documented and undocumented), refugees or internally displaced populations and Indigenous people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

A partir del año 2013 la Dirección de Sida y ETS del Ministerio de Salud de la Nación Argentina creó un área de trabajo con vistas a fortalecer el enfoque de derechos humanos aplicado a la salud. El objetivo de esta área es trabajar en la difusión y la exigibilidad de los derechos, desde un abordaje integral, facilitando la participación de las organizaciones sociales en búsqueda de la equidad y el pleno disfrute del derecho a la salud para la personas con VIH en la República Argentina. En esta acción, la Dirección tuvo el apoyo integral del Programa Conjunto de las Naciones Unidas sobre el VIH/sida (ONUSIDA), tanto desde el financiamiento de consultores y actividades, como así también del sostenimiento de la posición de respaldo del enfoque de derechos humanos aplicado al derecho a la salud de las personas con VIH y el Sida.

Se partió de la premisa de que existen barreras de accesibilidad sobre las cuales se debe trabajar desde la gestión pública para conseguir que los recursos del Estado alcancen a cada vez más personas y que las políticas diseñadas lleguen efectivamente a ellas. Desde un comienzo se planteó que esta área actúe como conector entre el Estado y la sociedad, ofreciéndose como una línea directa de comunicación a través de la cual las personas con VIH que residen en Argentina, los programas jurisdiccionales, otras agencias estatales, los servicios de salud, las organizaciones sociales y activistas puedan recibir el asesoramiento necesario para evitar la vulneración de los derechos fundamentales de las personas con VIH.

Teniendo en cuenta el carácter federal y descentralizado de la salud en la República Argentina, el área también pretende servir de nexo articulador entre las distintas jurisdicciones y entre estas y las diferentes áreas del Estado Nacional que deban involucrarse en la respuesta a fin de elaborar estrategias conjuntas y abarcativas aplicando el enfoque de derechos humanos en salud a la gestión pública.

Trabajar en conjunto con las organizaciones de la sociedad civil, con las personas afectadas y los efectores públicos, intentando detectar las dificultades de implementación de las políticas decididas y buscando resolver estas dificultades teniendo como horizonte la ampliación de derechos, son los ejes centrales del área. Prestar asesoramiento legal brindando herramientas de empoderamiento complementa dicho eje, teniendo como horizonte la formación de redes de trabajo en territorio.

El objetivo es articular sinérgicamente los distintos actores involucrados en la respuesta al VIH, para lograr un abordaje integral desde el enfoque de derechos y a su vez el armado de una red de contención jurídica que difunda los derechos y asesore en su defensa.

BENEFICIARIES AND IMPLEMENTERS

Los beneficiarios del programa son las personas infectadas y afectadas por el VIH, incluyendo las poblaciones LGBTIQ, trabajadorxs sexuales, usuarios de drogas inyectables, migrantes, poblaciones originarias, equipos de salud, agencias estatales y sociedad civil.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

El programa se desarrolla y se implementa a nivel nacional.

- 2014- 400 consultas
- 2015 -700 consultas
- 2016-1100 consultas
- 2017 -+ de 1500 (estimado)

FINANCING AND SUSTAINABILITY

El programa se financia con el presupuesto correspondiente a la Dirección de sida y ETS del Ministerio de Salud de la Nación, institucionalizado anualmente.

DESCRIPTION

El servicio del programa se desarrolla a través de la recepción de consultas y/o reclamos que llegan a través de la línea 0800 gratuita, el correo electrónico, el formulario web de la página de la Dirección de sida y ETS, teléfono directo, redes sociales a través de comunicación y personalmente en la dirección.

El equipo del área, analiza el contenido de la consulta y realiza un control de calidad de la información recibida y toma contacto con el consultante dentro de las 48 horas. Se articula con las agencias que corresponden según el caso y se contacta al consultante con dicho servicio para la solución del caso. Cuando la consulta se produce en una provincia se articula con los actores locales. Una vez finalizada la consulta se registra el caso en una base de consultas de datos que es confidencial. Esta base de información sirve para análisis y desarrollo de programas específicos de intervención. Anualmente se realiza una evaluación cuantitativa y cualitativa de todos los casos como una especie de observatorio nacional de acceso a servicios y al derecho a la salud.

RESULTS OF THE PROGRAMME

A nivel nacional se lleva un registro de casos que arroja el siguiente resultado que se incrementa anualmente.

- 2014- 400 consultas resueltas
- 2015 -700 consultas resueltas
- 2016-1100 consultas resueltas
- 2017 -+ de 1500 (estimado)

OUTCOMES AND IMPACT OF THE PROGRAMME

A través del análisis y evaluación anual del programa se ha obtenido información estratégica para elaborar la revisión de la ley Nacional de Sida 23798 que se encuentra en el Congreso Nacional para su aprobación.

También, a través de el análisis se determinan las regiones más vulnerables en cuanto a acceso a servicios para las poblaciones claves, informando a la Dirección la necesidad de realizar en dichos lugares capacitaciones y encuentros a los fines de fomentar políticas y acciones programáticas provinciales de acceso al servicio de salud sin discriminación. Para el incremento de acceso, cambio de prácticas, actitudes y calidad de atención el programa articula con los organismos especializados para la resolución rápida de los casos evitando la judicialización de los mismos y la demora en el tiempo.

Los beneficios que se generan es el monitoreo constante de los servicios de salud a través del diálogo constante con las organizaciones de la sociedad civil que son las fuentes de información principales. Asimismo, se han capacitado equipos de salud en cuanto al enfoque de derechos humanos en salud, aumentando el acceso de las poblaciones claves y más vulnerables a los servicios de salud.

A través de las capacitaciones y casos puntuales resueltos, se ha reducido considerablemente el estigma y discriminación en los servicios de salud a nivel nacional. Para ello se están formando y actualizando sobre legislación vigente, guías y nuevas prácticas a los equipos de salud.

En resumen este programa ha creado una cultura de (mutual accountability) en la ejecución de las políticas y programas provinciales, como también acciones dirigidas al público directamente para acceso a la justicia.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Se realiza acciones de evaluación y monitoreo en forma bienal para el control de calidad del programa y sus servicios a través de encuestas dirigidas a los equipos de salud (jefes de programas provincial de VIH) para analizar si la calidad y las metas se están efectivizando. Con el análisis de la información obtenida se ajustan las acciones de trabajo para el mejor acceso a los servicios de salud para las poblaciones claves. Dentro del equipo de trabajo se analizan las acciones desplegadas y se ajusta el plan de trabajo en forma dinámica buscando la línea que garantice un acceso a los servicios de salud sin discriminación.

LESSONS LEARNED AND RECOMMENDATIONS

Este programa tiene el apoyo político e institucional del Ministerio de Salud de la Nación y se refleja en el presupuesto anual de la Dirección de sida y ETS., tiene el apoyo de las organizaciones de la sociedad civil de VIH, incrementa anualmente la demanda por parte de particulares, agencias estatales y programas jurisdiccionales en cuanto a colaboración de

casos particulares, solicitudes de capacitaciones sobre el enfoque de derechos humanos aplicado en salud y a las organizaciones sociales que dan respuesta en VIH. Este programa es reconocido por los gobiernos provinciales y municipales que nos solicitan capacitaciones, materiales, etc.

Las dificultades que se presentan en el desarrollo del programa, son entre otras, la falta de recursos humanos y financieros para expansión de las líneas de trabajo y para mantener una cantidad mínima de encuentros entre equipos de salud y particulares que utilizan esos servicios. Una dificultad que se trata de disminuir constantemente es la autodiscriminación y frustración de las personas que no han accedido a los servicios de salud y desconocen cómo exigir su derecho.

Nuestros análisis demostraron que por cada una persona que reclama efectivamente en el área, hay otras personas que no tuvieron voz para reclamar sus derechos.

CONCLUSIONS

La conclusión del programa es positiva ya que desde su creación ha expandido su difusión e implementación de líneas de trabajo efectivas para mejorar el acceso a derecho de las personas en cuanto al acceso a los servicios de salud. Intentamos replicar el modelo de trabajo a nivel provincial y municipal teniendo en cuenta las particularidades de cada región, siempre en consulta permanente con la sociedad civil y grupos vulnerables para eliminar el estigma y discriminación en los servicios indicados.

ANNEXES/ADDITIONAL RESOURCES

- Informes anuales 2014, 2015 y 2016 y resultados con recomendaciones.

14.2 ARGENTINA: Consultorios amigables para la población LGTBI

TITLE OF THE PROGRAMME: Consultorios amigables para la población LGTBI

CONTACT PERSON

Name: SERGIO MAULEN

Title: CONSULTORIOS AMIGABLES PARA LAS PERSONAS DE LA DIVERSIDAD SEXUAL

Organization: DIRECCION DE SIDA Y ENFERMEDADES DE TRANSMISION SEXUAL
MINISTERIO DE SALUD DE LA NACION

Address: AV. 9 DE JULIO 1925 – PLANTA BAJA – CIUDAD AUTONOMA DE BUENOS AIRES

Tel: +54-11- 4379-9000 INTERNO 4056

Email: prevenciondsyets@gmail.com

- **Start Date of the Programme:** October 2010
- **End Date of the Programme:** Continua funcionando.
- **Responsible Parties:** Government, Civil society, UN or other inter-governmental organization
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Gay men and other men who have sex with men, Prisoners and other populations in closed settings, Sex workers, Transgender people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan other than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Situation epidemiológica de Argentina

Los datos aquí consignados fueron extraídos del Boletín sobre el VIH-sida en la Argentina N° 33 publicado por la Dirección de Sida y ETS del Ministerio de Salud de la Nación en diciembre de 2016.

En Argentina se estima que existen 120.000 personas que tienen VIH de los cuales el 30% desconoce su diagnóstico. Cada año se siguen reportando 6500 nuevos casos. En cuanto a las características de las personas diagnosticadas entre 2013 y 2015, más del 90% adquirieron la infección durante prácticas sexuales desprotegidas. Por cada nuevo diagnóstico de mujeres se producen dos de varones. La mediana edad de diagnóstico es de 32 años para las primeras y de 33 años para los segundos. El 20 % de los diagnósticos se producen en personas menores de 25 años y el 21% en personas de 45 años o más. El 32% de los varones y el 23% de las mujeres se diagnostican cada año en forma tardía. A su vez, la tasa de mortalidad por sida en 2014 se ubicó en 3,4 por 100 mil habitantes. Ambos indicadores no muestran cambios en relación a lo informado en los últimos años.

En cuanto a la transmisión perinatal del VIH, cada año dan a luz alrededor de 1.600 mujeres con VIH. La tasa de transmisión perinatal del VIH se encuentra estable en un valor de 5,2% para el período 2013-2015, en tanto que la tasa de sífilis congénita ha aumentado los últimos años.

La prevalencia de VIH en nuestro país es de 0,4 % entre los jóvenes y adultos de toda la población, mientras que es del 34 % para personas trans, 12% en hombres que tienen sexo con hombres y 5 % en trabajadoras/es sexuales.

Los indicadores presentados son de carácter nacional, por lo que las realidades pueden cambiar de provincia en provincia e incluso entre los grandes centros urbanos y ciudades más pequeñas.

Antecedentes desde la DSyETS

En el año 2008 se creó el área de Prevención dentro de la DSyETS, que incluía un equipo dedicado a la diversidad sexual y otro al trabajo con la sociedad civil. Estos equipos fueron los responsables de crear y sostener en el tiempo las políticas sanitarias destinadas a la población de la diversidad sexual en el marco de la respuesta nacional a la epidemia de VIH. Una de las primeras acciones de estos dos equipos, que contó con el apoyo de PNUD, ONUSIDA, UNFPA y OPS, fue la realización de una investigación diagnóstica multicéntrica y participativa con el objetivo de conocer la experiencia de las personas gay, trans y bisexuales en 14 ciudades del país, así como su relación con el sistema 18 de salud. También incluyó entrevistas a integrantes de los equipos de salud de 13 hospitales con el fin de indagar sobre la actitud y el grado de conocimiento que tenían respecto a los grupos de la diversidad sexual.

Los resultados principales de esta iniciativa inédita en el país fueron volcados en una serie de publicaciones (resumen ejecutivo, tres informes y ocho separatas), que se difundieron ampliamente y que al final se encuentran los links de consulta.

Las conclusiones de esta investigación impulsaron a la DSyETS –en articulación con las agencias de Naciones Unidas– a realizar un primer proyecto de creación de consultorios amigables (CA) como una estrategia para mejorar el acceso de los grupos de la diversidad sexual al sistema público de salud.

Los resultados de la investigación permitieron identificar tres núcleos fuertes que afectaban de modo negativo la relación de la diversidad sexual con los servicios de salud, limitando el acceso y la calidad de la atención. Estos fueron:

- El temor a revelar la orientación sexual o las prácticas sexuales obstaculizaba el acceso y enturbiaba la relación equipo de salud-paciente;
- Las personas trans temían ser objeto de burlas y malos tratos;
- Las instituciones y los equipos de salud no estaban (ni se sentían) en general suficientemente capacitados para trabajar de modo más específico con esta población.

Fue así que a la evidencia epidemiológica que mostraba la desigual distribución del VIH en la Argentina, se sumó la fuerza de los resultados cualitativos producidos por la investigación, poniendo de manifiesto la necesidad de experimentar algún tipo de intervención destinada a mejorar el acceso al sistema público de salud y la calidad de la atención que éste brindaba.

BENEFICIARIES AND IMPLEMENTERS

Los beneficiarios y beneficiarias prioritarios del programa son las personas trans femeninas y masculinas, personas gay, trabajadoras y trabajadores sexuales. Asimismo acceden personas cisgénero que no acceden al sistema de salud por diferentes barreras (económicas, geográficas, culturales, etc.)

Por otro lado, las personas involucradas para la creación y funcionamiento de los consultorios amigables son integrantes de equipos de salud a nivel local (puede ser de un hospital o centro de atención primaria), gobierno local (municipal y/o provincial) y organización de la sociedad civil. En este sentido las poblaciones clave forman parte de la planificación y creación del programa.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

El programa se implementa en todo el territorio nacional. Actualmente se encuentra en funcionamiento en la provincia de Buenos Aires, Santa Fe, San Juan y Ciudad Autónoma de Buenos Aires.

FINANCING AND SUSTAINABILITY

El financiamiento es múltiple. Los gobiernos locales garantizan el espacio físico y la contratación de los integrantes del equipo de salud. El gobierno nacional financia a las organizaciones de la sociedad civil, realiza las capacitaciones a los equipos de salud y produce y distribuye las guías y recomendaciones para la atención de la salud sin discriminación ni estigmatización.

DESCRIPTION

Desde 2010 se ha implementado el programa "Consultorios amigables para poblaciones clave" (CA).

Desde el inicio, el objetivo del programa consistió en crear servicios de salud para la prevención, diagnóstico y atención del VIH-SIDA y las ITS, y oferta de atención integral de personas de la diversidad sexual (LGTBI).

El propósito es mejorar el acceso a la prevención del VIH y la atención prestada por los hospitales públicos en todo el país.

Los servicios o consultorios amigables han sido diseñados para constituirse como una estrategia de inclusión de la población LGTB en el sistema de salud pública. El programa traduce las directrices y recomendaciones internacionales con respecto a la participación de las comunidades afectadas en la práctica.

Los servicios amigables se crean dentro de instituciones de salud pública existentes (por ejemplo hospitales o centros de salud) y se focalizan en dar respuesta a las necesidades específicas y las características de la población objetivo. Este enfoque ayuda a garantizar la sostenibilidad a largo plazo del programa.

Los servicios amigables están constituidos por representantes de la sociedad civil con experiencia en VIH-SIDA y derechos sexuales y equipos de atención médica de hospitales públicos.

La función específica de la sociedad civil es llegar a las poblaciones objetivo dentro de la comunidad y promover el uso de los servicios. Los miembros de la sociedad civil de los equipos también están a cargo de acompañar y / o recibir a las personas al acceder a los servicios amigables.

El equipo de salud que atiende el servicio amigable recibió capacitación sobre temas tales como conceptos de diversidad sexual e identidad de género, estructura y funcionamiento del servicio amigable, terapia hormonal, salud anal, diagnóstico del VIH y otras ITS; y aspectos legales del VIH y los derechos humanos;

El equipo realiza la atención en horario amplio y flexible (por las tardes o por la noche); El equipo provee, bajo demanda, una serie de servicios como atención clínica, consejería, diagnóstico de VIH y otras ITS, apoyo psicosocial y tratamiento hormonal para personas trans.

El proyecto es implementado por la Dirección Nacional de SIDA e ITS, que creó un equipo coordinador, que se encarga de otorgar los siguientes recursos a los equipos involucrados en el programa a nivel local:

- Capacitación en diversos temas de salud relacionados con la población del LGTB,
- Financiamiento mediante subsidios a organizaciones de la sociedad civil que presenten proyectos para promover acciones de promoción y prevención entre pares.
- Distribución de los recursos materiales necesarios para la ejecución del proyecto (preservativos, geles, lubricante, materiales gráficos y de promoción).
- Reuniones de seguimiento y evaluación del programa del equipo local.

Características distintivas del Consultorio Amigable

- Es una estrategia destinada a mejorar el acceso y la calidad de la atención de la población de la diversidad sexual en el sistema público de salud.
- Propone generar al interior de los establecimientos sanitarios espacios de efectiva reafirmación de los derechos a la salud de la diversidad sexual
- Materializa el lineamiento político que recomienda el trabajo conjunto de la sociedad civil y el Estado en una propuesta concreta de organización del trabajo sanitario. Se trata de un reordenamiento de recursos existentes (lo que apuesta a la sustentabilidad de la estrategia en el tiempo) centrado en las características y necesidades específicas de esta población.
- Consiste en conformar un equipo mixto de trabajo entre las OSC con trabajo en VIH-sida y/o derechos sexuales y un equipo de salud inserto en un Hospital Público o Centro de Salud.
- Las funciones específicas de la OSC serán la promoción del Consultorio en los escenarios donde se mueven los grupos de la diversidad, ya sea lugares de esparcimiento, lugares de encuentro y/o lugares de trabajo sexual. Serán también los encargados de acompañar y/o recibir a esta población cuando acceda al Consultorio.
- El equipo de salud asume el compromiso de capacitarse en temas novedosos y brindar en horario aceptable (de preferencia vespertino o nocturno) y por demanda espontánea una canasta de prestaciones tales como atención clínica, asesoramiento y diagnóstico en VIH y otras ITS, apoyo psicosocial y hormonización para el caso de las personas trans que lo demanden.

RESULTS OF THE PROGRAMME

La información que aquí se expone fue publicada a inicios de 2017 y fue resultado de un proceso de sistematización del año 2015-2016.

En la siguiente tabla se detallan los 21 servicios amigables que formaron parte del estudio. Se indica su localización geográfica, el nombre del establecimiento y el año de creación.

PROVINCIA	LOCALIDADES	ESTABLECIMIENTO	AÑO DE CREACION
Buenos Aires	Mar del Plata	Centro de Salud Nº 1	2010
	San Martín	Hospital Local Alexander Fleming	2012

	Lanús	Hospital Evita	2012
	José C. Paz	Centro de Salud "Las Heras"	2013
	Tigre	Programa municipal. Varios centros de salud	2013
	Ezeiza	Servicio Penitenciario Federal CPF 1 (Complejo Penitenciario Federal 1)	2013
	Chivilcoy	CIC	2014
	Morón	Hospital Municipal Lavignole. Consultorios externos	2014
Ciudad de Buenos Aires		Asociación Civil Nexo	1992
		Hospital Ramos Mejía	2006
		Centro de Salud y Acción Comunitaria N° 11	2009
		Centro de Salud y Acción Comunitaria N° 25	2013
		Hospital Fernández	2013
		Hospital de Clínicas	Sin fecha
Santa Fe	Rosario	Centro de Salud Martín	2006
	Rosario	Hospital Centenario	2012
San Juan	San Juan	Hospital Dr. Guillermo Rawson	2010
	Departamento Rawson	Centro de Adiestramiento René Favaloro	2010
	Pocitos	Hospital Dr. Federico Cantoni	2014
	Chima	Centro de Salud Báez Laspiur	2014
San Luis	Villa Mercedes	Policlínico Regional Juan Domingo Perón	2013

En términos de cantidad de CA, la Provincia de Buenos Aires se ubica en primer lugar con 8 espacios, uno de los cuales (Ezeiza) es el único CA dentro del Sistema Penitenciario Federal.

En segundo lugar se encuentra la Ciudad de Buenos Aires, que cuenta con 6 CA. Se destaca la Asociación Civil NEXO, ya que se trata del primer servicio amigable creado en el

país por parte de una ONG pionera en la lucha por los derechos sexuales de la diversidad y en la respuesta al VIH y sida para la comunidad LGTB. Es el único consultorio que se ubica por fuera del sistema público de salud, aunque forma parte activa de la política de la Coordinación Sida (el programa municipal de VIH de la Ciudad de Buenos Aires). Los otros servicios se han ido conformando como parte del estímulo de la Coordinación Sida, siendo el del Ramos Mejía el pionero en funcionar dentro de un hospital, en articulación con una ONG.

Un caso especial es el del espacio ubicado en el servicio de ginecología del Hospital de Clínicas, único establecimiento que no identifica una fecha de inicio de sus actividades con la población de la diversidad sexual. Como se verá más adelante, se destaca la presencia de población trans masculina que accede por la posibilidad de recibir cuidado médico para su hormonización.

En tercer lugar se ubica la provincia de San Juan (4 CA), que inició la propuesta con el apoyo de la DSyETS en el año 2010 y fue sumando consultorios en diferentes municipios en un plan sistemático y siempre coordinado por el programa provincial de VIH y ETS.

Rosario fue pionera en la creación de un CA en el sistema público de salud, con la apertura de un espacio amigable en el Centro de Salud Martín en trabajo conjunto con el área de Diversidad Sexual del Municipio.

La Secretaría de Salud Pública de Rosario fue la primera en comprar hormonas para entregar de modo gratuito a las personas que solicitaron atención.

El consultorio de Rosario comenzó funcionando en un horario especial y acotado -los martes en turno vespertino- y con el paso del tiempo logró transformar a la institución (el centro de salud) en un establecimiento amigable, ya que la atención de las personas trans se realiza en el mismo horario de funcionamiento general del centro de salud.

La experiencia de Rosario fue fundamental para el desarrollo de los CA en la medida que la DSyETS tomó esta experiencia como modelo para implementar más consultorios en el país. En el año 2012 Rosario agregó su primer consultorio en el marco de un hospital, el Centenario, y promovió la capacitación e implementación de cirugías de reasignación de sexo.

En el caso de San Luis se ha incluido un consultorio que funcionaba en Villa Mercedes por impulso y voluntad de una médica infectóloga. En este consultorio se ha consolidado un equipo interdisciplinario y atiende en horario nocturno dos veces por mes.

Modelo de atención y conformación de los equipos

LOCALIZACIÓN INSTITUCIONAL

La mayoría (45%) de los consultorios amigables (10) se encontraba localizado en hospitales; el 36% (8) en Centros de Salud, y uno en un CIC (Chivilcoy) que forma parte de la red de atención del municipio. Uno se encontraba en el Sistema Penitenciario Federal (SPF) (Módulo 6 del Pabellón de la Diversidad Sexual, CPF I de Ezeiza) y uno en una ONG, la Asociación Civil Nexo.

MODELO DE ATENCIÓN

Por “modelo de atención” nos referimos a la manera en la que los equipos de salud se organizan para brindar servicios preventivos, diagnósticos y asistenciales. La elección de un horario específico, acotado y de preferencia vespertino para el inicio del trabajo de los CA

fue una de las recomendaciones generadas por la DSyETS (Guía de Consultorios Amigables disponible mas abajo) con la idea de consolidar en el inicio un núcleo fuerte y de alta calidad de atención que pudiera, con el paso del tiempo, funcionar como puerta de entrada a los otros servicios que brinda el establecimiento para la población general.

El modelo de atención que están implementando los consultorios muestra dos modalidades básicas:

EQUIPO AMIGABLE

Un grupo de profesionales, un servicio o un establecimiento se volvieron “amigables” y ofrecen un horario relativamente extenso en el cual las personas pueden acudir. Es decir que el equipo de salud sostiene su horario habitual de trabajo para la población general y abre sus puertas a la diversidad. El pionero Centro Martin de Rosario inició sus actividades en el año 2006 con la modalidad de horario específico y con el paso del tiempo todo el centro de salud se volvió un equipo amigable.

OFERTA CONCENTRADA

En un horario específico (uno o dos segmentos de 4 horas, de preferencia vespertino) se constituye un equipo generalmente integrado por profesionales del sistema público de salud que por decisión política del municipio cambian su horario de trabajo para participar del consultorio amigable.

Consideraciones:

- Es importante tener en cuenta la existencia de estos dos modelos en los consultorios bajo estudio a la hora de considerar los resultados que se presentan a continuación.
- En general, los consultorios que se transformaron en equipos amigables disponen de un horario de atención más extenso y se encuentran integrados por una mayor cantidad de profesionales, aunque la oferta puede ser menos específica.
- En general, los consultorios que adoptan la forma de oferta concentrada tienen una propuesta más enfocada, en un horario específico y realizan mayores esfuerzos en materia de promoción de sus actividades y prevención en espacios comunitarios.
- La experiencia mostraría que resulta más conveniente iniciar el trabajo en la modalidad oferta concentrada y que el paso del tiempo lleve al modelo equipo amigable.

HORARIOS DE ATENCIÓN

El 60% de los CA tiene sus puertas abiertas por la tarde y el 40% ofrece un horario nocturno. En general los horarios de mañana (35% de los efectores) se corresponden con equipos del modelo amigable, mientras que los que ofrecen horarios de tarde y vespertinos se corresponden a los del modelo oferta concentrada. Un total de seis consultorios tienen la opción de más de un segmento horario (uno en San Martín: mañana y noche; dos en Rosario: mañana y tarde y tres en CABA: dos de ellos mañana y tarde y uno por la tarde y noche). Se destaca, además, que el Centro de Salud Martin de Rosario y el Hospital Ramos Mejía de la Ciudad de Buenos Aires ofrecen servicios de alta calidad en horario extendido. Es interesante notar que estos son los espacios amigables pioneros de la propuesta en el país.

INTEGRANTES DEL EQUIPO

¿Quiénes y cuántos son los profesionales o personas con otro perfil que integran los consultorios amigables? El análisis de los 21 consultorios muestra lo siguiente:

- Los consultorios se encuentran conformados por un número que va desde tres hasta 15 integrantes, siendo lo más frecuente un equipo integrado por tres a seis personas.
- Los perfiles más frecuentes son médico (generalista, clínico, infectólogo, ginecólogo y endocrinólogo), psicólogo, trabajador social y promotor. Además se han identificado bioquímicos, odontólogos, enfermeros, técnicos extraccionistas, fonoaudiólogos y administrativos.

En cuanto al equipo ampliado -esto es, otros profesionales o servicios del mismo establecimiento o de otros cercanos con los que se interactúa de modo permanente y pautado con turnos preferenciales programados- se han mencionado urología, proctología, cirugía plástica, cirugía general y toxicología.

De los equipos básicos y/o ampliados participan, en la mayoría de los consultorios, integrantes que no pertenecen al sector salud. Se trata de organizaciones de la sociedad civil que trabajan en diversidad y/o derechos sexuales. En los consultorios estudiados las organizaciones eran: 100% Diversidad y Derechos, Bachillerato Popular Trans “Mocha Celis”, ATTTA, Conurbanos por la Diversidad, Rita, Unidos contra el sida, Red Bonaerense de personas viviendo con VIH, VOX y Red Diversa.

También, muchos CA están integrados por representantes de organismos municipales que implementan políticas de género, desarrollo social, derechos sexuales y desarrollo sociocultural.

Estas participaciones “intersectoriales” están fuertemente vinculadas a la promoción de los servicios (el rol de los/as promotores de la diversidad) así como a una gama de prestaciones más amplia (asesoramiento legal, apoyo para actividades culturales de promoción y prevención, acceso al DNI, acceso a otras prestaciones sociales y defensa ante vulneración de derechos). La presencia de diferentes organismos es en muchos casos un indicador del apoyo político que brinda el municipio a la respuesta integral a la población de la diversidad sexual y al consultorio.

Merece destacarse el rol que cumplió el Ministerio de Desarrollo Social de la Nación, que fue mencionado por varios integrantes de los consultorios como el lugar adonde recurrían para obtener las hormonas femeninas y masculinas para las personas trans que se atendían en los CA.

Todos los consultorios contaban con un equipo interdisciplinario. La mitad de los CA se encontraban conformados por la asociación con una ONG y más de la mitad contaba con promotores que pertenecían a los grupos de la diversidad, aunque no necesariamente a una organización. En varios lugares la alianza se había realizado con otro organismo del Estado (generalmente municipal) que cumplía el rol de promover el servicio en la población objetivo. La mayoría de los consultorios han compartido el trabajo con ONG o promotores diversos. Es indispensable señalar que en los casos en los que esta alianza no fue posible o se desintegró, el CA no se pudo terminar de conformar por la ausencia de demanda.

El caso más notorio fue el del Municipio de Tigre, que incluyó cinco centros de salud para las capacitaciones a fin de consolidar los CA. Pero la firme decisión política de no articular con las ONG hizo que los equipos quedaran conformados pero la población no concurrió a los consultorios.

En otros lugares, como en el caso de los CA de San Juan, el proyecto comenzó trabajando con una ONG pero las desavenencias hicieron que la alianza se rompiera. Sin embargo los CA pasaron a contratar promotores de la diversidad sexual con fondos provinciales.

Otro ejemplo paradigmático lo constituye el CA del Hospital de Clínicas. Comenzaron a trabajar con un promotor trans masculino, quien traccionaba población al consultorio. Pero los diferentes modos de entender la atención (el equipo de salud quería comenzar con estudios y actividades que eran excesivas para los hombres trans, quienes solo querían recibir las hormonas) hicieron que la alianza se disolviera.

Finalmente, los CA más “antiguos”, como es el caso del Centro de Salud Martín de Rosario y el CA del Hospital Ramos Mejía, manifestaron que, si bien comenzaron con un fuerte apoyo de las ONG para atraer población, con el paso del tiempo se fue extendiendo el “boca a boca” y las personas comenzaron a llegar solas, sin necesidad de ser traccionadas por un par.

PRESTACIONES DE LOS C.A. ACTIVIDADES DE PROMOCIÓN Y PREVENCIÓN

La creación de un espacio amigable conlleva dos instancias organizativas que se diferencian en términos de procesos de trabajo, pero que al mismo tiempo son indisolubles para tener un CA en funcionamiento.

Por un lado, es preciso construir un equipo de trabajo que esté capacitado y que logre articular con otros para conformar un equipo ampliado, capaz de brindar una oferta atractiva para la población de la diversidad sexual.

Por otro lado, es fundamental el trabajo de los promotores o pares a la hora de “convencer” a una población tradicionalmente excluida de que en el CA será bien recibida y atendida.

La experiencia de los últimos cinco años demuestra que en varios CA fue más fácil constituir un equipo de salud que atraer a la población a dicho servicio.

Por ello iniciamos el apartado sobre los servicios que brindan los CA haciendo mención a las estrategias que utilizar para promover su existencia entre la comunidad LGTB.

PRESTACIONES CLÍNICAS Y DIAGNÓSTICAS

Las prestaciones estaban fuertemente condicionadas por las experticias de base de los integrantes del equipo, al igual que las articulaciones. Por ejemplo, los equipos que se anclaron en infectología articulaban con proctología o ginecología; los que anclaban en medicina general articulaban con infectología, etc.

Vale la pena destacar que la mayoría de los consultorios brindaban sin derivación una de las prácticas más solicitadas por la población trans: la hormonización. Esta prestación la realizaban médicos que se formaron para este fin en el marco del proyecto, con excepción de los CA del Hospital Fernández (Servicio de Endocrinología) y del Hospital de Clínicas (Servicio de Ginecología).

La mayoría de los CA brindaban por demanda espontánea atención clínica, alguna clase de apoyo psicosocial o asesoramiento. En tres CA se instaló la estrategia de generar en la sala de espera conversaciones sobre los diferentes temas e inquietudes que traía la población, coordinadas por un integrante del consultorio.

Casi todos los CA contaban con acceso al diagnóstico de VIH, sífilis, hepatitis B y C. Muchos disponían del test rápido para VIH. En el caso de los test tradicionales, la

devolución de los resultados para VIH era rápida (entre 7 y 10 días), siendo un poco mayor la demora para los diagnósticos de las hepatitis.

La mayoría hacía diagnóstico clínico y tratamiento de gonorrea, clamidia y VPH, y casi todos disponían de la medicación necesaria para tratar las ITS en el CA. En varios lugares se mencionó también la disponibilidad de reactivos para realizar estudios de laboratorio para confirmar gonorrea y clamidia.

En solo un consultorio el acceso al diagnóstico estaba severamente restringido, pero esto afectaba a la población general del municipio.

Con respecto a otras prestaciones, la posibilidad de resolver las demandas de forma inmediata o a través de un turno programado con otros servicios estaba fuertemente condicionada por la especialidad del o los médicos que integraban el CA.

Las prestaciones más frecuentes, además de clínica médica, acceso al diagnóstico y asesoramiento psicosocial eran la hormonización (con estudios de laboratorio de dosaje de hormonas), infectología, ginecología, salud mental y apoyo social para la realización de diversos trámites legales (como el DNI), incluido los pedidos de hormonas al Ministerio de Desarrollo Social. También se mencionó el acompañamiento en situaciones de internación (ver al final del documento los resultados sobre prestaciones).

La gran mayoría de los CA tenía circuitos armados para derivaciones protegidas a las siguientes especialidades: infectología, urología, proctología, endocrinología, ginecología, patología mamaria, psiquiatría, toxicología, odontología y fonoaudiología. Con menos frecuencia pero varias veces mencionadas fueron las articulaciones para realizar PAP anal, cirugía general y cirugía plástica. Las intervenciones más frecuentemente mencionadas fueron mastectomía y masculinización de pectorales para trans femeninas. Solo en el Hospital Centenario (Rosario) se mencionó la orquiectomía (extirpación de testículos). Para las personas trans masculinas se realizaban ablaciones de útero y ovarios.

La población que más se estaría beneficiando de los CA es la población trans, con mayor presencia de trans femeninas que de trans masculinos. La segunda población es la de varones gay. Esto parece razonable, teniendo en cuenta que la población trans es la más estigmatizada dentro del sistema público de salud (debido a su incapacidad de "ocultarse") y la que más prácticas de intervención (hormonización, implantes, cirugías) requiere para lograr la adecuación corporal del género con el que se identifica.

Principales demandas de atención por grupo poblacional (en orden de importancia)

Trans	Gay	Lesbianas	T.S.	HTS
<ul style="list-style-type: none"> •Hormonización •Cirugía •Salud mental •Servicios sociales y legales 	<ul style="list-style-type: none"> •Infectología •Control de salud •Laboratorio •Servicios sociales y legales 	<ul style="list-style-type: none"> •Control de salud •Ginecología •Infectología y laboratorio 	<ul style="list-style-type: none"> •Control de salud •Laboratorio 	<ul style="list-style-type: none"> •Infectología •Control de salud

Prestaciones más demandadas por toda la población



OUTCOMES AND IMPACT OF THE PROGRAMME

- Implementación por 8 años, de una política pública con una perspectiva de derechos humanos que promueve la accesibilidad de las personas LGBT al sistema de salud pública para reducir el estigma y la discriminación.
- Las iniciativas llevadas a cabo por la Dirección Nacional de Sida e ITS del Ministerio de Salud de la Nación, incluyen la producción de materiales destinados específicamente a equipos de salud, la población LGTBI y la comunidad en general.
- 21 CA instalados en el país y operando de acuerdo con las directrices de política de la Dirección Nacional de AISD e ITS.
- Los CA generaron una reorganización de los recursos existentes (lo que ayuda a garantizar la sostenibilidad de la estrategia a lo largo del tiempo) centrada en las características y necesidades específicas de esta población.
- Incorporación de organizaciones no gubernamentales (principalmente mujeres trans) al trabajo en equipo del CA.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Al principio, parte de los CA recibieron financiamiento inicial del ONUSIDA y el PNUD. Otros han recibido o aún reciben un subsidio de la Dirección Nacional de VIH-SIDA del Ministerio de Salud, para apoyar el trabajo de las organizaciones no gubernamentales (ONG). Los profesionales y promotores de la sociedad civil son financiados por los sistemas de salud provinciales y municipales.

