Achieving Quality in Programs to Remove Human Rights- and Gender-Related Barriers to HIV, TB and Malaria Services

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This short guidance summarizes the necessary considerations to achieve quality as countries implement programs to remove human rights- and gender-related barriers to health services (hereafter referred to as "programs") in their national responses. It focuses on removing barriers to HIV, TB and malaria services, as supported by the Global Fund. However, given the COVID-19 pandemic, it also refers to issues that may be relevant in that context. (For more complete guidance on human rights and COVID 19, please see the COVID-19 Guidance Note: Human Rights in the Times of COVID-19[1]).

What you need to consider to achieve quality programming

- Remove human rights- and gender-related barriers to services that follow and support the national plan and strategy, as well as clearly identify the barriers the programs seek to remove.
- Use a population-centered approach to better understand and address the barriers.
- Develop a theory of change that clearly spells out which particular program will help remove which identified barrier.
- Integrate human rights programs/interventions into services involving prevention, testing, treatment and care, key population programming, community system strengthening and the Resilient and Sustainable Systems for Health (RSSH) response, and as relevant, COVID-19 programming.
- Combine a number of human rights programs strategically for greater impact.
- Avoid one-off activities.
- Build human rights capacity and sustainability in government, among service providers, CBOs and community-led organizations, as well as among key and vulnerable populations.
- Leverage and fund local human rights capacity and expand good existing programs.
- Ensure that all programs are gender-responsive.
- Address safety and security issues faced by community implementers and community members.
- Build in monitoring and evaluation to measure barriers and their impact, as well as programs and their impact.

[1] https://www.theglobalfund.org/media/9538/covid19_humanrights_guidancenote_en.pdf

1. **Make programs support and follow the National Plan/strategy and the prevention, treatment, key population programming, and as necessary COVID-19 programming, addressing the barriers to these services.**
   a. Have a Theory of Change (ToC), e.g. – "with these programs, we will be able to remove these barriers to these services for these populations".
   b. The ToC can and should be based on the priorities (prevention and treatment services, key and vulnerable populations) that are already outlined in the National Strategy or investment case and/or COVID-19 response plan.
   c. It is important to: (i) identify which populations are not accessing sufficient prevention and treatment services, including those related to COVID-19, (ii) identify the most common human rights-related barriers to these services and their root causes, and (iii) where these barriers occur, select which interventions or combinations of interventions will reduce which barriers.
   d. Whenever possible, link programs/interventions to prevention, treatment, key population programming, community system strengthening and RSSH response and as relevant to COVID-19 programming, so as to directly support access to these.

2. **There are many existing sources of information on barriers/populations:**
   a. Reports from consultations with key and vulnerable populations and/or their representatives and local human rights groups
   b. Baseline assessments of the 20 countries in the Global Fund's *Breaking Down Barriers* initiative[2]
   c. Legal environment and gender assessments, including Stop TB CRG assessments
   d. Community-based monitoring and advocacy
   e. *Stigma Index* and other measurements of stigma and discrimination
   f. Programmatic mapping to improve program access for key populations
   g. Populations size estimates and differentiated service delivery data
   h. Coverage estimates for COVID-19 measures/programming, and
   i. Routine data and special surveys (e.g. IBBS, patient pathway analysis (TB)).

3. **Integrate programs *into* prevention, treatment, key population programming, community outreach services, community system strengthening and broader RSSH response, and COVID-19 programming/measures, where-ever possible.**
   a. Human rights programing can and should be integrated into the following services: community health workers; peer prevention outreach; all testing services (index testing, partner notification, social network testing, community- and facility-based); one-stop shops for key and vulnerable populations; community health outposts; key population programming; treatment adherence and care retention support; case management approaches; and where relevant, COVID-19 programming.
   b. Examples: peer educators/navigators trained as peer human rights educators or peer paralegals; patients' rights and legal support as part of differentiated forms of treatment delivery; patient rights materials developed/posted in health outposts, clinics, community centers; capacity-building efforts for health care workers under the Human Resources for Health as part of RSSH to integrate medical ethics trainings
   c. Key messages on nondiscrimination for people infected with COVID-19 and/or key populations that are being shunned in the COVID-19 context can be developed and integrated into information/service platforms.

[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 and Ukraine

d. Where a population is excluded from health services, put programs in place for them so that they can organize, learn about their rights, and advocate for and receive access to health services that are available, accessible, acceptable and of quality.

4. **Combine different programs to remove human rights-related barriers for maximum impact to benefit a population or a location. Examples:**
   a. To reduce stigma and discrimination in health care settings, combine: training of health care workers; development of patient rights /materials and activities; and community-based monitoring of health care services. Where there is training and community-based monitoring, material relevant to COVID-19 can be integrated, e.g. nondiscrimination, duty to treat, the rights of health care workers.
   b. To reduce punitive and illegal police practices, combine: sensitization of police; legal literacy activities for sex workers, people who use drugs and LGBT; peer paralegals to represent these key populations; joint activities with police; community-based monitoring of violations. Any sensitization/training of police and prison official regarding COVID-19 related isolation/quarantine measures should include training on proportionate responses; nonviolent and non-punitive approaches; and non-discrimination against key and vulnerable populations.
   c. To address violence against women and girls, combine: activities to change harmful gender norms; GBV prevention; engaging religious and traditional leaders; training and deployment of peer women/transgender paralegals and peer human right educators. As there is likely to be increased inter-personal violence due to COVID-19-related isolation and stay-at-home policies, there should be increased messaging regarding prevention of IPV and increased resources for shelters, counselling, police protection, monitoring.

