Global Fund Breaking Down Barriers Initiative

Summary of Key Findings of the Baseline Assessments in 20 Countries

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Disclaimer

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

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1. Introduction

As part of its strategy *Investing to End Epidemics, 2017-2022*, the Global Fund to Fight AIDS, TB and Malaria has joined with country stakeholders, technical partners and other donors in efforts to expand investment in programs to remove human rights-related barriers to HIV, TB and malaria services. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. Strategic Objective 3 of the strategy commits the Global Fund to "introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services".[1]

As part of attaining that objective, the Global Fund has undertaken an ambitious initiative, *Breaking Down Barriers*, to dramatically scale up programs to remove human rights-related barriers to HIV, TB and malaria services. Through *Breaking Down Barriers*, the Global Fund is providing intensive support to 20 countries[2] where needs, opportunities, capacities and partnerships provide real possibilities for scale-up that will result in important gains for the health of those affected. This support has taken the forms of: (a) provision of significant additional, so called matching funds for programs to remove human rights-related barriers; (b) implementation of baseline assessments of such barriers and existing programs to reduce them; (c) multi-stakeholder meetings in country to review the baseline assessments and develop and fund jointly a comprehensive national response to the barriers; (d) support in the development of multi-year, country-owned plans or strategies to reduce human rights-related barriers to services; and (e) follow-up studies to assess impact of scale-up.

The 20 countries in the initiative range across Global Fund regions and include high impact countries, challenging operating environments, countries nearing transition, countries with concentrated epidemics, and countries that are part of efforts to scale up programs for women and girls and address gender-related barriers to services. A list of the countries and the disease focus of the baseline assessments in each one is found in the Table provided below.

The purpose of this paper is to summarize the results of the baseline assessments that were conducted in 19 of the 20 countries from 2017 to 2019 (the Kenya assessment is expected to be finalized soon) and provided the basis for further planning and implementation of comprehensive responses to human rights-related barriers to HIV, TB and malaria services.

2. Objectives and Methods of the Baseline Assessments

The objectives of the baseline assessment were to:

- Identify the key human rights-related barriers to HIV, and in some cases TB and malaria services in each country (see Table below)
- Describe recent or existing programmes to reduce such barriers, among other things, to provide a reference point against which the impact of scaled-up programs can be measured at later stages
- Indicate what a comprehensive response to existing barriers would comprise in terms of the types of programmes, their coverage and costs; and
- Identify the opportunities to bring these to scale over the period of the Global Fund's 2017-2022 strategy.

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

[2] Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda, Ukraine.

Human rights-related barriers to health services encompass a wide range of factors. To guide the assessments, the Global Fund stipulated that the baseline studies focus particularly on categories of barriers that have been demonstrated empirically to be important in undermining access to services, particularly for HIV and TB. These include:

- Stigma and discrimination, including that based on health status or disability, as well as based on social or legal status, age, gender, sexual orientation and gender identity, engagement in sex work or drug use, and immigration/refugee status.
- Gender inequality and gender-based violence
- Punitive policies, practices, laws and law enforcement that may undermine access to health services; and
- Poverty and economic and social inequality that increase health risks.

In outlining the program areas that should be the focus of the baseline studies, the Global Fund aligned itself with countries and partners (for HIV, UNAIDS and governments in terms of programs which countries committed to implement in the *Political Declarations on HIV and AIDS, 2011 and 2016*, and for TB and malaria, consultations with the TB and malaria experts and communities)[3]. For HIV, these program areas comprise:

- Programs to reduce HIV-related stigma and discrimination
- Programs to train health care workers on human rights and ethics related to HIV
- Programs to sensitize lawmakers and law enforcement agents
- Programs to provide legal literacy ("know your rights")
- Programs to provide HIV-related legal services
- Programs to monitor and reform laws, regulations and policies related to HIV, and
- Programs to reduce discrimination against women and girls in the context of HIV.

For tuberculosis, the program areas guiding the assessment include the seven programs noted above for HIV. These are also deemed relevant in reducing human rights-related barriers to TB services: Other programs relevant to TB include:

- Programs that protect confidentiality and privacy in TB services
- Programs that mobilize and empower TB patient and community groups, and
- Programs to improve TB services in prisons and other closed settings.

For malaria, which is an area in which human rights-based barriers are only beginning to be studied and understood, program areas included, at the time of the baseline assessments:

- Assessing and addressing gender-related barriers to services
- Programs to reduce barriers faced by refugees, migrants and other mobile populations strengthening community participation and participation of affected persons in service delivery; and
- Improving services in prisons and closed settings.