En el caso de la provincia de San Juan, los/las promotores trans son financiados por el Ministerio de Trabajo local. Programa GECAL (Gestión de empleo en formación laboral).

CONCLUSIONS

La experiencia ayudó a generar una serie de recomendaciones detalladas a continuación:

- El papel de los promotores comunitarios fue esencial para construir una demanda para el centro de salud. El equipo de promotores debe estar compuesto por personas que representen a diferentes grupos de la diversidad sexual, principalmente personas que se identifican como homosexuales o trans. En algunas localidades también se incluyeron lesbianas y trabajadoras sexuales.
- La identidad de género o la orientación sexual del promotor es una condición necesaria para el trabajo, pero no es suficiente. Es importante que los promotores tengan o adquieran una experiencia de trabajo por pares, habiendo construido previamente vínculos de confianza con la población objetivo.
- Es importante que conozcan la configuración de la comunidad en la que realizarán la promoción del servicio. Esta condición es esencial para el caso de trabajo en "zonas

rojas" o circuitos de trabajo sexual donde se pueden generar situaciones peligrosas para aquellos que desconocen los códigos de ubicación.

- La distribución gratuita de preservativos y geles es un recurso indispensable para el trabajo de los promotores.
- La oferta de tratamiento de hormonas con apoyo del equipo de salud fue la más valorada por la población femenina y masculina trans.

En cuanto a la ubicación de los CA en el espacio y el tiempo, podemos destacar los siguientes aprendizajes:

- Para la población objetivo, la noche es el mejor momento del día para acceder a los servicios. Para el equipo de salud, esto significa un horario especial. La recomendación es comenzar a trabajar por la noche y eventualmente ir en busca de un horario adecuado para todos, tanto para la población y para el equipo de salud.
- Es aconsejable comenzar con uno o dos días semanales (podría ser cuatro horas cada día). La propuesta requiere un esfuerzo excepcional; no es aconsejable extender por más tiempo a menos que cuente con recursos suficientes para que los diferentes equipos cubran la atención. Cabe señalar que la demanda se construye a lo largo del tiempo (la gente está de acuerdo con el proceso y tarda unos meses, en el mejor de los casos, en instalar la confianza en la población objetivo).
- En la mayoría de las localidades se observó que aunque la población entró a través del CA, entonces comienzan a circular en el hospital en otras ocasiones que originalmente programadas, puede acceder a otros servicios y recursos hospitalarios. Esto se espera, ya que la creación de un CA es un esfuerzo extraordinario para abrir una nueva puerta a la población que fue excluida del sistema de salud pero tiene los mismos derechos que otras personas para ser tratadas en el sistema de salud pública, a veces y en general espacios.
- Se recomienda que el CA esté ubicado lo más cerca posible de la entrada del hospital, en un lugar de fácil acceso.
- Es sumamente importante que se señale la ubicación del CA en el hospital.
- El trabajo en equipo debe prever cómo proceder con aquellos aspectos que se resuelven durante el día, como la apertura de historias clínicas, la asignación de turnos a otras especialidades médicas, almacenamiento o procesamiento de muestras de sangre, el suministro de medicamentos básicos y la limpieza.
- Aunque la iniciativa de los CA fue impulsada por profesionales vinculados a la problemática del VIH / SIDA, la experiencia demostró que es mejor ubicar los CA en los consultorios externos y ser conducido por médicos generalistas, clínicos e incluso ginecólogos, siendo la especialista en enfermedades infecciosas un referente que acompaña.
- La instalación de los CA en los servicios de infectología refuerza el vínculo existente entre el "SIDA" y la "población LGTB", lo que desalienta la demanda del servicio por parte de la población objetivo.

ANNEXES/ADDITIONAL RESOURCES

- Boletín epidemiológico nacional N° 33 año 2016
http://www.msal.gob.ar/images/stories/bes/graficos/0000000918cnt-2016-11-30_boletin-vih-sida-2016.pdf
- Guía de implementación Consultorios amigables para la diversidad sexual
http://www.msal.gob.ar/images/stories/bes/graficos/0000000323cnt-2014-01_guia-implementacion-consultorios-amigables.pdf
- Resumen ejecutivo. Consultorios amigables para la diversidad sexual
<http://www.msal.gob.ar/images/stories/bes/graficos/0000000327cnt-2014-01-resumen-ejecutivo-consultorios-amigables.pdf>

- VIH, Salud y Desarrollo. Consultorios amigables para la diversidad sexual
http://www.msal.gob.ar/images/stories/ryc/graficos/0000000526cnt-2014-01_folleto-consultorios-amigables.pdf
- Consultorios amigables: un primer paso en la atención de las personas de la diversidad sexual http://www.msal.gob.ar/images/stories/ryc/graficos/0000001088cnt-2017-05_consultorios-amigables.pdf
- Atención integral de la salud de las personas trans.
http://www.msal.gob.ar/images/stories/bes/graficos/0000000877cnt-2016-09_atencion-personas-trans.pdf
- Guía básica sobre diversidad sexual.
http://www.msal.gob.ar/images/stories/bes/graficos/0000000322cnt-2016-07_guia-diversidad-sexual-2016.pdf
- Relaciones sexuales anales. Conceptos y recomendaciones para equipos de salud
http://www.msal.gob.ar/images/stories/bes/graficos/0000000111cnt-2016-09_cuadernillo-anal.pdf

15. BRAZIL: Discrimination is still the worst symptom of Aids: Promoting health and reducing stigma

TITLE OF THE PROGRAMME: Discrimination is still the worst symptom of Aids: Promoting health and reducing stigma

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- **Start Date of the Programme:** December 29, 2013
- **End Date of the Programme:** June 10, 2015
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** People living with HIV
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

In the literature of the social sciences, Erving Goffman is one of the authors who delved more on stigma, consolidating its concept and making it fundamental for the discussion of themes such as social identity, the standardization of behavior by societies and its view on behaviors considered deviant.

According to Goffman, three types of stigma can be characterized: one related to physical deformities (motor deficiencies, auditory, visual, facial disfigurements, etc.), another to deviations of character (mental disorders, addictions, drug addictions, sexual, prison imprisonment, etc.), and yet another, tribal stigma (related to belonging to a race, nation or religion). The stigmatized individual is one whose real social identity includes any attribute that frustrates the expectations of normality.

As Goffman states, "the attitudes that we normally have with a person with a stigma, and the acts we undertake in relation to it, are well-known insofar as they are the responses that benevolent social action attempts to soften and improve. By definition, of course, we believe that someone with a stigma is not completely human. Based on this, we do various types of discrimination, through which effectively, and often without thinking, we reduce their chances of life: We build a theory of stigma; an ideology to explain its inferiority and to account for the danger that it represents, sometimes rationalizing an animosity based on other differences, such as those of social class".

Throughout the history of mankind, many diseases such as cholera, black fever and tuberculosis have caused their sufferers not only physical ills, but through stigma and prejudice, have caused them psychological damages and social exclusion. Also, AIDS at the end of the century was especially included in the list of stigmatized diseases, and consequently the groups initially identified as vectors of HIV transmission, which were

already groups stigmatized by social status or sexual identity, as prostitutes and homosexuals, passed to suffer even more prejudices and to have their rights violated:

"HIV/AIDS-related stigma is a real or perceived negative response to a person or persons, by people, communities or society. It is characterized by rejection, refusal, discredit, disregard, under-valuation and social distance. It often leads to discrimination and violation of human rights."

Stigma and discrimination is a problem that has been present in the daily lives of people living with HIV since the beginning of the epidemic and continues to this day. As Richard Parker (2001) says about stigma:

"... Despite the immense resources that have already been mobilized to control the epidemic, the issue of stigma remains at the heart of the entire fight against the global AIDS pandemic. While there have been clear victories - particularly in the development of new and more effective treatments and therapies for people living with HIV in resource-rich settings - much less has been achieved in attempting to overcome the impact of stigma and discrimination in the lives of those affected by the epidemic. Being biologically as complex as the Human Immunodeficiency Virus, this complexity pales in comparison to the complexity of the social forces involved in the production and reproduction of stigma in relation to HIV and AIDS. "

Stigmatizing actions violate fundamental human rights and create a social environment that reproduces and legitimizes prejudice. Therefore, stigma, discrimination and stereotyping have a negative impact on self-care of people living with HIV and produce psychic suffering for those people who end up excluding themselves from social life. In addition, in this context of stigmatization of AIDS, the self-care of people in general is also affected, so in Brazil, for example, we still have a low rate of HIV testing.

Stigma and prejudice about people living with HIV require a combination of multiple actions to be properly addressed. From the perspective of the history of the epidemic and of the HIV and AIDS social movement, we agree with Richard Parker (2001) that empowering the community affected by stigma is the most important step:

"Interventions designed to motivate the resilience of stigmatized populations and communities have been rarer - despite this, empirical studies on empowerment and social mobilization in response to HIV and AIDS clearly demonstrate that the most powerful and effective responses to epidemics (or 'natural experiences' if we prefer the language of most of public health research) have occurred precisely when affected communities have mobilized to fight against stigmatization and oppression related to their lives."

BENEFICIARIES AND IMPLEMENTERS

The project was carried out by Gestos and was primarily aimed at people living with HIV and AIDS (PLHA). The general population (women, men, youth, adolescents, the elderly, among others) were also achieved through community educational actions.

The project included 600 people as direct beneficiary population, distributed as follows:

- 100 seropositive people attended by Gestos psychology service;
- 20 people living with HIV trained by Gestos to develop actions in community environments;
- 40 seropositive leaders in the North and Northeast of Brazil;
- 500 people directly reached through community workshops

Twenty people were selected from those who were attended by the Gestos's Psychology Service. After processes of psychological strengthening, they participated in 12 specific workshops on stigma and prejudice with the objective of acting educationally in the spaces of Gestos and external community. The workshops were held weekly, over four months, lasting 4 hours each, totalling 48 hours of training.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The activities took place in Recife, in the Northeast of Brazil. 660 people were benefited. Most of them were residents of Recife and its metropolitan region, but 18 leaders of the HIV/AIDS movement of the Northeast of Brazil also benefited from the project, as they took part of a 2-day training (16 hours) meant to transfer them the methodology employed on the project.

FINANCING AND SUSTAINABILITY

The project was financed by a grant received (approximately US\$ 90,000 at the time – US\$ 58,000 at the current exchange rate) through a public competition of the Ministry of Health. This grant covered all the activities, which were developed over 18 months, making it a considerable low cost and scalable project, as this relatively small amount ensured that 102 people had psychological support (through individual and group sessions) and that almost 600 people were reached through educative actions. It also made it possible to carry out communication workshops that gave origin to a folder and a poster that disseminated information about stigma and discrimination regarding HIV/AIDS and the people living with it, as well as ways to address it in different settings, and a training with leaders of the HIV/AIDS Movement in the Northeast of Brazil to share the experience and the methodology of the project.

DESCRIPTION

The main objective of the Project was to address and minimize stigma, stereotypes, prejudice and discrimination directed at people living with HIV and AIDS through peer educational actions in communities in the North and Northeast of Brazil.

To achieve this, the project:

- Provided psychological assistance to people living with HIV who were victims of stigma, prejudice and discrimination;
- Formed a reference group on peer education on stigma and prejudice reduction;
- Carried out community educational actions to promote reflection about and minimization of stereotypes, stigmas, prejudices and discrimination;
- Produced communication materials on stigma and prejudice with people living with HIV and AIDS;
- Systematized a methodology to deal with stigma and prejudice;
- Transferred this methodology to leaders of the AIDS movement of the North and Northeast of Brazil.

The methodology was composed of several strategies, mainly:

- a) Individual psychological strengthening;
- b) Community and peer education actions, using workshops built on popular health education.

The first moment corresponded to psychological support with theories and techniques of individual and group psychotherapy, operative group and mutual aid, fulfilling the therapeutic indicators of strengthening self-esteem (individual and public), self-altruism, capacity and ability to recognize the forms of production of stigmas, stereotypes, prejudice and discrimination.

The second moment corresponded to the identification and selection of PLHA assisted by Gestos's Psychology Service. Twenty people were selected and, after processes of psychological strengthening, they participated in 12 specific workshops on stigma and prejudice with the objective of acting educationally at Gestos and in external communities. The workshops were held weekly, over four months, and lasted for 4 hours each, totalling 48 hours of training.

The third moment was the welcoming of peers (PLWHA who sought Gestos for the first time), specifically addressing their complaints regarding the impacts of stigma, prejudice and discrimination on the experience of living with HIV/AIDS. The welcoming/reception of peers was carried out by 10 PLHAs who experienced the psychotherapeutic and therapeutic experience and who participated in the second moment, being trained and prepared to this action. Another activity of the peer reference group was the conducting of lectures, dialogues and other educational actions directed at peers in reference hospitals, HIV/AIDS diagnosis and specialized care centers, as well as the general public in schools, residents' association and other social and community facilities.

The fourth moment involved the systematization and sharing of the methodology with 18 seropositive leaders from the Northeast, aiming at the formation and replication of the methodology in their States of origin and institutional projects. The multiplication of the methodology took place in a training carried out over three days (8 hours per day). In this course the concepts used as central to the project were presented and the participants had theoretical sessions as well as practical sessions, when the peer-reference group would replicate their actions with participants to the meeting, who then could experience in practice the topics and issues discussed during the workshops and lectures that were held.

RESULTS OF THE PROGRAMME

The project directly benefited 579 persons through trainings and educative activities. 102 people received psychological care, both in individual and group sessions, and 34 people living with HIV were supported by peers to address the repercussions of stigma and discrimination related to HIV and/or AIDS. Additionally, 17 leaders of the Aids Movement of North-eastern Brazil took part of a training that shared with them the methodology and the experiences of the project.

All activities took place in Recife, North-eastern Brazil, and most of the people benefited by the project lived in the State of Pernambuco, in the same region.

OUTCOMES AND IMPACT OF THE PROGRAMME

This project was the first initiative addressing stigma and discrimination against people living with HIV in the region. Moreover, it chose to address this issue through the empowerment of people living with HIV, who received training in order to identify and deal with situations of stigma and discrimination, providing them tools to overcome or to mitigate the repercussions of this situation. This had an intense and direct impact on their self-esteem and self-awareness as citizens who live with HIV, and it showed on their perspective of their own lives, their relationships with relatives, friends, acquaintances, professionals, colleagues, etc., at the same time that changed their attitude and perspective when utilizing services, including in the health care system. The peer activities were highly regarded as well, since

they could relate to the situations that were presented and reported feeling extremely satisfied for being able to help and support people that were going through situations that were similar to experiences of their own. Besides the satisfaction of feeling that they were “helping” someone, it had, in their words, a “healing” effect, as they could prevent peers of going through difficult situations alone or “be there” for them, what was not always the case with them.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The project was monitored and evaluated through regular monthly meetings with the participants, who then would present their views on the activities that were being developed at the time and provide their inputs on how to move on, improve and/or overcome any challenges. Monthly meetings of Gestos’s team and the coordination of the organization would evaluate the progress of the project in the context of the institutional activities and planning as a whole.

As it was a public grant of the Ministry of Health, the project was also monitored and evaluated by the National Office of Epidemiological Surveillance.

LESSONS LEARNED AND RECOMMENDATIONS

Empowering people living with HIV to develop skills to address and fight against stigma and discrimination against PLHA in a variety of settings. Their interaction with people whose HIV-positive status has only recently been discovered has proved to be beneficial for both sides, providing a positive perspective against the negative images and fears that surround the idea of living with HIV for many people. At the same time, the peers of the reference group report an almost cathartic experience, since they feel like they are “being there” for people in a time a need, something that not all of them had at their own time. It has also stimulated them to take better care of themselves through better eating, exercising and adherence to treatment, in a renewed sense of being full of life and with a future ahead. Many have reported that they wanted to make sure that they are “walking the talk”, and that their attitudes and practices match their discourse, in a positive circle of wellbeing.

CONCLUSIONS

Developing a project is a moment of learning. It is the moment to reflect upon the path trailed, but also to know how far we have come and what remains to be done. And we almost always conclude that we have much to do yet. But both the team and the participants of the project are certain that it is important to move forward and this feeling comes from the results that were achieved.

At the end of the project the participants were surprised by realizing their potential for making a difference through peer welcoming/reception, other participants, by how the educational actions made them feel. At the end, the group had the intention of voluntarily maintaining the project until new funding became available, to continue the actions that we were built collectively and that brought a lot of meaning to all of them.

A testimony from one of the women who participated in the project summarizes it:

"Just as I was wanted to be taken care of when I found out about my HIV status, when I did not know and had no information about HIV, I took care of others. I could do it. And just like it felt good for me to do it, it was good for them. People feel lost; they think they're going to die, that it is over... And then they look at you and they see a different image and perspective. They come across a person who has the same problem as themselves, but one that feels good and has their self-esteem up there. This is very important! I'm not dying, I'm getting stronger and stronger!"

ANNEXES/ADDITIONAL RESOURCES

- <http://www.bibliotecadigital.abong.org.br/bitstream/handle/11465/1588/191.pdf>

16. DOMINICAN REPUBLIC: Advancing Partner & communities USAID/APC/GEA

TITLE OF THE PROGRAMME: Advancing Partner & communities USAID/APC/GEA

CONTACT PERSON

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- **Start Date of the Programme:** October 01, 2016
- **End Date of the Programme:** September 30, 2018
- **Responsible Parties:** Civil society, UN or other inter-governmental organization, USAID
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, Young people/adolescents, Gay men and other men who have sex with men, Sex workers, Transgender people, Migrants (documented and undocumented), refugees or internally displaced populations, People living in humanitarian emergency settings, Haitian immigrants
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

The GLBT and Sex worker and Haitian have a long history of the most vulnerable to HIV and our country is no an exemption, this project is to educated this groups on prevention of HIV/STD and encouraged then to know their HIV status the newly HIV diagnostic will be admitted to health care facilities to received HIV treatments free of cost and without discriminatory treatments to reach a undetected Viral Log, good health that will reduce the transmission of this virus to other. Our population was under represent in Hospital Francisco Gonzalvo in La Romana, D. R. in less than a year with feel out this gap and at this moment they're receiving good health care and the therapies to control the virus of HIV and we're continuing monitoring the services to protect them from discrimination or stigma for sexual preferences, sexual work, race. or under-privilege. This action are reported monthly to UASID/JSI/APC.

BENEFICIARIES AND IMPLEMENTERS

The intended beneficiaries of this programs are first the PLWHIV, the GLBT community, SW, and Migrants. The selection of our NGO was base in previous history represents this communities and the good results. Our NGO offer working position to this minorities groups specially the PLWVIH due to the discrimination that persist in our country towards these persons.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

La Romana City is where Grupo Este Amor, Clinica de Familia La Romana and Hospital Francisco Gonzalvo are working in this pilot project and two more NGO one in the capital City and another in Puerto Plata in the north region. In the first year they reported that we are the best.

FINANCING AND SUSTAINABILITY

This program sustainability is through donation from USAID the benefit compare to cost is in favor of the benefits the national health care system is helping in this implementation because at them and of this plan pilot the promise is to continuing with governmental support in benefit of the beneficiaries.

DESCRIPTION

We begin in the communities of the most vulnerable people in La Romana city of D.R. with education in prevention of HIV/STD and the benefit of known their HIV status to enter early in treatment if the result is positive, and to negative result to maintain this status with the preventive precaution that we teach them using the condoms and lubricants in every sexual activity. A compressible education of HIV and emotional support is implementing before introducing the PLWHIV to health care. During the process our health promotor in a continuing education and emotional support are vigilant and accompanying them through therapies initiations and monitoring assistance and adherence to prescribed therapies until the show stability, acceptance that HIV is a chronic condition that can be controlled with medication and maintained good health.

RESULTS OF THE PROGRAMME

In Dr. Francisco Gonzalvo of La Romana City in one year 206 people LWHIV are receiving health care and HIV therapies introduce in their programs and monitoring by Grupo Este Amor (GEA)

OUTCOMES AND IMPACT OF THE PROGRAMME

This program is changing the attitudes of health care personal in Hospital Dr. Francisco Gonzalvo in La Romana a tourist province in the East side of Dominican Republic hopping will be implement in other parts of this island and in the Caribbean in benefit of the PLWVIH, GLBT, SW, and other underprivileged communities.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The results are measured by input and satisfaction of the beneficiary, well keep documentation of the different activities, M&E of all activities and keeping the best practices. Recon aching the best practices of our staff

LESSONS LEARNED AND RECOMMENDATIONS

We learn during this past year to be patients we other, in other to change a behavior that was there for years, listening is better than talking too much and teach with a sample is the best way, to change people behavior. The biggest challenger us the acceptance of a group of PAJAROS this way we're been called by the hospital staff in the beginning and today they call us Mr and young fellow.

CONCLUSIONS

A comprehensive education about HIV is very important after a positive HIV result, emotional support, accompaniment and let then now that is hope you can live with the virus is you take control. We have a beautiful history of a girl that was infected by birth with adopted her as our she lives with her grandparent that is Haitian, she was educated very young about her condition, went to school we our support and today she keep her HIV therapy all her live she live positively and working in a tourist airport of our region and not body know of her condition because she is healthy and productive.

ANNEXES/ADDITIONAL RESOURCES

- [grupodeapoyoesteamor@facebook](#).

17. ECUADOR: Successful experiences in eliminating discrimination in health services in Ecuador

TITLE OF THE PROGRAMME: Successful experiences in eliminating discrimination in health services in Ecuador

CONTACT PERSON:

Name: Monica Martinez Menduiño

Title:

Organization:

Address:

Tel:

Email address: monicaun@hotmail.com

Implementation of public policy for health care to GLBTI population, sex workers and people with disabilities

Virtual Course "Human Rights and Good Practices in HIV Health Care Procedures"

Process:

Since September 2016, this virtual course has been implemented, aimed at all the personnel of the National Health System (including the Public Health Integral Network and the Private Complementary Network). It comprises 8 modules emphasizing healthcare from the human rights, gender, equality and interculturality approach, through the adoption of good professional practices that allow users to access progressive health services free of discrimination. The target key populations are: men who have sex with men, sex workers, transgender people, people deprived of their liberty and vulnerable populations: pregnant women, children, adolescents, the elderly, People with disabilities.

Outcomes:

- Participants from Ministry of Public Health approved in 2016: 34.278
- Participants from Ministry of Public Health approved in 2017: 8.817
- Participants from Ecuadorian Social Security Institute approved in 2017: 21.643
- Participants from Social Security Institute of the Army approved in 2017: 2.352
- Participants from Social Security Institute of the Police approved in 2017: 1.361
- Participants from the Private Complementary Network approved in 2017:
- Total: 75.943 people approved the course

Nationwide training on Sexually Transmitted Infections, including HIV

Process:

At the moment, this Ministry is developing a training program about sexually transmitted infections, including VIH, HIV counseling, Human Rights, key and vulnerable population. The objective is to ensure good health care for all, especially for key and vulnerable population.

Outcome:

- Trained personnel in all zones and districts

Comprehensive health care for persons deprived of liberty

Process:

Persons deprived of liberty receive health care at the national level. Since August 2017, an intervention was initiated in the Regional Social Rehabilitation Centers, with the objective of providing comprehensive care to this population, as well as to create a digitized Clinical History.

Outcomes:

- Comprehensive care for persons deprived of liberty.
- Diagnosis, treatment, and follow up of persons deprived of liberty living with HIV

LGBT Population

Inclusive centers certification

Process:

To certificate health centers as inclusive is a strategy of the Undersecretariat for Health Promotion and Equality, which seeks that establishments incorporate health promotion actions through 4 standards in their management: free of discrimination, free of pollution, participation, and that promote healthy actions.

Outcome:

- In 2016, 253 health centers were certificated as inclusive, in all 9 Zones.

Implementation of the Sex-Gender variable, in the Automated Daily Registry of Ambulatory Care (RDACCA)

Process:

The process to implement the Sex-Gender variable in the Automated Daily Registry of Outpatient Care (RDACCA) began in May 2014 to February 2015. It took from May to September 2015 the pilot implementation in 18 Inclusive Centers. Subsequently, in February 2016, the Sex-Gender variable was established in the 2.200 establishments of the Ministry of Public Health. Finally, the Ministry worked on training and sensitizing medical personnel at the national level on the use and registration of this variable.

Outcomes:

- 100% of medical personnel trained in 2016
- 75.821 health attentions to LGBTI people in 2016:
 - Lesbian: 13.161
 - Gay: 3.885
 - Bisexual: 12.365
 - Trans male: 37.154
 - Trans female: 9.256

Health Care Manual for LGBTI person

Process:

One of the goals of the Ministry of Public Health is to improve access, availability and care in health services for all people. Therefore, the Manual is an instrument whose purpose is to guarantee the right to health care and good treatment of this group of people. The Manual includes criteria and recommendations of health care based on the needs and particularities of lesbian, gay, bisexual and transgender people. It incorporates contributions and inputs from LGBTI organizations.

Outcome:

- Ministerial agreement 0125, in force since November 2016.

Update of the Ministerial Agreement 000080 "Control and Surveillance of establishments that provide treatment services to persons with problematic consumption of alcohol and other drugs."

Process:

The Ministry has responded to allegations of human rights abuses in addiction treatment clinics where they offer "dehomosexualization" treatments. To protect victims and prevent these violations, the Ministry has created several agreements that seek to control the granting of operating permits and to provide rules and procedures.

Outcomes:

- Ministerial Agreement 000080 updated.
- Letter of commitment to respect Human Rights as a requirement to grant the permit of operation of these establishments.
- Instruction for referral of cases of human rights violations in these centers, to the competent authorities. (This document will be ready for the first quarter of 2018).

Inclusion of the LGBTI population within the process of convening Primary Health Care Technicians (TAPS)

Process:

In 2015, the Undersecretariat for Health Promotion and Equality developed the selection criteria for technicians for Primary Health Care Technicians LGBTI, sex workers, people living with HIV. It was convened nationwide in February 2015. 32 aspirants from the LGBTI population, sex workers, and people with HIV entered the process. National Leveling and Administration System approved 18 LGBTI students.

Outcome:

- Nowadays, 15 students continue the training process.

Sex workers

Integral Health Care Manual for people who engage in sex work

Process:

This manual was approved through Ministerial Agreement 109-2017 and published on 23, August 2017. It includes a wider perspective as to the subject of rights that are women and men who engage in sex work, from their sexual diversity.

Outcome:

- Comprehensive health notebook for sex workers, included in the Manual. (Currently in the process of printing). There will be 10,000 copies.

Palliative care standards: Ministerial Agreement 5232

Process:

The Ministry of Public Health guarantees palliative care for people with chronic, progressive, advanced and limited life prognosis. Among these, attention is given to people in the AIDS phase, regardless of their sexual orientation, gender, age, among others.

Outcome:

- Intervention plan to provide palliative care to persons in the AIDS phase that require it. It permits the mobilization of human resources to the residence of the person.

18.1 JAMAICA: GIPA Capacity Building Project

TITLE OF THE PROGRAMME: GIPA Capacity Building Project

CONTACT PERSON:

Name: Mr. Joseph Reynolds

Title: Executive Director

Organization: National Family Planning Board

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Tel: 968-1629- 33, 968-1636

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- **Start Date of Programme:** N/A
- **Responsible Parties:** Government, Civil Society
- **Population Group(s) Reached:** People living with HIV, Men who have sex with men, Sex workers, Women
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

The NFPB, Jamaica has maintained a GIPA Unit since the integration of HIV in the Family Planning Board operations in 2013 to centralise PLHIV issues and concerns in the response.

The current structure of the national response has the NFPB and the HST Unit at the MOH carrying two aspects – Prevention, EEHR, and Monitoring, Evaluation and Research and; HIV care, support and treatment respectively.

The HIV response has come a long way, from the days when PLHIVs were seen as people without worth, while there were no policies on care and support. Death was common place and the lives of PLHIV were constantly under threat. There were reports of PLHIV being beaten, ostracised and abandoned by families, communities and workplaces. This would be worsened if the PLHIV is found out or alleged to be MSM. The work of the PLHIV leaders, other CSO actors and the government made serious inroads to changing the status quo.

Collaboratively, two PLHIV community leaders worked with the Ministry of Health on National Anti-stigma Media Campaign where they became the face of AIDS in Jamaica. The two Anneisha Taylor and Ainsley Reid did not only attend media interviews while their commercial spots on Positive truly Positive and Getting on with life were running concurrently, they conducted face to face sessions across all parishes on the island of Jamaica. On the heels of this campaign, a Needs Assessment was done to determine the priorities for involving PLHIV in the response. As a response, the GIPA Unit was created with support from a Global Fund grant. The Unit was housed at the Ministry of Health's NHP to implement empowerment initiatives for People Living with HIV in their diversity. The Unit worked subsequently with JN+ and the NFPB to create the PHDP Curriculum for Community Leaders Living with HIV which kick started the GIPA Capacity Building Project in 2011. Up to 2017 graduates periodically assessed and did ongoing work on developing the first and second editions of the PHDP Curriculum. Select graduates were deployed to the national authorities on health and labour. Those in health work on the service delivery to their peers

and labour worked on the National HIV workplace policy and the related Voluntary Compliance Programme.

In April 2017, partnership was created through the NFPB (GIPA Unit), JN+ and the Regional Health Authority (RHA) to further deploy graduates focusing on reaching their peers who have been loss to follow up.

According to national statistics, among persons living with HIV (PLHIV) who know their status, only 48.7 % are accessing services or retained in care (GARPR Report, 2016). This is worrying as failure to improve Jamaica's treatment cascade will inhibit effort to achieve the 90-90-90 targets or achieve the ultimate goal of zero new infections and zero AIDS-related deaths.

A review of the JN+ Membership database last year, showed that while 85% of members reported being on treatment, the vast majority were unable to provide information regarding their vitals. Approximately 55% did not know the name of their medication, or their CD4 Count. More than 70% did not know their viral load. When asked for an explanation, the response was either that the doctor did not tell them, they did not understand what the doctor said or they did not ask.

Several factors are felt to contribute to the high level of patient apathy towards access to treatment and being retained in care. Fear of stigma and discrimination (real and perceived) is believed to account in some measure for the current treatment cascade. Thirty-eight percent (38%) of respondents in the 2010 Stigma Index, reported having experienced some form of discrimination (UNAIDS/NHP, 2013) while another 52% said they feared being stigmatized or discriminated against. Whether real or perceived, the fear of discrimination may or usually leads to people diagnosed HIV positive, not accessing health care, not adhering to medication, and not participating in peer support group activities and other interventions geared towards people living with HIV and other key populations. - can you add a source for this?

More effective strategies need to be found to reduce the high prevalence of HIV in Jamaica, including measures to reduce their social vulnerability, combat stigma and discrimination, empower PLHIV to advocate for their own rights and concerns. Develop a sense of self efficacy as well as provide an effective reporting and redress system that holds everyone accountable.

Given the aforementioned challenges faced by PLHIV, the Deployment of Community Facilitators (CFs) is a timely intervention that, if managed properly, could contribute to a comprehensive programme for improving PLHIV adherence and retention in care. It is therefore critical, that as a part of the Community Facilitator Deployment project, activities be included to have those PLHIV who are patients and are empowered and virally suppressed, motivate and offer peer support to those who require it.

FINANCING AND SUSTAINABILITY

Participants who completed the skills transfer are assessed and selected for engagement as Community Facilitators. In addition to having successfully completed the skills transfer, they should, at least have one subject at the secondary school level, and be available for deployment with an appreciable comfort level with disclosure issues. During deployment they are assigned to health facilities of Regional Health Authorities for a period of six to nine months. They work alongside healthcare providers such as a psychologist to reach PLHIVs needing support, a Social worker to develop Support Groups for PLHIV to help with adherence, and with a BCC interventionist to reach key affected populations. This GIPA

Coordinator report to the Enabling Environment and Human Rights (EEHR) Unit at the NFPB.

Annual financial support for the GIPA Coordinator and Community Facilitators, meeting and materials shared between USAID, GOJ, and in the past GFATM.

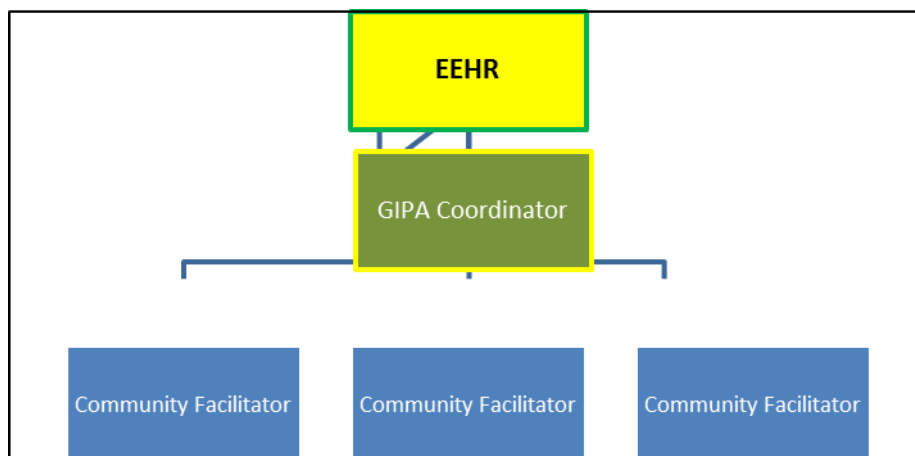


Figure 1: The community facilitator in the EEHR/ GIPA Unit Administrative Hierarchy

DESCRIPTION

Concept to action: GIPA/PHDP Capacity Building Programme

The framework is building on the nexus of three global approaches, namely GIPA Principle, PHDP Global Framework, and the Community System Strengthening (CSS):

GIPA Principle aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. People living with HIV have directly experienced the factors that make individuals and communities vulnerable to HIV infection—and once infected, the HIV-related illnesses and strategies for managing them. PHDP Global Framework highlights the importance of placing people living with HIV at the centre of managing their health and well-being (GAA, 2012). It is a model which links HIV treatment, prevention, and support and care issues within a human rights framework. Positive Health, Dignity and Prevention emphasises the importance of addressing prevention, and treatment simultaneously and holistically. Instead of a singular focus of preventing HIV transmission from people who test HIV positive, the Positive Health, Dignity and Prevention model promotes holistic health and wellness, including human rights, legal protection and a policy environment free of stigma and discrimination.

Community Systems Strengthening (CSS) – Enhancing those mechanisms and approaches that are designed and used by community actors to deliver goods and services to improve opportunities and quality of life of their constituency.

The main strategy undertaken by the GIPA Unit in operationalizing the PHDP principles has been building the capacity of PLHIV. This approach seeks to raise the level of awareness and improve the skills for effective and meaningful involvement and community leadership in the response. This approach has been utilised for the past nine (9) years informed by the GIPA conceptual framework.

