



MOZAMBIQUE

Progress Assessment

Global Fund Breaking

Down Barriers Initiative

November 2023

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DISCLAIMER

Towards the operationalization of the Global Fund Strategy 2023-2028, this progress assessment was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents the findings of the independent research team that carried out the assessment. The views expressed do not necessarily reflect the views of the Global Fund.

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1. Report Summary

1.1 Introduction

Since 2017, Mozambique has been one of twenty countries to participate in the Breaking Down Barriers (BDB) Initiative, a ground-breaking effort of the Global Fund to Fight AIDS, Tuberculosis and Malaria ('the Global Fund') to scale up programs to reduce or remove human rights and gender-related barriers to HIV and TB services. For the 2021-2023 allocation period, Mozambique received USD \$4 million in catalytic matching funds to scale-up its efforts to reduce or remove human rights-related barriers to HIV and TB services. This amount was fully matched from within the main 2021-2023 funding allocation request of \$12.6 million and an additional \$6 million prioritized above allocation request (PAAR)) to achieve a total investment of approximately \$16.5 million in programs to reduce barriers.

This investment is complemented by other support under the BDB Strategic Initiative to scale up and sustain programs to reduce human rights-related barriers to HIV and TB services including: (a) support for a baseline, mid-term and this progress assessment to strengthen monitoring and evaluation and determine the impact of investments to scale up the programs; (b) support to develop and finalize the *Operational Plan: Comprehensive Response to Human Rights and Gender-Related Barriers to HIV Services in Mozambique 2023-2025* ('the Human Rights Plan'); and (c) implementation support in the form of longer-term technical assistance.

In 2021, a [Mid-Term Assessment \(MTA\)](#) reviewed and 'scored' country progress to reduce or remove barriers during the 2018-2020 period.¹ During the period February to April 2023, a follow-up Progress Assessment was undertaken to document and assess the country's more recent achievements, to update Mozambique's scorecard and to support the development of Mozambique's Global Fund Cycle 7 (GC7) funding request submission. This report sets out the findings and recommendations from the Progress Assessment.

The process followed the methodology outlined by a team of researchers affiliated with Drexel University and approved by the Global Fund. The assessment for Mozambique was done by a team comprised of lead researcher, a second researcher and one national consultant. Data collection occurred during January to April 2023 and involved key informant interviews, group discussions, document reviews and, in addition to Maputo, site visits to Beira and Pemba. Preliminary findings were presented to the CNCS in March 2023.

¹ The assessment report is available at: https://www.theglobalfund.org/media/11034/crg_2021-midtermassessmentmozambique_report_en.pdf

1.2 Summary of Investments and Implementers

For the three-year, GC6 period, in addition to its overall allocation of US\$574 million for HIV and TB programs, Mozambique received US\$4 million in matching, catalytic funds to scale up programs to reduce human rights barriers to HIV and TB services. A total amount of \$16.5 million was budgeted for addressing human rights and gender-related barriers to HIV and TB within the Global Fund grant allocation and through Matching Funds and the Prioritized Above Allocation Request.

Of this amount, non-state actors Fundação para o Desenvolvimento da Comunidade (FDC) and Centro de Colaboração em Saúde (CSS) were allocated 80.6% (USD 13 242 711) of the total to support non-governmental and civil society partners. The remaining proportion was allocated under the Ministry of Health to support public sector efforts to reduce barriers.

1.3 Assessment Findings

The findings of the assessment make clear that over the 2021-2023 period, Mozambique made important progress to scale up programs to reduce barriers to HIV and TB services. Progress was also achieved to reduce human rights-related barriers in a number of program areas, with consequent improvements in uptake and retention in services. This was more apparent for the HIV program than for the TB program, however.

1.4 HIV Component

In most program areas for HIV, there was substantive progress to scale up interventions to reduce barriers, largely as a result of increased investments under the Grant Cycle 6 allocation, but also through contributions of other donors and partners. Integrated legal support services including legal literacy as well as legal advice and support provided by GF-supported implementers in respect of both HIV and TB-related access to service barriers using *activistas*, paralegals and pro bono lawyers is a promising practice that has been well evaluated and is showing results, including in respect of gender equality and GBV. Efforts to eliminate HIV-related stigma and discrimination in Mozambique address all settings but with varying degrees of focus and effectiveness. Data gathered by FDC *activistas* and paralegals in 2022 showed that fear of stigma and discrimination were the most important barriers to access to health services for men who have sex with men, people who use drugs and sex workers.² Also, self-stigma remains an issue of concern, with key populations themselves recognizing how self-stigma impacts on the willingness of sex workers and transgender people to disclose, and discrimination even amongst key populations themselves.³ Less progress was achieved with regard to ensuring rights-based law enforcement practices as, despite the efforts of the PMR and others to sensitize law

² FDC. Human rights component – community legal assistance, case identification, referral and management and resolution: Overall January to June 2022. Document on file with Global Fund.

³ Focus group discussion with KPs, 9 February 2023

enforcement officers on the public health impact of non-rights based policing practices, key populations, in particular sex workers and people who use drugs still face harassment and abuse at the hands of law enforcement officers. Limited progress to achieve law and policy change, particularly regarding the criminalization of certain aspects of sex work and drug possession which are regarded as drivers of stigma and discrimination and other rights violations faced by these groups.

1.5 TB Component

With regard to TB, there was a smaller degree of program scale up. To a large degree, efforts to remove barriers to TB services leveraged HIV investments through the integration of TB-related topics in these interventions, albeit with perceived lesser attention being paid to TB than to HIV. TB-related stigma continues to be a deterrent to both initial access to and adherence to HIV treatment,⁴ and people with TB continue to lack sufficient awareness of their health rights. Programs have yet to reach national coverage and still tend to focus more on HIV.

Progress has however been made in moving forward to identify and address human rights and gender related barriers to access to TB services - the NTB has conducted a community-level study on TB-related human rights and gender issues and has recently finalized a study on human rights and gender-related barriers at health facility level.⁵ The findings and recommendations of this assessment inform the Community, Rights and Gender Action Plan for Tuberculosis 2023 – 2026, which has recently been finalized.⁶ In addition, a Stigma Assessment is being planned by the National TB Program in partnership with CCS.