[3] *Seven Key Programmes to Address Stigma and Discrimination and Increase Access to Justice,* UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also *Political Declarations on HIV/AIDS*, 2011 and 2016. For TB and malaria, see the Global Fund Technical Briefs on Human Rights, TB and Malaria

The Global Fund selected, through a competitive process, four research groups to conduct the baseline assessments.[4] These research groups comprised academic experts, research-oriented NGOs and consulting firms. Each group worked in a subset of countries for which it had experience, contacts and language expertise. A steering group of independent experts was convened to advise on methods and procedures for the assessments. Members of the steering group, the four research teams and Global Fund staff met in November 2016 to agree on the main lines of methods and enquiry for the baseline assessments to ensure as much comparability as possible.

As of end 2019, baseline assessments have been conducted in all 20 countries in the *Breaking Down Barriers* initiative (in Kenya, the report of the baseline assessment is being finalized and has not yet been disseminated). It was decided that assessments would investigate HIV-related barriers and programs in all 20 countries, would assess TB-related barriers in 13 countries, and would assess malaria-related barriers in 2 countries. See Table 1 for the disease focus of each assessment. The methods used in all assessments were as follows:

- Desk review of scholarly and "grey" literature, including NGO and government reports, on human rights-related barriers to health services and existing programs to remove such barriers. Desk reviews often included telephone contacts and telephone interviews with key stakeholders in the country
- Preparation of in-country visits, including obtaining, where needed, ethics approval for the assessment, contacting and engaging local collaborators, and adapting the data collection tools to ensure that context-specific information would be captured
- An in-country inception meeting to present the plan for the assessment to key stakeholders which comprise representatives from the Country Coordinating Mechanisms (CCM), government, NGOs/CBOs, technical partner representatives, academic experts, local members of the assessment team, representatives of key and vulnerable populations, and
- In-country data collection by the research team, which in most cases involved about two weeks in the country conducting key informant interviews and focus group discussions, including with members of key and vulnerable populations, program managers, policy-makers, technical partners and donor representatives. The in-country period included a debriefing meeting with key stakeholders to give a general report on the data collection activities.

3. Data Analysis and Preparation of Assessment Reports

Baseline assessment reports used a standard format combining information from both the desk review and the in-country data collection. All reports include an executive summary, an introduction and description of methods, and for each disease a section on the nature of the epidemic and key affected populations; the nature and severity of human rights-related barriers to health services for that disease, including policy-level and legislative barriers; recent and/or existing programs to address human rights-related barriers to services, including an estimate of the costs associated with those programs; and a proposed five-year, scaled-up, costed comprehensive response to reduce the identified barriers. For this purpose, a comprehensive response is defined as programs that:

a) Comprise a set of activities that are internationally recognized as effective in reducing human rights-related barriers to health;

[4] The four research groups were: (1) APMG - AIDS Project Management Group; (2) HEARD - Health Economics and AIDS Research Division, University of KwaZulu Natal; (3) the ICRW Consortium - Enda Santé; International Center for Research on Women; Jamaica AIDS Support for Life; Johns Hopkins University; and (4) the JSI/USC Consortium - John Snow, Inc.; Program on Global Health and Human Rights University of Southern California

b) Are accessible or serve the majority of the estimated numbers of key and vulnerable populations affected by such barriers; and

c) Are adequately resourced to move from non-existence or one-off/small-scale activities to a level of implementation likely to significantly reduce human rights-related barriers to services (a sustained, mutually-reinforcing, broadly protective package at scale).[5]

Cost estimations undertaken by the baseline assessment teams were both retrospective and prospective according to a method agreed to by the research teams and the steering group. Cost estimates of past and current programs and of the proposed comprehensive response were based on real program costs in each country to the degree that these could be provided by program managers and/or donors.

The baseline assessments were also conducted according to human rights principles. Key affected populations participated meaningfully in the in-country data collection and in ways that respected their confidentiality and endeavoured not to expose them to any security threats. All respondents gave informed consent to participate in the assessment.

4. Findings of the Baseline Assessments

Cross-cutting findings

Over the years there have been other assessments of human rights-related barriers to health services, especially with regard to HIV and TB, but the baseline assessments brought together for the first time critical data on all of the following elements:

- Nature, scope and severity of human rights-related barriers to relevant health services
- Populations most affected by these barriers
- Scope, cost and quality of existing programs meant to reduce these barriers
- Capacity of CCMs, government ministries, civil society, and technical partners to support implementation of programs to remove barriers; and
- Content and estimated costs of a possible comprehensive response to the barriers.