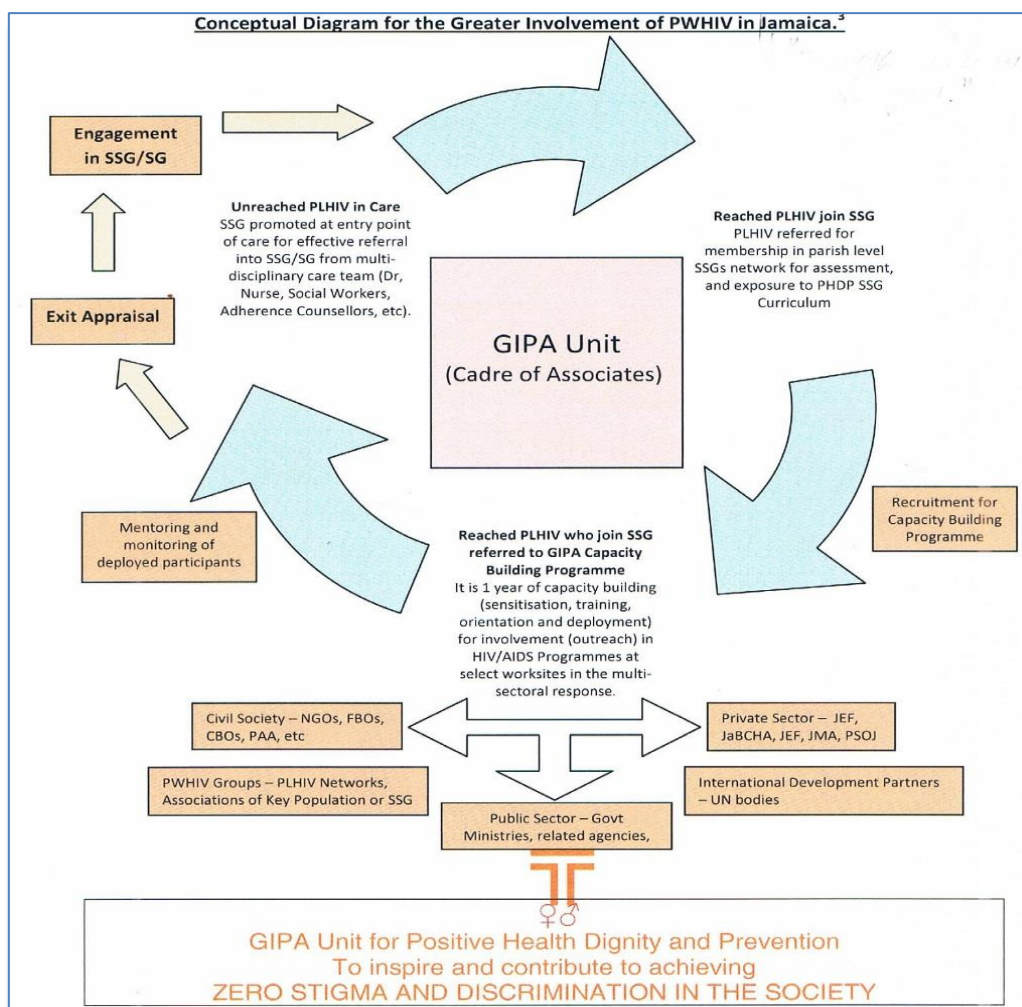


Figure 2: Conceptual framework for GIPA in Jamaica
(Source: Annual Report, GIPA Unit, 2014).

The priorities of the GIPA Capacity Building Programme include;

- Capacity Building Programme
- Development of the Positive Health, Dignity and Prevention (PHDP) Curriculum
- PHDP with Key Population (MSM) Initiative and
- Representation of PLHIV Community on decision making bodies (GIPA Annual Report, 2014)

The Positive Health, Dignity and Prevention Curriculum

The curriculum aims to implement and advocate for Positive Health, Dignity, and Prevention and promote community leadership at the country level, by training leaders to advocate and educate communities to reduce HIV-related stigma and discrimination, including Gender-based violence. The Second Edition of the Curriculum consisted of seventeen (17) modules.

A companion manual was developed to assist in the transfer of skills to facilitators who will actively use the PHDP curriculum.

The PHDP curriculum was conceptualized to be implemented through five phases, they are as follows:

Phase1: Recruitment and orientation –The first Cohort of PLHIVs were recruited and participated in the development of the curriculum with other key stakeholders. The criteria for selection were as follows:

- HIV infected adults from Treatment sites across Jamaica referred by Contact Investigator, Medical Officer, Social Workers, Nurses, and Adherence Counsellors.
- Possess a minimum of One (1) subject at the Secondary Education Level
- The GIPA Unit was tasked with screening the potential candidates through an interview process. The first cohort comprised 20 persons.

Phase 2: PHDP Curriculum Development- In this phase, a second cohort was engaged and the curriculum was tested for efficacy and ease of use with a view to improve group literacy and participation in the rollout of each module. Both cohorts combined consisted of fifty-four persons being engaged in the GIPA Capacity Building Programme.

Phase 3: Skills Transfer - In this phase participants were trained in communication skills to improve their ' ability to share PHDP related insights, knowledge, information and experiences among select audiences such as Peer/PLHIV, service providers, and other target groups.

Phase 4: Interim Assessment- The objective of the assessment was to determine how the participants benefitted from the knowledge exchange and skills transfer aspect of the project. There was significant delay in conducting this phase. The delayed assessment was conducted after all 4 cohorts were trained and did not precede the deployment process as conceptualized. Selected graduates from cohorts 2 -4 were deployed in various worksites including private sector and health facilities prior to the assessment.

Phase 5: Deployment- This phase included the orientation of Community Facilitators to worksite as well as the mentoring and tracking progress.

Implementing the PHDP curriculum

The PHDP curriculum is delivered through six (6) months to one (1) year of sensitisation and training. Each cohort in this programme participate as a leadership group to build in-depth knowledge about HIV; distil root causes of stigma, discrimination and gender-based violence; and develop skills and confidence to be able to strengthen their leadership in the space where they are active (UNGASS, 2010). The modules are facilitated during a series of workshops at varying locations throughout the island. Methods of facilitation include: presentations, interactive exercises and group discussions.

After the completion of workshops facilitating the introduction of all modules in the PHDP curriculum, participants attend a four (4) day Skills Transfer Workshop. Participants are required to give a presentation on a risk behaviour of their choice, with the aim of applying the trans-theoretical (TTM) to describe the potential for change process. Each participant is assessed and assigned a score at the end of the skills transfer capacity building activity.

According to the GIPA Unit over the period 2011 - 2016, one hundred and five (105) PLHIV have benefitted from active involvement in four (4) cohorts PLHIV in the GIPA/PHDP Capacity Building Project (GCP). Seventy-five (75) have successfully completed the programme that includes participation in all didactic workshops focusing on all modules of the PHDP curriculum and the assessment component of the programme.

# Participant who completed GCP by region			
Region	Male	Female	Total
South-Eastern (SE)	19	14	33
Southern (S)	5	4	9
North-Eastern (NE)	1	16	17
Western (W)	5	11	16
Total	30	45	75

Table I: Number of participants in GIPA capacity Building by regions

RESULTS OF THE PROGRAMME

Achievements of the GIPA/PHDP Capacity Building Programme

The GIPA End of Project Report for USAID, October 2015-2016 indicated the following as overall achievement of the capacity building programme:

- Positioning of Community Facilitators to improve visibility of Community Representation – JCCM, JN+ Board
- Community mobilisation and awareness building on PHDP.
- Work of CFs are best practices – Patient Satisfaction Survey (PSS), Training of Community Leaders in Self Support Group Model, Offering of coordinated Peer Support (facility-based, community-based, and home-based) to PLHIV and Key Populations, etc.
- Finalisation and publishing of the PHDP Curriculum through HP+ support
- Development of an Instructional Guide, developing three additional modules, namely Sexual Health, Human Rights, Resilient Leadership, and customising the curriculum for future cohorts.
- 16 participants graduated from Cohort 4 with certificates of completion
- 46 participants from Cohort 1 – 3 also received their Certificates of Completion.
- 15 community leaders who assisted in the development of the PHDP Curriculum were also given Certificates of Appreciation
- Sixty-two (62) graduates of the GCBP – PHDP Course were inducted into JN+'s membership. This was being done for the first time and was a request of the GIPA Core Group.
- Over 200 MSM sensitise on PHDP
- Over 166 Healthcare workers (psychologists, social workers, adherence counsellors, PLHIV Liaison Officers, and Case Managers)
- Over 120 Outreach Workers (Community Peer Educators, BCC Coordinators, Peer Navigators, and Target Intervention Officers)

OUTCOMES AND IMPACT OF THE PROGRAMME

Demand for PHDP influenced policy, products and services

- Community Engagement protocol
- Patient Strategy
- Support Groups
- Multi-sectoral engagement using PHDP
- Development of more IEC

Deployment of graduates/community facilitators

There are three types of outcomes for participants in the programme:

- Individual deployed to one of the following sector: Civil Society Organization, Private Sector and Government Agencies
- Individual deployed to work within the PLHIV community, such as Support Groups
- Individuals who do not display willingness to deal with disclosure issues

LESSONS LEARNED AND RECOMMENDATIONS

- Willingness of the some RHAs to facilitate CF engagement with their peers
- Mentoring process done by the GIPA Coordinator who has done this process in previous years
- Inadequate funding
- Disclosure issues affected the CF ability to reach a wider audience
- The need for Patient Strategy/Community Engagement Protocol

ANNEXES/ADDITIONAL RESOURCES

- A Process Evaluation of the Capacity Building Programme as administered by the GIPA Unit of the National HIV/STI Programme
- Photo of Participants in training
- CF TOR
- PHDP Curriculum
- Skills Transfer Manual
- Compendium of Best Practices

18.2 JAMAICA: Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans

TITLE OF THE PROGRAMME: Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans

CONTACT PERSON:

Name: Jaevion Nelson

Title: Executive Director

Organization: Equality for All Foundation Jamaica Ltd. (formerly J-FLAG)

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Email: jaevion@gmail.com

- **Start Date for the Programme:** July 01, 2015
- **Responsible Parties:** Government, Civil Society
- **Population Group(s) Reached:** Health care workers, users of healthcare services
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

J-FLAG implemented a project entitled “Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans” to foster the development of an enabling environment where LGBT people’s right to health are promoted and respected and LGBT people are able to seek essential HIV and AIDS services and support free from stigma and discrimination by improving their human rights situation. The project also sought to address problems with regards to the gaps in policies and laws which hinder LGBT from accessing HIV prevention, treatment, care and support services and the issue of stigma and discrimination at public health services or by health care providers and confidentiality in relation to sexual orientation and/or HIV status.

LGBT persons in Jamaica are often denied their rights and freedoms of expression, participation, health, equal opportunities, respect and inherent dignity. A study commissioned by J-FLAG which is entitled The Developmental Cost of Homophobia: The Case of Jamaica (2016) found that 71% of gays, 59% of lesbians, 35% of bisexuals and 29% of transgender persons experienced some form of harassment or discrimination in the last 12 months at the time of the survey. In the last 5 years, 32% of the more than 300 LGBT people surveyed reported being threatened with physical violence and 12% reported being attacked. 23.7% of persons were threatened with sexual violence and 19% were sexually assaulted.

There are also a number of challenges with access to and the provision of health services. A 2015 Situational Analysis in five public health clinics showed stigma and discrimination are barriers to accessing health care among LGBT people. The study on The Developmental Cost of Homophobia found 52.5% of LGBT persons were forced to undergo seemingly unnecessary medical or psychological testing, 32.2% experienced inappropriate curiosity regarding being LGBT, 17% felt they had not received equal treatment, 15% declined treatment because they felt fear of discrimination or intolerance, and 15% also felt the need to change their general practitioner or specialist because of negative reaction.

BENEFICIARIES AND IMPLEMENTERS

The project directly benefits healthcare workers at all levels, including frontline-non-medical workers such as porters, customer service representatives, security guards, etc. Users of healthcare services also benefit directly through sensitization sessions at the facilities. It is expected that by targeting these individuals LGBT people will have greater access to more non-discriminatory and responsive spaces to seek healthcare.

The project is implemented by J-FLAG in partnership with the Ministry of Health, Jamaica and National Family Planning Board, Jamaica

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Jamaica (island wide)

FINANCING AND SUSTAINABILITY

The project is financed with support from the Ministry of Health, USAID Jamaica, ViiV Healthcare Positive Action Programme, and US State Department - Bureau of Democracy, Human Rights and Labour.

DESCRIPTION

J-FLAG implemented a project entitled “Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans” to foster the development of an enabling environment where LGBT people’s right to health are promoted and respected and LGBT people are able to seek essential HIV and AIDS services and support free from stigma and discrimination by improving their human rights situation.

The intended primary beneficiaries were LGBT people and 25 Health care workers. The key issues identified were the issue of stigma and discrimination toward LGBT people, which continue to adversely affect HIV testing, uptake of HIV services, adherence to ART and access to supportive services. Reduction of stigma and discrimination continues to be important to HIV and AIDS prevention activities as well as seek to expand the range of services offered to the population and address important policy issues such as confidentiality and service standards.

The project also sought to address problems with regards to the gaps in policies and laws which hinder LGBT from accessing HIV prevention, treatment, care and support services and the issue of stigma and discrimination at public health services or by health care providers and confidentiality in relation to sexual orientation and/or HIV status.

RESULTS OF THE PROGRAMME

53 Frontline/Non-Medical Healthcare Workers trained and sensitized about human rights and dignity as it relates to sexual orientation, human rights and PLHIV.

Conducted 25 policymaker education meetings with 36 Minister of Government, other parliamentarians, business leaders, technocrats, policy makers and civil society partners
Four (4) policies/protocols/guides revised and developed:

- Guide on how to develop and maintain LGBT friendly public health facilities and programmes

- Screening guidelines for the Clinical Management of HIV disease and ensure gaps are addressed for example routine ano-rectal screening for STIs.
- Standard for the Treatment, Care and Support of LGBT Clients
- A Transgender and Gender Non-conforming guidelines for Healthcare Workers

Two (2) Situational Analysis conducted - One at five health facilities focusing on stigma and discrimination and tailored approaches for LGBT population and the other within Civil Society to evaluate the efficacy and/or availability of specific services for MSM, transgender people and lesbians

Two (2) High-Level Fora conducted with 613 participants within Civil society, Government, private sector, academia and Key Populations on issues affecting LGBT people in public health sector (around HIV)

45 Healthcare workers sensitized about transgender people and their health needs
394 general users of five Healthcare facilities sensitized about Stigma and discrimination and the rights of LGBT people

18 outreach sessions conducted with civil society, healthcare providers and general users to promote the Ministry of Health Client Complaint Mechanism in order to increase tracking of and response to human rights violations against LGBT persons.

OUTCOMES AND IMPACT OF THE PROGRAMME

The project is considered to be appropriate, relevant and effective in contributing to reducing stigma and discrimination against LGBT persons, including LGBT people living with HIV at the five targeted healthcare facilities. The project was highly relevant, as it sought to address priority SRH, HIV and AIDS needs of LGBT. The unacceptably high prevalence of HIV among MSM is a major area of focus in Jamaica's HIV response. The project's heavy reliance on data provided by the literature review and situation analysis whose results indicated among other factors, lack of knowledge of both SRH information and available services, limited access to such services and limited availability of LGBT friendly SRH services underscored the need to address stigma and discrimination (real or perceived) meted out to LGBT clients.

The project has had a real and measurable impact on the HIV response to LGBT clients. It has improved the capacity of stakeholders to deal with and address stigma and discrimination at the community and national levels as well as successfully bringing together and mobilizing critical state and civil society actors to work towards a common goal. At the personal and professional level the project has broadened/strengthened the awareness raising activities related to human rights and access to services for all Jamaicans.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The evaluation measures the implementation and results of activities and outputs as it relates to the project goal, objectives and desired outcomes and includes the assessment of key informants and stakeholders who were integral to the project activities and outcomes.

The evaluation employed 'Utilization-focused' and 'Objectives-testing approaches'. 'Utilization-focused', is an 'approach to making evaluations useful, practical, accurate, systematic, and ethical'. This framework ensures that the evaluation produces findings that support effective decision-making for JFLAG and other key stakeholders. The second approach used was 'objectives-testing', which provides a framework for assessing the extent to which the stated project objectives were achieved. The evaluation incorporated qualitative and quantitative data gathered through document analysis, face-to-face key informant

interviews, client satisfaction surveys, site audit and observation and focus group discussions.

Thirty-one key informant interviews were conducted with staff of non-governmental organizations (n=4) and public health facilities (n=27) who had participated in the Mitigating LGBT Health Risks Project – Front line Staff Sensitisation Training and NGO Advocacy Training. Staff members who had not participated in the training, but who were key members of the treatment staff at the targeted sites were also interviewed. 7 client satisfaction surveys were completed at four sites by six members of LGBT community and one female sex worker.

LESSONS LEARNED AND RECOMMENDATIONS

Findings

1. The ability by healthcare workers to personalize the training – through direct contact with the LGBT population, applying the lessons learned to their experience with LGBT family members, or personal situations and considering how stigma towards LGBT could in turn affect them – appeared to play a key role in the reported attitudinal and behavioural changes.
2. High level of recall and support by healthcare workers for anti-discrimination and equitable access to services for LGBT clients' messages. Almost all respondents identified the testimonials from LGBT speakers as having the most impact.
3. Strong partnerships developed with international development partners, national non-governmental organizations (NGOs), Ministry of Health, Regional Health Authorities that provide services and support the needs of LGBT clients.

Recommendations

1. LGBT Community members should continue to be engaged in the advocacy interventions, as they can dispel negative stereotypes and increase comfort level. Their participation significantly enhances the training experience.
2. Sensitization and trainings should be available to more persons or should be available more often. Suggestions included – including sensitization session in routine facility staff meetings, including relevant topics (sexual diversity and rights) in new staff orientation and, ensuring the attendance of Administration and customer service staff to future offsite trainings. Participants noted that customer service set the tone of the interaction with the facility before clients meet with clinical staff and so it was important for them to be sensitized.
3. Advocacy and interventions must include other patients and also extend into the surrounding communities. Interventions with other patients may include the ongoing delivery of the sensitization sessions for service users. Waiting room resources such as posters and brochures delivering key messages related to sexual diversity, patient rights, respect and confidentiality might help to influence a more enabling environment. Community interventions will also facilitate access to sites and support an enabling environment. These interventions might be most effectively delivered as components of broader initiatives.

CONCLUSIONS

The project is considered to be appropriate, relevant and effective in contributing to reducing stigma and discrimination against LGBT persons, including LGBT people living with HIV at the five targeted healthcare facilities. The project was highly relevant, as it sought to address priority SRH, HIV and AIDS needs of LGBT. The unacceptably high prevalence of HIV among MSM is a major area of focus in Jamaica's HIV response. The project's heavy reliance on data provided by the literature review and situation analysis whose results indicated among other factors, lack of knowledge of both SRH information and available services, limited access to such services and limited availability of LGBT friendly SRH services underscored the need to address stigma and discrimination (real or perceived) meted out to LGBT clients.

The project has had a real and measurable impact on the HIV response to LGBT clients. It has improved the capacity of stakeholders to deal with and address stigma and discrimination at the community and national levels as well as successfully bringing together and mobilizing critical state and civil society actors to work towards a common goal. At the personal and professional level the project has broadened/strengthened the awareness raising activities related to human rights and access to services for all Jamaicans.

19. MEXICO: Protocolo para el acceso sin discriminación a la prestación de servicios de atención médica de las personas lésbico, gay, bisexual, transexual, travesti, transgénero e intersexual y guías de atención específicas (Protocol for non-discriminatory access to the provision of health care services for lesbian, gay, bisexual, transsexual, transvestite, transgender and intersexual persons and specific care guidelines)

TITLE OF THE PROGRAMME: Protocolo para el acceso sin discriminación a la prestación de servicios de atención médica de las personas lésbico, gay, bisexual, transexual, travesti, transgénero e intersexual y guías de atención específicas (Protocol for non-discriminatory access to the provision of health care services for lesbian, gay, bisexual, transsexual, transvestite, transgender and intersexual persons and specific care guidelines)

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- **Start Date of the Programme:** June 24, 2017
- **Responsible Parties:** Civil Society, Government, Academic institution
- **Population Group(s) Reached:** Health care workers, Gay men and other men who have sex with men, Transgender people, Indigenous people, Lesbian, bisexual, intersexual
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Mexico's National Discrimination Survey 2017 demonstrated two important conditions: LGBTTTI people are more susceptible to being unable to effectively exercise their right to health; and the establishment of health service delivery protocols based on non-discrimination and with focus on human rights is still an opportunity area. This information highlight discrimination as a main barrier to access better health care services, and therefore on increasing protection against health risks and life expectancy.

BENEFICIARIES AND IMPLEMENTERS

The Protocol and the guides that integrate it are applicable and generally observed in all public, social and private health care establishments of the National Health System. The beneficiaries are LGBTTTI people.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Mexico

FINANCING AND SUSTAINABILITY

- Not applicable

DESCRIPTION

The Protocol established guidelines and specific actions to be performed during the provision of health care services in the National Health System establishments, which will contribute to guarantee effective and non-discriminatory access to the health services of LGBTTI people. The programme objective is contribute to guarantee the effective and non-discriminatory access to the health services of lesbian, gay, bisexual, transsexual, transvestite, transgender and intersexual people as well as the other that integrate the diversity of non-normative sexual expressions, by establishing criteria counselors and specific actions to be observed in the provision of health care services in the establishments that make up the National Health System.

RESULTS OF THE PROGRAMME

This programme is in the implementation phase, which includes the dissemination of the guidelines to the persons providing health services, and its reach is not yet analyzed. However, it is applicable throughout the country.

OUTCOMES AND IMPACT OF THE PROGRAMME

Promote mechanisms to ensure medical care without discrimination to LGBTTTI people, through the formation of a protocol general compliance in the provision of medical services of the NHS.

Establish specific care criteria in the medical care of lesbian and bisexual women, Gay and bisexual men, transsexual people and intersex people; through the formation of specific reference guides for the care of each of these populations.

Guide the heads and managers of health care establishments of the National Health System on the policies they must establish to avoid discrimination against LGBTTTI people.

Promote in all staff working in the health care establishments of the SNS, the culture of respect for the human rights of LGBTTTI people

Contribute to effective access to quality health services by establishing patterns of action that avoid discrimination based on gender identity and / or expression, variation in sexual differentiation and sexual orientation.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

This programme is in the implementation phase, which includes the dissemination of the guidelines to the persons providing health services, and its reach is not yet analyzed. However, it is applicable throughout the country.

LESSONS LEARNED AND RECOMMENDATIONS

The discussion and elaboration of the protocol included the participation of the civil society of the LGBTTTI population, academia, government, private sector, which contributed to the strengthening of the program.

CONCLUSIONS

This protocol for the provision of health care services will avoid discriminatory expressions and attitudes towards the LGBTTTI population.

ANNEXES/ADDITIONAL RESOURCES

- www.gob.mx/cms/uploads/attachment/file/233408/210617Protocolo_Comunidad_LGBTTI_DT_Versi_n_III_17_3.pdf

20. PERU: A citizenship initiative to decriminalize consensual sexual relations among adolescents ensuring their access to HIV and reproductive health services

TITLE OF THE PROGRAMME: A citizenship initiative to decriminalize consensual sexual relations among adolescents ensuring their access to HIV and reproductive health services

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- **Start Date of the Programme:** January 04, 2011
- **End Date of the Programme:** October 4, 2017
- **Responsible Parties:** Civil Society / UN or other inter-governmental organization
- **Population Group(s) Reached:** Young people/adolescents
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

In 2006, Law No. 28704, declared that sex, consensual or not, with an adolescent from 14-18 years of age were approved crime. This standard was a barrier to access to sexual and reproductive health, including HIV prevention, in this population.

This prohibition found that adolescents feel fear of going to health services for information of contraceptives and prevention of sexually transmitted infections. Moreover, pregnant adolescents did not attend prenatal care. The law placed adolescents in a situation of greater risk of contracting an infection or get pregnant.

The intervention developed by the UNFPA Peru Office was designed with the main objective to overcome this legal barrier through the promotion of youth participation in both the design and implementation of advocacy actions to overcome this important obstacle to the exercise of their sexual and reproductive rights.

This barrier occurred in a context of significant challenges for the sexual and reproductive health of adolescents, which is maintained for years, even in the last Health and Family Survey (2016). According to this survey, an aspect of great interest is the fertility of adolescent women aged 15 to 19, who are already mothers or who report being pregnant at the time of the survey. What is relevant still remains that about 60% would have wanted to postpone it in the period 2015-2016. Maternity and unplanned pregnancy in these adolescents continues to express one of the biggest deficits to fulfill the debt that we have as a country to them.

In this case, the increasing prevalence of pregnancy on the Coast, particularly in Metropolitan Lima, which together congregate more than half the population of women aged

15 to 19 in the country, is striking. Pregnancy in the capital went from 4.4% in ENDES 1991/92 to 6.8% in 2015-2016 (in that period the population of Lima grew by almost 40%); while in the rest of the Costa goes from 10.8% to 14.0% in the same period. Among adolescents with higher education in the last twenty-five years, pregnancy increased from 2.7% to 6.8% per year 2015-2016. How many of these pregnancies were planned?

Obviously, we cannot continue to analyze fertility and teenage pregnancy by looking only at the national average, not looking only at the departments, if we do not complement it also with analyzes according to income strata or levels of study, as well as qualitative studies. That adolescents with higher education levels, who have increased more than five times since the early 1990s, are mothers or are pregnant, also tells a lot about the changes in mentalities (perhaps associated with lower monetary poverty, if any), but also about the desertions and missed opportunities that would be generating in the face of unplanned pregnancies. And the urgent need for sex education, complemented by the participation of parents who demand it, as well as guidance, counseling and provision of contraceptive methods in those who have sexual activity.

In this context, the overcoming of the legal barrier is a measure aimed at improving the conditions for the exercise of sexual and reproductive rights of adolescents and favors access to sexual and reproductive health services and contraceptive supplies.

BENEFICIARIES AND IMPLEMENTERS

Implementers

- UNFPA Perú Country Office
- Civil Society Organization (CSO) under INPPARES leadership with high participation of youth organization
- Defensoria del Pueblo (Ombudsman Office)
- Beneficiaries: Adolescents, male and female, between 14 and 18 years old, at national level.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The participation of young organizations in the process of drawing up and monitoring the action was very active and, although it was led from Lima, committed the participation of young people of all the country. Also, it has to be said, that the court's decision has a national scope.

FINANCING AND SUSTAINABILITY

The strategy was developed in partnership with INPPARES/IPPF involving multiple actors of civil society and the Ombudsman Office as a strategic partner. Each organization has contributed providing technical assistance in the process with their experts. UNFPA investment to count on with extern specialists and to carry out the mobilization and advocacy actions in a period of two years is estimated in US\$ 50,000.

DESCRIPTION

In 2006, Law 28704 criminalized consensual sex with adolescents (14-18). This law fails to recognize the needs of today's youth and their ability to make responsible decisions regarding their sexual health establishing a barrier to access to health services including using effective protection against sexually transmitted infections and HIV/AIDS.

According to research with health users, the approved law blocked adolescent's access to health facilities placing adolescents in a high-risk situation.

UNFPA developed a comprehensive strategy involving multiple actors. In a first phase we generated evidences about the unconstitutionality of the norm and its impact in adolescent's sexual rights; developed advocacy actions with policy makers and public awareness activities to change social perceptions about adolescent's sexuality.

In a second phase the strategy focalized in a citizen mobilization under youth leadership aimed to remove the law through a decision of the Constitutional Court (CC). This process of citizen participation, unique in Latin America, made possible to present a claim in the Court. It was signed by 10,000 young people and adults at national level. Public campaigns involving the media, as informal visits to the magistrates were done to aware about adolescent's sexuality. UN submitted an Amicus Curiae to the Court. In 2013, the Court decriminalized consensual sex with adolescents and recognized their rights to sexual freedom, health, privacy and information.

In this process, UNFPA submitted a document to the Court with the arguments that supported the unconstitutionality of the law. In January 2013, the Constitutional Court decriminalized consensual sex with children 14 to 18 years old and recognized that adolescents have the right to sexual freedom and health, privacy and information on issues related to sexual freedom. The document presented by UNFPA and UNAIDS (complemented by informal visits to the Constitutional Tribunal to advocate for the human rights of young people) was a contributing factor for this decision.

To spread the Constitutional Court judgment two booklets were published and 06 regional training workshops to 936 prosecutors, service providers and health authorities of six regions were provided. A strategy for dissemination of the effects of the judgment of the TC through social networks was also implemented.

First, UNFPA prioritized the production of material about the unconstitutionality of the norm and the impact of the restriction on the prevention of teenage pregnancy and maternal health care for adolescents. This material was essential for developing evidence-based advocacy in Congress to amend the law. In second place, given the reluctance of Congress to change the law, UNFPA promote a youth mobilization process to remove this legal barrier through a decision of the Constitutional Court.

This process of citizen participation, developed only in Latin America, based on the diffusion of rights of young people and empowering them to exercise citizenship, made possible the presentation of a claim by signing over 10,000 young people, twice legally required, and determined the overcoming of the legal barrier.

RESULTS OF THE PROGRAMME

- Advocacy strategy lead by youth organizations designed and implemented.
- First action of unconstitutionality presented by youth organizations.
- First decision of the constitutional court that addresses the exercise of the right to sexual and reproductive health of adolescents and recognizes the ownership of sexual freedom in adolescents 14 years and older issued.
- Legislative framework of the Ministry of Health which guarantees the access of adolescents to contraceptive supplies and health services to exercise their sexuality in a healthy and responsible manner.
- Youth organizations strengthened in their capacities for the development of advocacy strategies on sexual and reproductive health and rights.

OUTCOMES AND IMPACT OF THE PROGRAMME

- The legal barrier that restricted the exercise of sexual and reproductive rights of adolescents was overcome.
- The Ministry of Health adjusted its regulation to this pronouncement of the court
- There are better conditions for the exercise of sexual and reproductive rights of adolescents, including the access to contraception.
- Major empowerment of young organizations in the development of advocacy strategies in sensitive issues.
- High visibility of adolescent's sexual and reproductive rights in the public agenda.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

Permanent follow-up to the normativity related to sexual and reproductive health of adolescents to continue strengthening their implementation and avoid setbacks.

LESSONS LEARNED AND RECOMMENDATIONS

- Empowering young people to exercise citizenship based in their own experience of rights' violation was crucial to persuade the Court.
- It is needed to create stronger alliances with policy makers in favor of adolescent's sexual rights due to conservative groups influence.
- The Historical Court's decision placed the Peruvian legal framework in line with international treaties returning adolescents their right to sexual freedom, access to health facilities including protection against STI/HIV/AIDS.
- Adolescents demonstrated their leadership and capacities to influence in policy makers through a well-organized citizenship initiative persuading them about the consequences of their decisions on young people's lives.

CONCLUSIONS

- Teens have regained their right to sexual freedom, access to sexual and reproductive health, including HIV prevention
- The Court's decision placed the Peruvian legal framework in line with international treaties to protect adolescent's human rights.
- The challenge is to ensure the implementation of the judgment in health services and in the administration of justice by changing cultural and social norms.
- UNFPA will continue to work in partnership to eliminate all legal barriers that restrict adolescents and other key population to education, sexual and reproductive health and other key services.

ANNEXES/ADDITIONAL RESOURCES

- https://drive.google.com/drive/folders/0B0b__Jm6R8X5VVVrYkUzLVh6YzQ?usp=sharing

V. WESTERN EUROPE AND OTHER STATES

21.1 CANADA: Supervised injection/safer consumption services: repealing discriminatory legal barriers to harm reduction services for people who use drugs

TITLE OF THE PROGRAMME: Supervised injection/safer consumption services: repealing discriminatory legal barriers to harm reduction services for people who use drugs

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- **Start Date of the Programme:** June 01, 2015
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women, People who inject drugs, Sex workers, indigenous people
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

Canada's Controlled Drugs and Substances Act (CDSA) makes it a criminal offence to possess or traffic certain controlled substances, including various opioids (such as heroin) and cocaine. Section 56 of the Act gives the federal Minister of Health the authority to issue an exemption to "any person or class of persons" from the application of sections of the Act if, in the Minister's opinion, "the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest." Without such an exemption, users and operators of a drug consumption room face possible criminal prosecution for possession and/or trafficking of controlled substances.

In September 2003, Vancouver's regional health authority received a legal exemption from the federal Minister of Health to operate the first legally-exempted medically supervised injection facility (SIF) in North America. The exemption allowed the Vancouver Coastal Health, in partnership with the PHS Community Services Society, to operate Incite as a scientific research project. As a result of the exemption, when within the confines of Incite, users of the facility are not liable to criminal prosecution under the CDSA for possession of a controlled substance and staff members are not liable to prosecution for trafficking.

The initial ministerial exemption for Insite, based on necessity for a scientific purpose, was granted for a period of three years, starting on September 12, 2003. In January 2006, a new Conservative government was elected, which has declared its hostility to supervised injection facilities. However, under extensive advocacy pressure, including during the 2006 International AIDS Conference held in Toronto, the new Minister of Health granted an extension first until December 2007 and then again until June 2008, but rejected requests for long-term solution permitting Insite to continue operating indefinitely.

Faced with the possibility of Insite's closure, harm reduction activists began two court actions that sought to keep Insite open and also challenged both the application of Canada's drug laws to Insite and the laws themselves as being unconstitutional. One action was initiated by VANDU, the other by PHS (the agency operating Insite) and two individual users of the facility. Ultimately, the case was heard by the Supreme Court of Canada. In September 2011, the Court issued a unanimous judgment ruling in favour of Insite. [1] The Court upheld the constitutionality of Canada's prohibitions on drug possession and trafficking, because the law also gives the Minister the power to grant exemptions, as had been done already with Insite. However, the Court found fault with the Minister's exercise of that power.

The Court found that the federal government had effectively decided to deny any further exemption to Insite and that this decision was "arbitrary", in that it undermined public health and safety, which are ostensibly the very purposes of Canada's drug laws. The Court said such a decision was also "grossly disproportionate: the potential denial of health services and the correlative increase in the risk of death and disease to injection drug users outweigh any benefit that might be derived from maintaining an absolute prohibition on possession of illegal drugs on Insite's premises." The Court was persuaded by evidence that people who use drugs are considerably safer administering their own injections under medical surveillance rather than injecting hard drugs on the streets. As the Court succinctly declared, "Insite saves lives. Its benefits have been proven." It ruled that shuttering Insite would constitute an impermissible violation of the human rights under the Charter of some of those who are most vulnerable. It ordered the Minister to grant an exemption to Insite immediately, in order to respect the constitutional rights of facility users and staff.

In response to this loss in the Supreme Court of Canada, the government of the day passed a new law (the ill-named Respect for Communities Act), which, contrary to the spirit and letter of the Court's decision, created a new, more restrictive exemption regime specifically for SCS under the CDSA (a new section 56.1). The Act codified multiple hurdles that must be cleared before it is even possible to obtain an exemption. (See summary brief critiquing this legislation [here](#).)

Under this law, the federal Minister of Health was not even legally able to consider an exemption application unless and until the Minister has received at least 25 different items of information listed in the Act (with more possibly required if the Minister or government chooses). This list included a report on consultations with a "broad range" of local community groups. The application also had to include information and "opinions" (which need not be based on any evidence) from a wide range of provincial, local and health professional authorities who may choose to stall or block the process. An organization applying for an exemption also had to identify staff members (and provide a police background check on them) even before any decision can be made about the exemption.

After these hurdles have been cleared, the Act declared that the Minister may only grant an exemption in "exceptional circumstances" (contrary to the direction of the Supreme Court) after considering a number of principles stated in the Act — some of which are irrelevant to a decision about whether such a health service should operate, but instead reflect a commitment to criminal prohibitions on drugs.

Instead of enhancing access to critical, life-saving health services, the Respect for Communities Act made it unnecessarily difficult to obtain exemptions from the CDSA so that these services can operate without risk of criminal prosecution. It is impossible—particularly in light of the comments made repeatedly by various ministers of the government of the day highly critical of supervised consumption sites before and after the Supreme Court's decision, including in the course of arguing for this new, highly onerous and restrictive regime—to overlook that it represented a governmental act of profound stigmatization of, and discrimination against, people who use drugs and of an evidence-based health service

needed by them (including for HIV prevention). The burdensome legal regime, flying in the face of an apex court decision based on constitutional rights, was a deliberate attempt by the government of the day to make it exceedingly difficult, and perhaps even impossible, to successfully obtain a ministerial exemption allowing a supervised consumption site to operate without risk of criminal prosecution of its clients or staff. It was an attempt to impede health services for people who use drugs; an attempt that was rooted profoundly in, and deliberately reinforced, stigma and discrimination against a key HIV-affected population, in both intent and effect.