1.6 Other Findings

From the assessment findings, it was apparent that there is improvement in national ownership for reducing or removing human rights- and gender-related barriers to HIV and TB services are evidenced by the adoption of *Mozambique's National Strategic Plan for HIV/AIDS 2021-2025* (PEN V), as well as the *National Strategic Plan To End Tuberculosis in Mozambique 2023-2030* ('the TB NSP'), both of which have a strong emphasis on the removal of human rights and gender related barriers⁷. In addition, the country's clear commitment to reducing human rights and gender related barriers to HIV services is outlined in the *Operational Plan: Comprehensive response to human rights and gender-related barriers to HIV services in Mozambique (2023-2025)* which aims to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV programs that reduce new infections, AIDS

⁴ De Schacht C, Mutaquiha C, Faria F, Castro G, Manaca N, Manhica I, et al. (2019) Barriers to access and adherence to tuberculosis services, as perceived by patients: A qualitative study in Mozambique. PLoS ONE 14(7): e0219470. <https://doi.org/10.1371/journal.pone.0219470>. See also Daftary A, Frick M, Venkatesan N, et al/ Fighting TB stigma: we need to apply lessons learnt from HIV activism *BMJ Global Health* 2017;2:e000515; MISAU & The Global Fund (2023). Assessment Of Human Rights- And Gender-Related Barriers To Accessing TB Services In Mozambican Health Facilities. Maputo, Mozambique.

⁵ MISAU & The Global Fund (2023). Assessment Of Human Rights- And Gender-Related Barriers To Accessing TB Services In Mozambican Health Facilities. Maputo, Mozambique.

⁶ PNCT, CCS & The Global Fund (2023). Mozambique Community, Rights and Gender Action Plan for Tuberculosis 2023 – 2026. Maputo, Mozambique

⁷ See para 2.4 for further details on these plans.

related deaths and discrimination against people living with HIV and other key and vulnerable populations in Mozambique and to facilitate better coordination and strategizing for the effective scale-up of programs to remove human rights and gender-related barriers to an effective HIV response.

A significant shortcoming across the board however is the lack of a monitoring and evaluation system that is capable of tracking outcomes of human rights and gender programming and thus makes it difficult to track progress in terms of the impact of current programming to reduce human rights and gender related barriers to access to HIV and TB services.

1.7 Scorecard Results

The scorecard results by disease component and program area are shown below.

HIV component

Program Area	Baseline (2017)	MTA (2021)	Progress (2023)
Eliminate stigma and discrimination in all settings	0.5	3.0	4.0
Ensure non-discriminatory provision of health care	1.2	1.7	2.3
Ensure rights-based law enforcement practices	0	0.5	2.6
Improve legal literacy ("know your rights")	1.2	3.0	4.3
Improve access to justice (HIV-related legal services)	2.0	3.0	4.0
Improve laws, regulations and policies related to HIV and HIV/TB	0	1.5	2.3
Reducing HIV-related gender discrimination	1.5	3.0	4.3
Community mobilization and human rights advocacy	*	*	2.0
Average Score	0.91	2.24	3.40[#]

*: Note that the average scores only consider the first seven programs to ensure consistency.

TB component

Program Area	Baseline (2017)	MTA (2021)	Progress (2023)
Eliminate TB-related stigma and discrimination	0	1.0	2.6
Ensure people centred and rights-based TB services at health facilities	1.3	1.6	2.3
Improve TB-related legal literacy	1.0	3.0	4.3
Improve access to justice in the context of TB.	1.0	3.0	4.0
Ensure rights-based law enforcement practices for TB	0	0	0.5
Improve laws, regulations and policies related to TB	0	0	0
Reduce TB-related gender discrimination	0	0	1.0

Support community mobilisation and advocacy	1.0	1.3	2.3
Address needs of people in prisons and other closed settings	1.0	1.0	1.3
Average Score	0.53^{##}	1.21^{##}	2.03

^{##}: Note that the average scores for baseline and mid-term take into account ten program areas, the nine shown above plus “Ensuring confidentiality and privacy” that was removed from the progress assessment.

2. Background and Country Context

2.1 Introduction

Since 2017, Mozambique has been one of twenty countries to participate in the Breaking Down Barriers (BDB) Initiative, a ground-breaking effort of the Global Fund to Fight AIDS, Tuberculosis and Malaria (‘the Global Fund’) to scale up programs to reduce or remove human rights and gender-related barriers to HIV and TB services. For the 2021-2023 allocation period, Mozambique received USD \$4 million in catalytic matching funds to scale-up its efforts to reduce or remove human rights-related barriers to HIV and TB services. This amount was fully matched from within the main 2021-2023 funding allocation request of \$12.6 million and an additional \$6 million prioritized above allocation request (PAAR)) to achieve a total investment of approximately \$16.5 million in programs to reduce barriers.

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In 2021, a Mid-Term Assessment (MTA) reviewed and ‘scored’ country progress to reduce or remove barriers during the 2018-2020 period.⁸ During the period February to April 2023, a follow-up Progress Assessment was undertaken to document and assess the country’s more recent achievements, to update Mozambique’s scorecard and to support the development of Mozambique’s Global Fund Cycle 7 (GC7) funding request submission. This report sets out the findings and recommendations from the Progress Assessment.

By April 2023, the Ministry of Health (MOH), along with its partners and stakeholders, had continued to take important steps to address and mitigate the health and social impacts of the interlinked epidemics of HIV and TB. The country remained committed

⁸ The assessment report is available at: https://www.theglobalfund.org/media/11034/crg_2021-midtermassessmentmozambique_report_en.pdf

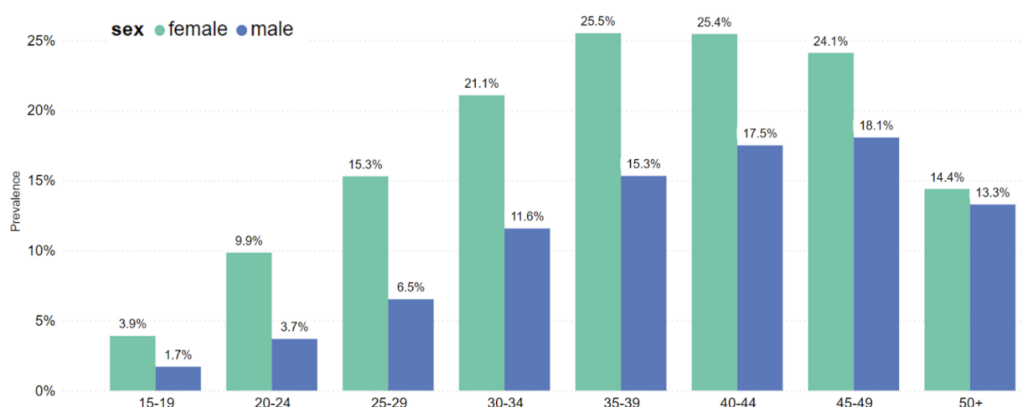
to ending these as public health threats to the population by 2030. A brief overview of the status of the HIV and TB epidemics is given below to set the context for the Progress Assessment.

2.2 Status of the HIV epidemic

Over the last decade, new HIV cases in Mozambique have fallen by 34%; AIDS-related deaths have declined by 27% and the number of people on antiretroviral therapy (ART) has risen by more than 1 million. Yet, Mozambique continues to bear one of the highest burdens of HIV and TB in the world.⁹

According to Spectrum estimates 2023, in 2022 Mozambique had 2.4 million [2.3 million - 2.6 million] people living with HIV (PLHIV), including 2.3 million adults [2.0 million - 2.5 million] and 150,000 children [125,000 - 170,000]. HIV prevalence is 12.5% among adults aged 15+ years (15% in women and 9.5% in men). up from 11.5% in 2015.¹⁰ Women face a disproportionate HIV burden throughout the life cycle, but the disparity is most pronounced among young women aged 20 -24 years, whose HIV prevalence is 3.1 times greater than their male peers (11.8% vs. 3.8%) (Figure 1 & 2).