Though the 20 countries in the *Breaking Down Barriers* initiative represent all Global Fund regions and different social and political contexts, many of the baseline assessments studies share a number of observations and conclusions as follows:

4.1 Barriers to health services are many and severe.

In spite of the considerable attention that has been paid to human rights-related barriers related to HIV services for several decades, all of the baseline studies reported deeply entrenched human rights-related barriers in all of the categories of barriers outlined by the Global Fund. Stigma and discrimination related to both HIV and TB are reported to be prevalent in health services, employment, education and other domains, even where there are laws protecting people from HIV-related discrimination. Moral judgments and harsh laws are reported to contribute to discrimination and exclusion faced by people who use drugs, sex workers, LGBT people, prisoners and former prisoners. Police practices are reported to be harsh toward key populations in nearly all of the 20 countries, whether it be abuse of men who have sex with men in police custody (e.g. in Tunisia, Cameroon and Senegal), or appropriation and use of condoms as evidence against sex workers (e.g. in Jamaica). Members of key populations fear seeking health services and are reported in many countries to have few means of access to justice. Gender inequality is a constant in the

[5] This definition of "comprehensive" was developed in consultation with the Global Fund Technical Working Group on Human Rights and Monitoring and Evaluation. Paper available on request from the Global Fund.

countries subject to the baseline assessments, and about half of them discuss both subordination of women and girls that increases their vulnerability to infection, as well as intransigent norms of masculinity that encourage risky sexual behaviors among men and boys and discourage them from seeking health services. Several reports, (e.g. Cameroon), observed that the National Strategic Plan for HIV or TB had human rights language and implied human rights commitments, but these were not adequately budgeted for or made concrete through implemented programs. The Cameroon assessment was also one of several noting that constant pressure to attain the 90-90-90 HIV goals articulated by UNAIDS was not well understood by health workers as something requiring attention to human rights-related barriers.

4.2 There is high intersectionality of barriers to health services.

Most of the baseline assessments highlighted the inter-relatedness of barriers faced by many of those most excluded from HIV and TB services. For example, women face gender-related discrimination, violence and disempowerment; women who use drugs face those barriers, as well as police abuse, moral judgment, incarceration, loss of custody of children and other barriers to health and social services linked to both drug use and gender. Living in poverty was reported to intersect with and exacerbate many forms of exclusion and discrimination, and impeded not only access to health services but also to legal services and to mechanisms of complaint and redress. Discrimination and exclusion related to mental illness and physicial disabilities were also noted as adding to the range of abuses faced by people living with HIV and with TB, as well as members of other key populations. The intersectionality of human rights-related barriers led to recommendations in a number of baseline assessments for establishing or strengthening community-based monitoring of a wide range of barriers faced by key populations.

4.3 Programs to address human rights-related barriers exist but are small, inadequately supported, not coordinated and not evaluated.

Virtually all the assessments found that, at the time the assessments were undertaken, programs existed in all seven of the program areas relevant to removing human rights-related barriers to HIV services. It is striking that even in challenging operating environments, such as the Democratic Republic of Congo, there were programs in all seven areas. But at the time the assessments were undertaken, the programs were generally not sufficiently supported in terms of funding and local capacity, were not at a scale that makes a significant difference, and otherwise lacked the scope to reach the populations who need them.

Furthermore, programs that existed at the time of the assessment appeared to have been implemented in an *ad hoc* fashion largely dependent on available funding and the interests, capacity and objectives of national and local NGOs and CBOs who implement the programs. Though impressive work was being done in many countries, there were also many situations where the programs were not coordinated with each other and were not strategic. Further, many were based in (capital) cities without existing in other parts of the country. The result was significant gaps in coverage of key populations, as well as duplication where programs with similar objectives and target populations were implemented side by side in overlapping fashion. The passage below from the baseline assessment of Mozambique captures themes raised in almost all of the assessments:

For the most part, [programs to address human rights-related barriers] are not well coordinated, are of limited scale and duration, are insufficiently funded and are not routinely evaluated. The needs of certain key populations are not effectively addressed at all….Furthermore, there is need for greater human rights capacity in government and the NGO and community sector to do longer-term planning and implement well-coordinated, multi-year actions to bring about sustained change in knowledge, attitudes, perceptions and practices regarding human rights-related barriers to

services experienced by key and vulnerable populations. Significant and sustained investment of technical and financial resources is needed to ensure that the approach can be fully implemented.[6]

4.4 Programs to remove human rights-related barriers to services are not sufficiently integrated into or linked to the prevention, treatment and key population programming they are meant to support.