BENEFICIARIES AND IMPLEMENTERS

People who use drugs are the beneficiaries; NGO human rights advocates (including lawyers) and organizations of people who use drugs were the primary implementers of the program of law and policy reform to create the more enabling legal environment and remove discriminatory legal barriers to access to health services; health care workers (particularly nurses and social workers) are the primary implements of the health services facilitated by the more positive legal environment.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Canada; reform of federal criminal law regarding controlled substances and the provisions for getting an exemption to provisions of said law.

FINANCING AND SUSTAINABILITY

- Law/policy reform advocacy financed by private foundation funding.

DESCRIPTION

Civil society advocates of various sorts—including human rights lawyers, people who use drugs, and others—mobilized against the law, but were unable to prevent its passage by the federal government, given its absolute majority in Parliament. However, mobilization against the law continued despite its enactment. This included extensive, regular media commentary and lobbying of MPs (and of candidates and parties during the 2015 federal election). Following a federal election in 2015, the new federal government was more open to and supportive of harm reduction. Civil society advocacy continued to seek the repeal or substantial revision of the Respect for Communities Act.

OUTCOMES AND IMPACT OF THE PROGRAMME

Ultimately, in late 2016, the government introduced legislation (Bill C-37) to repeal the previous government's legislation and to replace it with a less onerous regime for obtaining a ministerial exemption. Intensive advocacy continued by civil society groups through various means, including submissions to Parliamentary legislative committees, and ultimately a new, less onerous legislative framework was adopted in March 2017. While it is not fully satisfactory to many civil society advocates, who have argued that it should be streamlined further, it is a very substantial improvement. The new legislation regime now in effect goes a very significant way toward removing a stigmatizing and discriminatory law that was impeding access to this health service. Canada now has close to 20 ministerially-exempted safer consumption services, in numerous cities across the country; other applications for exemptions are under consideration and more applications are likely. Currently, these services operate in 4 provinces of Canada

The law reform advocacy campaign -- and the delays occasioned by the more prohibitive, onerous legal regime -- also spurred action on other fronts to challenge the discriminatory denial of evidence-based health services to people who use drugs. In particular, it spurred

two provincial governments (British Columbia, Quebec) to publicly and officially state their opposition to the restrictive federal law and to call for its repeal or substantial revision in order to create a more enabling legal environment. One of those provincial governments (British Columbia) also proceeded unilaterally to start supporting, politically and financially, similar services under a different name ("overdose prevention sites" rather than supervised injection sites), without requiring operators to seek federal ministerial exemption before receiving support; this was a political tactic to increase pressure for reform of the federal law. It has also meant a rapid expansion of services in that province that are akin to more developed, elaborate supervised injection sites.

This move by the provincial government was itself prompted in part by civil society advocates simply proceeding, without any federal legal authorization (and hence at theoretical risk of criminal prosecution) and without any political or funding support at the outset from the provincial government, to open up such "pop-up" overdose prevention sites, as both (1) a means of addressing the discriminatory gap in access to needed services in the face of governmental inaction rooted in stigma against people who use drugs, and (2) putting pressure on governments to take action to circumvent or change the legal barriers that had been created.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The principal indicator of the impact of the law/policy reform campaign is that the federal law was changed, and the assessment of advocates as to the substance and significance of those changes. The complete repeal of the previously burdensome legislative regime is a major success of the initiative; it has been replaced with a much simpler regime that is easier to navigate in order to secure a federal exemption removing the risk of criminal prosecution for drug offences for operating a health service for people who use drugs (that prevents HIV and HCV transmission among other health benefits). The new regime is not as streamlined and "low-threshold" as many civil society advocates had been urging, but it is nonetheless a very substantial improvement in the law; this is the general consensus of advocates involved.

Whether legislative reforms will be fully accompanied by necessary adjustments at the level of governmental practice when reviewing applications for exemptions from the federal minister for such sites remains to be fully evaluated, as the legislative changes are fairly recent (March 2017) and their impact is still being assessed.

Certainly, the number of exempted services has risen quickly in the course of 12-18 months in response to civil society advocacy, as well as the ultimate streamlining of the legislative framework that advocacy achieved.

Various supervised consumption services and/or 'overdose prevention sites' are tracking data of their service-users. Results will obviously vary, but there is no doubt that the expansion of such services has meant greater access in more cities across the country. This, too, remains a work in progress.

LESSONS LEARNED AND RECOMMENDATIONS

Factors contributing to success of the law/policy reform campaign:

- Civil society tenacity.
- Involvement of people who use drugs.
- Availability and deployment of technical legal expertise to prepare analyses of legislative framework that could be basis for advocacy, including identifying needed reforms.
- Formation of a broad consensus among many different actors -- in part through sustained dissemination (including through media coverage) -- of the critical analysis of the onerous legislative framework and the case for repeal/revision.
- Willingness of new federal government to embrace evidence-based policymaking, including in relation to drug policy -- and specifically support for harm reduction -- and therefore an openness to ultimately hear criticisms of the onerous federal legislative regime (which was inherited from previous government of a different political party).
- Willingness of a provincial government to challenge inaction by federal government on removing discriminatory legal barriers to health services.
- Willingness of civil society organizations and some health care workers to begin operating necessary health services without funding (initially) and without federal legal exemption (and hence at risk of criminal prosecution).

CONCLUSIONS

The law/policy reform campaign has substantially improved the legal environment for a particular health service for people who use drugs, thereby facilitating the scaling-up of those services and access to them. This translates into blood-borne infections (including HIV) averted, as well as lives saved (e.g., from fatal opioid overdose). Case study illustrates the importance of supporting advocacy by civil society organizations, including human rights organizations and people who use drugs.

ANNEXES/ADDITIONAL RESOURCES

- See short summary of brief outlining the case for repeal of the burdensome legal regime at: <http://www.aidslaw.ca/site/respect-for-communities-act-the-case-for-repeal/?lang=en>.

21.2 CANADA: Litigating for prisoners' right to HIV/HCV prevention measures: the case of prison needle and syringe programs

TITLE OF THE PROGRAMME: Litigating for prisoners' right to HIV/HCV prevention measures: the case of prison needle and syringe programs

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- **Start Date of the Programme:** September 01, 2012
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** People living with HIV, People who inject drugs, Prisoners and other populations in closed settings, indigenous people
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Implementing needle and syringe programs in Canada's federal prisons could prevent numerous new HIV and HCV infections each year, saving tens of millions of dollars. However, because of profound stigma against people who use drugs and against prisoners, at this time, no prison in the country, whether federal or provincial, has such a program.

Canada's current federal government has repeatedly declared its commitment to harm reduction and evidence-based policy, to constitutional rights, and to the health and welfare of vulnerable Canadians. Prison-based needle and syringe programs reflect all of these. The party now governing federally in Canada, with a majority in Parliament, explicitly agreed in writing during the 2015 election that there is "compelling evidence" for such programs.

Indeed, that evidence shows that in Canadian prisons, injection drug use is common, injection equipment is shared out of necessity, and HIV and HCV are rampant. The government's own figures indicate federal prisoners have rates of HIV and HCV many times higher than in the Canadian population as a whole. Meanwhile, rates of HIV and HCV among Indigenous prisoners—and Indigenous women in particular—are higher still. Just as they do outside of prisons, needle and syringe programs in prisons reduce the harms of drug injection (including HIV and hepatitis C infections and overdose), without leading to increased drug use or jeopardizing the safety of prisoners or prison staff. These programs further improve prison safety by virtually eliminating the risk of accidental needle-stick injuries in the workplace. First introduced in Switzerland 25 years ago, such programs now operate in a growing number of countries.

There have been numerous studies and reports done in Canada examining the scope of the problem of HIV and HCV in prisons, including reviews by the Correctional Service of Canada, the Public Health Agency of Canada, and the federal body responsible for assessing health

technologies. All of those have identified the need for prison-based needle and syringe programs. Given this overwhelming evidence, implementing prison-based needle and syringe programs has been recommended by the Correctional Investigator of Canada, Canadian Human Rights Commission, Canadian Public Health Association, Canadian Nurses Association, Canadian and Ontario Medical Associations, World Health Organization, UNAIDS and UNODC, among others. (UNODC has even produced a handbook on how to implement PNSPs.) Two UN human rights treaty bodies—UN Committee on Elimination of Discrimination Against Women (CEDAW) and the UN Committee on the Elimination of Racial Discrimination (CERD)—have, in the past year, in their respective reviews of Canada's compliance with its obligations under their relevant human rights conventions, recommended the implementation of prison-based needle and syringe programs.

At this writing, the federal government in Canada has not been willing to commit to implement PSNPs on firm timeline, and so the litigation continues. Delaying the implementation of prison-based needle and syringe programs is an enormous waste of public money, not only to defend against the lawsuit but to treat prisoners and members of the broader community with HIV and hepatitis infections that can be prevented. If this government is serious about public health and human rights, including for some of the most vulnerable people in Canada, it must firmly commit—now—to establishing needle and syringe programs in all federal prisons without delay.

BENEFICIARIES AND IMPLEMENTERS

Implementers of the advocacy program (in this case strategic, public interest litigation, complemented by other modes of advocacy -- lobbying of political decision-makers, media advocacy) are civil society organizations and an individual ex-prisoner; the work of this group in advancing the litigation is led by the Canadian HIV/AIDS Legal Network.

The beneficiaries of the law reform effort, if successful, will be people who use drugs who are in prisons, who will gain access to an evidence-based health service for HIV and HCV prevention. The implementers of said health service, if the legal environment is successfully changed to enable it, will likely be health care workers working inside federal prisons.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Canada; country-wide.

FINANCING AND SUSTAINABILITY

The strategic litigation and related law/policy reform advocacy is supported by private foundation funding and by some modest grant from Legal Aid Ontario (which has a fund for test-case litigation).

DESCRIPTION

In 2012, after more than two decades of advocacy with decision-makers and in the media, and facing the prospect that, notwithstanding the evidence, the government of the day would never agree to implement these health services in the prisons, the Canadian HIV/AIDS Legal Network led a coalition of four civil society organizations and a former prisoner (who acquired HCV from using non-sterile equipment while imprisoned in initiating a constitutional court case, seeking to compel the federal prison system to implement prison-based needle and syringe programs (PNSPs). The case invokes the domestic constitution's guarantees of the right to security of the person and the right to equality, as well as the basic principle in international law that prisoners are entitled to health care that is equivalent to that available outside prison in the country in question.

RESULTS OF THE PROGRAMME

The litigation is ongoing; a hearing on the merits of the constitutional rights claims is expected to occur in 2018.

However, the litigation and related advocacy has already led to a number of statements, directly to the advocates involved and on the public record, by various government ministers of the government's commitment to evidence-based policymaking -- which itself follows the written acknowledgment by the now-governing Liberal Party, during the last federal election, of the "compelling evidence" in support of PNSPs. It has also led to supportive media coverage - including editorials - by large, mainstream newspapers, as well as statements on the record to the government by MPs belonging to its own parliamentary caucus that they are supportive of moving ahead with PNSPs.

Finally, while details are not publicly available at this time, initial evidence suggests that, faced with an actual court proceeding, and not just theoretical threats by civil society advocates to turn to litigation, the federal government has begun discussions in earnest about what might be involved in implementing this health service -- presumably in part to prepare to respond to the litigation but also to anticipate what might be required should the government lose in court and be compelled to take some action as a matter of respect for constitutional rights.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

This impact is evaluated by observation of government statements to the media and directly to advocates, and by information indirectly obtained suggested internal consideration by government of the details of implementing this health service in prisons.

LESSONS LEARNED AND RECOMMENDATIONS

Stigma and discrimination against people who use drugs and prisoners -- and especially people who use drugs while in prison -- is profound, and is the fundamental underlying reason why the health service of PNSP is not available in Canada's federal prisons despite an evidence base recognized by the government itself as "compelling" and the widespread and repeated recommendations of a host of health and human rights expert bodies, both domestic and international - including UN agencies such as UNAIDS, WHO and UNODC. In addition, opposition from some important stakeholders -- i.e. correctional officers, supported by opposition federal political party -- creates an additional barrier to acting to create a more enabling legal/policy environment in prisons for ensuring access to this harm reduction intervention.

Ultimate success of the advocacy initiative -- i.e., a changed legal environment (recognizing prisoners' human right to access to this health service), followed by actual implementation of PNSP -- is still to be seen. However, the litigation has helped attract media coverage (largely supportive) and the prospect of perhaps ultimately losing the court case and being compelled to implement PNSP has focussed the mind of government decision-makers as never before on some preparations regarding what steps might be required operationally to implement such a health service in federal prisons.

CONCLUSIONS

Years of political advocacy and lobbying helped build the support from PNSPs from various quarters, and hence build the case for their implementation. But it has not yet achieved actual implementation; litigation as a strategy has proven necessary -- at least so far -- because it may offer a means of compelling action by the government, by law, as a matter of respect for constitutional rights, to implement this health service.

ANNEXES/ADDITIONAL RESOURCES

- For more detail about the issue and the case, see <http://www.prisonhealthnow.ca/learn-more/index.php>.

22 FRANCE: Développer l'interprétariat en santé en tant que vecteur de qualité des soins des migrants allophones dans les consultations de dépistage et dans les services hospitaliers de maladie infectieuses sur l'ensemble du territoire français.

TITRE DE PROGRAMME: Développer l'interprétariat en santé en tant que vecteur de qualité des soins des migrants allophones dans les consultations de dépistage et dans les services hospitaliers de maladie infectieuses sur l'ensemble du territoire français.

PERSONNE CONTACTE:

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Titre: Chef de bureau

Organisation: *Ministère des solidarités et de la santé - Direction générale de la santé Sous-direction de la santé des populations et de la prévention des maladies chroniques (SP) Bureau des infections par le VIH, les IST, les hépatites et la tuberculose (SP2).

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- **Date de début du programme:** January 1, 1992
- **Responsable(s):** Gouvernement, Société civile
- **Groupe(s) de population atteint(s):** Agents de santé, Migrants (documentés et non documentés), réfugiés ou populations déplacées à l'intérieur de leur propre pays
- **Le programme a-t-il été évalué/analysé?** Oui
- **Le programme fait-il partie de la stratégie nationale de lutte contre le sida?** Oui
- **Le programme fait-il partie d'un plan national autre que la stratégie nationale de lutte contre le sida?** Oui

INFORMATIONS DE BASE

Environ 10 % de la population vivant en France est composée de personnes migrantes, nées à l'étranger. La caractéristique de la population migrante vivant en France est d'être originaire d'une grande diversité de pays, et donc de langues maternelles diverses.

Environ 150 000 personnes vivent avec le VIH en France. Parmi les découvertes de séropositivité des 10 dernières années, près de la moitié (48 %) concernent des personnes nées à l'étranger.

L'enjeu du programme est de permettre un soin de qualité respectueux des obligations déontologiques et des droits des patients dans le contexte de patients non francophones.

La mise en pratique de l'ajout législatif qui a été introduit par la loi du 26 janvier 2016 dans le Code de la Santé Publique (art L.1110-13) :

<https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665∓idArticle=LEGIARTI000031919839>

Le recours à l'interprétariat professionnel, notamment dans le contexte de dépistage ou prise en charge d'une infection par le VIH, permet de respecter les principes éthiques et déontologiques concernant le respect du secret médical, le recueil d'un consentement libre et éclairé, le droit du patient à la confidentialité concernant sa maladie (Art L1110-4 du Code

de la Santé Publique : « Toute personne prise en charge par un professionnel, un établissement, un réseau de santé ou tout autre organisme participant à la prévention et aux soins a droit au respect de sa vie privée et du secret des informations la concernant. » / Art. L.1111-4 du CSP : « Aucun acte médical ni aucun traitement ne peut être pratiqué sans le consentement libre et éclairé de la personne », et enfin le respect du principe d'égalité dans l'accès aux soins, par delà les difficultés linguistiques. Rappelons que le respect de la confidentialité et du secret médical sont des obligations déontologiques dans l'interprétariat professionnel. »

Bénéficiaires et responsables de la mise en œuvre

Patients allophones se rendant dans une consultation de prévention, de dépistage ou de soins qui nécessite la délivrance d'une information complète, le recueil d'un consentement éclairé.

Professionnels de santé exerçant dans :

- Les consultations de dépistage sur tout le territoire : CeGIDD (VIH, IST) et CLAT (tuberculose)
- Les services hospitaliers de maladie infectieuse de tout le territoire

Emplacement géographique et couverture programmatique

- Tout le territoire national – 5 000 consultations / an environ

Financement et pérennité

Le programme actuel est financé par la subvention annuelle allouée dans le cadre d'une convention pluriannuelle d'objectif d'un montant de 201 400 €.

Le montant de cette subvention étant plafonné, la montée en charge progressive n'a pas pu être honorée et l'ensemble des besoins des services hospitaliers de maladie infectieuse en matière d'interprètes linguistique ne sont pas totalement couverts.

Pour l'ensemble des services hospitaliers, l'étude conduite en 2012 évaluait à un coût moyen de 1031 € par hôpital demandeur et par mois.

Une estimation de l'enveloppe ONDAM (objectif national des dépenses d'assurance maladie) nécessaire avait été faite en 2014 et se montait à 3 M €.

Description

1. Programme d'accès facilité à des interprètes professionnels par téléphone pour les consultations de dépistage du VIH sur l'ensemble du territoire et pour les services hospitaliers de maladies infectieuses. Depuis 25 ans, une convention pluriannuelle d'objectifs lie la Direction générale de la santé du ministère chargé des solidarités et de la santé et une association d'interprètes intervenant par téléphone sur l'ensemble du territoire national 24h/24, proposant plus d'une centaine de langues et dialectes les plus couramment rencontrés dans l'immigration en France. Cette convention permet de promouvoir l'accès à un interprétariat professionnel de qualité dans le domaine de la santé. Elle facilite le recours gratuit à des interprètes, familiarisés avec les documents d'information santé et formés sur les sujets spécifiques des IST, du VIH, des hépatites et de la tuberculose. Ces interprètes sont compétents et liés par le secret professionnel. Ce programme est utilisé pour assurer sans rendez-vous environ 5 000 prestations d'interprétariat téléphonique par an sur tout le territoire

national sur plus d'une cinquantaine de langues différentes, réparties dans les consultations de dépistage, dans les centres d'accueil pour migrants précaires, dans les services de maladie infectieuses et d'hépatogastroentérologie, dans les centres de lutte anti tuberculose.

2. Evaluation de ce programme dans le cadre d'une étude comportant une revue internationale de la littérature, une évaluation médico économique de l'interprétariat en santé, une enquête sur l'observance des patients non-francophones dans différents services hospitaliers, des recommandations « Usage et opportunité du recours à l'interprétariat professionnel dans le domaine de la santé – Analyse des pratiques d'interprétariat en matière de prévention et de prise en charge du VIH/sida, de la tuberculose et du diabète »

Résultats du programme

L'évaluation médico économique conduite à partir du programme expérimental d'accès à des interprètes professionnels par téléphone a permis d'établir un état des lieux détaillé et de formuler des recommandations aboutissant à une inscription législative et à l'élaboration de référentiels pour les professionnels de santé.

Les constats de l'étude :

- Une forte diversité de langue : à la différence des pays anglo saxons, les patients allophones en France sont d'origines très diverses : 95 langues ou dialectes ont été demandées dans les hôpitaux d'Ile de France étudiés, ce qui exclut une organisation privilégiant le recours à des médecins eux-mêmes bilingues (sauf pour la langue arabe) ou la présence permanente d'interprètes professionnels dans les structures de soins.
- Un nombre conséquent de consultations ont lieu sans aucune assistance linguistique : un nombre conséquent de patients non francophones se retrouvent en consultation sans aucune possibilité de dialogue avec le médecin : c'est le cas de plus de la moitié des patients enquêtés non francophones en services de maladie infectieuse, où il est plus rare que les enfants accompagnants assistent le patient, comme dans le cas du diabète.
- Une compréhension de la consultation et une observance dégradée : La compréhension de la consultation et la connaissance du traitement et des examens prescrits sont moins bonnes chez les patients non francophones accompagnés par un membre de la famille, et encore moins bonnes chez ceux accompagnés par une tierce personne qui tient le rôle d'interprète.
- Les évaluations subjectives des médecins et des patients valident une moindre observance chez les patients allophones par rapport aux patients francophones. Les mesures objectives (charge virale, contrôle de glycémie...) corroborent une situation dégradée chez les patients non francophones.
- Une méconnaissance de l'existence d'interprètes professionnels : Les médecins, et plus encore les patients, ne connaissent pas la possibilité pratique de recours à des interprètes professionnels. L'accompagnant du patient est la modalité d'interprétariat privilégiée par les chefs de service et les médecins, du fait de sa facilité d'organisation et aussi parce que cela augure d'un accompagnement du patient au-delà de la seule consultation.
- Une transgression du secret médical et du recueil d'un consentement éclairé : L'absence de toute assistance linguistique ou l'assistance d'un tiers interprète non professionnel imposé « faute de mieux », transgressent les principes éthiques et déontologiques concernant le respect du secret médical, le recueil d'un consentement libre et éclairé, le droit du patient à la confidentialité concernant sa maladie.

- Un fardeau pour les aidants familiaux : La moitié des patients enquêtés auraient préféré avoir l'assistance d'un interprète professionnel à celle de leur accompagnant. Les patients et les accompagnants estiment que cela allégerait leurs charges et favoriserait l'autonomie de la personne accompagnée dans le suivi de sa prise en charge.
- Une estimation du coût moyen nécessaire par hôpital demandeur : L'offre permise par le partenariat DGS/ISM Interprétariat a montré que des modalités plus faciles et plus rapides d'accès à des interprètes professionnels incitent à recourir à leur assistance. Une simulation permet d'évaluer ce que serait, dans un cadre optimal, la demande dans les hôpitaux concernés par une file active non francophone importante :
- ce qui se pratique actuellement serait multiplier par 3, soit une moyenne de près de 35 demandes par mois et par hôpital concerné, équivalent à un coût moyen de 1031 € par hôpital demandeur et par mois.
- Une efficacité particulièrement avérée pour la tuberculose : L'efficacité du recours à l'interprétariat professionnel a été examinée par le biais de la construction d'un modèle médico-économique exploratoire et non par l'évaluation médico économique des pratiques rencontrées sur le terrain (qui aurait nécessité une étude longitudinale, voire un essai contrôlé randomisé, conduits dans une population importante de patients allophones, en comparant différentes modalités d'assistance linguistique).

Ce modèle et les analyses de sensibilité testées ont conclu à l'efficacité de l'interprétariat professionnel tout particulièrement dans la tuberculose dont l'horizon de traitement est court et conduit à la guérison, mais aussi dans la prise en charge du diabète et du VIH, notamment du fait d'une meilleure adhésion au traitement et de transmissions secondaires évitées pour le VIH.

Répercussions et impact du programme

- Ajout législatif introduit par la loi du 26 janvier 2016 dans le Code de la Santé Publique (art L.1110-13) concernant l'intérêt du recours à des interprètes professionnels pour faciliter l'accès à la prévention, au dépistage et aux soins des publics non francophones :
<https://www.legifrance.gouv.fr/affichCodeArticle.do?cidTexte=LEGITEXT000006072665&idArticle=LEGIARTI000031919839>
- Travaux de la Haute Autorité de Santé pour établir des référentiels de compétences, de bonnes pratiques et de formation, valider une charte professionnelle (publication des référentiels en cours) :
https://www.hassante.fr/portail/upload/docs/application/pdf/201702/interpretariat_dans_le_domaine_de_la_sante.pdf

Suivi et évaluation/validation de l'impact

L'étude conduite en 2012 a procédé à des entretiens avec près de 500 patients et pris en considération les points de vue des accompagnants.

La Haute Autorité de Santé a auditionné en 2016 les parties prenantes et ouvert une consultation publique. A partir de ces éléments ont été élaborés des référentiels de compétences, de bonnes pratiques et de formation et ont été validées des chartes professionnelles.

Enseignements tirés et recommandations

A partir des études et auditions conduites, les recommandations suivantes ont été établies :

1. Simplifier et organiser les modalités de recours à des interprètes professionnels en milieu de soins :
 - Mieux identifier les lignes budgétaires mobilisables, envisager une prise en charge pérenne par l'assurance maladie ;
 - Faciliter l'accès le plus direct possible aux interprètes professionnels formés et ayant signé la charte de référentiels et de bonnes pratiques professionnelles en matière d'interprétariat médico-social ;
 - Prévoir l'organisation et la formation des personnels hospitaliers faisant office d'interprètes dans certains établissements.
2. Faire connaître aux personnes non francophones et aux personnels soignants les possibilités de recours à un interprète professionnel (charte du patient hospitalisé, livret d'accueil...)
3. Introduire, dans les formations initiales et continues des professionnels de santé, la question de la prise en charge des personnes non francophones.

Conclusions

Le programme expérimental d'accès facilité à des interprètes professionnels de santé, son évaluation dans le cadre d'une étude comportant un volet médico économique et une modélisation pour l'efficacité comparée dans différents services hospitaliers, les travaux de la Haute Autorité de Santé ont donné toute légitimité à la mobilisation de moyens organisationnels, humains et financiers, à la hauteur de l'enjeu que représente l'accès à la prévention, aux dépistages et aux soins des populations non francophones souvent en situation de précarité et éloignées des systèmes de santé.

Dès la publication des référentiels de la Haute Autorité de Santé :

- Des instructions seront rappelées aux agences régionales de santé pour que puissent être mobilisés les moyens permettant que toute consultation le nécessitant puisse bénéficier des moyens appropriés d'aide linguistique
- La direction générale de la santé et la direction générale de l'organisation des soins s'engageront dans une réflexion pour faciliter et harmoniser sur l'ensemble du territoire la levée des obstacles linguistiques, en mobilisant le cas échéant l'assurance maladie pour faciliter, en médecine hospitalière et en médecine libérale, l'accès à des modalités appropriées d'interprétariat.

Annexes/ressources supplémentaires

- Synthèse de l'étude réalisée pour le compte de la DGS en 2012 : « Usage et opportunité du recours à l'interprétariat professionnel dans le domaine de la santé »
http://solidarites-sante.gouv.fr/IMG/pdf/synthese_rapport_interpretariat_professionnel_sante-4.pdf
- EHESP note de synthèse : « Développer l'interprétariat en santé, vecteur de qualité des soins des migrants allophones »
<https://www.presses.ehesp.fr/produit/developper-linterpretariat-sante-vecteur-de-qualite-soins-migrants-allophones/>

23.1 GERMANY: "No fear of HIV, HBV and HCV in dental care"

TITLE OF THE PROGRAMME: "No fear of HIV, HBV and HCV in dental care"

CONTACT PERSON:

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- **Start Date of the Programme:** December 01, 2016
- **Responsible Parties:** Government, Civil Society and Federal Chamber of Dentists
- **Population Group(s) Reached:** Health care workers and people living with HIV
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes

BACKGROUND INFORMATION

In Germany, provision of treatment and care for PLHIV is offered in specialised clinics and private practices, which offer a non-discriminatory setting for PLHIV and other key populations.

The Stigma-Index showed that stigma and discrimination happen often in other specialist care, i.e. gynaecology, proctology, orthopaedics, any kind of surgery, and dental care. 19% of the respondents reported some form of discrimination, while 10% did not seek medical care anymore due to previous discrimination experienced in health care settings.

As PLHIV get older, the need of specialist care increases in all areas of care and medicine and the problem of discrimination has to be addressed so that PLHIV can have similar quality of life to the general population.

BENEFICIARIES AND IMPLEMENTERS

The beneficiaries are in first line dentists and dental care staff, PLHIV and people living with co-infections, and in general also people living with hepatitis and other blood-borne diseases.

The Federal Chamber of Dentists and Deutsche AIDS-Hilfe (including PLHIV) jointly produced the information material, the video and the training material. The distribution is realised by the Federal Chamber of Dentists (mailing to all registered dentists in Germany and to the regional chambers of dentists).

The Ministry of Health enabled the programme and the cooperation by inviting the Federal Chamber on World AIDS Day 2014 to give a statement against discrimination as a first step.

The regional counselling services (Aidshilfen) are offering trainings for dental care staff in the clinics.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- The provision of the information material is distributed nationwide to all dental clinics and dentists.
- The Aidshilfen(120) and the networks and groups of PLHIV active in Germany distributed the material.

FINANCING AND SUSTAINABILITY

- The programme is managed and coordinated by the Deutsche AIDS-Hilfe.
- The Federal Chamber of Dentists in cooperation with the regional chambers support the programme.
- The programme is financed by the Health Ministry, the Federal Chamber of Dentists co-financed the printing and the distribution of the material.

DESCRIPTION

The programme aims to decrease dental care staff's fears by giving them information on HIV, Hepatitis B and C, the ways of transmission and the ways of protection. Many health workers in dental care stick to pictures of HIV from the 80s and 90s, a lack of knowledge and the feeling of high risk at the workplace foster discrimination against patients living with HIV and/or hepatitis.

All materials have been produced jointly by the Federal Chamber, Deutsche AIDS-Hilfe and PLHIV.

The programme includes information for dentists on the websites of the Federal and the Regional Chambers which bring up to date information and explanation of appropriate protection and hygienic measures instead of exaggerated measures which often are taken or the refusal of treatment in general. A brochure explains in a more elaborated way HIV and hepatitis and the ways of dealing with those infections and with PLHIV and/or hepatitis.

A short video, especially addressing dental care assistants, who are often young, serves as a first contact with the topic and gives the most important information in a casual way. For the trainings, material is offered to enable trainers to give up to date information to the dental care staff.

Deutsche AIDS-Hilfe dedicated staff member offers counselling for PLHIV who experienced discrimination in any setting but especially in health care setting and helps PLHIV to lodge a complaint. The staff member also collects and reports on cases and does the follow-up of complaints.

RESULTS OF THE PROGRAMME

- Over 30.000 dental care health services with around 70.000 dentists received the material.
- PLHIV were reached by different networks of PLHIV, counselling services, via social media and media work.
- An increase of complaints and answers to the complaints and more case reporting are results of the programme.
- An increase of HIV-friendly dental services nationwide.

OUTCOMES AND IMPACT OF THE PROGRAMME

- We see a change of behaviour towards PLHIV in dental care and a change of practices regarding hygiene measures in some health centers.
- Decreased fear of the dental staff is reported.
- PLHIV are empowered to not accept discrimination (more complaints, more case reporting, more good answers) and have an improved access to dental care services.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- The project started only 9 months ago, but some of its effects are already remarkable.
- A direct monitoring and evaluation system is not planned. For the Stigma-Index, a second round is planned in the upcoming years (2019/2020).
- The collection of cases is done by Deutsche AIDS-Hilfe.
- There are reports of good cooperation of regional partners in trainings for health care workers.

LESSONS LEARNED AND RECOMMENDATIONS

It is a long way to implement a programme in the health system, a lot of patience and energy is needed to find a working basis and an understanding among the partners (Deutsche AIDS-Hilfe and Federal Chamber).

The Health Ministry enabled the programme by inviting partners to the first meeting and supporting their collaboration.

PLHIV contributed with their personal experience and their high levels of knowledge of HIV. A challenge was/is the federal system of Germany: the Federal Chamber has no entitlement to impose rules and regulations on their regional members, they only can offer recommendations, training and material. Changes have to be made on the regional level.

It is not possible to work with 16 regional chambers in a direct way.

CONCLUSIONS

Regardless the science around HIV and the general good public knowledge of HIV in Germany, there are still fears in health workers as in the early times of the epidemic.

These fears can only be met if GOs, NGOs, PLHIV and their representatives of the health system work together and make a change of behaviour possible.

Due to the case-reporting, we have individual stories and testimonies which we could offer.

ANNEXES/ADDITIONAL RESOURCES

The material is in German only.

- the brochure: <https://www.aidshilfe.de/sites/default/files/documents/zahnaerzte-final.pdf>
- the video: https://www.youtube.com/watch?v=zOZrJw_aleQ
- the training material (sent in email attachment)

23.2 GERMANY: Case Study: Undetectable=Untransmissible- Health Care Workers living with HIV and Labour Law in Germany

TITLE OF THE PROGRAMME: Case Study: Undetectable=Untransmissible- Health Care Workers living with HIV and Labour Law in Germany

CONTACT PERSON

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Organisation: European AIDS Treatment Group

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- **Implemented by:** Civil society
- **Populations group(s) reached:** People Living with HIV

DESCRIPTION

Applying U=U in the health system includes changing the rules for health care workers (HCW). In Germany, the Federal Labour Court (FLC) ruled in 2013 (6 AZR 190/12) that nobody must be discriminated against at work, based on HIV-status only. The ruling directly affected a chemist, who had applied to work in a hospital laboratory. The ruling stipulated that the exclusion of people with HIV as job candidates was illegal, if the employer could not prove a specific risk to patients. The Federal Labour Court thus provided the same protection to people living with HIV as to anyone else living with a disability. The ruling held that both the UN Convention on the Rights of Persons with Disabilities and the German Antidiskriminierungs- und Gleichstellungsgesetz (AGG) are applicable to people living with HIV.

More generally, this FLC ruling also relates to people with HIV already employed as HCW. They cannot be generally regarded as infectious and thus discrimination must only be practised based on more relevant criteria. The regulations of patients' and workplace safety must be more specific (Hoesl 2013). Only, when there is a specified and individual risk of transmission of HIV associated with the actual tasks of a HCW it is legal to exclude someone from such practice. This ruling of the FLC applies to job application processes as well as to decisions about established work contracts.

National guidelines have been developed to further define the rules and conditions of discrimination against HCW living with HIV (DVV/GfK Commission - Rabenau 2012) to protect their patients from nosocomial HIV-infection. According to these, HCW living with HIV can practice all non-invasive and operative procedures as long as these are not "exposure prone" (DVV 2007, Henderson 2010). Exposure prone procedures must not be carried out by HCW living with HIV and with a viral load >50 copies/ml. Under these circumstances the transmission of HIV is considered to be virtually impossible in the 2012 guidelines. These statements are put to question, however, by the commission demanding that for ethical and legal reasons a patient is to be informed, if an exposure to blood from an HCW living with HIV has occurred. A guideline developed to offer Post-Exposure Prophylaxis to HCW and patients (DAIG 2013) identifies a risk of infection for patients, when there is a massive inoculation of blood (>1ml).

RESULTS OF THE PROGRAMME

In practice, these guidelines are interpreted with considerable difficulty. We hear reports from HCW without any “exposure prone” tasks (e.g. nursing staff members, non-operative paediatrician), who have been demanded to provide the results of viral load testing before being allowed to practice. We see demands placed on HCW with a viral load <50 copies/ml, which are incompatible with ordinary labour practice. E.g. a surgeon is required to take ART and to provide quarterly viral load results, plus, he may not practice tissue punctures, operations in the lower abdomen, thorax, lung or oesophagus, nor deep tissue sutures. These detailed restrictions add up to a factual exclusion from practice. A physiotherapist is asked to not only prove his viral load in order to become employed – he is also requested to wear rubber gloves in patient contacts and not to see patients without a colleague in the room. He is asked to sign a statement that he will not aim to resuscitate a patient in case of an emergency. Such problems with the interpretation of the guidelines persist to this day.

It is difficult to estimate the size of the problem of HCW living with HIV being discriminated against. Nobody knows, how many are excluded from practice. The number of cases cannot be concluded from the number of cases brought to court. The pressures to keep stigma and discrimination a secret and not to seek legal support are multiple from both sides: employers fear the stigma of having “HIV-staff” as much as HCW with HIV fear and end to their career. More cases are reported under conditions of confidentiality and anonymity. There is no separate register for HIV-based discrimination against HCW. Discrimination also extends to HCW working with HIV-patients – they are considered to work “at risk” and face exclusion from opportunities to work elsewhere (“contaminated curriculum”). The size of this problem is unknown.