HIV Prevalence by Gender and Age



HIV Prevalence Estimates (Spectrum/Naomi 2023, 2022 Estimate)

HIV prevalence by province

There is significant geographic variance in Mozambique’s HIV epidemic (Figure 3 & 4). At the provincial level, adult HIV prevalence in 15+ is highest in Gaza (20.9%) and lowest in Manica (7.9%)¹¹. At the district level excluding Maputo City, prevalence is highest in Quelimane (18.8%) and lowest in Macanga (1.2%)¹²

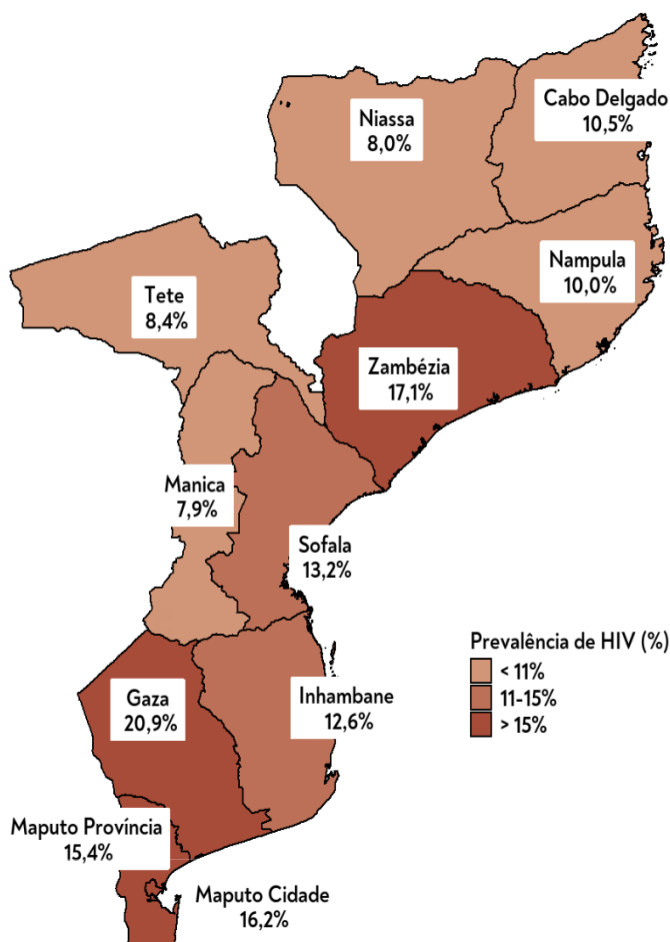
⁹ <https://data.theglobalfund.org/location/MOZ/overview?components=HIV>

¹⁰ Mozambique National Survey on The Impact Of HIV and AIDS in Mozambique INSIDA 2021

¹¹ ibid

¹² Naomi 2023

Nacional	Prevalência de HIV (%)	IC 95%
Moçambique	12,5	11,5-13,4
Provincial		
Niassa	8,0	5,3-10,7
Cabo Delgado	10,5	7,2-13,8
Nampula	10,0	7,4-12,5
Zambézia	17,1	13,0-21,2
Tete	8,4	6,7-10,1
Manica	7,9	6,0- 9,8
Sofala	13,2	9,9-16,4
Inhambane	12,6	10,5-14,7
Gaza	20,9	16,7-25,0
Maputo Província	15,4	13,3-17,5
Maputo Cidade	16,2	13,7-18,7



While Mozambique has a generalized HIV epidemic, it is characterized by distinct sub-epidemics that require targeted responses. PEN V defines key populations as sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), transgendered people (TG), and prisoners. The plan also considers adolescent girls and young women (AGYW) aged 15-24 years, mobile and migrant workers (mine workers and truck drivers) and sero-discordant couples as vulnerable populations.¹⁶ Size estimates and prevalence data is shown in the table below.

Population size estimates and HIV prevalence for key and vulnerable populations in Mozambique¹³

Population	Size Estimate	HIV Prevalence	Coverage of HIV prevention programs*
Female Sex Worker	97,000 (2022)	26.5% (2019-2020)	82.7% (2022)
Male Sex Worker	No data	No data	No data
Men who have sex with men	72,000 (2022)	6.8% (2020-2021)	40.4% (2022)
People who inject drugs	9,100 (2022)	45.8% (2014)	38.5% (2022)
Prisoners	21,301 (2022)	Total: 25.5% (2022)	54.0% (2022)
		Male: 25.4% (2022)	No data
		Female: 31.5% (2022)	No data
AGYW (aged 15-24 years)	3,375,366 (2022)	8% (2021)	26.2% (2022)
Transgender-Men	3,600 (2022)	No data	No data
Transgender-Women	4,000(2022)	No data	No data
Transgender- All	7,600 (2022)	No data	11.0% (2022)

a. *Based on program data (FDC+PASSOS), 2022

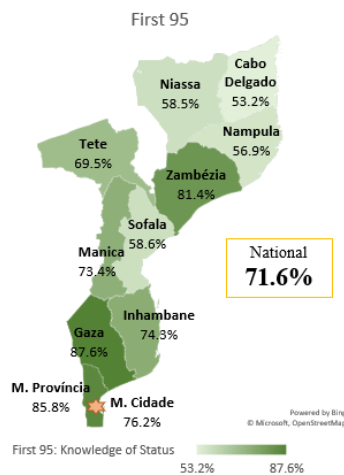
Progress towards 95-95-95 targets among adults living with HIV

As indicated in the table below, 71.6% of adults (15 years of age and older) living with HIV know their HIV status. The percentage differs slightly between men and women (73.3% of women and 68.5% of men). The north and center of the country have disproportionately lower rates than the south, with Sofala, Niassa, Cabo Delgado, Nampula all under 60%¹⁴.