Though the baseline assessments showed that programs to remove barriers to services exist as described above, findings did not indicate that they had been planned and implemented strategically so as to most effectively remove the barriers to existing prevention, treatment and key population programming. This would require the programs to "follow" the national prevention and treatment strategies in that they are rolled out as part of those strategies so as to benefit the same populations that are meant to benefit from prevention, treatment and retention efforts. This would further involve that particular interventions are integrated, where possible, into prevention, treatment and retention programs, e.g. a cohort of community health outreach workers are trained as peer human rights educators or paralegal; key population programming includes legal literacy and community monitoring components; human rights, medical ethics and patients' rights materials are included where health care workers are trained in the latest on provision of treatment. Where there are insufficient prevention and treatment for excluded populations, the programs to remove barriers to services should be designed to overcome that exclusion by empowering excluded populations to know their rights and mobilize and advocate around them, and by changing laws and policies that result in exclusion. The baseline assessments did not show these kinds of linkages, integration or sufficient attention to overcoming exclusion.

4.5 Capacity of and support for key population-led organizations is insufficient.

It is a consistent theme in the baseline assessments that to bring to scale and sustain programs to reduce human rights-related barriers in many settings it is necessary that organizations led by key populations themselves be meaningfully involved in service delivery. But, as noted in many of the assessments, key population-led organizations often have the poorest access to sustained funding, particularly core funding, and their activities are often hampered by social marginalization and inappropriate criminalization of their staff and those they serve. Like other community-based organizations, they are often in need of building their capacity for program management, design, implementation, monitoring and evaluation, in addition to their capacity for mobilization and policy advocacy. A number of suggestions were made to address these needs, including working with all donors to raise awareness of the need for sustained funding for key population organizations, ensuring that key populations are both represented and listened to in CCMs, and even, in the case of Kyrgyzstan, encouraging key population members to stand for elected office. It is clear from the baseline assessments that finding systematic ways to provide technical and management assistance and sustained funding to key population groups will be central to reducing human rights-related barriers to services in a comprehensive way.

4.6 There is need for adequate support to and roll out of increased monitoring and evaluation efforts.

Related to the previous point but not exclusive to key population-led organizations, the majority of baseline assessments stressed the need for better and more systematic monitoring and evaluation of programs to reduce human rights-related barriers. The assessment reports note that the lack of rigorous evaluation of such programs is an impediment to securing sustained funding and to scaling up activities. Evaluations that link activities to reduce human rights-related barriers to quantitative evidence on uptake of and adherence to prevention and treatment services are urgently needed, according to the baseline assessments. Almost all of the assessments called for regular repeated administration of the HIV Stigma Index, which has become something of a

[6] See Baseline Assessment for Mozambique, available at https://www.theglobalfund.org/en/human-rights/

standard tool for evaluation of stigma reduction efforts and situation analysis. The regular implementation of more such tools is needed.

4.7 Costs for comprehensive programs are not being met.

For most of the 20 countries, the estimated annual costs of comprehensive programs to remove human-rights barriers to HIV services was from 2 to 12 times more than the estimated costs of such programs existing in a recent year. For TB, the disparity was even greater, because in some cases, there were no existing programs to reduce human rights-related barriers to TB services. Though the *Breaking Down Barriers* initiative has resulted in significantly increased funding for these programs, it is not yet clear that there is sufficient funding for fully comprehensive national response to the barriers.

4.8 The range of donors available to support programs is limited.

In many of the countries in the *Breaking Down Barriers* initiative, the Global Fund, through the main allocations of its grants, was the principal supporter of programs to reduce human rights-related barriers to health services. In the last funding cycle, the Global Fund increased its support for these programs through additional funding in the form of so-called matching funds. The baseline assessments indicate that other donors have been involved in supporting programs but not to the degree necessary to reach a comprehensive response to human right-related barriers at national level. The baseline assessments catalogue donors in addition to the Global Fund that have supported these programs. These comprise UN agencies, the Stop TB Partnership, USAID and PEPFAR (including through the *Linkages* project now ended), the bilateral assistance agencies of France and Germany among others, Frontline AIDS, the Open Society Foundations, Mac AIDS, Comic Relief, the Elton John Foundation, and a wide range of donors supporting programs for adolescent girls and young women. The lists of donors compiled in the baseline assessments are useful for follow-up mobilization of donors interested in supporting the scale-up to comprehensive levels of programs to reduce human rights-related barriers.