Deutsche AIDS-Hilfe (DAH, and local AIDS Service Organizations) provide confidential and anonymous counselling to HCW living with HIV. DAH identifies qualified lawyers and medical staff to help with consultation and expertise. The majority of cases brought up through this network does not come to court. Commonly, HCW living with HIV change their jobs, places of practice and places of living to escape the climate of stigma and discrimination the encounter from within the health system. Publications aim to inform the public about the legal situation, national seminars are held to identify relevant common issues and to coordinate the supportive response.

LESSONS LEARNED AND RECOMMENDATIONS

- In order to support the rights of HCW against stigma and discrimination services must combine psychosocial, legal and medical expertise in an environment that offers confidentiality and anonymity. Hands-on practical advice is needed to respond adequately to the challenges posed in practice. Service providers should be prepared to intervene vis-à-vis employers, staff commissions and the like.
- In order for guidelines to form a reliable normative framework contradictions between guidelines, current knowledge and actual practice must be identified and resolved. Guidelines must be reviewed periodically and they must be informed about unwanted outcomes of their guidance at regular intervals, too.

CONCLUSIONS

Hidden discrimination against HCW living with HIV and the effects of discrimination against people living with HIV on workplaces in health systems must be seen as intrinsically linked experiences. Understanding the level of damage to individual careers and the impact on the delivery of health services should be addressed as two parts of the same environment. Efforts aimed at empowering people living with HIV must take the specific needs of HCWs into account.

ANNEXES/ADDITIONAL RESOURCES

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www.daignet.de/site-content/hiv-therapie/leitlinien-1/Deutsch_Osterreichische%20Leitlinien%20zur%20Postexpositionellen%20Prophylaxe%20der%20HIV-Infektion.pdf
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24 PORTUGAL: Anti-Discrimination Center (CAD)

TITLE OF THE PROGRAMME: Anti-Discrimination Center (CAD)

CONTACT PERSON

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- **Start Date of the Programme:** January 1, 2010
- **Responsible Parties:** Civil society
- **Population Group(s) Reached:** Health care workers, People living with HIV, Young people/adolescents, Gay men and other men who have sex with men, People who inject drugs, Prisoners and other populations in closed settings, Sex workers, Transgender people, Migrants (documented and undocumented), refugees or internally displaced populations.
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** Yes.

BACKGROUND INFORMATION

HIV infection is still an important public health problem in Portugal, with 9.5 new cases per 100,000 inhabitants (2015 adjusted rate), higher than the EU/ESA average of 6.3 per 100,000 population, although the number of new infections shows a decreasing tendency. 75% of people with HIV in Portugal are adults between the ages of 25 and 54, and live in Lisbon, Oporto, Setubal and Faro. (in "Programa Nacional para a Infecção VIH, Sida e Tuberculose 2017").

The social impact of HIV infection, fuelled by stigma and discrimination, is still very significant in Portugal, as showed in the Stigma Index Portugal study, conducted in 2013. In this study, people living with HIV reported being discriminated 1 to 2 times per year, 60% didn't confront the perpetrators of discrimination, and 20% to 50% had self-discrimination behaviours.

In face of such circumstances, two Portuguese NGO's (Ser+, Portuguese Association for AIDS Prevention and Challenge, and GAT - Treatments Activists Group) pioneered in 2010 the Anti-Discrimination Center (CAD) with the purpose of fighting stigma and discrimination of people living with HIV, viral hepatitis, and vulnerable populations, by ensuring, promoting and securing the implementation of their fundamental rights. Throughout its seven years of existence, the Anti-Discrimination Center (CAD) received almost 400 complaints, 26% of them in the field of health services.

That led us to conduct the investigation/action project Respect Portugal (2017), in collaboration with the Regional Health Administration of the Lisbon and Tagus Valley (ARSLVT) area and the National AIDS Plan/General Directorate of Health. This pilot project

was part of Work Package 7 (Stigma and legal barriers to the provision and uptake of HIV testing services), of Optest, and its main goals were: 1) Identify and assess the barriers associated with HIV stigma and discrimination (and groups vulnerable to infection) that make it difficult to propose HIV testing and follow-up of people living with HIV in primary care centers; and 2) Outline strategies to overcome those barriers, in order to promote testing, increasing early diagnosis and better and more equitable access and care for people living with HIV.

BENEFICIARIES AND IMPLEMENTERS

Anti-Discrimination Center is a project promoted by two Portuguese Patient Associations (Ser+ and GAT). Its first coordinator (until last year) lives with HIV, and is an important activist in defending Human Rights and fighting discrimination toward people living with HIV. CAD team gathers other people with HIV, along with social workers and lawyers, allowing us to combine technical expertise and the experience of people directly affected by HIV and more sensible to discrimination issues. The Stigma Index Study we developed in 2013 was entirely conducted by PLHIV, and they are actively involved in many of CAD activities.

To address specific discrimination issues CAD made some strategic partnerships, namely, the National AIDS Plan/General Directorate of Health, the Regional Health Administration of the Lisbon and Tagus Valley (ARSLVT) area, Primary Care Centers, the Portuguese Association of Occupational Medicine, and the Nurses' Union.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Cad has a national scope, receiving complaints and supporting people from all over the country, and developing training sessions for professionals from all districts. Since 2010, CAD gave support to 385 people, and trained almost 3000 professions in HIV related discrimination issues and Human rights, including health care professionals and people living with HIV.

The intervention in primary care centers (Respect Project) were limited to Lisbon district, and involved 167 health care professionals (doctors and nurses) from 3 primary care centers in Amadora, Cascais and Loures/Odivelas municipalities.

FINANCING AND SUSTAINABILITY

The services are at no-cost to end users. CAD won two major calls in the past – in 2011, a four-year grant from the National Aids Program and, in 2015, a one-and-a-half year grant from EEA grants.

During no funding periods, both GAT and SER+ have covered the running costs of CAD, rearranging tasks or working hours of permanent staff, and with some support of pharmaceutical industry.

We will submit the project to the next EEA grants call – by mid-2018 - and to other national calls, where suitable. As a recipient of the fund from November 2014 to February 2016, and with a good evaluation from the Portuguese operator of the Fund, the Calouste Gulbenkian Foundation (<https://gulbenkian.pt/wp-content/uploads/2015/10/Brochura-EN.pdf>), we believe that all the conditions to win again in the next round, when available, are in place.

Cooperation with European organizations with the same objectives is currently being developed and may open funding opportunities within the European Union.

The annual cost of CAD rounds €76.000, not including the investigation projects. Respect project had a budget of €15400 , and for the replication of Stigma Index Study, in 2018, with nation scope, we will need an additional €60.000.

Knowing that stigma and discrimination have high impact in prevention and treatment of HIV infection we believe that the cost of the project is surpassed by the benefits (social and financial) in terms of improving the quality of life of people living with HIV and reducing the chain of transmission and late diagnosis.

DESCRIPTION

The main goals of CAD are:

- To support people living with HIV, viral hepatitis and vulnerable populations, subject to discrimination;
- To promote legal and social solutions and tools, to defend the rights of people living with HIV, viral hepatitis and vulnerable populations;
- To empower people living with HIV/viral hepatitis, as well as community members in key sectors, to reduce stigma and prevent discrimination;
- To gather relevant national and international publications in the areas of discrimination, Human Rights, HIV and viral hepatitis;
- To contribute to the production of knowledge about discrimination, Human Rights, HIV and viral hepatitis;

CAD is organized in three major areas: i) personal assistance and counseling, including mediation, administrative, legal and juridical support and follow-up of cases of discrimination against people living with HIV (PLHIV)/viral hepatitis; ii) training and awareness sessions to empower people living with HIV/viral hepatitis, as well as community members in key sectors, to reduce stigma and prevent discrimination; and iii) on-line free access repository of documentation related to Ethics, Human Rights, Discrimination, HIV and viral hepatitis .

Knowing that more than 1/4 of the discrimination situations were related with the health sector, we developed this year the Respect Project. Its main goals are: 1) Identify and assess the barriers associated with HIV stigma and discrimination (and vulnerable groups) that make it difficult to propose HIV testing and follow-up of people living with HIV in primary care centers; and 2) Outline strategies to overcome those barriers, in order to promote testing, increasing early diagnosis and better and more equitable access and care for people living with HIV.

Respect project has 3 implementation phases:

- i. Research – Open, prospective study, using a standard questionnaire, with the objective of identifying the main obstacles to the implementation of the early testing – knowledge, attitudes, awareness, information, facilities and internal organization.
- ii. Action – based on the analysis of the research phase, together with the primary care centers involved, intervention and action strategies and programs are being planned, implemented and evaluated. Action plans will be adapted to the realities found and actions will be implemented at health units' level for each center.
- iii. Evaluation – After the implementation of every action, a new questionnaire, similar to the first one, will be applied in similar conditions to evaluate the impact of the interventions in HIV screening practices and in the follow up of PLWHV and the replication impact of actions taken.

RESULTS OF THE PROGRAMME

Since 2010, CAD has attended 385 discrimination cases from all over the country, and is experiencing increasing demand, especially since 2015. The complaints received by the Center are mainly in the field of health services (26%), employment and labour relations (21%), disclosure of information about private life and breach of confidentiality (20%), access to bank loans, credit and insurance (16%). All this situation received counselling and support to solve the discrimination issue, and the institutions or people accused of discrimination along with the regulatory entities were informed and pressured to act accordingly.

At the training level, CAD developed more than 140 sessions throughout the country, aimed at NGOs, PLWHIV and activists, health professionals, social support structures, vocational training centers, companies, teachers and youth. In this 7 years nearly 3000 people have been trained by us in HIV, Human Rights and Discrimination, being more prepared to receive and integrate PLWHIV in schools, professional training, companies, home care services and residences for elderly.

The Documentation and Information Center of CAD collected (until now) 15.233 documents of different typology (regulations, reports, conference proceedings, scientific articles, master's and doctoral theses, fieldwork, legislation and jurisprudence) in the areas of HIV, Viral Hepatitis, Sexual Transmitted Infections and Human Rights. These documents are organized and catalogued in a digital database made available under free access and has registered more than 320.000 visitors.

We also developed 2 investigation projects: Stigma Index 2013, reaching more than 1000 PLWHIV, allowed us to have a better picture about discrimination in Portugal; and Respect Project, specially aimed at primary care centers. In the first phase of Respect a total of 167 questionnaires were applied to health professionals. The results showed: 1) Insufficient knowledge of HIV infection, in particular regarding ways of transmission (60% admits the possibility of HIV transmission by saliva or vomit; 75% by kissing in the mouth; 77% are afraid when providing first aid and 38% when performing a gynaecological exam to PLWHIV); 2) Attitudes towards PLWHIV and vulnerable populations based on stereotypes and preconceptions; 3) Misguided practices in providing care by taking unnecessary precautions (40% always wears gloves when attend an HIV patient, and 9% wears a mask); 4) Insufficient compliance with safety and hygiene standards associated with possible failures in provision of individual protection materials; 5) Poor communication mechanisms resulting in the lack of knowledge of national norms for proposing HIV testing; 6) Undefined procedures for applying rapid tests, and poor accessibility to test material; 7) Insecurity in the proposition the test, counselling and returning the result; 8) Management of confidentiality the diagnosis, namely in relation to the partner and other health professional;

Based on this result some interventions were planned with each Health Center, namely: 1) To develop a training program, to health professionals of the Centers; and 2) To develop a training for trainers' program, targeted at young doctors and nurses, interns, to capacitate them to implement the follow up and replicate the training courses, during and included in their internship program, in order to reach all the staff of the Health Centers.

Training sessions had already occurred in 2 of the health centers, reaching 55 health professionals. It was possible to observe a significant improvement in knowledge and attitudes towards HIV, through a questionnaire filled out by the trainees at the beginning and end of training, where there were 74% (Loures/Odivelas) and 71% (Amadora) of correct answers in pre-test, and 99% in post-test (in both Centers).

OUTCOMES AND IMPACT OF THE PROGRAMME

The complaints CAD received led us to some advocacy actions, such as: 1) Government pressure to change the anti-discrimination law, making it more comprehensive; 2) Changing discriminatory regulations to access public swimming pools (after the intervention of the Ombudsman); 3) Changing discriminatory practices in Hospitals (such as serving meals in disposable utensils to PLWHIV), after the recommendation of the General Inspection of Health Activities; 4) Pressure hospital pharmacies to dispense antiretroviral medication for the minimum legal period (90 days), and/or report drug stockouts in order to prevent them; 5) Pressure prisons to facilitate access to treatment for inmates living with HIV; 6) Complaint and change of practice in the application of HIV testing by occupational medicine in several companies; 7) Facilitation immigrant access to treatment and linkage to care.

CAD training program resulted in an increase of knowledge and a change of attitudes among trainees, promoting a better integration of PLWHIV in schools, professional training, companies, home care services and residences for elderly. The training enables people from specific professional activities to both disseminate the information and change standard working procedures and perspectives.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

CAD monitoring and evaluation is done through interviews and individual complaints records, with periodic contact with the complainant to assess if the situation has been solved or if it still persists. The increasing demand that we are experiencing shows that people are satisfied with the support they are given.

We also monitor the amendment of laws and regulations with discriminatory provisions, in order to change the bad practices and promote the good ones.

To evaluate the training sessions, we use: 1) a final evaluation questionnaire passed to the trainees, in order to gather their opinion on the various aspects of the session, asking them to rate them between 1 (Very Bad) and 5 (Very Good). 2) Initial and final questionnaires are given to the trainees before and after training, to assess their level of knowledge and attitudes towards people with HIV; 3) Presence sheet.

LESSONS LEARNED AND RECOMMENDATIONS

The personal experience of living with HIV or HEP C qualify some staff members as peers, with a better understanding, personal experience and empathy with users and the situations they present and facilitate the development of a very user-friendly environment, not reachable to professionals without that background. In other hand, including PLWHIV in the team is the way to empower and allow them to have a meaningful impact in the solution of a problem that affects every PLWHIV (GIPA/MIPA).

The team works together for seven years now, and this includes the external law office. This long standing professional relation and commitment to the rights of PLWHIV make them a rare case, in the NGO movement, and the experience created a common “language” and methodology that facilitate the suggestion of feasible and correct solutions to the problems.

Establishing local partnerships is also crucial. We believe that one of the reasons to CAD success is the partnership with healthcare service providers at all levels (primary care units, hospitals) and civil society organizations, including representation of vulnerable groups (men who have sex with men, migrants, sex workers, trans-people and people who use drugs and inmates), across the country.

The methodologies used in training sessions also contributed to the success of the programme. Training is based on group discussions of anonymised real-life cases in the context of the trainees' professional background and testimonies of personal experiences by PLWHIV. Several PLWHIV are trained and empowered by CAD to perform support and counselling functions, either at CAD or at network members.

The most important challenge is to involve in a structured organised way organisations working in the field with PLHIV to reach every person that feels discriminated, through its usually support networks.

Some target groups – sex workers, IDU, migrants – are more difficult to reach as they are less organised and some of the organisations working with them may have conservative approaches.

The lack of political leadership and national policies to address stigma and discrimination and the resulting lack of public financial resources, make the project strictly depending on the promoting NGO.

To overcome these limiting factors, CAD actively involves all stakeholders in the evaluation of problems and definition of tailored responses, and work through existing NGO networks and platforms.

Guidance materials, instructions, procedures and good practices already developed and other to be developed yet may facilitate the replication of the project in any country, upon translation. At the national level, all materials can be used by other community services, in different environments, to promote Human Rights and support people object of any kind of discrimination – gender, religious, etc.

CONCLUSIONS

Throughout its seven years of existence, the Anti-Discrimination Center (CAD) could demonstrate the need, felt by people living with HIV, for services specifically geared to their defence in situations of discrimination.

The work of CAD and the services it provides are now well established and recognized by multiple stakeholders as innovative, directed and promoted by the community.

CAD will continue to raise awareness to the ZERO Discrimination target at political and administrative level and making all efforts to guarantee that the National Plan for HIV, Viral Hepatitis and TB address the stigma and discrimination and resources are allocated to the established policies.

One of our most success stories is the fire-fighter discrimination case:

Brief description of the problem

On January of 2014, a commander of a corporation of firefighters in Portugal starts sending SMS to a volunteer firefighter, threatening her by saying that, unless she quits the course she was completing in order to become a professional firefighter, he will inform the whole corporation that she is HIV+.

According to the Commander, the firefighter and the doctor who gave her a statement attesting her suitability for the job, were endangering public health. The Commander told her she had 24 hours to quit her volunteer job.

The firefighter declined to file for dismissal and said she would not accept to be fired by SMS. In retaliation, the Commander threatened her by saying that he would come to her regular job to tell her boss that she was living with HIV. He also told her that since she was not ashamed to have endangered the health of firefighters and their families and did not realize that she was obliged to reveal that she had HIV, he would disclose her HIV status to the entire Fire Brigade – which he did.

Steps taken

CAD - Anti-Discrimination Center, after several diligences in a letter to the responsible entities and interested parties, decided to file a lawsuit, and the indictment was concluded in June 2015.

The court accepted that:

- There is no legal obligation to disclose an HIV infection;
- That the competent authority to certify the capacity to work as a firefighter is the doctor who passed her certificate and not the Commander;
- That the means of transmission of HIV have been known for a long time and there is no "increased danger" in professional relations. Therefore, the cares that must be taken are the same for everyone.
- And it was proved that:
 - The Commander disclosed the firefighters HIV status to the Fire Brigade.
 - The Commander abused his authority and damaged the firefighter's honor and her right to intimacy and privacy.
 - And that by the volume of SMS, while the firefighter was exercised her other profession, he had intended to disturb the private life, peace and quiet of the firefighter.

How we resolved it

On May 2017, the Commander was sentenced to 14 months' imprisonment, with suspended a sentence, and he was also obliged to pay a compensation. In addition, at the trial hearing, he was forced to apologize due to an agreement to waive one of the complaints.

Lessons learnt

Although the length of time for justice is more time consuming than we would like it to be, innovative judgments, such as this one, make case law and serve as a precedent that will greatly facilitate us to help HIV positive people in similar situations. All findings, of the indictment and the outcome of the sentence, will be made public in order to inform and dissuade anyone who intends to discriminate against someone at work because of HIV.

ANNEXES/ADDITIONAL RESOURCES

- http://www.gatportugal.org/projetos/centro-anti-discriminacao_8
- <http://www.sermais.pt/content/default.asp?idcat=fuiDiscriminado&idCatM=paraPessoasVivemComVIH&idContent=4BD8BED4-527D-45E4-8EFA-CA14926D5EA6>
- <https://gulbenkian.pt/project/centro-anti-discriminacao-vihsida/>
- <https://www.publico.pt/2011/01/31/sociedade/noticia/ha-casos-de-discriminacao-a-seropositivos-em-hospitais-1477940>
- <http://24.sapo.pt/tag/centro-anti-discriminacao>
- <http://www.atlasdasaude.pt/publico/content/casos-reportados-ao-centro-anti-discriminacao-vihsida-aumentaram>

25.1 SWEDEN: Stockholm syringe programme and HIV testing

TITLE OF THE PROGRAMME: Stockholm syringe programme and HIV testing

CONTACT PERSON

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- **Start Date of the Programme:** January 01, 2008
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** People living with HIV, People who inject drugs, Sex workers, Homeless
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

There was no national program, except one in Malmö, which was on a trial until 2016. In 2006, there was an infection bubble in Stockholm among the target population of PID. We contacted a similar organization for technical and practical support to set up the needle/syringe exchange programme, as it is not permitted under Swedish law to buy or import injection perefina. In 2008 we started the programme and we had between 90-120 visitors per day. Thanks to our effort In 2013, the official syringe replacement/exchange program opened in Stockholm driven by the medical services at a local hospital in Stockholm. We have continued our unofficial syringe programme and today, the program has between 30-40 visitors per day. And 1800 people have enrolled with us on regular basis.

BENEFICIARIES AND IMPLEMENTERS

Beneficiaries of the programme are mainly illegal immigrants, parents (mothers with children), people under the age of 20, persons who are enrolled in addiction care, people who are in need of Hepatitis C treatment. and people who have low confidence in society. The Official syringe replacement programme requires an ID card, to validate age and geographic listing which is seen as a hinder for access. The age limit has now been lowered to 18, which is a great success but many years too late. We know that many start injecting drugs as young as 13-15 years.

It is a unique programme in Sweden as it is planned, managed and implemented by drug users, for drug users. The staff of the programme are volunteers at the Drug User's Union. All of our volunteers are drug users, former drug users or have personal experience of using drugs. This creates a peer to peer atmosphere that enables talking about HIV and Hepatitis C both from a prevention/testing perspective but also from a treatment and adherence perspective.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- The Stockholm region

FINANCING AND SUSTAINABILITY

The financing is non-existent, all injection paraphernalia are donated to the programme from other countries. Because the work is done by volunteers, the program does not have any costs for staff. The operation is carried out in existing premises, which does not represent an additional cost to the association. This program is in a juristic gray zone in Sweden, for municipal and regional funding. That is why it is not monetary funded. The program is unique in its kind in Sweden in its design and that it is conducted by peers, something that is extremely important for the target audience.

DESCRIPTION

The program has two objectives, 1, to reduce infections caused by injections. 2, contribute to harm reduction for injecting drug users, in order to inject safely and harmlessly. 3, help reduce risk behaviors caused by psychological stress by not getting rid of drugs when they do not have optimal tools.

RESULTS OF THE PROGRAMME

About 10000 visitors per year, the geographic coverage is about 300 km radius around Stockholm, but mainly people from the Stockholm region.

OUTCOMES AND IMPACT OF THE PROGRAMME

Until 2015, statistics were submitted on the number of equipment that was returned and returned, including disease incidents, statistics were reported. Demography, addiction, state of health, infectious disease such as HIV or hepatitis C, injection habits.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- Surveys conducted together with the drug users.

LESSONS LEARNED AND RECOMMENDATIONS

We have learned, above all, that registration with Identification Card Control scares users and exclusion of people with children. In this group, we see a greater risk behavior and infection spread. In the case of migrants, unskilled, knowledge about infectious diseases, information efforts for the group need to be adapted directly to the target group's conditions and needs. Exclusion of groups or persons in programs may increase the risk of injury to persons. Peers have been central to the success of the program to be able to discuss and be open with their own HIV status or hepatitis facilitates and creates trust. We have learned how to work with the target group of the target group themselves, to have short courses that are straightforward. From that we have learned how naloxone should be used, in the form of peer education.

CONCLUSIONS

There must be teams to change in Sweden. Individual programs do not cover the need, the excluded group becomes more risky. We have a woman about 40 years old who has three home-grown children, with well-ordered lives, she has been a central stimulant for about 20 years and is a highly functioning user with neuropsychiatric disorder, which she has self-medicated. Her life does not work without this program in order to inject drugs safely. For a person she is the disaster if the authorities are interrupted when she can lose their children and their job. People who have subtreatment treatment cannot go to the official syringe replacement program because they cannot inject other drugs.

ANNEXES/ADDITIONAL RESOURCES

- <https://www.brugarforeningarna.se/stockholm/#oss>
- <http://www.hiv-sverige.se>

25.2 SWEDEN: HIV Today

TITLE OF THE PROGRAMME: HIV Today

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- **Start Date of the Programme:** January 01, 2015
- **Responsible Parties:** Government
- **Population Group(s) Reached:** Health care workers, People living with HIV, Migrants, General public, Gay men and other men who have sex with men.
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

In Sweden approximately 7,000 persons in total currently live with a known HIV diagnosis and health care contact in Sweden, which corresponds to approximately 69 cases per 100,000 inhabitants or 0.07 per cent of the population. In 2015, 450 new cases of HIV infection were reported, of which 60 per cent were men. Of the cases, 18 percent identified Sweden as the transmission country. Heterosexual transmission routes dominated among women while sex between men was the most common transmission route among men.

HIV is covered in the law of infectious Disease Control, and testing and treatment is free of charge for everyone. The preventive work in Sweden is based on the national strategy against HIV/AIDS and certain other communicable diseases. One of the main objectives in the strategy is to improve the awareness about HIV in the public sector, in work places and in the general population.

Sweden's Public Health Agency is coordinator of the national HIV prevention, a task that also includes undertaking actions aiming to reduce the stigma and discrimination associated with the infection. National surveys show that the knowledge about HIV and the living conditions of people living with HIV in Sweden in the public is relatively low, and has to improve. Another study shows that people living with HIV in Sweden are afraid to talk openly about the infection, because of the risk of negative reactions. The mental health in the PLHIV is good, but the lower than in the public, due to the stigma related to HIV.

In 2015, the public agency in cooperation with civil society organizations developed a national information campaign about HIV in Sweden targeted towards the general public and health care staff. Within the campaign, we funded local activities in the regions and through civil society organizations (CSO). We ran an information campaign and added targeted information towards health care staff. Activities funded in regions and by CSOs were in many cases educational activities towards health care staff for example web trainings.

BENEFICIARIES AND IMPLEMENTERS

People living with HIV

The government has earmarked funds in order to create conditions for national, regional and local actors, within the public sector as well as in the civil society, to carry out efforts in accordance with the national strategy against HIV/ADS. Sweden has a number of CSO organizations with long experience in HIV prevention work and good capacity to work with information campaigns. Organizations were invited during the creation process of the campaign and also received funding to work with the key message of the campaign in their own target groups, for example MSM, migrants and people living with HIV. County councils also received earmarked funding in order to run local activities, such as trainings for health care staff and campaigns in the local public transport.

The campaign was diffused through media, both digital and prints on national, regional and local level. All primary health care centers, child care centers, dentists, school nurses and youth clinics received information in advance about the campaign, including training material for the staff. A special web site for health care staff was created with up-to-date information about HIV and the living conditions for people living with HIV in Sweden today.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

National, regional and local.

- 44 % of the public between 18-79 yrs had seen the campaign.

Regarding activities on the local and regional level there are not any national follow up available. Instead the public health agency arranged continuous meetings where all actors (public sector as well as CSO) who received funding to work with activities aiming to spread the campaign message, were invited. In these meetings, the actors presented their projects, knowledge and experiences were exchanged, and cooperation possibilities were identified. A final meeting where the actors presented the results of their efforts.

FINANCING AND SUSTAINABILITY

The program was managed on a national level and on a national level advertising has continued during 2016 and 2017. Funding for local, regional and CSO activities has been reduced by the government but there might still be some activities going on included in the ordinary work of different actors.

DESCRIPTION

In 2013 the public health agency of Sweden made a statement: a person with a well-managed HIV treatment, who has undetectable levels of HIV virus in the blood, which means that the risk of transmission to another person is minimal. This new knowledge had to be spread to doctors and other health care staff, as well as to the public. The public health agency in Sweden decided to do so through an information campaign. The campaign included a first step which was mailing to all primary health care centers in Sweden. The letter contained information about the upcoming campaign but also training material for the staff, in order to improve the knowledge about HIV among the staff. A special website for health care staff was set up: folkhalsomyndigheten.se/hividaag.

The information campaign had the general public as its main target group, and sub target groups were MSM and migrants. The key message was: "Living with HIV in Sweden today is not like it was yesterday. The treatment of HIV is now so effective that it can reduce virus

levels to practically zero and minimise the risk of transmission. Today, HIV is no longer a fatal disease but a chronic, treatable infection. With prompt intervention, you can expect to live for as long as you would have done without HIV”.

The messages were packaged in short films 5 and 20 s, banners, and posters, all referring to the campaigns website hivdag.se. The campaigns units were translated in to a number of languages.

The campaign materials were designed in soft colors and the films all show people in every-day-situations in nice, loving atmosphere, to picture the positive change that has taken place in the last years thanks to the effective treatment available for people living with HIV. A tool box was developed with material that the county councils could use.

RESULTS OF THE PROGRAMME

The media campaign ran from November 1, 2015 to 31th of January 2016. During this period the website www.hivdag.se had a total of 152 126 unique page views. The campaign films were seen 5,6 million times, and 5 million interactions (clicks, shares) were undertaken with the campaign units. The external follow up show that 44% of the general population have seen the campaign, and 7 out of 10 say it made a positive impression. 79% say it was credible and 78% say the purpose of the campaign was clear. 70% believe the campaign was relevant and 57% say they liked it. 52% say it improved their knowledge. 33% say the campaign made them actively update their knowledge about HIV.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- google analytics, external companies made the survey. Results were spread to all actors involved.

LESSONS LEARNED AND RECOMMENDATIONS

Media campaign worked out well despite a complex subject which rises low interest in the general public. Message was strong and the design helped spreading it.

The activities targeted at the health care staff was much more difficult to evaluate. The public health agency do not have a mandate in relation trainings targeted at the primary health care. The primary health care centers are under pressure, and resources are scarce, meaning that time for training is limited.

CONCLUSIONS

The most important impact would be a decrease in stigma towards people living with HIV. Nearly fifty percent in the ages of 18-79 years have been aware of the campaign and in this group the campaign has greatly increased the overall level of knowledge about HIV and also reduced the fear of being infected with HIV. Hopefully when we do the next study of the quality of life among people living with HIV we will see a decrease in stigma.

ANNEXES/ADDITIONAL RESOURCES

- Health care staff: <https://www.folkhalsomyndigheten.se/hivdag/>
- general public: <http://www.hivdag.se/>

25.3 SWEDEN: Aging with HIV in Sweden

TITLE OF THE PROGRAMME: Aging with HIV in Sweden

CONTACT PERSON

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- **Start Date of the Programme:** November 01, 2016
- **End Date of the Programme:** November 01, 2019
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** Health care workers, People living with HIV
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Today, it is possible to live long and to age with HIV. This means that HIV population are becoming older. We see the first generation who are aging with HIV. More elderly are diagnosed with HIV.

An increasing number of people who have lived a long time with HIV are beginning to reach retirement age. In the near future, increasing demands will be made on, for example, society's work, treatment and skills regarding the life situation and the needs of elderly people living with HIV in terms of care and care for the elderly.

Uncertainty about cause and effect:

HIV virus, medication, aging and lifestyle factors are all affecting the life quality and of PLHIV. And many are concerned about aging and have strong concerns about the health care staff's attitudes towards HIV now that they begin to receive elderly care and are directed from special care to the primary health care. Primary health care and elderly care have previously not met this patient group and have no tools or experience to meet the group.

- There are no HIV-specialized geriatrics in Sweden
- Infectious diseases specialists lack knowledge about aging
- Primary health care staff are not HIV-conscious and lack preparedness
- Staff within the elderly care and home care services have no action plans and in some cases lack basic HIV knowledge
- There is no research on the subject in Sweden

With the aim of meeting the needs of both boats to basically counteract discrimination and stigmatization in healthcare. The elderly project was designed based on an explicit need from the primary target group, older people living with HIV. The aim of the project is to improve the quality of life for the elderly people living with HIV in Sweden and based on mapping and

needs analysis develop relevant method material for healthcare professionals. Target group for the project is primarily older people who live with HIV in Sweden, both women and men, as well as people with a foreign background, and their affiliates. The project is also aimed at professionals who meet the target group, for example in healthcare and elderly care. An important goal for the project is that the target group should be included in a meaningful way, therefore it is important to several patient associations for people living with HIV and Borlänge municipality's elderly care are involved in the project. Borlänge municipality has a central role as pilot municipality.

BENEFICIARIES AND IMPLEMENTERS

7033 people live with HIV in Sweden, 42% are over the age of 50. There are great variations when it comes to the needs and the challenges depending on how long one has lived with HIV, how long they have been in treatment and how long time passed before they started treatment. The target group and beneficiaries are PLHIV over the age of 50. and people who in the profession meet PLHIV over the age of 50. Implementers are both PLHIV and health care staff with the technical support and assistance from our project leaders and staff.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- All of Sweden, and the method will be implemented and tested in the municipality of Borlänge in the region of Dalarna in Sweden.

FINANCING AND SUSTAINABILITY

The project has a secured financing for a three-year period by the Swedish Inheritance Fund. The aim to develop and test a training method for increasing awareness about HIV in the health care setting, and using the first early adopters as role models and as positive examples for other hospitals and care givers to implement the training method.

DESCRIPTION

The program is a national initiative of the civil society to engage the target group of people living with HIV over the age of 50 to formulate their needs, fears and challenges themselves. The program will also collect the healthcare staff's needs in order to meet, as for them, a new patient group.

The questions are many and at present Swedish care is lacking preparedness to take care of elderly people living with HIV. People with HIV meet healthcare professionals who lack experience and updated knowledge of what it means to age with HIV. There are many examples of lack of treatment and misleading knowledge of HIV that affect the quality of meetings with the health care leading to increased stigmatization and feelings of discrimination

Purpose of the project

Improve the quality of life for elderly people living with HIV in Sweden and based on mapping and needs analysis develop relevant methodology for healthcare professionals.

To highlight and make elderly and HIV perspectives visible

Associations and organisations working with people living with HIV also need to include the elderly perspective in their activities and develop skills and activities to better meet the needs and circumstances of the target group.

Organisations for the elderly should adjust to the conditions and need to develop their work to include and represent even people with HIV.

Overall objective

Increase awareness and improve the life situation of elderly people living with HIV in Sweden
Areas of priority for the project

Promoting good mental and physical health

Participation and meaningful inclusion, self-strengthening and community strengthening
An important objective of the project is to include the target group in meaningful ways, so it is important that several patient associations for people living with HIV are involved in the project.

Interim goals

- Provide knowledge review
- Together with local working groups produce training a and method book.
- Develop action plans for increasing HIV competence to address stigma and discrimination with in the health care setting.

Method

To develop methodological material for bridging the gap through the needs analysis of the patient group and of the health care sector. The methodology will be implemented and piloted in Borlänge, Dalarna in 2018. It is a unique project, the only one in which civil society, municipalities and county councils are involved.

RESULTS OF THE PROGRAMME

Our programme started in 2016 and results will be seen in 2019. At the moment 42 people living with HIV are enrolled in the programme in the different regional work teams in 5 different geographic regions around Sweden. through these 5 regions we can reach the majority of the target group.

The teams have workshops on different themes to discuss different issues and aspects of aging and meeting the health care.

OUTCOMES AND IMPACT OF THE PROGRAMME

Since the start of the project planning process we have advocated for the need of ensuring and the needs and rights for PLHIV 50+ which has increased the awareness of HIV and aging amongst decision makers and officials. The programme has been highlighted through news articles and radio shows and an estimated 250000-500000 people have been reached through these channels.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

There is a monitoring and evaluation planned as a part of the programme feedback process. The results will be available in 2019.

LESSONS LEARNED AND RECOMMENDATIONS

One of the most important factors for success is the strong advocacy work that anchored the need but, also interest from different sides, to be included. The second most important factor for success is the participation of people living with HIV and the important stakeholders such as the health care staff and patient association. The third most important factor for success is the participation of the hospital in the municipality of Borlänge. They will be the first hospital to test the final methodology and systematically addressing stigma and discrimination of PLHIV in their hospital.

CONCLUSIONS

- "Over my expectations! Giving a good hope of a more positive future / aging. "
- "Nice new acquaintances. Good spirit. Come a long way in our work. "
- "Have a good overview of the complexity of the subject"
- "Get to know something that, in any case, you share with others. Break the insulation."
- One of the participants who is now undergoing cancer treatment said:
- "I will survive the cancer, because I want to be part of the project and see it through"

ANNEXES/ADDITIONAL RESOURCES

- <http://www.hiv-sverige.se>

25.4 SWEDEN: Legal consulting for PLHIV

TITLE OF THE PROGRAMME: Legal consulting for PLHIV

CONTACT PERSON

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- **Start Date of the Programme:** January 01, 2005
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** Health care workers, People living with HIV
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** Yes
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

The HIV epidemic, especially among key populations, continues to be highly stigmatizing with discrimination, violence, mental ill health, reduced empowerment and reduced rights as a result. One of the most important contributing factors pointed out in most and reports both the UNAIDS and WHO are laws and policies. These show that criminalizing legislation and practices lead to a deterioration and constitutes a challenge for effective HIV prevention, especially as key populations with HIV prevention are often more vulnerable. Therefore, legislation, policies and practices should be in place to protect the rights of key populations for good health and a life free from stigma and discrimination.