¹³ Estimating population size and HIV burden among Key Populations in Mozambique, 2023

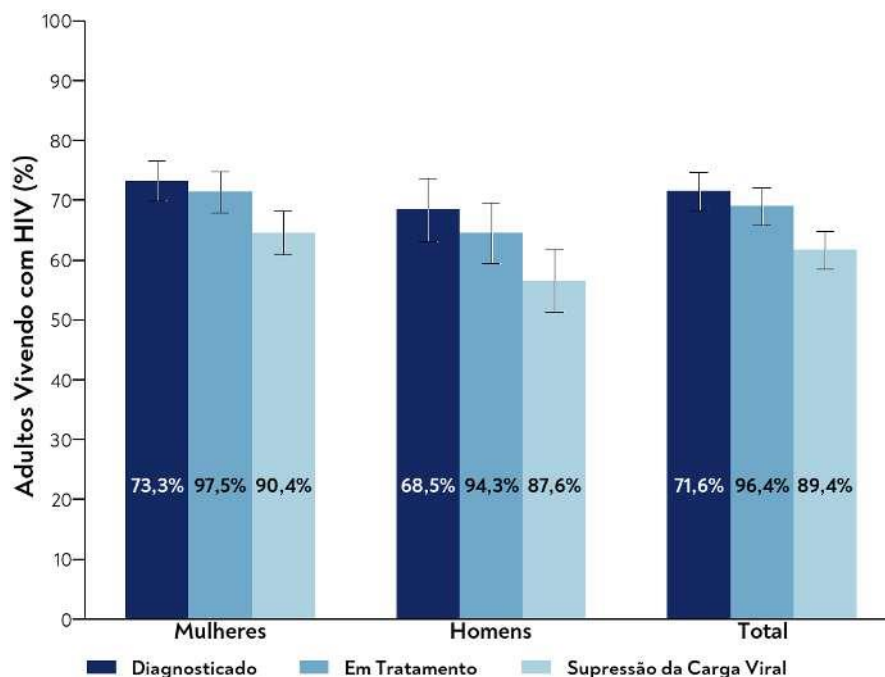
¹⁴ INSIDA op cit

Percentage of PLHIV who know their status



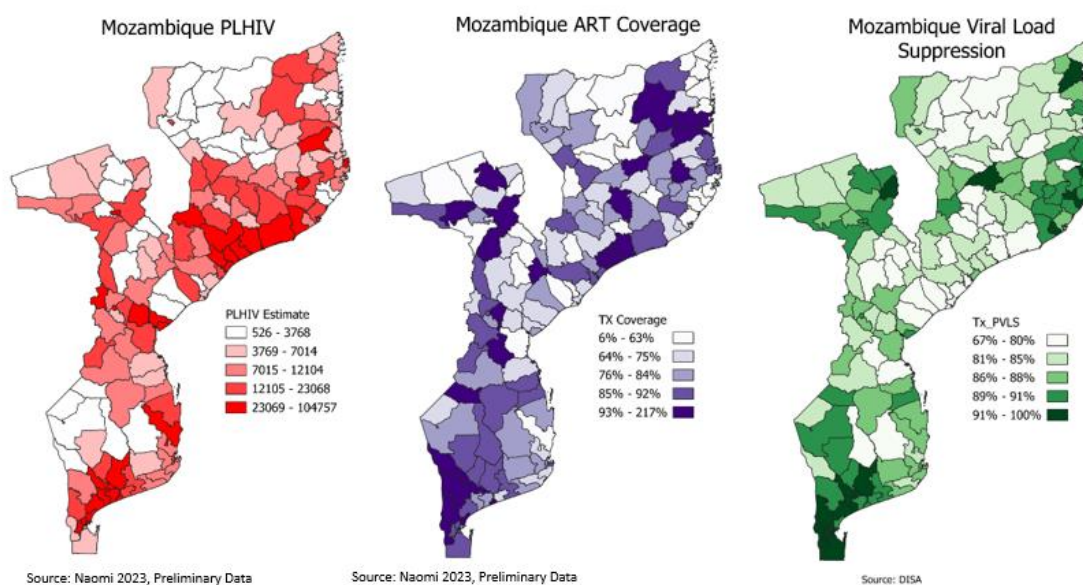
Of these, 96.4% of adults living with HIV who know their HIV status are on treatment. Similar to knowledge of HIV status, the percentage differs slightly between men and women (97.5% of women and 94.3% of men).

Of those who are on treatment, 89.4% of adults are virally suppressed (90.4% of women and 87.6% of men).



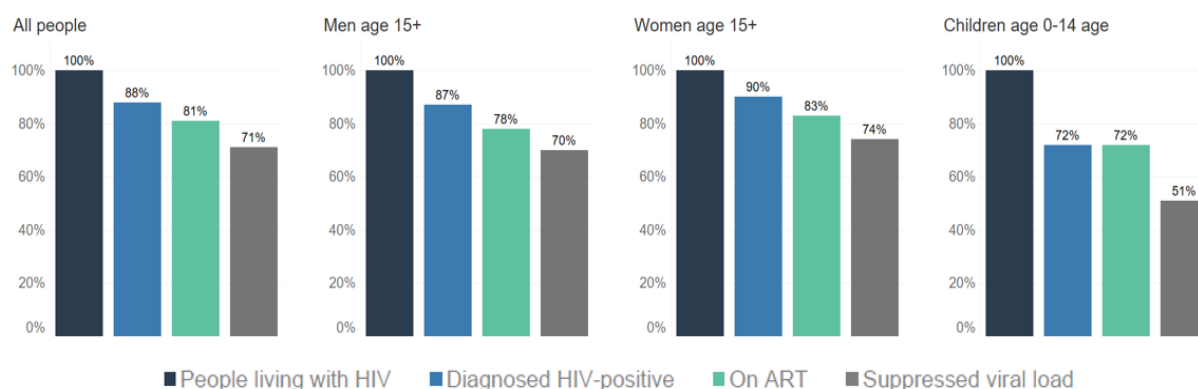
Antiretroviral therapy (ART) coverage, viral load testing and viral suppression are notably better in the southern parts of the county (Figure 5). Viral suppression rates in Cabo Delgado (42.5%), Nampula (47.9%) and Sofala (51.4%), are substantially lower compared to rates in Maputo City (69.3%), Manica (71.8%), Zambezia (74.5%), Maputo Province (76.0%) and Gaza (80.3%).

PLHIV (left), ART coverage (middle) and viral suppression (right) in Mozambique, 2023



Mozambique remains below the 2025 95-95-95 treatment targets, which out of all PLHIV, require 95% to know their status, 90% to be on ART, and 86% to be virally suppressed. In 2022, 88% knew their status, 81% were on ART, and 71% were virally suppressed (Spectrum 6.26). In the last quarter of 2022, routine Ministry of Health data from SIS-MA (Mozambique’s DHIS2 Platform) shows just 82% of adult PLHIV are on ART. Disaggregated cascades reveal age and gender inequities (Figure 8, Spectrum 6.26, preliminary data). Men fare worse than women along the entire cascade, which is being addressed through a comprehensive male engagement strategy in the previous funding request. PEPFAR program data suggest viral suppression is just 71% among adolescent boys 10-14 and 76% among young men aged 15-19 years (AJUDA Dashboard), which is particularly concerning given the abovementioned sources of risk for AGYW. INSIDA 2021 data show that knowledge of HIV status is lower for adolescent men and young women aged 15-24 years, at 45.3% and 56.4% respectively, indicating a need for more targeted testing approaches.