5. Findings Related to Particular Program Areas

In addition to the cross-cutting themes described above, the baseline assessments provided a number of observations about particular program areas. Among these are the following:

5.1 One-off activities are inadequate to lead to sustained change or to create local cadres of expertise.

Many of the assessments concluded that there had been several one-off trainings of health workers, police, corrections officers and other service providers on the importance of human rights and ethics in their service provision, but such trainings alone were seen by key populations and others as inadequate to change attitudes and practices. Further baseline assessments reported development, printing and dissemination of human rights materials with little effect. The majority of the assessments recommend both regular in-service human rights training as well as pre-service human rights training as a regular part of the curricula of medical and nursing schools, schools training other health professionals, police academies and other such institutions. Other ideas to make training more meaningful were also offered, such as repeated surveys of police and health worker knowledge, attitude and practices; development of professional standards and complaints procedures; monitoring certain practices of service providers as part of performance evaluation; ensuring that high-level persons and members of management in the service professions speak out and exemplify respectful practices; and community-based monitoring of provision of services. The report from South Africa noted the importance for the national HIV response of the completion and enforcement of a professional code of ethics for policing “based on international norms and standards”.

In addition to adequately training professionals to provide rights based serve provision, baseline assessments further noted that the training, management and remuneration of peer human rights educators, paralegals and community monitors would go a long way toward the creation of cadres of local expertise that could be built upon and could sustain change.

5.2 There is lack of sufficient attention to barriers in prisons and other closed settings.

Perhaps more than other assessments in the past, the baseline assessments highlighted the deep insufficiency and poor quality of HIV and TB services in prisons, pretrial detention, police lock-up and other closed settings. Several of the reports, including those from Ukraine, Kyrgyzstan, Tunisia and the Philippines, noted the urgent need for reform of policies related to the overuse of pretrial detention in order to address overcrowding in prisons, which is a direct risk factor for TB and undermines the provision of prevention and treatment services for all diseases. In Ukraine, it was also reported that health policies and regulations do not provide a clear basis for a government responsibility for HIV and TB treatment in prison. Several reports highlighted the continued failure to provide condoms to people in prison and pretrial detention. Several also noted the systematic abuses, including violence, faced by men who have sex with men and transgender persons in prison, particularly when the latter are not housed according to their gender preference.

5.3 Members of key populations do not have sufficient access to justice.

Virtually all of the reports underscored the profound need for programs to improve access to justice for key populations, including access to legal or paralegal services. In virtually all cases, there are free or subsidized legal aid services of some kind in these countries. But almost all of the reports conclude that legal assistance from qualified lawyers is inadequate to meet demand among people living with or vulnerable to HIV or TB who face discrimination and other abuses. Generally underfunded and weak justice systems were reported to exacerbate this problem in several countries. Some of the baseline assessments suggest ways to motivate more lawyers to be interested in HIV and TB issues or ways to optimize access to a few lawyers, such as the use of mobile legal clinics (as in the Philippines). Perhaps more importantly given the costs of lawyers, several of the assessments recount strategies that rely on peer or community paralegals, or even just people who accompany others to tribunals or other processes, and other approaches that do not depend on access to lawyers. The NGO Namati in Mozambique, as noted in the baseline assessment, uses a combined strategy of supporting community-based monitors who document harmful health practices and work with village health committees to ensure that users of health services know their rights and interact effectively with health authorities. Often community structures can change practices and obtain redress for rights violations even without recourse to formal legal assistance. In other countries, efforts to train a critical number of members of key populations as peer paralegals and peer human rights educators have also borne fruit.

5.4 Gender inequality and gender-based violence that lead to vulnerability to HIV, TB and malaria are not being sufficiently addressed.

While there are national strategies and programs to combat gender-based violence (GBV) in virtually all of the 20 countries, many of the baseline reports concluded that GBV efforts are not adequately linked to HIV services or well understood to be part of improving access to health services. GBV policies and programs were also frequently judged in the baseline assessments to be grossly underfunded, small in scale, and poorly, or not at all, evaluated. GBV programs were noted in several countries to exclude sex workers, women and girls who use drugs, and transgender people. There are a number of programs for adolescent girls and young women in most of the 20 countries, though rarely any that target young people who are also members of key populations. As already noted, programs to address norms of masculinity that put men at increased risk and also undergird violence, risky sexual practices and disempowering attitudes toward women and girls were judged to require substantially more support.