Although there are policies and legislation in place, the knowledge about ones rights and knowledge about where to turn to get ones rights is very low, especially among migrants living with HIV in Swedens. In order to ensure that human rights for people living with HIV in Sweden are respected, we have since 2005 provided legal consulting and services for people living with HIV, and worked as an important knowledge base for health care providers and other legal providers on HIV and rights.

BENEFICIARIES AND IMPLEMENTERS

The legal consulting and services provides over 200 counseling occasions every year. In addition to informing about the rights, obligations and opportunities one has when living with HIV in Sweden, we work to provide knowledge, and support for individuals and increase the sense of empowerment. In complex cases, the counseling acts as representative of the person and represents the person in court of law.

The legal counseling is also an expert competence for other defines lawyers, authorities and decision makers in policy matters relating to HIV.

The legal counseling deals with matters such as, workplace discrimination, discrimination for Disability, criminal cases relating disclosure or unprotected sexual activity or HIV

transmission, the right to treatment and. In 2016 our legal service represented and defended 5 clients who risked being deported to countries where they would not have access to the HIV treatment they needed.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- The coverage is all of Sweden, PLHIV from all around Sweden are referred and recommended to take contact with us.

FINANCING AND SUSTAINABILITY

The programme is financed with national funds for HIV and STD prevention work. The continuity and sustainability have been assessed and secured through measures for knowledge and experience transfer between all staff and between predecessor and successor to bridge knowledge gaps.

DESCRIPTION

The purpose and aim of Hiv-Sverige's legal counseling service is partly to provide legal assistance to persons who do not have access to legal representatives and to influence authorities and legal developments in certain priority areas. One of these areas is the extradition law and the right to a residence permit, where we work for asylum seekers living with HIV who do not have access to life-long treatment in their country of residence to be able to obtain permanent residence in Sweden.

In order to strengthen the conditions for equal rights for PLHIV, expert advice is also required for decision makers, authorities, judiciary and health care in matters relating to HIV. This is to protect the interest of the target group and strengthen the rights. Therefore, we need to continue offering expert advice.

There is a fear among people living with HIV to report cases that are perceived as discrimination or malpractice, as reports to the Ombudsman for Discrimination are publicly available. Therefore, the possibility of reporting cases and getting help and support from elsewhere is needed. Therefore, we offer a discrimination form where people affected by HIV can contact us and get advice and support in the individual cases and in contact with the affected parties.

RESULTS OF THE PROGRAMME

Since the start of the project in 2004 we have handled an estimated 2600 cases during the 13 years that the programme has been in place. For many people and our services have been the last resort for them and we have been able to help them obtain their human rights and in saving people from certain death.

OUTCOMES AND IMPACT OF THE PROGRAMME

The cases are also used in advocacy work to show real life cases on the terrible way legislation or public policies affect PLHIV. Some of our legal cases lead to ruling by the Supreme court or the European Court of Human Rights which are precedential, these rulings are very important because they affect all future cases. After many years we now have several acquittal rulings from the Appeal court regarding disclosure of HIV status to sexual partner, having unprotected sex when on effective treatment with undetectable viral loads.

LESSONS LEARNED AND RECOMMENDATIONS

An important factor for success of the programme is the linking between legal services and advocacy and policy work, they are interchanged in this programme. They work as interconnected gears that together help drive and ensure that the rights for all people living with HIV and for all key population are met.

CONCLUSIONS

The conclusion is that this type of services are needed when the knowledge gap between legal institutions and the medical institutions is wide. Legal services are essential for achieving a decriminalization in the face of criminalizing policies and legislation in our countries.

ANNEXES/ADDITIONAL RESOURCES

- <http://www.hiv-sverige.se>

26. UNITED STATES OF AMERICA: Programs to eliminate discrimination towards people living with HIV in health care settings, key populations and other vulnerable groups

TITLE OF THE PROGRAMME: Programs to eliminate discrimination towards people living with HIV in health care settings, key populations and other vulnerable groups

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- **Responsible Parties:** Government
- **Populations Group(s) Reached:** People Living with HIV, key population, LGBT people, women

BACKGROUND INFORMATION

The Health Center's mission is to improve the health of the nation's underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The Health Resources and Services Administration (HRSA) through the Bureau of Primary Health Care (BPHC) provides support for nearly 1400 health centers that operate approximately 10,400 health center sites in every state of the US and its territories. In 2016 the Health Center program served nearly 26 million people, which is 1 in 12 people in the US, and served 1 in 10 children and 1 in 3 people living in poverty.

DESCRIPTION

HRSA provides technical assistance to health centers in lesbian, gay, bisexual, and transgender (LGBT) care, including training and technical assistance in the collection of SOGI data, through its National Training and Technical Assistance Cooperative Agreement (NCA) with the National LGBT Health Education Center at the Fenway Institute. The education center provides educational programs, resources, and consultation to health care organizations with the goal of optimizing quality, cost-effective health care for LGBT people.

The Bureau of Primary Health Care provides training and technical assistance for health centers on connecting patients to legal services through a National Training and Technical Assistance Cooperative Agreements with the National Center for Medical-Legal Partnerships. The aim of this National Center is to improve the health and well-being of people and communities by leading health, public health and legal sectors in an integrated, upstream approach to combating health-harming social conditions.

Health Centers are authorized under Section 330 of the Public Health Service Act. Health Centers serve a population that is medically underserved, or a special medically underserved

population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing by providing required primary health services and additional health services, such as prenatal and perinatal services, HIV services and dental services.

Health centers are responsible for maintaining their operations, including developing and implementing operating procedures, in compliance with all Health Center Program requirements and all other applicable federal, state, and local laws and regulations. This includes but is not limited to those protecting public welfare, the environment and prohibiting discrimination; state facility and licensing laws; state scope of practice laws; Centers for Medicare and Medicaid Services (CMS) Conditions for Coverage for FQHCs; and State Medicaid requirements.

RESULTS OF THE PROGRAMME

Health centers provide HIV/AIDS care to patients, often with additional support from the Ryan White Care Act Program. Based on 2016 measures defined in the HRSA Uniform Data System (UDS), nearly 1,400 HRSA-funded health centers:

- Tested 1.42 million patients for HIV
- Served 158,323 HIV patients over 634,906 visits
- Linked 83.2% of HIV patients to care based on patients seen within 90 days of first diagnosis of HIV
- The Partnerships For Care demonstration, a collaborative effort of HRSA and the Centers for Disease Control, with funding from the Secretary's Minority AIDs Initiative Fund, was a three year demonstration that sought to improve access and health outcomes for HIV/AIDS patients served by health centers, through public health and primary care integration. In this demonstration, participating health centers and health departments, supported by a technical assistance and training provider, optimized the collection, sharing and use of data and health centers more fully developed care teams, workflows and population health management.

In 2016 health centers provided care and services to almost 15 million women, which is almost 58 percent of the total patients served at health centers. Health centers provide obstetrics and gynaecologic care as well as routine primary care, oral health and behavioral health care.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

One tool used to monitor compliance is through Operational Site Visits (OSVs). During an OSV, HRSA reviews and monitors health centers compliance with the Health Center program requirements.

VI. MULTIPLE COUNTRIES

27.1 MULTIPLE AFRICAN STATES: Peers to Zero (P2Z)

TITLE OF THE PROGRAMME: Peers to Zero (P2Z)

CONTACT PERSON

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- **Start Date of the Programme:** March 01, 2016
- **End Date of the Programme:** December 31, 2018
- **Responsible Parties:** Civil society
- **Population Group(s) Reached:** Health care workers, Girls, Young People/adolescents
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

The WHO Consolidated guidelines list eight global standards for responsive youth-friendly health services (YFHS), one of which is for health providers to respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect. Adolescents and young people are a critical key population of people living with, and at risk of HIV in sub-Saharan Africa. AIDS-related illnesses are the leading cause of death amongst adolescents in the region, with AIDS-related mortality in this age group tripling.

Evidence on the poor health outcomes of ALHIV in sub-Saharan Africa makes a strong case for the imperative to better understand and respond to their unique needs for care and support. An emergent body of literature outlines the importance of adolescent-friendly health services (AFHS) and an adolescent-friendly environment.

Strategies and programmes that support AYPLHIV to adhere to antiretroviral therapy (ART) and clinic appointments to achieve viral suppression, good psycho-social and health outcomes is critical but is being undermined by high levels of health provider stigma and discrimination that deters young people from accessing or staying in care as reported recently by UNAIDS. Equipped with first-hand experience of the socio-cultural challenges of living with HIV, AYPLHIV are well-placed to understand, support and respond to the needs of other adolescents and young people in their communities and the P2Z project shows that they also play a critical role in sensitizing health providers.

"I can't take it when someone who is older than my mom is talking to me about sex. I need to go to someone my age, a peer, and talk about sex. Honestly me, I am a patient at (clinic name), when the nurse asks me if I use protection, I tell her yes. But when I go to (peer supporter), I tell her the truth, that I don't use condoms. We can speak freely as young people." - Peer supporter, PATA 2016 Youth Summit

BENEFICIARIES AND IMPLEMENTERS

P2Z targets networks of YPLHIV, youth Peer Supporters, network leaders and their health providers and associated health facilities.

The project was built upon an existing peer support model, REACH and has been expanded and integrated into the READY+ programme. YPLHIV were active from the onset as both consortium partners leads (AY+) in the project but more directly through attendance of all peer supporters at a collaborative Regional Youth Summit, at project initiation which has been followed up with regular in-country a P2Z forums. At the Summit, and all subsequent forums AYP jointly develop AFHS quality improvement plans with health providers with key quality improvement areas defined in the Youth Summit Dar Declaration of 2016 or clinic based AFHS plans.

Peer supporters defined recruitment strategies that have been applied throughout and have included gender equity and affirmative action principles to ensure the participation and safety of young key populations.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Implemented in Zimbabwe (Harare, Buluwayo, KweKwe and Masvingo), Zambia (Kafue, Masabuka, Ndola and Lusaka district), Kenya (Nairobi, Kisumu), Uganda (Central, Gulu, Hoima, Entebber) Mozambique (Maputo, Beira), Swaziland and Tanzania (Dar esSalaam, Bukoba).
- It is implemented across 60 health facilities, targeting 7 national YPLHIV networks, 120 peer supporters and health providers.

FINANCING AND SUSTAINABILITY

P2Z is currently supported through d the Robert Carr Network Fund with complementary programmes such as REACH and READY+ relying on donor funds. There are however emerging examples of peer support and network activities becoming integrated into local CBO activities and or local district health budgets. Emerging youth leaders are increasingly able to secure positions within peer-led organisations and or are better placed to be absorbed into the health system and able to secure skills building opportunities.

DESCRIPTION

In response to increasing adolescent LTFU and low levels of engagement of YPLHIV in their own service delivery, coupled with high levels of reported health provider stigma the P2Z consortium was created.

P2Z focuses on 'Getting to Zero' through bringing the Young African Positives (AY+) network and PATA (Paediatric_Adolescent Treatment Africa), a network of health providers and associated health facilities together.

The programme aims to strengthen YPLHIV leadership to advocate for and secure their rights whilst promoting enabled health facility environments through health provider sensitization and the integration of YPLHIV as peer supporters who are actively engaged in designing, delivering and monitoring services that impact them.

Peers to Zero aims to enhance the HIV response implementation through mitigating facility level stigma and discrimination of AYPLHIV to create a more enabling environment and hence increase opportunity for AYPLHIV to provide input into the planning, implementing and evaluation of HIV services at national and regional levels. Strengthened accountability and

technical capacity of P2Z will improve regional network capacity to effectively engage and respond to the service delivery needs of AYPLHIV. Building the leadership and advocacy capacity of AYPLHIV will contribute to human rights advocacy and prioritization of adolescents at national, regional and global levels as well as contribute towards the building of a stronger, empowered and coordinated YPLHIV movement in Africa during a time of increasing economic scarcity and donor withdrawal.

RESULTS OF THE PROGRAMME

AP surveys undertaken (54 health providers from 29 health facilities across 5 countries and 68 YPLHIV from 8 countries) reported that 41% of YPLHIV experience being scolded by health providers with 81% reporting fear in discussing SRH with providers. Results indicate a substantial discrepancy between health provider reports versus YPLHIV accounts of youth services.

It would appear that providers have little insight into young people's experience of services as discriminatory. Beyond much needed efforts towards YFHS policy reform, training, standards and criteria, fundamentally there remains a blind spot in providers' insight, values clarification, and willingness to serve and carry out the health provider mandate without judgement.

Much of P2Z efforts, outside linking peer supporters to national network structures and promoting patient level advocacy among A/YPLHIV has been exploring mechanisms and processes that can integrate YPLHIV into clinic structures, build trust, create increased familiarity between health providers and their adolescent patients through inter-generational dialogue, and mechanisms for YPLHIV to provide feedback. This is underpinned by a strong peer support delivery model integrated into the health facility.

The project is still being implemented but has already gathered anecdotal evidence to suggest that the mechanisms above provide a more enabling environment and contribute positively to sensitizing health providers whilst creating improved leadership and learning opportunities for YPLHIV.

"Young people offer a unique voice in the global fight against HIV. We play a crucial role as peer educators and peer supporters, providing and linking youth to quality HIV and SRHR services" - Call to Action - Peers to Zero Dar es Salaam Peer Supporter Declaration

OUTCOMES AND IMPACT OF THE PROGRAMME

- *"Peer Supporters bridge the gap between health facilities and patients."* – Health Worker, TASO Gulu, Centre (Uganda)
- Together, REACH and P2Z facilities care for 21,440
- ALHIV in urban (81%) and rural (19%) settings. One of the key lessons from the programmes is that whilst community models importantly drive demand, sensitise communities and link to care, facility-based models like REACH are best situated to improve health services, sensitise health providers and engage adolescents accessing care, assisting them to navigate the health system and providing safe and supportive facility-situated spaces and engaged responses.
- Peer supporters have empowered adolescents through disclosure support (95%), defaulter tracing (90%), adherence counselling (85%), support groups (75%), dedicated spaces or times (75%), and teen camps or clubs (75%). Over the past 12 months, the paediatric and adolescent patient base at participating facilities has increased by 34%, and retention increased by 1%. All facilities added at least one new adolescent-focused service, with peer supporters instrumentally contributing to such expansion.

- Ninety-five percent of facilities include peer supporters in staff meetings; of these, 85% reported that peer supporter contribution at these meetings has resulted in programmatic change.

P2Z youth leaders have represented the programme at international UN High level meetings, PCB meetings and have engaged as well as presented in a number of conference workshops and sessions.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- Annual PATA health facility Rapid Assessment Data
- Monitoring of AFHS quality improvement plans
- Peer Supporter surveys
- KAP surveys of both health providers, and peer supporters
- Capacity assessments undertaken of Networks of YPLHIV

LESSONS LEARNED AND RECOMMENDATIONS

Involving AYPLHIV as peer supporters in the design, implementation and evaluation of HIV services for children and AYPLHIV can offer experiential opportunities for them to improve future career prospects, self-esteem and resilience. At the same time, peer service providers can support the health, wellbeing and service uptake of AYPLHIV through the provision of highly-relevant and context-specific services, while reducing staff workload and better sensitizing staff to the needs and experiences of YPLHIV.

Despite their potential benefits, peer-led services require careful planning and implementation to ensure that services are meaningful and effective. Requisite organisational and staff capacity and support include training, psycho-social support, and financial support. Given that peer service provision is not a long-term career opportunity, such services work best when facilities manage peer expectations while investing in their resilience building. This can develop skills, build confidence and link peers to a variety of opportunities for improved personal growth, economic security and health.

CONCLUSIONS

“IF YOU TRUST US, HELP US TO DO IT BY OURSELVES” – Promising practices in peer support for adolescents and young people living with HIV

- http://teampata.org/wp-content/uploads/2017/10/Dar-Declaration_WEB.pdf
- <http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf>
- http://teampata.org/wp-content/uploads/2017/09/170913_PP8_HCW-Sensitization_WEB.pdf

Youth networks are under-resourced and unsupported with many functioning at a voluntary association level, relying on in-kind support and the good-will of its membership. This makes it difficult for the establishment of a strongly coordinated youth-led response in sub-Saharan Africa that legitimately represents a collective versus that of supporting and advancing individual youth leaders. There are many different youth-based responses and interventions resulting in potential overlap and duplication. There is an urgent need for greater alignment and coordination of youth-led interventions as well as representative structures. Greater investment needs to be made, both nationally and regionally, in a consolidation of youth-led networks. More attention needs to be placed on exploring the translation of meaningful youth engagement in practice versus that of tokenism, which does little to build the capacity and youth leadership in the long term. To the same degree,

networks should also be held accountable to the highest standard so that they build the needed capacity and develop skills that are transferrable, and hence open pathways to different options and opportunities for young people needing to age out of youth spaces.

Facility-based peer support is a valuable intervention that does not have sufficient evidence to be fully integrated into given policies and practice. Many facilities and health providers consider the mere fact that they provide services to adolescents and young people or engage young people as peer supporters, enough to be adolescent-friendly. Health providers overestimate their ability and level of sensitivity towards adolescents and young people, which often contradicts the perception of service users. Often peer supporters are underutilized and not fully integrated into the facility in order to take maximum advantage of their unique linkage to their peers. Fundamentally, young people, are more comfortable talking to their peers, and need to be relied upon to promote retention in care and treatment adherence. Young people themselves are also the most powerful tool in combating health provider stigma and sensitizing health providers.

ANNEXES/ADDITIONAL RESOURCES

- <http://teampata.org/wp-content/uploads/2017/04/Youth-Summit-Report-2016.pdf>
- http://teampata.org/wp-content/uploads/2017/10/Dar-Declaration_WEB.pdf
- http://teampata.org/wp-content/uploads/2017/09/YPEER-Network_Youth-Peer-Education-Toolkit-The-Training-of-Trainers-Manual.pdf
- http://teampata.org/wp-content/uploads/2017/09/Good-Practice-Guide_-Adolescent-HIV-Programming.pdf
- <http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf>
- http://teampata.org/wp-content/uploads/2017/09/170913_PP8_HCW-Sensitization_WEB.pdf
- http://teampata.org/wp-content/uploads/2017/06/REACH_WEB.pdf
- http://teampata.org/wp-content/uploads/2017/06/One-stop-adolescent-shop_WEB.pdf
- <http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf>
- http://teampata.org/wp-content/uploads/2017/06/Expert-Patient-Promising-Practice_WEB.pdf
- <http://teampata.org/wp-content/uploads/2017/06/Peer-led-Services-Promising-Practices.pdf>
- <http://teampata.org/wp-content/uploads/2017/06/CHWToolkit.pdf>
- http://teampata.org/wp-content/uploads/2017/07/170606_SA-AIDS-Poster_v2_PRINT.pdf

27.2 MULTIPLE AFRICAN STATES: Action to Promote the Legal Empowerment of Women in the Context of HIV and AIDS

TITLE OF THE PROGRAMME: Action to Promote the Legal Empowerment of Women in the Context of HIV and AIDS

CONTACT PERSON

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- **Start Date of the Programme:** January 01, 2010
- **End Date of the Programme:** December 31, 2013
- **Responsible Parties:** Civil Society
- **Population Group(s) Reached:** Women living with HIV, paralegals, Women
- **Has the programme been evaluated / assessed?** Yes
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Globally, in 2016 there were an estimated 17.8 million women living with HIV (15 and older), constituting 52 per cent of all adults living with HIV. In 2016, of the total estimated 1.7 million new HIV infections globally, 790,000 or 48 per cent were among women; in sub-Saharan Africa adult women (15 and older) comprised 56% of new infections. As in many parts of the world, women in sub-Saharan Africa do not enjoy the same rights, privileges, opportunities and access to resources or services as men. Discriminatory laws and customary and traditional practices often limit or deny women's rights to property and inheritance. These inequalities place women at heightened risk of HIV infection, constrain their ability to seek care, support and treatment and undermine their ability to cope with the consequences of illness and to care for themselves and their families. Women living with HIV are particularly vulnerable to property and inheritance rights violations because of the widespread stigma associated with HIV. They are often stripped of their assets and forcibly evicted from their lands and homes. For some, the dispossession interferes with or precludes their ability to access HIV treatment, care and support. These issues are exacerbated for widows, who are often blamed for the AIDS-related deaths of their husbands.

BENEFICIARIES AND IMPLEMENTERS

From 2010 to 2013, UN Women has awarded \$2.2 million in small grants (of up to \$75,000) to twenty legal service organizations, community-based/grassroots networks, and organizations of women living with HIV in Cameroon, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe. A second grant was provided to ten organizations who had excelled in implementation.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The programme achievements included:

- Enhanced knowledge and awareness of more than 3,700 duty bearers at national and local levels and of 29,000 community members on the need to protect women's property and inheritance rights in the context of HIV and AIDS;
- Enhanced knowledge and skills of 900 new and existing community justice and legal service providers, including traditional rulers and law enforcement actors, to support women's access to property and inheritance rights in the context of HIV;
- Increased legal literacy and rights awareness of more than 16,200 women living with or affected by HIV and AIDS through community sensitization, information dissemination and radio programmes;
- Approximately 1,270 property and inheritance-related cases reported to or handled by community paralegals or community dispute resolution mechanisms as a result of increased availability and accessibility of legal services for women living with HIV at community level;
- Improved security of tenure for more than 700 women in Tanzania and Zimbabwe. In Tanzania, more than 400 plots have been awarded to women in six villages. In Zimbabwe, 312 women living with HIV obtained land allocations;
- Over 470 grass-roots women and 5,100 children at risk of disinheritance registered and obtained the necessary legal documents, such as birth certificates, death certificates, and identification cards, to secure their property rights through local registration drives organized in Kenya.

FINANCING AND SUSTAINABILITY

UN Women's programme, "Action to Promote the Legal Empowerment of Women in the Context of HIV and AIDS" has been implemented with support from the Foreign Affairs, Trade and Development Canada. UN Women has awarded \$2.2 million in small grants (of up to \$75,000) to twenty legal service organizations, community-based/grassroots networks, and organizations of women living with HIV in Cameroon, Ghana, Kenya, Malawi, Nigeria, Rwanda, Tanzania, Uganda, and Zimbabwe. A second grant was provided to ten organizations who had excelled in implementation.

DESCRIPTION

UN Women's programme, "Action to Promote the Legal Empowerment of Women in the Context of HIV and AIDS", implemented with support from the Foreign Affairs, Trade and Development Canada aimed at the following:

- Increasing the number of legal frameworks and processes that effectively promote and protect women's property and inheritance rights in the context of HIV and AIDS and reduce discrimination at the community level.
- Strengthening the enabling environment for promoting and protecting women's property and inheritance rights at the community level.
- Working with local groups and NGOs to help women living with HIV and AIDS to better claim and advocate for their property and inheritance rights.

RESULTS OF THE PROGRAMME

The programme achievements included:

- Enhanced knowledge and awareness of more than 3,700 duty bearers at national and local levels and of 29,000 community members on the need to protect women's property and inheritance rights in the context of HIV and AIDS;
- Enhanced knowledge and skills of 900 new and existing community justice and legal service providers, including traditional rulers and law enforcement actors, to support women's access to property and inheritance rights in the context of HIV;
- Increased legal literacy and rights awareness of more than 16,200 women living with or affected by HIV and AIDS through community sensitization, information dissemination and radio programmes;
- Approximately 1,270 property and inheritance-related cases reported to or handled by community paralegals or community dispute resolution mechanisms as a result of increased availability and accessibility of legal services for women living with HIV at community level;
- Improved security of tenure for more than 700 women in Tanzania and Zimbabwe. In Tanzania, more than 400 plots have been awarded to women in six villages. In Zimbabwe, 312 women living with HIV obtained land allocations;
- Over 470 grass-roots women and 5,100 children at risk of disinheritance registered and obtained the necessary legal documents, such as birth certificates, death certificates, and identification cards, to secure their property rights through local registration drives organized in Kenya.

OUTCOMES AND IMPACT OF THE PROGRAMME

Overall, as a result of the programme implementation, 130,774 people living or affected by HIV in the nine sub-Saharan countries have increased access to information about women's legal, property and inheritance rights. 85% of these beneficiaries were women. There is an increased number of community-level legal frameworks and processes that effectively promote and protect women's property and inheritance rights in the context of HIV and AIDS. Eight grantees made progress towards changing the national-level legal frameworks and legal procedures regarding women's property and inheritance rights in Cameroon, Ghana, Kenya, Nigeria and Zimbabwe. Five grantee projects directly challenged customary laws, or tried in their activities to enforce legislation protecting women. A greater understanding achieved among the general – especially male – population of the immediate needs of women in the context of HIV/AIDS and how to address those problems in favour of disadvantaged women. An evidence base has been increased concerning legal empowerment for the targeted women, especially regarding procedures and training for the dimensions of empowerment.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- The programme was evaluated. The final evaluation can be downloaded from <http://gate.unwomen.org/Evaluation/Details?evaluationId=4755>

LESSONS LEARNED AND RECOMMENDATIONS

Key lessons learnt:

- As a body of evidence increases, so does the need for new definitions (e.g. empowerment) and approaches: when the grantee projects started, the focus was on legal empowerment. Over time, the grantees noted that there were many dimensions to empowerment, including economic and social empowerment.
- The process of law reform takes a very long time, and it takes resources to support legal reform.
- Women were not the only target group of the programme; men and children also benefitted.

CONCLUSIONS

Recommendations

- To replicate the programme experience through the new longer-term programme (minimum 5 years), covering more countries in the region.
- In the interest of sustainability, future programme/s should aim at advocating and helping the governments to identify costs and setting up of national spending categories for paralegal services for women living with HIV.
- Ensure the future programme strategies cover all aspects of empowerment (legal, political, social and economic).
- Small grant portfolios in future programme/s should be diversified to provide separate funding for grantees willing to lobby and advocate for national-level changes in laws.

ANNEXES/ADDITIONAL RESOURCES

- The final programme evaluation
<http://gate.unwomen.org/Evaluation/Details?evaluationId=4755>

28.1 MULTIPLE LATIN AMERICAN AND CARIBBEAN STATES: Increase the understanding of allies and decision-makers about the reality of Women Sex Workers in Latin America and the Caribbean and their vulnerability to HIV, for the improvement of national strategies against stigma and discrimination in health services

TITLE OF THE PROGRAMME: Increase the understanding of allies and decision-makers about the reality of Women Sex Workers in Latin America and the Caribbean and their vulnerability to HIV, for the improvement of national strategies against stigma and discrimination in health services

CONTACT PERSON

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- **Start Date of the Programme:** January 01, 2013
- **Responsible Parties:** Civil society
- **Populations Group(s) Reached:** Sex workers
- **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 INFORMATION

Stigma and discrimination are still part of our daily lives. The effects of stigmatization can be seen in institutional violence and the systematic human rights violations we suffer from State security forces, health and justice providers. Also, many public officers in our countries are reluctant to enter a dialogue with WSWNO making it harder for us to be included in creating public policies, perpetuating inadequate responses to WSWs' real and specific needs.

Recent RedTraSex research (2016) confirms that more than 70% of surveyed WSWs reported having been victims of institutional violence. At least 318 WSWs have been murdered in the last 10 years across the region. However, when WSWs report violence, it is estimated that 99% of the cases go unpunished.

This violence is also reflected in abuses perpetrated by health providers that lead to access barriers and a failure to enjoy comprehensive health care. WSWs are subjected to discriminatory HIV and STI regulations. For instance, in 8 countries (Argentina - some provinces only, Bolivia, Chile, Colombia, Guatemala, Honduras, Panama and Uruguay) WSWs are subjected to compulsory gynaecological and infectious diseases check-ups at health facilities designed for them only; this is stigmatizing and discriminatory.

In the year 2013 we carried out an investigation with a sample of 1006 female sex workers named: Study on situations of Stigma and Discrimination in access to WSWs Health

Services in Latin America and the Caribbean (See: <http://www.redtralsex.org/spip.php?article1294>). some of the outstanding results are:

- In the region as a whole, the public health system offered by the State, which in many countries is totally or partially free, covers almost 8 out of 10 respondents. 8% access private medicine, and 3% use private prepaid medicine.
- 98% of the WSW surveyed consulted a doctor or health service for illness or control at least once during the past year. The analysis was the most mentioned reason (76% of the WSW surveyed), followed by voluntary health checks that were mentioned by 7 out of 10 respondents. Almost 40% of the WSWs surveyed in the last year consulted on issues related to HIV or AIDS (Costa Rica, Guatemala, Bolivia, Colombia and Peru have the highest values, the Southern Cone the lowest). In addition, 31% conducted consultations on sexually transmitted infections.
- The obligation to perform health checks among sex workers (WSW) is reflected in the following data: 32% of respondents said that they consulted with a professional or health service in the last year "because they were forced to control themselves by the health card or other legal provision" and a similar proportion said that it did "because they forced it in their work to have a control".
- Bolivia was the country where this motive was repeated the most, with 84%. It is worrying that the proportion close to 18% of WSW surveyed who had to turn to the doctor or health service in the last year for having been the victim of blows or violence (highest in Central America). In Peru a quarter of the respondents said they had never consulted a doctor or health service. This proportion is also high in Ecuador, Uruguay, Guatemala and Nicaragua (between 19% and 14%).
- 89% of the WSW surveyed said they had a gynaecological consultation in the last year (95% in Central America). The most common reason for consultation is the performance of gynaecological controls (e.g. PAP and breast control), mentioned by 87% of the WSWs surveyed. The search for condoms as a reason for consultation was mentioned by slightly more than half of the respondents. Only 42% have sought care in the last year regarding contraceptive methods. A smaller but significant proportion have consulted for pregnancy or childbirth in the last year (15%), while little more than 8% reported having consulted for complications, loss or termination of pregnancy.
- In the sub-region of Central America and the Caribbean where a higher proportion of WSWs respondents experienced experiences of direct discrimination in the health services because they were sex workers: 28% were forced to change hospitals or health services because of discrimination because it was WSW (versus 20% in the general sample) and 21% were denied attention because they were sex workers (versus 12% in the general sample). In addition, other stigmatizing attitudes on the part of health professionals - such as referral to infectious diseases, advising them to stop sex work, referral to psychological assistance for being SW - also occur to a greater extent among WSWs surveyed in Central America and the Caribbean.

The WSW surveyed in the Dominican Republic are the most affected by stigma and discrimination in health services: 9 out of 10 have been forced to undergo WSW analysis; 80% recommended that they give up sex work; 70% were referred to infectious disease services, although the consultation was for another reason and half of them were referred to psychological assistance because it was WSW. On the other hand, 7 out of 10 took care away from where they live to prevent people close to find out that it is WSW.

Another of the countries that presents worrying levels of discrimination and stigma in health services is Bolivia: 81% of the WSW in that country was forced to perform analyses for being WSW.

Approximately one-third of the WSW respondents who took the HIV test did not receive any counselling or counselling when they gave the result. If we compare the two moments of counselling, we see that pre-test counselling is more common: 72% received pre-test counselling and only 65% post-test counselling.

Two-thirds of the WSW respondents who had ever had an HIV test (N = 970) said that they talked about sex work at the time of the test or at a consultation related to this infection. Almost a third of them did not speak about the subject on one such occasion.

Finally, Sex workers' organizations are the top places to provide condoms: 63% said they get them there. Health centers and hospitals, mentioned by 60% of the women surveyed, also play a major role in providing condoms to sex workers. More than half of those surveyed also said they obtained them in pharmacies and a similar proportion in cabarets / hotels.

BENEFICIARIES AND IMPLEMENTERS

We have improved services for WSWs in each country (health, education, strengthening of movement through technology) and broadened our outreach (currently, more than 30,000 WSWs per year). To overcome stigma, discrimination and human rights violations we trained more than 4,282 security force personnel and 1,375 health providers. In Nicaragua we have 18 legal facilitators who have assisted in more than 680 legal cases (civil and penal cases including 5 WSWs murders). We have supported the creation of 13 WSWs-led National Commissions to monitor HIV State budgets with other organizations, with economists providing basic information to feed our advocacy. We conducted 7 research projects in the last 5 years on the conditions of social injustice in our work and published the findings.

The member organizations of the RedTraSex and implementers of the program are:

- AMMAR- Asociación de Mujeres Meretrices de Argentina
- ONAEM- Organización Nacional de Activistas por la Emancipación de la Mujer, Bolivia
- Fundación Margen, Chile
- ASMUBULI- Asociación de Mujeres Buscando Libertad, Colombia
- OTRASEX- Organización de Trabajadoras Sexuales, Dominican Republic
- Asociación La Sala, Costa Rica
- Movimiento de Mujeres Orquídeas del Mar, El Salvador
- OMES- Organización Mujeres en Superación, Guatemala
- La Red de Mujeres Unidas por Nuestros Derechos REDMUDE, Honduras
- AMETS- Alianza Mexicana de Trabajadoras Sexuales
- Asociación de Mujeres Trabajadoras Sexuales Girasoles, Nicaragua
- MDDP- Mujeres con Dignidad y Derecho, Panama
- UNES- Unidas en la Esperanza, Paraguay
- REDTRASEX Peru.

Sex workers are the protectors of this program and from their national organizations, establish strategic alliances with the Health Centers (managers), as well as at the level of Ministries of Health so that workers and health center personnel can be reached through training and awareness-raising workshops against stigma and discrimination. On the other hand, in the basic research to be able to develop the program, 1006 WSW participated through a survey applied by the same sex workers.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

This program is being developed in 14 countries of Latin America and the Caribbean, in the provinces and capitals where the national organizations of sex workers have their headquarters.

FINANCING AND SUSTAINABILITY

This program is managed and coordinated by the Executive Secretariat of the RedTraSex based in Buenos Aires Argentina, is monitored by a team of consultants within the framework of the Regional Project of the TraSex network with the Global Fund within the framework of the 10th round in the fight against HIV / AIDS, Malaria and Tuberculosis. The title of the Project with the Global Fund is: "Sex Workers of Latin America and the Caribbean, working to create alternatives that reduce their vulnerability to HIV: a regional strategy for a real impact", initiated in February 2012 and in current implementation (until January 2018). The project was awarded in the Tenth round of financing of the FM, the last three years being conditional to the programmatic and budgetary performance achieved. In August 2013, continuity was requested for three years (Phase two), from February 2014 to January 2016, which was granted at 100% of the amount requested due to the success in complying with the indicators. Finally, in July 2016, an extension was requested based on a request for funds and the existing savings, which was granted in October 2016 at 100% of the requested amount.

During phase one, 2012 to 2013, the project was implemented in Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Nicaragua, Peru, Panama, Paraguay and Uruguay.

During the second phase and extension, the project was implemented in Argentina, Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Peru, Panama and Paraguay.

In order to guarantee the sustainability of the program, the WSW have been trained so that they can apply the surveys at the time of the investigations, to facilitate the sensitization workshops for the staff in health centers, awareness-raising guides against stigma and discrimination towards the WSW in the context of access to the right to health.

DESCRIPTION

Objective of the Program

- Increase knowledge about the status of sex work and HIV, and fight stigma and discrimination against STDs.

Sub components years 1 and 2 of the regional project

- Carry out a diagnostic and systematization study on factors that affect the vulnerability of STMs to HIV in the different STOs that make up the Latin American network
- Implement actions to understand the reality of MTS with allies and regional and national decision makers
- Sensitization against stigma and discrimination in health services
- Elaboration of material for health centers against stigma and discrimination against STDs adapted to each country component of the network.
- Sub components years 3, 4, 5 and 6 of the regional project:
- In addition to the above, the following components were added:
- To make visible the agenda and demands of TS in relation to the right to health.

- Leading social monitoring actions with other organizations on National HIV program and budget (focusing on prevention).

RESULTS OF THE PROGRAMME

- With more than 1,375 health providers between 2016 and 2017. And with more than 1.500 WSW involved.
- The countries where it has been implemented are: Argentina, Bolivia, Chile, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panamá, Paraguay, Perú, República Dominicana, Uruguay y Ecuador.
- At least 10 National Monitoring Committees of the HIV prevention budget have been formed in 2017.