Treatment cascades in Mozambique, disaggregated by age and sex, 2022



Poor retention is a major cause of treatment cascade ‘leaks. Economic migration/mobility, and poor relationships between the health system and patients, lead to repeated cycles of patient disengagement and re-engagement in HIV care.

2.3 Status of the TB epidemic

Mozambique is among the World Health Organization (WHO)’s list of high-burden countries for Tuberculosis (TB), TB and HIV co-infection, and multidrug-resistant TB (MDR-TB). In 2021, there were 116 000 incident TB cases, among which 4 800 were multidrug- and rifampicin-resistant TB (MDR/RR-TB).

Mozambique finalized the First National Pulmonary Tuberculosis Prevalence Survey in August 2021.¹⁵ Based on the survey, the extrapolated TB prevalence rate of 361/100,000 (95% CI, 223-532) population of all forms of TB was lower than previously estimated by WHO (551/100,000 - 95% CI, 356-787) though within the confidence interval.

The prevalence of MDR-TB is 3.5%, but only 30% of these are diagnosed per year. Some diagnosed patients are lost before starting treatment. The death rate for MDR-TB is high, at 12%, which is linked to a high loss to follow-up rate (8.4%).

The TB treatment success rate among new and relapse cases is 94%, though there are challenges with reducing the traveling time and other barriers to access to treatment services.

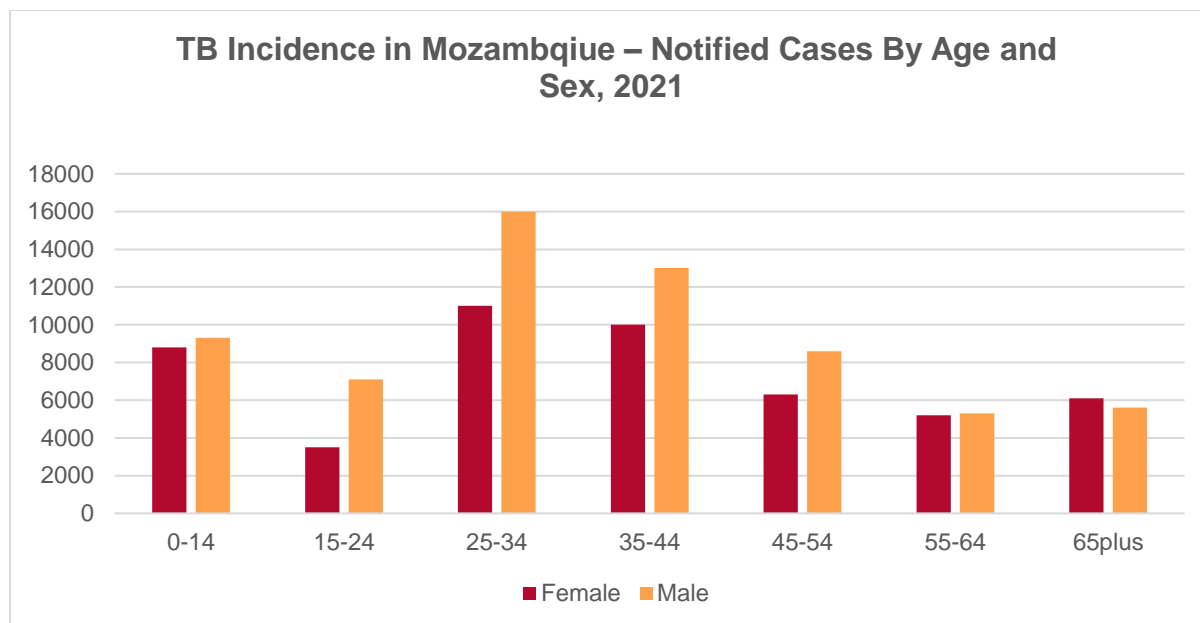
Since 2018, the case notification has plateaued at around 93,000-98,000 cases per year. The number of missing people with TB has reduced from 18 907 in 2020 to 17 515 in 2021 – a decrease of 7%.

About one third of all people with TB in Mozambique are co-infected with HIV, although this declined from 33% in 2020 to 27% in 2021. Among co-infected individuals, 99%

¹⁵ Mozambique TB CRG Action Plan 2023-2026 (draft)

started cotrimoxazole prophylaxis and 95% started HIV treatment. The co-infection rate for MDR-TB is much higher (47%).

There are gender inequities in Mozambique’s TB epidemic. Men aged 24-34 years experience the highest burden, with 16 000 incident cases in 2021¹⁶. The greatest disparity is among young people, where young men aged 15-24 years are more than twice as likely as their female peers to contract TB.



Coverage of TB preventive treatment (TPT) remains suboptimal. Among children under five years old who are household contacts of bacteriologically-confirmed TB cases, 89% are on TPT. The Global Plan to End TB 2018–2022 set a TPT target for Mozambique of 374,574 people, but only 85 910 individuals received it.¹⁷

2.4 Law and policy context

Mozambique’s National Strategic Plan for HIV/AIDS 2021-2025 (PEN V) was adopted in 2021 and seeks to (i) articulate a strategic framework that will guide the political and programmatic vision of the response to HIV and AIDS for the next five years (2021-2025), with a view to ending AIDS as a threat to public health in Mozambique by 2030; inform stakeholders at national, provincial, district, municipal and community level of the strategic guidelines to be taken into account in the preparation of the implementation plans; and (iii) serve as a framework for coordinating and monitoring the implementation of the HIV and AIDS response actions of the various actors at all levels.

¹⁶ WHO Global TB Report 2022

¹⁷ Satyanarayana, S., Pretorius, C., Kanchar, A., Garcia Baena, I., Den Boon, S., Miller, C., ... & Falzon, D. (2023). Scaling Up TB Screening and TB Preventive Treatment Globally: Key Actions and Healthcare Service Costs. *Tropical Medicine and Infectious Disease*, 8(4), 214. Online at <https://www.mdpi.com/2414-6366/8/4/214>

Among the reasons articulated in PEN V for the failure to achieve the targets set out in the previous *National Strategic Plan for HIV/AIDS* (PEN IV) are the following:

- The intersection of inequalities - including those based on HIV status, gender, sexual orientation and gender identity, income level, drug use, sex work and incarceration; and
- The unacceptable levels of stigma and discrimination that still persist in health services and other areas of the public sector, such as education and justice, as well as in families, communities and workplaces.

PEN V thus specifically provides that the HIV response shall be guided by the principles of “no stigmatization and discrimination” and “protection of human rights and gender justice”.

One of the strategic objectives of PEN V is to strengthen the response to HIV based on human rights principles and approaches through the implementation of the following interventions:

- Reduction of stigma and discrimination;
- HIV-related human rights training and medical ethics for health providers and educators including at community level;
- Legal literacy (“know your rights”);
- HIV-related legal services, including legal information, counseling and representation, alternative or community dispute resolution;
- Monitoring and reform of HIV-related laws, standards and policies, including reviewing the impact of laws and law enforcement on the response to HIV;
- Raising awareness among legislators and law enforcement officials on issues related to HIV response aspects and related human rights aspects;
- Reduction of discrimination against women and GBV in the context of HIV.