5.5 There is insufficient attention to and understanding of human rights-related barriers to TB services.

A major contribution of the baseline assessments is describing unrecognized human rights barriers to TB services, including stigma based on unscientific ideas about TB, the failure of many countries to provide basic TB protections in risky workplaces, and the inadequate coordination of HIV and TB services for those living with or at risk of coinfection. The baseline assessments also reported an emerging interest in gender issues relevant to TB, some of which are related to gender-linked workplace risks for miners, construction workers and other professions likely to be occupied by men. Another such issue involves the stigma TB-affected women face from the belief that a woman who has had TB cannot bear children or is unhygienic, as reported in a few countries. The lack of support for TB-oriented NGOs and patient groups to increase their capacity to recognize and address human rights-related barriers to TB services is noted in several reports. The proposed comprehensive responses to human rights-related barriers to TB services in the baseline reports are the first such proposals made for multiple countries.

5.6 The understanding of human rights-related barriers to malaria services is in its earliest phase.

The study of human rights-related barriers to malaria services has not been pursued as it has in the case with HIV and to a lesser degree with TB. It is not surprising that the few baseline assessments to investigate malaria found that human rights thinking among practitioners and affected communities is not well established or clear. But the assessments helped to open some discussion, as in Uganda, about barriers faced by women because of lack of decision-making power or control of resources in the household, for example, or the types of exclusion faced by mobile populations and migrants in some parts of the country that increased their vulnerability to malaria. Strategies to improve opportunities for meaningful participation of affected communities in decision-making about malaria service provision can build on lessons from human rights-related work in TB and HIV. As noted in the Uganda baseline report, the new tool called the Malaria Matchbox, developed with Global Fund support, will be useful as countries seek to assess social and human rights-related determinants of access to malaria prevention, diagnosis and care.

6. Limitations of the Baseline Assessments

The baseline studies were necessarily rapid assessments, limited to relatively short periods of data collection in-country. As a result, the baseline research teams often could not reach all key and vulnerable population groups and representatives and other stakeholders with whom they wished to interact. In some countries, it was possible to complement the in-country assessment with phone calls and email exchanges, but this was not always the case. In addition, some members of key populations may have feared speaking out because of the prospect of repressive policing or criminal sanctions. In some countries, it was possible to visit stakeholders only in a relatively small number of locations. The baseline assessment explain the selection of locations, often focusing on high-impact areas for the three diseases or the places where key population groups were present, but this selectivity necessarily excluded some locations and populations of interest.

In the early phase of the *Breaking Down Barriers* initiative, it was intended that the baseline assessments would be completed in time to inform the countries' proposals for the additional funding available through the initiative. Unfortunately, in a few countries, the baseline studies were delayed, and the matching fund proposals did not benefit from their analysis. In some cases, delays were caused by having to wait for ethics approval for the assessments.

Cost estimations were reported by the baseline assessment teams to be particularly difficult. In many cases, program managers did not have good information on fixed and variable costs of programs and could not project what it would cost to scale up their activities. Even programs that had been evaluated with some rigor often did not have good information on costs or cost-

effectiveness. The baseline teams note that their projections of the costs of a five-year comprehensive program to reduce barriers are in some cases not sufficiently aligned with costs of existing programs.

A common challenge on data is well described in the South Africa baseline report:
There is a large gap in current and comprehensive quantitative data on a number of the human rights and gender-related barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.[7]

The assessment teams could rely in very few cases on credible data from rigorous evaluations or key population surveys. It was unfortunately often necessary to rely on anecdotal accounts, though much good information was gleaned in spite of these constraints.

7. Conclusion

The baseline assessments in the 20 countries of the *Breaking Down Barriers* initiative are an important source of new and practical programmatic information on human rights-related barriers to HIV, TB and malaria services; the populations affected by them; recent or current programs to address these barriers; and ways in which all 20 countries could realistically consider mounting a comprehensive response to reduce these barriers. In most countries, the baseline assessments informed the development of proposals for the catalytic human rights funding that is part of the initiative. In all countries, the baseline results have helped to shape subsequent discussions among all stakeholders of strategies and actions for developing a scaled-up, comprehensive response to human rights-related barriers to health services.

[7] South Africa baseline report, available at https://www.theglobalfund.org/en/human-rights/