OUTCOMES AND IMPACT OF THE PROGRAMME

When analyzing the indicator "Number of MTS attending health centers that implement good care practices and express satisfaction with the care received" (Indicator 3.2, Second Phase of the project), it is possible to value part of the products and impact of our actions. It is important to say that throughout the project actions and strategies were implemented to influence the practices of health personnel, among which the development of a Guide to Good Practices in Health System Personnel "Put in our shoes "and the articulations, trainings and agreements with different actors of the health system to guarantee their application in the treatment with MTS.

The baseline used to compare this indicator comes from the Study on Stigma and Discrimination in health services to STDs in Latin America and the Caribbean (RedTraSex, 2013), which showed practices of rejection, discrimination and violence in the attention of the health personnel. This information was expressed in Indicator 3.4, First Phase "MTS that show satisfaction with regard to health care".

Sample survey

The satisfaction survey was applied in the 13 countries of the project to 801 MTS. In each country was applied by the partners of the national organizations to around 60 MTS that are served in health centers or hospitals with which the project has developed some type of link.

Countries Number of respondents

- Argentina 61
- Bolivia 61
- Chile 59
- Colombia 71
- Costa Rica 60
- El Salvador 59
- Guatemala 60
- Honduras 62
- Nicaragua 59
- Panama 60
- Paraguay 61
- Peru 68
- Dominican Republic 60
- Overall total 801

94% of the MTS surveyed stated that in the last year they attended a public health service (hospital, ward, dispensary)

How do you feel treated by the doctor when talking about TS?

66.9% of the respondents said they felt accepted by the doctor who attended them when talking about TS. At the baseline this percentage was 50.9%. With that there was an improvement of 16% between what was relieved in 2013 and in 2016.

The level of rejection perceived at the beginning was 12% and now it has been reduced by half, with 6% feeling rejected in the attention when talking about TS.

Differences by Region

The highest levels of acceptance are observed in the Southern Cone countries. As well as lower levels of rejection. Thus, it is the Region in which there was less variation between 2013 and 2016.

The Central America and Caribbean Region had the lowest level of TS acceptance in 2013 (41%) and took a big leap in 2016 with a perception of acceptance of 71.2% of the cases. Concomitantly, it was observed that the rejection level decreased significantly from 17.1% to 8.6% and that indifferent situations also changed drastically.

The results of the Monitoring Committees on the HIV budget can hardly be assessed in 2018 at the end of the execution of the regional project.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

The monitoring and evaluation of the indicators of the regional project are carried out from the staff of consultants that make up the technical team of the Secretariat of the RedTraSex. In turn, the instruments, their application, processing and results are reviewed and validated by the monitoring and evaluation team of the International Organization of Migration which is the recipient of the Global Fund resources.

On a quarterly basis, the Project Management Unit reports and reports for each indicator. On the other hand, in the case of research such as Stigma and discrimination in health centers carried out in 2013, the instrument was applied, and the research was coordinated by a team of expert consultants from CONICET, Argentina.

The program is still under development, so it is not possible to determine its impact.

LESSONS LEARNED AND RECOMMENDATIONS

Our recommendations on the subject of stigma and discrimination are:

- Develop awareness activities among health professionals and especially administrative staff and public attention.
- Promote the recognition of rights associated with health care among female sex workers. From the data collected in this study it is observed that the knowledge of the rights by the female sex workers modifies their position and the tools that they have in dealing with the difficulties in health care.
- Promote the strengthening of sex worker organizations in order to expand their capacity to influence health services.
- To develop strategies of denunciation and political incidence in relation to the deficiencies in the system of mandatory controls for female sex workers.
- Collaborate in the construction and dissemination of a comprehensive health care paradigm for women sex workers.

From this program we have been able to:

- Progress towards the sustainability of RedTraSex and the Organizations that integrate it: The project has allowed RedTraSex to build its own management procedures, and consequently to strengthen the installed capacity in organizations in relation to project management, and the involvement of MTS in technical and administrative procedures so as to familiarize themselves with mechanisms of surrender and coordination. Established monitoring systems, such as attendance sheets, systematization of participants' assessment of activities, oral evaluations of activities, or travel reports, visits and meetings, have been adopted as belonging to the Network beyond of this project. It also allowed 13 ONMTS to be able to count on fees for their National Coordinators, Program and Financial Advisors during the 6 years of execution, also with advisers in Communication, Legal and Institutional Psychologists in certain periods of execution.
- Increasing the capacity and expertise of RedTraSex in strengthening health systems issues with governments and HIV program managers in the countries of the region, UN agencies and cooperation agencies; as well as their capacity and experience in human rights, gender and sexual orientation issues and gender identities: In presenting the initial proposal 10 ONMTS had considerable experience in these areas, whereas currently 13 ONMTS project have been strengthened in their capacities in the areas of rights, integral health, gender, advocacy, accountability, project management and coordination, and organizational development.
- Improvement in the services provided by the ONMTS to the MTS of their country. Although all the NMHSs were implementing actions prior to the start of the regional project, the increased capacity and strength gained allowed them to increase their reach, improve their systematization and strengthen their articulations. In health topics, the work of HIV prevention through the delivery of condoms and leaflets, advice on Consistent Use of the condom through promotoras or pairs, accompaniment to the MTS in the test is highlighted. The ONMTS also participate in specific health services for MTS and also carry out integral and gynaecological health campaigns among its members and awareness of health personnel. In addition, they carry out training activities (talks and workshops) on gender, gender violence, HIV, human rights, political influence, identity, self-esteem, etc.; Legal assistance, in particular legal advice regarding complaints, provision of legal information in general and to migrants; MTS care at headquarters.
- Increased participation of WSW in national, regional and international decision-making spaces:
 - Of 4 NOWSW members of the Country Coordinating Mechanisms (MCP) before the implementation of Phase 1, 8 organizations are now integrated (Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Paraguay, Dominican Republic). It should be noted that the CCM does not work in Argentina and Chile, but both ONMTS have a working relationship with the National HIV Program addresses, which translates into a daily dialogue and the development of joint activities.
 - 9 NOWSW we integrate the National Intersectoral Commissions of HIV (Bolivia, Chile, Costa Rica, Guatemala, Honduras, Nicaragua, Panama, Peru, Paraguay.
 - 4 WSW we participated in the Thematic Hearing to the Inter-American Commission of Human Rights in March 2017.
 - We present 3 country reports: Guatemala, Peru and Argentina on the human rights situation of STM before the IACHR.
 - 6 WSW participated in the ECLAC / UN Follow-up Conference held in April 2017 on ODS and follow-up to the Montevideo Consensus.
 - 7 WSW we participated in the General Assemblies of the OAS Numbers 46 and 47.

- We participate in at least 113 national areas of Political Incidence (Health, Human Rights, Public Policies, etc.).

CONCLUSIONS

There is still much to be done, but WSW attending health centers where awareness-raising workshops and partnerships for better care for sex workers have been conducted, report greater acceptance of service quality. On the other hand, the organizations of sex workers have been working in a process of empowerment and training of the WSW so that they know and can assert their rights. The combination of both strategies of action have been positive for the achievement of the proposed objectives.

Some testimonies from the WSW

"The treatment in health centers, in all departments, there will be one or two that do not, but always the doctor marginalizes us. It always puts us like we are the focus of infection. And always, the population considers us as being the population with the most positive diagnosis on the subject of HIV". (WSW Bolivia)

"I used to feel fear, I used to come in with fear, and when they asked me for a job or profession and sometimes I said a sex worker and they put a housewife there, they did not put a sex worker on it, one was so scared I told them and they stayed with Housewife". (WSW Nicaragua)"

"I went to do a gynaecological prophylaxis, as we say in Ecuador, were the practicing boys, so I told the Doctor, I went in and I said, doctor I do not want them to see me because I'm a little shy and I do not like to be seen. Then he said: when you work, do not go to bed with guys because it's very serious. We are watching and discussing". (WSW Ecuador)

ANNEXES/ADDITIONAL RESOURCES

- Guide of good practices in Health Centers:
<http://www.redtrasex.org/spip.php?article1328>
- Research on Stigma and Discrimination in Health Centers in Latin America and the Caribbean: <http://www.redtrasex.org/spip.php?article1294>
- <http://www.redtrasex.org/>

28.2 MULTIPLE LATIN AMERICAN AND CARIBBEAN STATES: VAMOS. App with georeferenced information on sexual and reproductive health services in Latin America and the Caribbean

TITLE OF THE PROGRAMME: VAMOS. App with georeferenced information on sexual and reproductive health services in Latin America and the Caribbean

CONTACT PERSON

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- **Programme is being implemented since:** October 18, 2017
- **Responsible party/parties:** Civil society
- **Populations group(s) reached:** People Living with HIV, Young people/adolescents,
- **Has the programme been evaluated /assessed?** No

BACKGROUND INFORMATION

Young people 10 to 24 years old in Latin America and the Caribbean (LAC) make up 30% of the world's population. Access to health services for adolescents and young people continues to be inadequate in many countries in LAC.

LAC has the highest rate in the world (22%) of adolescent girls that report having had sexual relations before they were 15 years old. One in 20 young people in LAC have an STI. In the Caribbean, approximately 1.6 percent of people aged 15 to 24 live with HIV. AIDS-related complications represent one of the five most common causes of death among young people.

Adolescence is characterized by rapid physical changes that correlate with social and psychological changes conducive to intellectual and sexual maturity and other processes that gradually reduce the dependence of the adolescent on adults. Physical development occurs several years before psychological and social maturity is reached. In the adolescent stage, there are very diverse and specific needs related to the scope of full and healthy development.

In this context, there is a need to strengthen the provision of high-quality, youth-friendly services. In 2016, IPPF/WHO partners provided more than 30 million sexual and reproductive health services, averted more than two million unintended pregnancies, and provided access to a wide range of services, including contraception, breast and cervical cancer screening tests, HIV prevention, and safe abortion.

The programme presented aims to improve youth access to high-quality health care services in order to tackle the problems young people face on sexual and reproductive health.

BENEFICIARIES AND IMPLEMENTERS

IPPF/WHR works with 45 partner organizations in 41 countries across the region. Its local partners are autonomous, locally-owned organizations that share a common mission: ensuring sexual and reproductive rights for all, including universal access to quality sexual and reproductive health services and comprehensive sexual education.

Fundación Huésped is dedicated to advancing reproductive and sexual health and rights and works specifically to address HIV/AIDS, viral Hepatitis, and Dengue and Zika prevention. It also works on a variety of preventable diseases and STI prevention. Based in Argentina, it has been working on these important issues by having a strong presence in the national dialogue since 1989.

Fundación Huésped takes a comprehensive approach dedicated to developing research, identifying practical solutions to the public health challenges in the country and in the region, and investing in public awareness media campaigns.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

VAMOS aims to reach young people from Latin America and the Caribbean who look for sexual and reproductive health services. Although both website and application can be used by any person.

FINANCING AND SUSTAINABILITY

VAMOS is financed by IPPF/WHR, with its support the platform was created and will be updated including new features to improve users and system administrators' experience. Both IPPF/WHR and Fundación Huésped are committed to maintain the platforms using institutional resources regardless the existence of external funding. Therefore, the sustainability of the initiative is guaranteed.

DESCRIPTION

The programme (VAMOS) is an app and website to find sexual and reproductive health services and gather users' feedback to improve their quality. It also let monitor and report on levels of discrimination in health care settings.

VAMOS is an open source platform that works from any device with an Internet connection. It can be used anonymously, safely, and can be downloaded as an app for Android OS. It has been developed since January 2017 and launched on October 18th 2017.

VAMOS helps users find service providers that offer sexual and reproductive health services: HIV and other sexually transmitted infection testing, condoms distribution, access to contraceptives, breast and cervical cancer screenings, reproductive and sexual health services, access to legal abortion if the procedure is legal in the country of residence of the user.

RESULTS OF THE PROGRAMME

Currently there is georeferenced information of 225 IPPF/WHR Member Associations, associated clinics and partner organizations from 30 countries. On a near future, VAMOS will also include data from other establishments collected through alliances with the public sector and open data from the governments. With VAMOS users can check out the providers near their location through the GPS of their devices, and also make a search on another place entering the name of the city where they want to find a service.

It also gives the opportunity to rate the service quality through an anonymous survey. The data in the surveys will be used by IPPF/WHR and Fundación Huésped to give a feedback to the establishment that offers the services. The evaluations made by the users of public services will be a tool to advocate to improve services' quality and to reduce barriers that restrict sexual and reproductive rights.

LESSONS LEARNED AND RECOMMENDATIONS

The first version of the website was developed by Fundación Huésped in collaboration with other partners in the region. During this process, Fundación Huésped worked closely with a youth organization (Colectivo de Juventudes por los Derechos Sexuales y Reproductivos) in order to validate the content of the platform and its usability.

In 2017, with the help of the International Planned Parenthood Federation's Western Hemisphere Region (IPPF/WHR), VAMOS' reach was expanded across countries in Latin America and the Caribbean.

CONCLUSIONS

VAMOS has not been formally evaluated, but there is some information about the use of the platform obtained through the analysis of site's traffic. In less than three weeks, the webpage has had 579 sessions and 427 users and the app was downloaded by 478 persons. Website traffic, downloads of the app and services qualification received are one of the results to measure periodically.

IPPF/WHR Member Associations, associated clinics and partner organizations will register if the persons attending the clinics found them using VAMOS, on that way will be measured how useful is the platform to favour access to health services.

Finally, reports from the users about service quality will be systematized and used to give a feedback to the establishments and policy makers. IPPF/WHR and Fundación Huésped aim that the platform can collect data about users' experiences, especially young people, to offer qualitative evidence about the barriers faced and also about good practices.

ANNEXES/ADDITIONAL RESOURCES

- VAMOS website: www.vamoslac.org
- VAMOS app at Google Play: VAMOS. Sexual and reproductive health services

29. MULTIPLE COUNTRIES FROM SEVERAL REGIONS: Documenting Lessons and Measuring Progress towards Global HIV/TB/hepatitis C Targets in Indigenous Communities

TITLE OF THE PROGRAMME: Documenting Lessons and Measuring Progress towards Global HIV/TB/hepatitis C Targets in Indigenous Communities

CONTACT PERSON

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- **Start Date of the Programme:** April 01, 2017
- **End Date of the Programme:** October 31, 2018
- **Responsible Parties:** Civil society, Government
- **Populations Group(s) Reached:** Health care workers, People living with HIV, Women, Girls, Young people/adolescents, Gay men and other men who have sex with men, People who inject drugs, Prisoners and other populations in closed settings, Sex workers, Transgender people, Indigenous 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

BACKGROUND INFORMATION

This project responds to the recognized need to document and share domestic and international best practices and approaches that demonstrate results in meeting global goals aimed at reducing HIV, tuberculosis, hepatitis B and C, and sexually transmitted infections among indigenous peoples.

In many parts of the world, indigenous peoples experience significant health disparities. In those countries with robust epidemiology collection processes, it is clear that indigenous peoples are disproportionately affected by a range of diseases. These include HIV, sexually transmissible infections, tuberculosis, hepatitis C and hepatitis B, with indigenous peoples having higher rates of these diseases when compared with their non-indigenous counterparts in the same country.

Within this context of disadvantage, indigenous peoples experience racism, stigma and discrimination when accessing health and social services. This inequitable treatment has a severe and adverse impact on the health and well-being of indigenous peoples (Harris et al, 2013; Paradies, 2009). Often this discriminatory treatment of indigenous peoples is so entrenched that services are unable to develop strategies to ensure equitable outcomes for all people, regardless of their ethnicity. As a consequence, indigenous peoples in many parts of the world suffer worse health than their non-indigenous peers.

BENEFICIARIES AND IMPLEMENTERS

- The beneficiaries of this project are indigenous peoples living with HIV, and the families and communities to which they belong.
- The project aims to engage with indigenous peoples living with HIV and their communities in a number of international locations which include Canada, Australia, New Zealand, Guatemala, Peru, Chile, Mexico, and Bolivia.
- Consultation with indigenous peoples from these countries took place via teleconference, and at a three-day face-to-face meeting in Ottawa, Canada.
- The principal purpose of this consultation was to ensure that the project was led and informed by indigenous peoples affected by HIV. During the consultation phase of the project, indigenous peoples provided examples of wise practices and identified factors that contributed to the elimination of discrimination and stigma associated with health services for people living with HIV.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The project focused on indigenous populations in Australia, Bolivia, Canada, Chile, Guatemala, New Zealand, Mexico, and Peru. Approximately 60 people attended the consultation meeting. Participants provided an important link with the indigenous communities that they represented and it was expected that information from the consultation meeting would be translated to these communities. As such, the reach of the project is extensive and embraces a variety of international locations and communities.

FINANCING AND SUSTAINABILITY

The project is funded by a grant from the Office of International Affairs for the Health Portfolio (OIA) at the Public Health Agency of Canada (PHAC) under the International Health Grants Program (IHGP) and is timed to take place over 18 months.

DESCRIPTION

This project aims to:

- Identify and document best and promising approaches and models that respond to Canada's global health priorities and international commitments related to HIV, TB, and hepatitis C and assess transferability to other health environments as opportunities for a more comprehensive response to HIV, TB, and hepatitis C amongst Indigenous populations.
- Foster knowledge transfer between Indigenous persons, policy makers, programme developers, and researchers through the sharing of lessons learned, and of wise and promising models of care for translating these lessons into effective policies and programmes.
- Develop and strengthen relationships with key HIV, TB, and hepatitis C partners and stakeholders that will serve to inform and enhance both domestic and global responses to HIV/AIDS, TB, and hepatitis C amongst Indigenous persons in Canada and internationally; and
- Identify areas, including concrete recommendations for advancing work toward global targets on HIV, TB, and hepatitis C, including making concrete recommendations for ways of strengthening monitoring and evaluation systems to track results around global HIV, TB, and hepatitis C targets.

RESULTS OF THE PROGRAMME

It has not been possible to quantify the number of people reached by this project. However, it is expected that the project will be far reaching because of the wide range of people from international jurisdictions who are engaged in the program.

Approximately 60 indigenous community representatives participated in the data collection meeting in Ottawa (July 2017) and these participants will engage with their communities in relation to the project. Potentially, the reach of the program could extend to hundreds of participants with a geographic coverage in at least eight countries internationally.

OUTCOMES AND IMPACT OF THE PROGRAMME

The project is ongoing

To date, the project has engaged with indigenous representatives from a range of countries that include Australia, Canada, New Zealand, Guatemala, Chile, Mexico, Peru and Bolivia.

The principal output to date has been an increased awareness among indigenous peoples of the need to address issues related to stigma and discrimination and other factors that limit and prevent indigenous peoples from accessing health service providers.

An important feature of the project is that it has been designed and implemented in partnership with government policy agencies who anticipate using the report and its recommendations to help design future HIV prevention projects for indigenous populations.

The partnership model between an indigenous community-based HIV organisation and a government policy agency underpins the project and is a feature that has helped to ensure the success of the project, as well as its acceptability and impact within federal health policy agencies.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- The project is ongoing and evaluation is not yet complete.
- Affected populations and indigenous people living with HIV were involved in all stages of the project, from design and inception, to planning and implementation.
- Satisfaction surveys and interviews indicate high levels of satisfaction with the project and its outcomes.

LESSONS LEARNED AND RECOMMENDATIONS

Lessons learned and recommendations include:

- Models of care for indigenous peoples must be based on respectful engagement with indigenous people living with HIV
- Recognizing and facilitating the leadership role of indigenous people living with HIV is an essential component of strategies to prevent the transmission of HIV, as well as care and support programs
- Models of best practice are those which are built on strong relationships with indigenous communities, and especially with elders
- The elimination of stigma and discrimination is essential and will only happen by supporting the establishment of culturally responsive health services for people living with HIV and their families
- Integrating HIV health services with other indigenous health services will help to ensure enhanced access to service for indigenous peoples affected by HIV

CONCLUSIONS

A key feature of this program will be an evaluation to determine the impact of the project on indigenous communities in Canada and internationally.

Early indications suggest that the project has had a wide impact with an expectation that the project outcomes will have significant impact on HIV service delivery for indigenous peoples in Canada and other countries.

By helping to eliminate barriers to service for indigenous peoples, it is expected that the project will help to improve the health and well-being of indigenous peoples living with HIV and their families and communities.

30.1 GLOBAL: Ending discrimination in health care: declaration of commitment of the International Federation of Medical Students Associations (IFMSA) to eliminate discrimination in healthcare

TITLE OF THE PROGRAMME: Ending discrimination in health care: declaration of commitment of the International Federation of Medical Students Associations (IFMSA) to eliminate discrimination in healthcare

CONTACT PERSON

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Title: Liaison Officer for Sexual and Reproductive Health issues incl. HIV/AIDS

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- **Start Date of the Programme:** May 21, 2017
- **Responsible Parties:** Civil society, International Federation of Medical Students Associations (IFMSA)
- **Populations Group(s) Reached:** Health care workers, People living with HIV, Women, Young people/adolescents, Gay men and other men who have sex with men, Transgender 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 INFORMATION

Discrimination, stigma, violence and grave human rights violations continue to pose important challenges for people living with HIV, key populations most affected by the epidemic (including gay men and other men who have sex with men, transgender, injecting drug users, and people who sell sex), and women. Young people aged 15-24, and especially adolescents from these populations, are at increased risk and vulnerability of being discriminated against and stigmatized.

In many settings, young key populations continue to be criminalized, and adolescents face prohibition to access sexual and reproductive health services, including HIV testing, due to harmful legal and policy barriers related with age of consent. In countries with high levels of early and forced marriage, adolescent girls also face constraints to access services due to laws and policies requiring spousal consent. Examples of discrimination in health-care settings also include misinformation, requiring third-party authorizations for the provision of services, lack of privacy and breaches of confidentiality. Healthcare services is one of the most common settings in which discrimination, stigma and violence against people living with HIV, key affected populations and women, take place. In response to these persistent challenges, in 2016 the Joint United Nations Program on HIV/AIDS (UNAIDS) the Global Health Workforce Alliance in March 2016, launched the Agenda for Zero Discrimination in Healthcare Settings.

The International Federation of Medical Students' Associations (IFMSA):

- Having met in Geneva on 17-21 of May 2017 at a pre-conference hosted by IFMSA, with the support from UNAIDS and The PACT, previous to the Seventieth World Health Assembly;
- In collaboration with young people living with HIV and young key populations most affected by HIV, and in support of the Agenda for Zero Discrimination in Healthcare Settings;
- Acknowledging our important role to eliminate discrimination in healthcare, as medical students, future doctors, nurses and healthcare professionals, young activists and change makers;

Presents this Declaration of Commitment to Eliminate Discrimination in Healthcare Settings:
<https://ifmsa.org/2017/05/23/declaration-commitment-ifmsa-eliminate-discrimination-healthcare/>

BENEFICIARIES AND IMPLEMENTERS

IFMSA, Y+, YVC, and JYAN signed an MoU to enhance their dialogue and cooperation, as well as develop a plan of action to combine and coordinate their efforts to achieve their common goals, especially concerning the promotion of non-discrimination in health care:
[MoU Y+ YVC JYAN Signed.pdf](#)

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

Global

The International Federation of Medical Students Associations (IFMSA), founded in 1951, is one of the world's oldest and largest student-run organizations. It represents, connects and engages every day with medical students from 127 national members organizations in 119 countries around the globe.

Our work is divided in four main global health areas: public health, sexual and reproductive health, medical education, human rights and peace. Each year, we organize over 13,000 clinical and research exchanges programs for our students to explore innovations in medicine, healthcare systems and healthcare delivery in other settings. IFMSA brings people together to exchange, discuss and initiate projects to create a healthier world. It trains its members to give them the skills and resources needed to be health leaders. It advocates for the pressing issues that matter to shape the world they want. And it does deliver: their projects, campaigns and activities positively impact the physicians-to be, the communities they serve, as well as the health systems around the world in which they practice as a trainee and eventually a medical doctor.

FINANCING AND SUSTAINABILITY

The programme is managed and coordinated by IFMSA in cooperation with technical and financial support of UNAIDS and other partners. It has been cleared by the IFMSA General Assembly

- Find link to IFMSA annual report 2016-2017 - <https://ifmsa.org/wp-content/uploads/2017/09/AR1617-LowRes.pdf>

DESCRIPTION

IFMSA, Y+, YVC, and JYAN developed a plan of action to combine and coordinate their efforts to achieve their common goals, especially concerning the promotion of non-discrimination in health care.

- a) Joint advocacy - identifying key advocacy issues, spaces and tools to help us position them in global, regional and national decision-making spaces.
 - Develop an advocacy brief on how to avoid discriminatory and stigmatizing practices against young people living with HIV and young key populations.
 - Highlight the challenges faced by young people to access services due to discrimination in healthcare, at national and global reviews of the Sustainable Development Goals, including through Voluntary National Review and technical meetings related to the High Level Political Forum.
- b) Sensitization of medical students – using online tools and in-person collaborations to sensitize, and support medical students as change-makers to tackle discrimination in healthcare that include but are not limited to:
 - Implementing a set of at least 5 webinars (1 per region - Americas, Asia-Pacific, Africa, Eastern Mediterranean Region and Europe), aimed at sensitizing medical students on HIV, gender equality, human rights and eliminating discrimination in healthcare.
- c) Learning together - exchanging lessons learned from ongoing collaborations and fostering cross-insemination of best practices between countries and regions.
 - Develop and moderate an online community on how to tackle discrimination in health care through the use of social media and IFMSA platforms such as email servers to:
 - Reach interested members from the involved parties to find common grounds of collaboration at local, national and regional levels.
 - Include key populations representatives to build capacity and clarify values among future healthcare providers in IFMSA's internal and community based activities.
- d) Improve national medical academic curricula - mainstreaming non-discrimination in healthcare in the emerging health workforce.
 - Develop a guidance note with theoretical and practical standards to inform medical schools and other teaching settings of the importance to include the elimination of discrimination in healthcare in the curricula.
- e) Strengthening alliances at the country and regional level - from global to local, information sharing with our member organizations, and fostering country-level alliances.
 - Promote this agreement and enhance the hosting of national in-person dialogues every semester between medical students, young people living with HIV and young people most affected by the epidemic, on the trends of impact of discrimination in healthcare, best practices and outline potential strategies to tackle it.
 - IFMSA will provide every year an early registration spot for one of their General Assemblies to a member of the Global Network of Young People Living with HIV (Y+), Youth Voices Count (YVC) or the Jamaica Youth Advocacy Network (JYAN) so they can actively contribute as an external speaker to sessions related to the Zero Discrimination Agenda.
- f) Resource mobilization - develop a joint proposal to mobilize resources and sustain our collaboration.
 - Develop a financial resource mobilization proposal to expand and implement a similar agreement to the present MoU, in priority countries where discrimination disproportionately affects young people's access to HIV and Sexual and Reproductive Health services.

RESULTS OF THE PROGRAMME

- Starting implementation

OUTCOMES AND IMPACT OF THE PROGRAMME

- Starting implementation

MONITORING AND EVALUATION/VALIDATION OF IMPACT

- Starting implementation

LESSONS LEARNED AND RECOMMENDATIONS

- Starting implementation

CONCLUSIONS

- Starting implementation

ANNEXES/ADDITIONAL RESOURCES

- <http://ifmsa.org/policy-and-advocacy/>
- For more information on IFMSA contact Carles Pericas (carlespericas@gmail.com) or UNAIDS Youth Officer Ruben Antonio Pages (pagesr@unaids.org)

30.2 GLOBAL: Key Barriers to Women's Access to HIV Treatment: A Global Review

TITLE OF THE PROGRAMME: Key Barriers to Women's Access to HIV Treatment: A Global Review

CONTACT PERSON

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- **Start Date of the Programme:** October 01, 2014
- **End Date of the Programme:** January 1, 2016
- **Responsible Parties:** Civil Society, UN or other inter-governmental organization
- **Population Group(s) Reached:** Health care workers, People living with HIV, Women
- **Has the programme been evaluated / assessed?** No
- **Is the program part of the implementation of the National AIDS Strategy?** No
- **Is the program part of the National Plan Broader than the National AIDS Strategy?** No

BACKGROUND INFORMATION

Gender inequality continues to hamper progress in ending AIDS. Women face gender-related barriers in accessing and staying on treatment. Current coverage and access measures focus predominantly on biomedical and behavioral dimensions that do not adequately consider the differential experiences of women and men in accessibility, availability, acceptability and quality of HIV treatment, care and support. Little research has been undertaken to understand women's access and adherence to treatment across the entire life cycle; their experiences of treatment access, availability and their decision-making around uptake; and the impact of treatment programmes on women and girls living with HIV.

To complement the existing evidence on treatment coverage and to investigate barriers and challenges to women's access to treatment, UN Women commissioned the 'Key Barriers to Women's Access to HIV Treatment: A Global Review', carried out by ATHENA Network, AIDS Vaccine Advocacy Coalition (AVAC), and Salamander Trust.

BENEFICIARIES AND IMPLEMENTERS

This community-based, participatory, user-led, mixed methods study was conducted among and by women living with HIV. Methodology included a literature review, quantitative and qualitative data collection, analysis through community dialogues and three country case studies, guided by 14 women living with HIV from 11 countries as reference group. This included a diverse range of younger and older women, and transgender women. Some group members have experienced drug use, sex work, detention, conflict and migration.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

The study involved over 200 women living with HIV from 17 countries (Australia, Bolivia, Cameroon, Italy, Jamaica, Kenya, Nepal, Portugal, Puerto Rico, Russian Federation, St. Martin, Tunisia, Uganda, Ukraine, United Kingdom, United States, Zimbabwe).

FINANCING AND SUSTAINABILITY

UN Women commissioned the 'Key Barriers to Women's Access to HIV Treatment: A Global Review' and it was carried out by ATHENA Network, AIDS Vaccine Advocacy Coalition (AVAC), and Salamander Trust.

DESCRIPTION

The Global Review resulted in a number of solid findings. Violence against women and girls living with HIV, which includes physical, sexual, psychological/emotional, financial and structural violence at the level of intimate partner, family/community and institution, coupled with fear of violence, served as the most commonly cited barrier in access and adherence to treatment. Gender roles and care responsibilities, such as women having to ask permission from partners or other family members, was highlighted as a significant structural barrier to treatment access for some women. The review also included as barrier the related lack of access to and control over resources that allow women to move freely. This lessens their ability to pay for costs associated with accessing treatment (e.g., user fees, costs for tests and transportation costs others).

Women in nearly all the focus groups raised the problem of the high cost of transport and the distance to facilities, particularly those living in rural areas. Side effects of the HIV treatment were consistently cited as a barrier to adherence to long-term treatment for women. Some side effects, especially changes in body shape, resulted in mental or emotional repercussions particularly around gender norms and expectations for women's bodies and women's sexuality. Women across all of the focus groups struggled to meet both their own and family's basic needs in regards to livelihood, food security, nutrition and housing, and, in this context, deprioritizing their own health needs.

Women living with HIV across the community dialogues frequently raised stigma and discrimination, dismissal, fear of disclosure or being refused employment because of their HIV status as among key barriers to treatment access and adherence. Low treatment literacy and poor quality of care around HIV treatment, particularly in resource-constrained settings, were also cited by women living with HIV as substantial barriers to access and adherence.

The Global Review also facilitated the identification of a number of effective strategies women living with HIV exercised to overcome these barriers, highlighting areas for resilience and agency. These included the importance of engagement in support groups, networks and peer support services. The women also considered increasing their own and others' treatment literacy as another strategy for a more informed choice and decision-making around health issues.

RESULTS OF THE PROGRAMME

The study involved over 200 women living with HIV from 17 countries (Australia, Bolivia, Cameroon, Italy, Jamaica, Kenya, Nepal, Portugal, Puerto Rico, Russian Federation, St. Martin, Tunisia, Uganda, Ukraine, United Kingdom, United States, Zimbabwe). The findings reveal uneven progress in women's informed choice over treatment access and adherence across their lifecycle; gaps in related sex-disaggregated data collection; persistent gender-related barriers at micro-, meso- and macro-levels; with some enablers, including peer

support, to enhance access. Most frequently cited barriers included: at micro-level, actual and/or fear of violence, stigma and discrimination, treatment side effects, and low treatment literacy; at meso-level, gender roles and care responsibilities, lack of access to and control over resources, dismissal, fear of disclosure or of HIV-related employment refusal; and at macro-level, punitive laws.

Some of the barriers related to stigma and discrimination in health care settings that women respondents faced included:

- Stigma, discrimination and abuse by health professionals was raised as a serious concern in about half the focus groups discussions –particularly in Bolivia and Tunisia– and in two of the interviews. Participants described experiences that included breaches of confidentiality whereby HIV status was disclosed in front of family members, other staff and clients. In some cases, this resulted in stigma and discrimination and potentially placed women at risk of intimate partner or domestic violence.
- Women also mentioned instances in which they or their children were refused treatment and care by health professionals based on their HIV-positive status. Some participants expressed fear of revealing their HIV status when seeking care for a non-HIV-related issue in case they were turned away. For all these reasons, women may avoid accessing health services altogether.
- In some instances, women reported that there is still a belief or attitude among service providers that women living with HIV should not conceive, have children, or even have sex. A few women said they continue to be discouraged from having children despite the existence of clinical guidelines and treatment to prevent vertical transmission. In some cases, they reported the advice of service providers goes far beyond discouragement and moves into ill treatment, abuse and violence against women living with HIV who are pregnant, delivering or in post-partum care. Participants cited examples of women being neglected during pregnancy and labor, stigmatized by health workers, receiving poor quality care, being forced to undergo or refused abortion, being forced or coerced into sterilization or witnessing the neglect of their children.
- Interrelated and overlapping with quality of care and attitudes of health-care workers are additional sexual and reproductive health and human rights violations experienced by women living with HIV when they become mothers. These, too, serve as barriers to ongoing access to treatment, care and support. Women in focus groups discussions in Tunisia and Bolivia commonly reported experiencing human rights violations when seeking care, especially prenatal care and during pregnancy/delivery, or in relation to their sexual and reproductive health more broadly.

OUTCOMES AND IMPACT OF THE PROGRAMME

- The Global Review identified several forward-looking recommendations with regard to antiretroviral therapy access for women, with specific attention to emerging strategies, such as treatment as prevention and Option B+.
- The Global Review creates an opportunity to discuss how gender inequality affects women's access to HIV/AIDS care and treatment. It also focuses on adherence to treatment and retention and presents key findings from meta-analysis of the academic literature, group discussions and in-depth interviews related to barriers to treatment access for women and adolescent girls.
- The review also offered an innovative model of meaningful engagement of networks of WLHIV in robust methodologies for evidence-building. The Global Reference Group model presents a framework for involving women living with HIV that emphasizes the critical contributions of women's agency, quality of care, rights and choice.

MONITORING AND EVALUATION/VALIDATION OF IMPACT

UN Women organized a satellite event for the 8th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, held in Vancouver on 19 July 2015 and a side event during the 2016 International AIDS Conference at the Women's Networking Zone to launch the Global review, highlight the innovative participatory methodology, and present its key findings and recommendations.

LESSONS LEARNED AND RECOMMENDATIONS

- Women and girls face multiple forms of exclusion and discrimination, which poses obstacles in accessing HIV services. Targeted research regarding women's experiences of treatment availability, and their decision-making around uptake, and how treatment programs are impacting women and girls living with HIV is needed.
- The Global Review identified several forward-looking recommendations with regard to antiretroviral therapy access for women, with specific attention to emerging strategies, such as treatment as prevention and Option B+.
- The Global Review creates an opportunity to discuss how gender inequality affects women's access to HIV/AIDS care and treatment. It also focuses on adherence to treatment and retention and presents key findings from meta-analysis of the academic literature, group discussions and in-depth interviews related to barriers to treatment access for women and adolescent girls.
- The review also offered an innovative model of meaningful engagement of networks of WLHIV in robust methodologies for evidence-building. The Global Reference Group model presents a framework for involving women living with HIV that emphasizes the critical contributions of women's agency, quality of care, rights and choice.
- UN Women and partners will continue disseminate the findings of its Global Review of Women's Access to HIV Treatment, Care and Support for further policy and programmatic actions and interventions to address gender-specific and other social determinants of health.