Similarly, a key prioritized activity in the National Strategic Plan To End Tuberculosis in Mozambique 2023-2030 (‘the TB NSP’) is to generate community demand, community involvement in TB care for TB services, and address human rights and gender barriers that impede access¹⁸.

The TB NSP also prioritizes specific activities, including:

- Organizing rights-based, gender-focused and stigma-reducing literacy programs.
- Engage men, local women's groups, community leaders and activists to mobilize women for TB services.
- Publicize labor laws in workplace to allow employees to access TB treatment without losing their jobs.
- Adopt special strategies to reach men (aged 15-45 years) in large numbers with TB education and screening services in workplaces and other crowded settings.
- Strengthen and expand the Community Help Centers, where all citizens including women can report any violation of their rights while accessing TB and health services.

¹⁸ PNCT, 2023, pg. 44

- Integrate TB services with existing gender-sensitive programs such as gender-based violence (GBV) mitigation.
- Establish a paralegal system to guide, support and advise patients to get the correct care they deserve in health facilities (against treatment refusal, discrimination, and abusive practices).
- Establish patient-friendly channels where patients can freely express treatment adherence challenges, adverse drug reactions, and other treatment-related constraints.
- Use existing community health committees/facility management committees to include discussions of TB-related issues (diagnosis, treatment, referrals, etc.).
- Organize regular meetings between TB patients and their families to share knowledge, experiences and challenges related to TB diagnosis, treatment, TB care and support.

The country's clear commitment to reducing human rights and gender related barriers to HIV services is outlined in the *Operational Plan: Comprehensive response to human rights and gender-related barriers to HIV services in Mozambique (2023-2025)*. The aim of the Human Rights Plan is to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV programs that reduce new infections, AIDS related deaths and discrimination against people living with HIV and other key and vulnerable populations in Mozambique. It seeks to close the gaps that are preventing progress towards ending AIDS as a public health threat in Mozambique by 2030.

Despite the strong national and international legal and policy frameworks and commitments to protect human rights, people living with HIV, key and vulnerable populations in Mozambique still face ongoing stigma, discrimination, violence and other rights violations in law, policy and practice, which prevent access to HIV and TB services and treatment.

In 2018 the Global Fund's [Baseline Assessment - Mozambique](#) found that overall, stigma (including self-stigma) and discrimination against people living with HIV and other key and vulnerable populations remain the dominant barrier for access and uptake of HIV services.

The Baseline Assessment noted that while instances of discrimination in health services and poor service quality for people living with HIV were generally declining in Mozambique, more substantial challenges remained for other key populations.

Discrimination, violence and punitive laws – such as laws against drug use – have limited the development of harm reduction interventions for people who inject drugs. Although same-sex sex is not criminalized, the inability of organizations such as LAMBDA, representing the interests of lesbian, gay, bisexual, transgender and intersex (LGBTI) Mozambicans, to register as an organization, has created barriers to providing for the rights and welfare of LGBTI people in Mozambique. Poor conditions in prisons, specifically severe overcrowding, have limited both the availability and the accessibility of HIV and TB interventions. Finally, harmful gender norms and gender inequality, coupled with severe poverty, have continued to place adolescent girls and

young women at high risk of HIV infection and have also limited their ability to use HIV and other services when they need them.¹⁹

In 2021, the Global Fund-supported [Mozambique: Mid-Term Assessment](#) (MTA) concluded that Mozambique had taken significant steps toward creating a supportive environment for addressing human rights-related barriers to HIV and, to a lesser extent, TB services. It found that while progress on TB-related discrimination was insufficient and there was still much work needed in order to achieve comprehensive programs, there were indications of Mozambique having developed a solid foundation on which to build future programs to remove human rights-related barriers to both HIV and TB services. This included a strong policy framework; the adoption of an evidence-informed, integrated approach for embedding anti-stigma and discrimination, legal literacy and legal services in community networks of diverse stakeholders and a strengthened national base of support for integrating gender-responsive programming and reducing the impact of HIV among girls and young women in all human rights-related program interventions.²⁰

Areas of marked scale-up since the Baseline Assessment of 2018 included legal literacy programs and access to legal support programs provided through paralegals. The MTA noted the successes of integrating legal literacy and legal support services with stigma and discrimination reduction programs carried out by diverse community networks. Strong radio campaigns to reduce stigma and discrimination also served as platforms for increasing legal literacy and access to legal services.

The MTA cautioned, however, that progress in has been slower in training of health care workers and police on HIV, TB and human rights, as well as the sensitization of lawmakers. Moreover, it noted the limited number of programs in Mozambique to reduce human rights-related barriers to TB services. Some broader health education and advocacy efforts as well as legal literacy and legal services programs include both HIV and TB- affected populations, but no TB-specific human rights-related initiatives were identified in other program areas. It recommended the need for ongoing investments to build capacity for sustaining and scaling up the roll out of human rights programs nationwide.²¹

The negative impacts of the legal context on progress to reduce human rights barriers are addressed throughout the findings of the assessment.

2.5 COVID-19

COVID-19 including lockdown and related restrictions caused significant interruptions of human rights-related programming. For instance, activities reaching out to communities in-person, such as legal literacy sessions, community dialogues and paralegal activities, were paused or limited due to restrictions on face-to-face gatherings. In addition, the Ministry of Health (MISAU)'s training sessions for health care workers were delayed until September 2020. The update to the Stigma Index

¹⁹ Global Fund, Mid-term Assessment Mozambique: Breaking Down Barriers Initiative (2021), page 14.

²⁰ Global Fund, Mid-term Assessment Mozambique: Breaking Down Barriers Initiative (2021), page 9.

²¹ Global Fund, Mid-term assessment Mozambique: Breaking Down Barriers Initiative (2021), page 6.

Study planned by the National AIDS Commission (CNCS) and involving face-to-face interviews with people living with HIV and key populations, was suspended.²²

Quarantine measures presented tremendous challenges for key and vulnerable populations affected by HIV and TB. Many people faced economic hardships, and those working in the informal economy – such as sex workers – were hard hit. Key and vulnerable populations were unable to access their regular avenues for receiving HIV information, prevention and treatment services. In addition, COVID-19 restrictions saw an increase in cases of stigma, discrimination and violence against key and vulnerable populations. For instance, GBV against women and girls, especially cases of physical aggression, ill-treatment and psychological violence, increased.