5. **Avoid duplication and gaps.**
   a. In the past, there was *ad hoc* implementation of human rights programming depending on the location, interests, funding of NGO/CBOs that implemented these programs. This led to gaps in coverage as well as duplication of similar programs. It also resulted in implementation primarily in (capital) cities.
   b. Following the priorities of the national strategy, as well as reports of populations not receiving prevention and treatment services, roll out programs to benefit the populations that are in need of services but experience serious barriers to those services (using population size estimates and programmatic mapping, epi data, incidence/hotspots); and
   c. Support strategic coordination of programs to remove human rights-related barriers to achieve effective and equitable coverage and impact.

6. **Avoid one-off, small-scale activities that have no follow-up or sustained impact.**
   a. Avoid “one-off” activities (meetings, trainings, production of written materials).
   b. Avoid programs at such a small scale that they have no impact.
   c. Avoid programs with stand-alone activities that are not integrated into a comprehensive approach to remove the barriers; programs that do not apply the theory of change.

7. **Build capacity and sustainability regarding programs to remove human rights-related barriers to services.**
   a. Invest over time in institutionalized pre-service and in-service human rights/medical ethics education of health care workers, including information on nondiscrimination in the context of COVID-19 and the rights of health care workers to protection and compensation for on-the-job infection.

b. Provide pre-service and in-service sensitization of police and prison staff, including training on nondiscrimination and nonviolence in the context of COVID-related measures.
c. Increase legal, human and patients' rights literacy among key and vulnerable populations, including patients' rights literacy regarding COVID-19.
d. Support development of cadres of peer human rights educators, peer paralegals, and peer community monitors that will continue to support communities. All of these can also be informed on COVID-19 to provide accurate information, referrals and to address COVID-related community and health care discrimination.
e. Assess, engage, strengthen existing human rights capacity, resources and political will of communities and government stakeholders.

8. Be aware of and try to address context of beneficiaries, including in terms of the challenges these groups face as they confront COVID-19.
a. For police – find ways to address high turn-over, low pay, systems of bribery, inadequate training, own vulnerability to 3 diseases.
b. For health care workers – engage management, admin and other staff at health facility; working conditions, including no and/or low pay and need for personal protection equipment; and measure and address stigma and discrimination in health care facilities.
c. Provide specialized training to different professionals (judges, parliamentarians, police), using respected peers and key and vulnerable populations as experts, advocates, trainers.
d. Set up systems to supervise and to remunerate peer paralegals/educators and community monitors.

9. Use local capacity and build on good existing programs to remove human rights-related barriers.
a. NGOs, CBOs, networks have been implementing programs at small-scale for years BUT often do not have sufficient managerial and financial capacity to be selected as PR/SR and/or do not benefit from the increased funding in ways that allow them to expand implementation of programs to remove human rights-related barriers.
b. Find ways to leverage/expand local human rights capacity and increase funding for those implementing quality programs.
c. In the context of COVID-19, NGOs, CBOs and networks may be a critical second line of response if health care systems are overwhelmed. They should be supported to respond to the needs of their communities and be provided resources, information and personal protective equipment to be able to do so effectively.

10. Ensure programs to remove barriers are gender-responsive.
a. Ensure meaningful engagement of key and vulnerable populations of all genders.
b. Ensure programs are designed and rolled out to address different vulnerabilities, realities and needs of women, men and gender-diverse populations of different age groups and to change harmful gender norms.
c. Employ male and female peers, as well as those from nonconforming genders.
d. Ensure that materials that are developed to promote rights (including patients' rights), laws and policies that are relevant to females, males and non-conforming genders.
e. Make sure that the gender dimensions of the national COVID-19 response are taken into account, including the need to address an increase in inter-personal and gender-based violence and any inability of women/adolescents/the elderly to have the agency and means to redress, get treatment, care and other emergency services.

11. Address safety and security.

Programs should be designed to not expose criminalized and marginalized populations to violence at the hands of the police or the community and to provide safety if they are exposed, including in the context of punitive COVID-19 measures and/or community panic and discrimination.

a. Prioritise safety and security in terms of where activities occur (e.g. location of drop-in centres); how services are delivered (e.g. outreach workers always in pairs); and how resources are allocated (e.g. contingency budget for crisis response, including safe house and legal aid).
b. Develop safety and security plans and protocols to prevent, mitigate and respond to safety and security situations.
c. Conduct risk and security assessments and take preventative measures and implement preventative measures according to findings.

12. Build in monitoring and evaluation.

a. Decide what to measure and what indicators to select, working with program and M&E officers to identify the most relevant indicators. Do not limit it to process indicators. Be innovative.
b. Focus on access to services. Look at existing programmatic indicators that could inform if the program is being successful (using a baseline and monitoring changes)
c. Consider quantitative/qualitative information from surveys e.g. exit surveys.

Programs in the time of COVID-19

In the time of the COVID-19 crisis, countries should maintain or even scale up programs to remove human rights and gender-related barriers to HIV, TB and malaria services and should tailor them, as necessary, to: (a) provide support to the COVID-19 response and (b) help ensure that COVID-19 emergency measures do not exacerbate stigma, discrimination and/or punitive measures for those most affected by HIV, TB, malaria or COVID-19. This will help to focus attention to the vulnerable and marginalized; reduce disproportionate, unscientific and discriminatory responses; and enable the engagement of communities. For more details, see the Global Fund guidance on COVID-19 and human rights.