CONCLUSIONS

More research is needed to better understand gender inequalities and other negative social determinants of women's lack of informed choice regarding access to treatment and adherence across their entire lifecycle, particularly, for adolescent girls and women outside pregnancy. Strategic responses that fully acknowledge structural and gender-related barriers to treatment, that are multi-sectoral and that build on women's resilience are much needed to facilitate women's autonomy regarding treatment, to reach the goals of ending AIDS. Furthermore, conventional understanding of access must also recognize underlying causes of gender-related, structural and human rights barriers that women face regarding their access to care, to treatment and life-long support.

ANNEXES/ADDITIONAL RESOURCES

- <http://www.unwomen.org/en/news/stories/2015/7/barriers-to-treatment-faced-by-women-living-with-hiv-aids>
- <http://genderandaids.unwomen.org/en/resources/2016/11/key-barriers-to-womens-access-to-hiv-treatment>

30.3 GLOBAL: Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Project (LINKAGES), SMS2

TITLE OF THE PROGRAMME: Linkages across the Continuum of HIV Services for Key Populations Affected by HIV Project (LINKAGES), SMS2

CONTACT PERSON

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Organisation: USAID-PEPFAR

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- **Responsible Parties**: Government
- **Populations Group(s) Reached**: People Living with HIV, key population

BACKGROUND INFORMATION

Stigma contributes to poor health outcomes for people living with HIV (PLHIV) and key populations (KPs) affected by HIV/AIDS. Several existing LINKAGES interventions, including health care worker training, peer navigation, and peer education and outreach with KPs seek to reduce KP-related stigma in health facilities and improve service quality.

DESCRIPTION

Short Message Service (SMS) based systems have been successfully used as part of social and behavior change communication messaging campaigns with key and vulnerable populations. In Malawi, Cote D'Ivoire, Burundi, DRC, and other countries, LINKAGES uses SMS2—an SMS-based quality assurance and quality improvement activity for KP health services to monitor and track stigma and discrimination experienced by KPs in health care settings. SMS2 is administered through existing community outreach activities. Trained outreach workers administer simple SMS assessments with KPs based on facilities they visited. These assessments measure KP-related stigma and overall overall satisfaction with services, and the information is shared with health care workers, KPs, outreach workers, and LINKAGES staff via SMS.

The SMS2 system is designed to (1) target and track outcomes of LINKAGES stigma reduction and service improvement interventions (monitoring), (2) provide a medium for reiterating key messages with HCWS and KPs (reinforcing messages), and (3) initiate a feedback loop among beneficiaries, project staff/community-based organizations, and providers to improve health services (feedback loop).

These components are designed to increase KPs' and HCWs' engagement in LINKAGES programming. In some countries, LINKAGES is working to integrate violence detection, response, and referral into the SMS2 to provide faster referrals and more comprehensive data collection on experiences of violence among KP beneficiaries.

ANNEXES/ADDITIONAL RESOURCES

For additional information, please see:

- <https://linkagesproject.wordpress.com/2017/03/01/zero-discrimination-day-linkages-uses-sms-to-collect-feedback-on-health-services-for-continuous-program-improvement/>

30.4 GLOBAL: CapacityPlus: Serving health workers, saving lives

TITLE OF THE PROGRAMME: CapacityPlus: Serving health workers, saving lives

CONTACT PERSON

Name: Deana Jordan Sullivan

Title: Senior Multisector Advisor for the Global Fund/WHO Liaison Officer

Organisation: USAID-PEPFAR

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- **Responsible Parties**: Government
- **Populations Group(s) Reached**: People Living with HIV, key population

BACKGROUND INFORMATION

Gender equality and non-discrimination promote the achievement of health workers' greatest potential, which can have a positive impact on the provision of high-quality health care. When all health workers, whether male or female, can access education, training, and leadership opportunities, the quantity and quality of the health workforce improves. Giving all health workers an equal chance of being employed, fairly paid, and supported through life events such as childbearing may contribute to improved morale, productivity, and retention—in turn contributing to high-quality health services and the achievement of national and international health goals. Further, promoting gender equality within the health workforce has potential to transform gender norms within the populations health workers serve, by promoting non-discrimination, nonviolence, and equality through the health services they provide. Gender equality in health systems also requires that health workers be able and willing to provide high-quality care for victims of gender-based violence (GBV). In many countries and communities, GBV is not recognized as a health problem. Health workers who encounter clients who have experienced GBV may dismiss their injuries, may not ask appropriate questions in a sensitive way about the origin of their injuries, and may not refer clients to available GBV services. Further, all clients, men and women, should be able to receive care for every health problem in a way that is gender-appropriate.

DESCRIPTION

CapacityPlus addressed the challenges of gender inequalities and discrimination in the health workforce and health systems by 1) developing learning tools to promote gender transformative principles among health workers and health system leaders; 2) building the capacity of stakeholders to use these tools for advocacy, policy-making, and the implementation of gender-transformative interventions to promote equal opportunity

and non-discrimination in the workplace, health professional education systems, and clinical care; and 3) training health workers to better recognize, treat, and refer clients who have experienced GBV.

The tools include:

- A gender and health systems strengthening (HSS) eLearning course that supports learners to understand how gender norms drive health behavior and decision-making and the provision and utilization of care, and presents evidence-based ways to improve health and social outcomes by addressing gender barriers. The course contributes to the aims of the USAID Gender Equality and Female Empowerment Policy and is designed to build the capacity of USAID field-based health officers, foreign-service nationals, and US government partners to promote gender equality and women's empowerment in health systems strengthening efforts in order to improve health and social outcomes. The course is also a mechanism to disseminate some of the USAID Interagency Gender Working Group's core gender analysis and integration concepts.
- An advocacy tool to address gender discrimination in health workforce development that outlines recommended combinations of gender transformative interventions to counter various forms of gender discrimination in learning environments, and provides advocacy strategies for stakeholders to develop plans to create, implement, and enforce conducive environments, equal opportunity, and non-discrimination policies. The tool draws from a technical report and brief published earlier in the project on strengthening the health worker pipeline through gender transformative strategies.
- A companion advocacy tool to promote gender equality in the health workforce (see Figure 1) that provides users with approaches to understand and examine common gender discrimination types— pregnancy and family responsibilities discrimination, occupational segregation, wage and responsibility discrimination, and sexual harassment—along with recommended gender transformative interventions and strategies for the health workforce and within health systems.

In addition, the project updated sexual and gender based violence (SGBV) curricula for health workers and trainers in Kenya and Mali. The curricula mainstreamed gender-transformative approaches, identified and filled health workforce skills gaps, and integrated new SGBV policy and service protocols to help these countries' health systems to better respond to children, adolescents, and women who have experienced sexual violence.

RESULTS OF THE PROGRAMME

Global Participation in Gender HSS eLearning Course

Since its June 2014 release, 1,474 learners from 57 countries have used the course and 637 (43%) have earned a certificate of course completion (see Figure 2), of whom 54% are female. In 2014, the project also led 22 participants from 10 countries in a two-week study group to enhance learners' understanding of the course content through moderated discussions. The first study group of its kind for the Global Health eLearning Center, the course had more than 98% of participants coming from outside the US.

Fostering Action through Pilot Application of Advocacy Tools at the Country Level

CapacityPlus field-tested the gender equality advocacy tools through a capacity-building workshop with 51 health workforce, gender, and preservice education stakeholders in Cross River State, Nigeria in 2014. The workshop discussions enabled the stakeholders to identify and prioritize gender-related challenges—including learning and working environments that may promote sexual harassment and GBV, caregiver responsibilities discrimination affecting midwife deployment and retention, and occupational segregation and wage discrimination—while working on a draft advocacy action plan. Workshop participants then nominated representatives to form a state-level Gender Human Resources for Health (HRH) Working Group, which met in May 2015 to further refine and pursue advocacy goals to advance

gender equality in the health workforce and at health professional education institutions, including promoting efforts alongside the state's forthcoming gender policy. In August 2015, a sex-disaggregated analysis of the CapacityPlus-supported Cross River State Ministry of Health workforce registry (customized from the project-supported iHRIS Manage software) was undertaken to develop a more robust evidence base on gender issues in the health workforce and better inform decision-making for how to promote and achieve gender equality. Preliminary results indicated that of the 3,626 health worker records that had a sex variable, 64% of health workers were female and 36% were male. Analyzing the age distribution of the Cross River State health workforce and disaggregating the results by sex revealed an important aspect of the female and male health worker life cycles. Figure 3 shows the number of men and women in the health workforce by age category. The proportion of females to males is 3.7 to 1 in the 26-35 age category, but 1.6:1 for health workers aged 36 to 45, and 1:1 for health workers aged 46 to 55. For those aged 56 to 65, this ratio is reversed, with almost twice as many male health workers (1.8) as females. This finding may imply that while many women start off their careers as health workers, there is attrition, with fewer women likely to remain in the profession until retirement. Alternatively, as these data represent only the current health workforce, this finding may imply that in recent decades there has been an influx of female health workers to the labor market, which would represent great potential in terms of achieving Nigeria's health goals. An analysis of data from the Community Health Practitioners Registration Board of Nigeria showed the sex distribution of Cross River State's three types of community health practitioners. As displayed in Figure 4, from left to right in order of the amount of training time that is required, it can be noted that while all professions have a majority of female health workers, the community health officer position that requires the longest period of study and practice has the largest proportion of men, indicating that there may be challenges that women face to complete additional training within the community health practitioner profession.

Improving Training on and Management of Sexual and Gender-Based Violence

Kenya: With approximately 160,000 children and youth living with HIV in Kenya and an estimated adult prevalence of 5.3%, the government is seeking to reduce HIV risk factors, including those associated with SGBV. At the request of the USAID Office of HIV/AIDS Gender Technical Working Group and in collaboration with the USAID FUNZOKenya project, CapacityPlus integrated PEPFAR's technical considerations for clinical management of children and adolescents who have experienced sexual violence into USAID's APhiAplus service delivery project in Kamili zone. The projects worked with the Ministry of Health (MOH)'s Reproductive and Maternal Health Services Unit (RMHSU) to develop a new module focused on children and adolescents for the revised national curriculum on SGBV, including supplemental training and performance support materials. Sections in the module and wider curriculum address HIV counseling and testing (as well as pregnancy testing and counseling), plus post-exposure prophylaxis, referrals, and forensic examinations. The revised national SGBV curriculum (2015) seeks to advance the MOH's mandate to train health workers on management of survivors of sexual violence. Additionally, a training needs assessment conducted before testing of the new children and adolescents-focused module among trainers and providers identified shortages of key equipment (e.g., forensic kits), deficiencies in performance support mechanisms for staff, and the existence of inherent biases against adolescents by a number of providers. Findings from this assessment assisted the Ministry in incorporating health workers' attitudinal aspects into the curriculum as well as taking corrective actions to ensure that appropriate equipment to address SGBV exists in health facilities. Mali: The armed conflict in northern Mali has displaced about 180,000 people; the United Nations' working group on violence found 2,383 cases of violence against women in 2012 and 3,330 in 2013 (UNFPA Mali 2015). In response to the crisis, in collaboration with USAID/Mali, CapacityPlus provided technical leadership to draft national health worker training materials in SGBV. National stakeholders from the Ministry of Health and Public Hygiene; Ministry for the Promotion of Women, Children, and the Family;

Ministry of Solidarity, Humanitarian Affairs and Reconstruction in the North; health facilities; and NGOs validated and finalized training materials, including a reference manual, facilitator guide, and participant workbook and job aids. To further support victims of SGBV in Gao region, CapacityPlus supported local NGO Groupe de Recherche d'Etude de Formation Femme-Action (GREFFA) to conduct informational sessions on SGBV and identify victims of SGBV. In June 2015, the Ministry of Health and Public Hygiene, with technical and financial assistance from CapacityPlus, organized a national training of 18 trainers in case management of SGBV and targeted regional participants from the health directorates and hospitals. In collaboration with the Gao Nursing School, the project also organized an orientation session on SGBV case management for 30 teachers and trainers. This intervention constitutes the first step in the introduction of these national curricula into preservice education institutions in Mali.

LESSONS LEARNED AND RECOMMENDATIONS

- The gender and health systems strengthening eLearning course proved an effective way to introduce a complex topic to a broad audience. Because gender discrimination and inequalities are context-specific, providing learners with case studies and examples is essential to illustrate gender dynamics. Additional course study groups could be offered—for example, in East and Southern Africa or among francophone countries—to create virtual communities of practice that can share experiences and support each other to promote gender equality.
- A functional, robust human resources information system (HRIS), such as the iHRIS-supported Cross River State health workforce registry, is key to monitor health workers longitudinally and promote sex-disaggregated analyses by cadre, location, and age to reveal where attention can be focused to address discrimination and promote equal opportunity. Similarly, student, graduate, and faculty tracking systems are important to identify where there may be gender challenges in health professional education systems.
- Gender advocacy action plans may need to differ from traditional development approaches. For example, many small “quick win” steps may need to be adapted as the strategy evolves. Further support is needed to develop compelling and timely data-driven gender advocacy messages, link them to specific “asks” to policy-makers, and hold policy-makers accountable for implementation.
- In countries with cultural and societal challenges to addressing SGBV (e.g., Mali) the rollout of SGBV curricula should be accompanied by community mobilization to include political leaders, traditional and religious leaders, health systems leaders, women's groups, youth groups, and a pool of health worker champions who are trained and identified as being supportive of SGBV victims and can motivate and inspire other health workers.

ANNEXES/ADDITIONAL RESOURCES

- <https://www.capacityplus.org/>

30.5 GLOBAL: Health Policy Plus: Ground-breaking Research and Initiatives to Measure and Reduce Stigma and Discrimination

TITLE OF THE PROGRAMME: Health Policy Plus: Ground-breaking Research and Initiatives to Measure and Reduce Stigma and Discrimination

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- **Responsible Parties**: Government
- **Populations Group(s) Reached**: People Living with HIV, key population

BACKGROUND INFORMATION

Stigma and discrimination (S&D) are firmly established as key barriers that impede scale-up of HIV care and treatment, impacting all stages of treatment cascade. Moreover, the populations most likely to experience HIV-related S&D are often those most at-risk for HIV infection. To achieve PEPFAR's ambitious targets for epidemic control, barriers that impede scale-up of HIV care and treatment must be addressed.

The Health Policy Plus (HP+) project is implementing comprehensive approaches to reducing S&D. The HP+ team has a history of advancing the field of S&D-reduction through ground-breaking research and leading initiatives to create globally standardized tools and indicators for measuring and addressing S&D in health facilities.

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

HP+ staff have worked with country partners to improve national reporting and monitoring of discrimination in Ghana and Jamaica; design and implement gender and sexual diversity trainings for PEPFAR staff in 38 countries; study the impact of S&D on access and adherence to care for adolescents, pregnant women, and sex workers; and design and test a S&D- reduction package of tools for health facilities.

HP+ is currently implementing the HPP total facility approach in three countries: Ghana, Jamaica and Tanzania.

DESCRIPTION

The facility-based S&D-reduction package, developed under HP+'s predecessor, the Health Policy Project (HPP), is a suite of tools that addresses the drivers of S&D through assessment, staff training, and review and strengthening of facility policies and standards of practice. This systematic process is designed to measure and address the drivers and manifestations of S&D in a healthcare facility, ultimately impacting the HIV treatment cascade. The assessment portion also allows for an evaluation of the intervention activities.

Activities in all three countries include a baseline assessment, tailored facility-based S&D-reduction interventions, and end line assessment to evaluate progress and develop S&D-reduction plans based on the data collected. Government (national, regional, and facility-level) and client stakeholders are engaged in adapting the assessment tools, reviewing baseline data to develop feasible facility-level responses, adapting the training and facility administrators' tools and utilizing data to plan next steps for S&D reduction at facility, subnational, and national levels. Guided by USAID and country stakeholders, each country has a slightly different focus, demonstrating the versatility and adaptability of the package. Preliminary baseline data is anticipated in all three countries by October 2017, with end line data by March 2018.

In Tanzania, in addition to the primary focus on S&D within health facilities towards adults living with HIV, there is an additional focus on stigma towards adolescents and young adults living with HIV. HP+ and local implementing partners Muhimbili University of the Health and Allied Sciences (MUHAS) and Kimara Peer Educators and Health Promoters Trust Fund (Kimara Peers), along with the National AIDS Control Programme are adapting and implementing the package's components to reflect this additional focus. The package is being piloted in two district-level government facilities in Morogoro region.

In Ghana, HP+ and local partner, Educational Assessment and Research Centre (EARC), in collaboration with the Ghana AIDS Commission and the National AIDS control Programme are implementing the HPP package in five PEPFAR priority regions with a focus on people living with HIV, men who have sex with men (MSM), transgender individuals, and sex workers. This includes baseline data collection in 20 facilities, S&D-reduction interventions in one facility per region, and end line data collection in the intervention facilities plus one comparison facility per region. This activity is jointly funded by the Global Fund who are covering in-country costs for the baseline data collection and interventions. A specific focus of the Ghana work is a costing study of the pilot interventions to guide future efforts at scale up of interventions in Ghana and beyond.

In Jamaica, HP+ and MOH are implementing and evaluating the package initially in three health facilities, selected because they have received less training on S&D than others. The focus is on health facility staff S&D towards both people living with HIV and key populations stigma, in particular towards men who have sex with men, sex workers, and transgender individuals.

While the focus of these current HP+ efforts are on government health facilities, the model is adaptable to other institutional and community settings. Information gathered from these efforts will also provide insights for country and population specific differentiated models of care. Of note, the basis for this facility-focused work builds on earlier community-based S&D-reduction work.

30.6 GLOBAL: Project SOAR- Updating the PLHIV Stigma Index

TITLE OF THE PROGRAMME: Project SOAR- Updating the PLHIV Stigma Index

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- **Start Date of the Programme**: 2016
- **End Date of the Programme**: 2017
- **Responsible Parties**: Government
- **Populations Group(s) Reached**: People Living with HIV, key population

BACKGROUND INFORMATION

Stigma experienced by people living with HIV (PLHIV) has resulted in poor quality health care, coercion and violence, job loss, and exclusion from social gatherings. HIV-related stigma and discrimination is not only a human rights violation, but it also impedes people's ability to access HIV testing, care and treatment. Manifestations of stigma and discrimination have detrimental effects on the health and well-being of PLHIV.

Given its impact on the HIV epidemic, addressing stigma and discrimination is a high priority. To that end, the UN's 2016 High-Level Meeting on Ending AIDS included "Eliminating HIV-related discrimination" as one of three critical targets to achieve by 2020, along with reducing the number of newly infected people, and the number dying from AIDS-related illnesses to less than half a million people each.

BENEFICIARIES AND IMPLEMENTERS

- Project Partners: Project SOAR, GNP+, ICW, UNAIDS, USAID

GEOGRAPHIC LOCATION AND PROGRAMMATIC COVERAGE

- Global

DESCRIPTION

The Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planned Parenthood Federation (IPPF), and UNAIDS developed the People Living with HIV Stigma Index—a survey instrument—to provide evidence on stigma and discrimination that can be used to advocate for the rights of PLHIV. In keeping with the GIPA principle (greater involvement of people living with AIDS), the Stigma Index is both a data collection tool and an empowering intervention for both the interviewers collecting data and the interviewees who are often being asked to talk about their experiences of stigma for the first time.

RESULTS OF THE PROGRAMME

The Index was launched in 2008 and as of April 2016:

- 75,000 PLHIV from nearly 80 countries have been interviewed using the survey instrument.
- More than 1,600 PLHIV have been trained as interviewers.
- The Index has been translated into more than 50 languages. Implementation of the Index has strengthened networks of PLHIV and has led to improved services and policies that protect PLHIV in a variety of settings. For example, in Ukraine, data collected from the Stigma Index resulted in the All-Ukrainian HIV Network developing in “Project RESPECT” to educate health care providers at the primary and secondary levels to provide better services for PLHIV.

LESSONS LEARNED AND RECOMMENDATIONS

Since the Stigma Index was launched, there have been shifts in the HIV epidemic, growth in the evidence base on how different populations are affected by stigma, and changes in the global response to HIV—particularly given the recommendation of early initiation of treatment. These developments have highlighted the need to update and strengthen the Index so it is more relevant and useful as a measurement and advocacy tool.

In October 2015, Project SOAR established a small working group (SWG) with representatives from GNP+, ICW, UNAIDS, USAID, and several experts within and external to SOAR to begin the process of assessing, updating, and pilot testing a strengthened PLHIV Stigma Index. The SWG outlined a process for evaluating and updating the Stigma Index that would be transparent and incorporate as many perspectives as possible in the process.

CONCLUSIONS

KEY STEPS TO UPDATE STIGMA INDEX

Stakeholder consultation, April 2016

To begin the process, a two-day consultation was held in Washington, DC to develop recommendations for updating the Stigma Index and its implementation. The meeting brought together 42 people with direct experience implementing the Stigma Index, as well as donors, bilateral organizations, and researchers with expertise in stigma research or scale development. In preparation for the consultation, Project SOAR researchers reviewed 13 Stigma Index country reports and four regional reports that describe a range of experiences in using the Index. The emphasis of the desk review was to summarize how data from the Stigma Index has been used and to identify key issues to be discussed at the consultation. In parallel with the desk review, SOAR researchers interviewed 15 key informants who had been recommended by GNP+ to represent a mix of viewpoints, countries, settings, and experiences with the Stigma Index. Most key informants had been involved in implementing the Stigma Index in their countries and one was a regional UNAIDS advisor. Key informants were asked to share their opinions about what worked well and what could be improved about the survey instrument. Based on the desk review, key informant interviews, discussions at the consultation, and recommendations from the SWG, SOAR researchers revised the survey instrument. In particular, they strengthened the section that explored experiences in the health care setting. They also revised the Index to better capture the experiences of key populations, such as men who have sex with men, sex workers, people who inject drugs, and transgender individuals, who often experience multiple stigmas.

Questionnaire pre-test workshops, July 2016

The first draft of the updated Stigma Index was pretested at the AIDS 2016 Conference in Durban, South Africa. More than 60 people attended three workshops in which participants administered the survey instrument (or specific sections) to each other and provided their feedback. Participants felt that many aspects of the Index had improved, but that more work needed to be done to make the instrument shorter and to better capture resilience among PLHIV in the face of stigma.

Pilot-testing the updated questionnaire

SOAR developed a second draft of the survey instrument based on input from the workshops, as well as comments from an expanded group of external reviewers. This version is being pilot tested in several countries, including Senegal and Uganda. The purpose of the pilot is to test the revised Stigma Index among approximately 400 PLHIV in each setting, including with key populations. The SWG will review the pilot results, make recommendations for an adapted Index, and disseminate the study results and the final version of the Index to global PLHIV networks. The updated Index—referred to as Stigma Index 2.0—will be available in 2017. The revised tool will be used in upcoming data collection rounds of by national PLHIV networks.

31. GLOBAL FUND: Baseline assessments in 9 countries on human rights barriers in access to health services

TITLE OF THE PROGRAMME: Baseline assessments in 9 countries on human rights barriers in access to health services

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- **Responsible Parties:** Civil society, Government
- **Populations Group(s) Reached:** People living with HIV, Men who have sex with men, People who inject drugs, Prisoners, Sex Workers, Transgender, Migrants, refugees or internally displaced people
- **Has the programme been evaluated /assessed?** Yes

BACKGROUND INFORMATION

The Global Fund has joined with technical partners on a major strategic effort to expand programs to remove human rights barriers to health services in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3(c) of the Global Fund strategy, Investing to End Epidemics, 2017-2022, which commits the Global Fund to: "Introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services". Through this strengthened commitment, the Global Fund has recognized that such programs to remove human rights barriers are an essential means by which to increase the effectiveness of Global Fund grants, moving from human rights principles to practical and effective programmatic responses that support people to take up health services and remain on them, ensuring that no one is left behind in national responses to HIV, TB and malaria.

Toward these ends, the Global Fund has taken several steps in support of country efforts. It has aligned to the UNAIDS-recommended programs to reduce stigma and discrimination and increase access to justice; convened TB and malaria experts to define which human rights programs are effective in the context of those epidemics; issued guidance on the content and evidence of effectiveness of these programs; made it a requirement that all countries include them in their grant proposals; and selected 20 countries for intensive support to scale up these programs. Significantly, the Global Fund has also established a catalytic fund of 45 million dollars to which these 20 countries can apply if they match, on a one to one basis, the amount for human right programs requested in their grant proposals. Thus, the Global Fund is potentially making available 90 million dollars for concrete programs to remove human rights-related barriers to health services.

A first step in significantly scaling-up such programs for a comprehensive response to human rights-related barriers is to document such barriers through methods and tools applied consistently and gleaning comparative data. In the 20 countries in the cohort, baseline, mid-term and end-term assessments will be conducted to document barriers and progress to address them, existing programs in place to remove human rights-related barriers to service, and what does it take to make such programmatic efforts comprehensive. In 9 out of the 20 countries in the cohorts, baseline assessments have been conducted, documenting key

barriers that include stigma and discrimination; punitive laws and practices; and gender inequality, gender-based violence, poverty and inequality.

The objectives of these baseline assessments are: (a) to identify the key barriers to health services; (b) describe existing programs to reduce such barriers; (c) make recommendations regarding the coverage and costs of programs needed to address the barriers comprehensively; and (d) identify the opportunities to bring these to scale over the period of the Global Fund Strategy.

The methods for the baseline assessments have included: (a) desk reviews of relevant information and data, including secondary data analysis where possible; (b) telephonic contacts/interviews with key stakeholders to guide in-country qualitative data collection efforts; (c) in-country visits to conduct key informant interviews and focus group discussions; (d) in consultation with key stakeholders, development of recommendations for scale up of programs to remove barriers to health services.

Key findings of baseline assessments in 9 countries: stigma, discrimination and other human rights-related barriers to health services

All reports have identified stigma and discrimination, particularly in health-care settings, as a pervasive barrier affecting prevention, testing, treatment and care services across the 3 diseases. Various forms of discrimination in healthcare have been recorded through the qualitative data collection stage of the baseline assessments, as well as analysis of existing peer reviewed and grey literature. The key findings in the 9 countries where baseline assessment reports are available include:

1. While non-discrimination is explicitly embodied in national laws and policies, people living with or affected by HIV, TB or malaria are frequently experiencing entrenched stigma and discrimination. In Nepal, for example, people living with HIV have reported experiencing discrimination in health facilities, and some avoided treatment due to fear of mistreatment and prejudice, or violations of confidentiality, while others reported being ignored and judged by medical staff after sharing their HIV status.
2. Denial of healthcare, poorer quality of care, delays in provision of care, intolerant attitudes and denigratory treatment are forms of discrimination stemming out of stigma, poor knowledge among healthcare personnel, workplace environments that are not protective, lack of access to means of protection for healthcare staff. Lack of empowerment, poor knowledge of own rights, limited ability to access legal services and seek redress among people living or affected by HIV, TB and malaria further exacerbate these barriers keeping people away from health services. Some baseline assessments have identified that hospitals and clinics in some of the countries are reported to be experiencing insecure financing, imperfect workforce training and supervision, imperfect regulatory enforcement, and unforeseen costs and stock outs of equipment and supplies, which in turn impacts the quality of care provided.
3. Across the board, widespread lack of confidentiality has been reported. Disclosure of health status within and outside health facilities occurs without the consent of people affected by the 3 diseases, and leads to extreme forms of isolation, stigma and discrimination within the community, education settings and workplace. Discrimination and other human rights violations in healthcare settings hence trigger a ripple effect, across all spheres of life, in turn discouraging people from seeking access to health services, including diagnosis. Confidentiality and privacy are critical challenges in facilities that are generally overcrowded and lack adequate infrastructure. Consequently, for example, patients may lack a private space within which to discuss their health concerns. Whilst this is a problem for everyone, it presents a greater barrier for key populations such as FSW, PWID, prisoners and MSM who already fear discussing their sexuality or sexual behaviour due to stigma.

4. Compounded stigma and discrimination is experienced by key populations across the 9 countries where the baseline assessments have been carried out, due to moral judgements, intolerance, misconceptions, criminalization and/or exclusion of such populations. A recent study in Ghana with health providers in Kumasi and Accra found notable levels of stigmatizing behavior: 37% of service providers reported always hearing their colleagues make derogatory remarks about key populations. Even where a specific key population, as men having sex with men, is not criminalized, there are high levels of stigma, discrimination and homophobia, affecting access to, adherence to and trust in healthcare and in turn, impacting coverage with health services and quality of life. Key populations frequently prefer to not disclose to healthcare providers their social identities or specific health needs associated to being part of a respective key population group. However, mere assumption of association with a key population group may lead to increased experiences of stigma, discrimination and other barriers to health services. For example, in Cameroon, only 8% of the sample of men having sex with men in a survey had disclosed their sexual orientation to healthcare providers; however, of the overall study sample, 5% had been denied HIV or other sexual and reproductive services and 8% mistreated. When men who have sex with men do access HIV services, they report many forms of discrimination in health care facilities throughout their testing and treatment process, as seen from a recent study in Indonesia.
5. Where health services are not tailored to the specific needs of key and vulnerable populations, or where prior history of stigma and discrimination in healthcare exists, key and vulnerable populations reported being more likely to delay seeking healthcare until diseases are advanced, and positive treatment outcomes are less likely.
6. The location and population divide has been documented in all 9 baseline assessments, with certain populations underrepresented in existing health services, and some locations, particularly rural areas, presenting more extreme manifestations of barriers and less actions to address them. In the same time, there are locations where certain key and vulnerable populations tend to be overrepresented or congregate, including prisons, but few services or programs to remove human rights-related barriers to care are available in such locations. Migrants, particularly undocumented migrants, continue to face many challenges in accessing health services even in locations where such exist.

Key existing programs to train healthcare providers in human rights and medical ethics, and other efforts to reduce discrimination in healthcare

In all countries where baseline assessments have been conducted, there are some efforts to begin addressing human rights-related barriers to services, but most of these are sporadic, one-off, and lack funding for being taken to scale. However, there seems to be buy-in among key national stakeholders of the need to undertake concerted efforts to address such human rights-related barriers to services. Some existing programs addressing stigma and discrimination in healthcare include:

- a. Capacity building for healthcare providers, those at primary healthcare level as well as those involved in secondary, tertiary and disease-specific care, has been identified as an important contributor to reducing stigma and discrimination and other human rights-related barriers to care. Institutionalization in pre-service and in-service training programs seem to be effective in reaching larger numbers of healthcare providers in a more sustained manner. In Mozambique, the ministry of Health (MISAU) has developed a guideline for the provision of HIV and other health services for key populations. It includes components addressing professionalism and non-discrimination in the provision of services. The improvement of quality of care, as well as the accessibility and reliability of care was addressed in the Saath-Saath Project in

Nepal, implemented by Family Health International that worked to improve health for key populations including female sex workers and their clients, transgender sex workers, migrant workers and their spouses, and people living with HIV. HIV-specific training and counselling for healthcare workers positively influenced their ability to work with and treat people living with HIV and limit the stigma these patients faced in their routine healthcare. In Benin, Project SIDA had worked to develop 'user-friendly' services for key populations, while UNFPA supported capacity building on human rights-based approaches to midwifery. ILO Cameroon has provided support to the Government of Cameroon through its "Zero@Work" campaign aiming at reducing stigma and discrimination in the work place. As part of the project, medical staff of 4 health facilities was trained to protect the rights of workers living with HIV, and 54 staff of the labour inspection division of the Ministry of Labour were trained in 4 regions on documenting human rights violations on the work place. CAMNAFAW has trained 240 healthcare workers on confidentiality and on stigma and discrimination-free services for MSM and FSW. A code of good conduct is currently being developed to augment the training and to be adopted by participants once the training has finished.

- b. Civil society and communities empowerment and meaningful participation have been referred to as important contributors to effective advocacy for the reduction of human rights-related barriers to services. In Kyrgyzstan, for example, some key informants believe problems related to violence and hostility towards key populations has come about partly from the lack of emphasis on human rights issues and reduction in funding to the NGO sector in recent years. Multi-disciplinary teams involving peer counsellors in Kyrgyzstan, or 'models of hope' peer case managers in Ghana, have been identified as other such examples of promising effects of community involvement on reducing human rights-related barriers to services.
- c. Rights and legal literacy, and access to legal services for key and vulnerable populations, are important corollary programs to efforts to build human rights competences of healthcare providers. Results related to reducing discrimination in healthcare are perceived to be better where users of health services who have encountered discrimination are aware of their rights, have access to a network of support and legal services, and are able to challenge such human rights-related barriers to services. In Nepal, an intervention on comprehensive and culturally applicable empowerment sessions that focused on autonomy, community activism, self-esteem/efficacy, self-care, optimism and control over the future, management of stress and anger, and human and health rights was assessed and found to be effective at improving quality of life, with overall decrease in stigma and discrimination after the intervention.
- d. Stronger push for accountability, including through civil society engagement with human rights mechanisms, has been attested as effective contributions to addressing stigma and discrimination in healthcare. Community Advisory Boards with the Office of the Ombudsman and within the health systems are perceived by respondents in Kyrgyzstan as important mechanisms for better engagement and partnership in addressing such human rights-related barriers to care, as well as for ensuring community monitoring and accountability. In Mozambique, Namati has developed a network of grass-root advocates monitoring the provision of health services in communities. These advocates are trained in the country's health-related laws and policies and in additional skills such as mediation, adult education, and advocacy. The advocates provide ways that individuals, including PLHIV and members of key populations, can raise problems with health care service delivery in communities and can mediate ways of addressing them through problem-solving dialogues and other means.

Key next steps

In the twenty-country effort, the goal is to move from small scale, ad hoc investments to comprehensive programs to reduce human rights-related barriers, which are defined as having the right programs delivered in the right places for the right people, at the right scale. The baseline assessments will assist the countries to identify the human rights-related barriers, assess the level of existing responses and work toward comprehensive responses. They will also comprise a baseline against which to measure the effectiveness of increased investment in programs to remove human rights-related barriers.

Key recommendations for a programmatic response to address stigma and discrimination in healthcare settings, stemming from baseline assessments, include:

- Human rights competences among healthcare providers need to be built and knowledge of medical ethics instilled through institutionalization into existing avenues of pre- and in-service training. E-learning and other innovative capacity building delivery need to be explored fully to reach a critical mass of healthcare providers aware of their human rights, their obligations, medical ethics, and patient-centered service delivery modalities.
- Capacity building endeavours need to target healthcare facilities beyond providers of healthcare; gate keepers as receptionists, guardians, as well as managers and administration of health facilities are important allies in provision on non-discriminatory respectful healthcare.
- Users of healthcare services that know their rights and are empowered to act to pre-empt discrimination or seek redress where their rights have been violated are important precursors of non-discrimination in healthcare. Programmatic efforts aimed at enhancing access to legal services, mechanisms of redress and to justice need to be built in efforts to address discrimination in healthcare.
- Efforts to address discrimination in healthcare cannot happen in isolation. Other human rights-related barriers to health services need to be fully considered, be they legal and policy barriers, or violence and harassment from law enforcement, or gender-related discrimination and violence, or poverty, isolation and marginalization. Comprehensive efforts are needed to eradicate human rights-related barriers to health services and achieve healthy lives for all.
- In the first half of 2018, multi-stakeholder meetings will be held in each of the 20 countries and 5-year plans to reduce human rights barriers will be developed to serve as a frame for joint efforts by national stakeholders to mobilize resources and implement in a concerted manner comprehensive programs to remove human rights-related barriers. The 5-year effort will be monitored and evaluated with follow up studies at mid and end points.
- The Global Fund is working with countries, technical partners and other possible donors to attain the highest possible investment in programs to reduce human rights barriers to services. This is ground-breaking work not only in the degree to which it moves human rights from principles to programs but also in the levels of support provided to make human rights an integral and pragmatic response to health challenges.