COVID-19 also prompted changes in the implementation of the HIV program, however, to meet patients with services when and where they were needed. These included rapid expansion of access to differentiated service delivery (DSD) models such as multi-month scripting and mobile brigades. Three-month drug dispensing was consolidated and expanded during COVID-19, and the proportion of stable patients on multi-month drug dispensing programs grew to 70% nationally. Mobile brigades have been successfully used in cases where access to health services is extremely limited. Government-supported community health workers were also deployed to provide community delivery of anti-retroviral medicines (ARVs). However, identification and linkage of new patients to treatment was hampered by restrictions in community activities such as index case testing.²³ To respond to increased reports of stigma, discrimination and violence, implementers increased the availability and vigilance of paralegals in client follow-up and engaged the assistance of community leaders to respond promptly to cases.²⁴

As health facilities reopened during 2021 and 2022, access to services has improved but health officials report ongoing confusion and uncertainty about returning to care. For many, lack of technological capacity (access to equipment and data) and fears of data leaks prevent key and vulnerable populations from transitioning to alternative forms of health services and rights-related programming on online platforms.

2.6 Investments

The Global Fund has continued to support the response to HIV in Mozambique through an investment of up to US\$466 million for 2021-2023. This supports two HIV and AIDS programs with the goal of reducing HIV infections and deaths in line with the National HIV Strategy. Furthermore, one TB program and one dual-component (TB/HIV) program were allocated combined funding of up to US\$108 million for 2021-2023. This supports interventions aimed at reducing TB incidence and mortality rates,

²² Global Fund, Mid-Term Assessment Mozambique: Breaking Down Barriers Initiative (2021), page 33.

²³ [2021 Mozambique Sustainability Index and Dashboard Summary](#)

²⁴ Global Fund, Mid-term assessment Mozambique: Breaking Down Barriers Initiative (2021), page 33

improving and sustaining TB case notification and treatment success rates, and helping to reduce new HIV infections and HIV-related deaths.²⁵

The 2021-2023 HIV/TB grant included a total of \$16.5 million for addressing human rights and gender-related barriers to HIV and TB within the Global Fund grant allocation and through Matching Funds and the Prioritized Above Allocation Request.

In addition, US\$ 4.2 million was allocated to community systems strengthening (CSS) interventions, a number of which included components to address human rights-related barriers in the HIV and TB contexts. This overall investment was substantive and represented the largest allocation to-date for such priorities for Mozambique.

A summary of the interventions included in this amount is shown in below along with an indication of the division of funds between the three Principal Recipients (PRs): Ministry of Health (MoH), Fundação para o Desenvolvimento da Comunidade (FDC) and Centro de Colaboração em Saúde (CSS).

Summary of allocations by program area

Removing Barriers Program Area	MoH	FDC	CCS	TOTAL	%
Eliminate stigma and discrimination in all settings	-	3 915 266	3 485 359	7 400 625	45.0
Improve legal literacy ("Know Your Rights")	-		1 870 394	1 870 394	11.4
Ensure non-discriminatory provision of health care	636 579	533 819	-	1 170 398	7.2
Improve access to justice	-	179 396	371 177	550 573	3.3
Ensure rights-based law enforcement practices	2 556 364		-	2 556 364	15.6
Monitoring and reforming laws, regulations and policies relating to HIV and HIV/TB	-		-		0
Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity	-	2 048 263	773 797	2 822 060	17.1

²⁵ Global fund's webpage: <https://data.theglobalfund.org/location/MOZ/overview?components=HIV>

Community mobilization and advocacy (HIV/TB)		65 240	-	65 240	0.4
Total	3 192 943	6 741 984	6 500 727	16 435 654	100 %
CSS Interventions					
Community-led monitoring	-	1 435 032	-	1 435 032	34.5
Community-led advocacy and research	-	-	-	-	0
Social mobilization, community linkages and coordination	-	1 200 262	-	1 200 262	28.9
Institutional capacity building, planning and leadership development		1 136 036	387 144	1 523 180	36.6
Total	0	3 771 330	387 144	4 158 474	100 %

Of the funds for programs to reduce barriers, FDC and CSS were allocated 80.6% (USD 13 242 711) of the total to support non-governmental and civil society partners. The remaining proportion was allocated under the Ministry of Health to support public sector efforts to reduce barriers. Program areas for stigma and discrimination reduction, ensuring rights-based law enforcement practices and reducing HIV-related gender discrimination received the most support across all PRs.

2.7 Implementation Arrangements

The implementation arrangements for programs to reduce barriers are shown below:

Implementation arrangements for programs to reduce barriers

Principal Recipients		
MoH	FDC	CCS
Sub-recipients		
CNCS	ADPP LAMBDA UNIDOS REENCONTRO ARISO AMDEC	

	KENGUELEKZE ECOSIDA MAHLAHLE AJULSID IBD AMODEFA KUBATSIRANA IAT ICRH ADRA SR 2 ZAMBEZIA IELM OVAVERELANA WATANA PROGRESSO ESTAMOS ARV	&	
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MoH=Ministry of Health, CCS=Centro de Colaboração em Saúde, FDC=Fundação para o Desenvolvimento da Comunidade

The program areas addressed by each implementer are summarized below:

Implementers and program areas

Program Areas	CCS	FDC	MISAU
Stigma and Discrimination Reduction	X	X	
Ensure non-discriminatory provision of health care		X	X
Legal Literacy	X		
Improve access to justice	X	X	
Ensuring rights-based law enforcement practices			X
Monitoring, Reviewing Law & Policy			
Gender Inequality & GBV		X	

3. Towards Comprehensiveness: Achievements and Gaps in Scope, Scale and Quality

3.1 Progress to remove barriers to HIV services

Over the 2021-2022 assessment period, Mozambique continued make progress to reduce human rights-related barriers to HIV services. For most program areas, there was a significant scale-up of activities (an increase in outputs), largely as a result of the increased investment under the current grant, but also due to increased contributions from other funders and partners. A number of interventions undergoing scale-up were continuations from the previous grant cycle (2018-2020). Progress was less certain, however, with regard to whether these scaled-up interventions had reduced or removed human rights barriers (increase in outcomes), or whether the reduction of barriers improved access and uptake of services (emerging evidence of impacts). These changes are described in the detailed findings by program area set out below.²⁶

(a) Eliminate stigma and discrimination in all settings

HIV program area	Score ²⁷		
	Baseline (2017)	Mid-Term (2021)	Progress (2023)
Eliminate stigma and discrimination in all settings	0.5	3.0	4.0

The elimination of stigma and discrimination is a program essential and thus should be at the core of the national HIV response in Mozambique. Global stakeholders have prioritized six settings for the elimination of HIV-related stigma and discrimination, including amongst individuals, households and communities; within healthcare, education, workplace, justice and legal systems; and in emergency and humanitarian settings.²⁸ Efforts to eliminate HIV-related stigma and discrimination in Mozambique address all settings but with varying degrees of focus and effectiveness. Mozambique’s commitment to eliminating stigma and discrimination is reflected in its participation, since 2020, in the Global Partnership for Action to Eliminate All Forms of HIV-Related Stigma and Discrimination (the Global Partnership). Interventions supported by the BDB Initiative contribute to Mozambique's overall goals and commitments as part of the Partnership.

²⁶ Starting with the GC7 funding cycle, the Global Fund introduced program essentials, defined as "key evidence-based interventions and approaches identified by partners as being necessary for achieving the global goals of ending the three diseases as epidemics by 2030, and as such should be at the core of all national disease programs." A number of program areas to reduce or remove human rights-related barriers are considered to be program essentials. Where relevant, this is indicated in the findings.

²⁷ See **Annex 1** for the interpretation of the scores.

²⁸ See UNAIDS. 2020. *Evidence for eliminating HIV-related stigma and discrimination*. Available: https://www.unaids.org/sites/default/files/media_asset/eliminating-discrimination-guidance_en.pdf

HIV-related stigma and discrimination in many forms and several settings have been identified for several years in national HIV strategies in Mozambique as key barriers to seeking, using and adhering to HIV services. Non-discrimination and non-stigmatization in HIV services is a key overarching principle of the current national HIV strategy, PEN V; and reduction of stigma faced by people living with HIV and key populations by 75% compared to the level measured in 2013 is central to one of its major objectives.²⁹ Reduction of HIV-related stigma and discrimination is also a central element of the recently finalized *Operational Plan: Comprehensive response to human rights and gender-related barriers to HIV services in Mozambique (2023-2025)*. Though efforts to address HIV-related stigma and discrimination have been pursued in Mozambique for years, many challenges remain in this area. The assessment by CNCS of the implementation of the fourth national HIV strategy, PEN IV, concluded that stigma and discrimination remain major barriers to realizing national HIV goals.³⁰ That assessment highlighted concerns such as poor coverage of interventions addressing structural factors important to key populations, limited community-led activities, and lack of funding for civil society-led programs.

The BDB Mid-Term assessment in 2021 found some progress in this area, noting especially the Viva+ Project which works to reduce stigma and discrimination (S&D) (as well as providing legal literacy, and support for identifying and referring rights violations) in 11 provinces and 63 districts using community dialogues and radio debates that enable people living with HIV and key populations to speak openly about barriers to health services that they face.³¹ Peer education, especially for key populations, under the President's Emergency Plan for AIDS Relief (PEPFAR)-funded Integrated HIV Prevention and Health Services for Key and Priority Populations (PASSOS) program was also cited as a way to overcome self-stigma and to promote access to HIV services for key populations. The MTA recommended support to complete the Stigma Index 2.0 study, which has been delayed for some time, as well as systematic inclusion of key population-led organizations as both advisors and implementers in stigma and discrimination interventions.

PEN V indicates that the country aspires to make progress in all six Global Partnership settings. Mozambique is also part of the Stigma and Discrimination Focal Countries Collaboration (FCC) of PEPFAR, the Global Fund and the Joint United Nations Program on HIV/AIDS (UNAIDS), which is meant to strengthen coordination among these three parties in activities to reduce stigma and discrimination in selected countries over a three-to-five-year period. FCC countries are supported to develop a shared collaboration plan to facilitate country-level planning and coordination in this area.

Stigma and discrimination reduction programs

Data gathered by FDC *activistas* and paralegals in 2022 showed that fear of stigma and discrimination were the most important barriers to access to health services for men who

²⁹ Conselho Nacional de Combate ao HIV/SIDA (CNCS). National strategic plan for HIV/AIDS (PEN V), 2021-2025 (English version). Maputo, 2021, pp. 12, 14, 71.

³⁰ Ibid., p. 32.

³¹ Global Fund. Mozambique mid-term assessment: Global Fund Breaking Down Barriers Initiative. Geneva, June 2021.

have sex with men, people who use drugs and sex workers.³² Also, self-stigma remains an issue of concern, with key populations themselves recognizing how self-stigma impacts on the willingness of sex workers and transgender people to disclose, and discrimination even amongst key populations themselves.³³ About 10% of people living with HIV in the 2013 Stigma Index survey reported that self-stigma was a barrier to their seeking health services when needed, with a much higher percentage among women than men.³⁴ One intervention in Mozambique showed that if people living with HIV knew that stigma in the community was relatively low, their anticipated and even their self-stigma declined.³⁵

Since 2013, the PEPFAR-funded non-governmental organization (NGO) Namati has trained health advocates (*defensores de saúde*), working with community (or village) health committees (VHCs), to raise community awareness of health rights through community meetings, mass media and other messaging, report on, and address poor-quality health services.³⁶ The twice-a-year health facility assessments assess the availability, accessibility, acceptability and quality of services including monitoring patient confidentiality, access to health information, medicine stock-outs, adequate toilets and sanitation, provisions for people with disabilities, water or electricity failures, staff absenteeism, promptness of services, and unjustified fees.³⁷ As of February 2023, Namati's health advocates working with VHC in the catchment areas of over 70 health facilities, had handled more than 17,000 grievances related to health services, of which an estimated 74% were satisfactorily resolved.³⁸ PEPFAR also funds a number of community-based organizations to conduct CLM, and Namati has provided training and developed training materials for health advocates and paralegals working with other NGOs in the country.³⁹

The Global Fund supports Principal Recipients FDC and CCS, who engage civil society organization (CSO) Sub-Recipients (SRs) for this work. The Global Fund also supported Namati's training of paralegals for FDC and CSS. CCS integrates S&D Reduction programs into the work of 164 paralegals (increased from 135 under CG5) in 87 districts (increased from 24 districts under GC5). FDC has scaled up integrated stigma and discrimination reduction, legal literacy and legal support services through 300 paralegals in 96 districts (3 per district), from 200 paralegals in 63 districts under GC5. FDC also works with over 3500 activists (*activistas*) from 21 SRs in the same 96 districts, working alongside existing community health committees, to monitor the quality of health services "that have a direct impact on the daily life of the community".⁴⁰ These *activistas* refer cases that go beyond discrimination in health care and require legal or paralegal support, to the paralegals.

³² FDC. Human rights component – community legal assistance, case identification, referral and management and resolution: Overall January to June 2022. Document on file with Global Fund.

³³ Focus group discussion with KPs, 9 February 2023

³⁴ IPPF, ONUSIDA, GNP+, ICW. Índice de Estigma de Pessoas Vivendo com HIV/SIDA – Moçambique, July 2013. <https://www.stigmindex.org/country-reports/#/m/MZ>

³⁵ Yu H. Social stigma as a barrier to HIV testing: Evidence from a randomized experiment in Mozambique. *Journal of Development Economics* 2023; 161:103035, <https://doi.org/10.1016/j.jdeveco.2022.103035>

³⁶ Interview of Ellie Feinglass and Nadja Gomes, Namati, with BDB assessment team, 2 Feb. 2023; see also Namati Moçambique, Grassroots justice and the right to health (statement), March 2021.

³⁷ Namati Moçambique. *Guia de levantamento dos desafios das unidades sanitárias*, Maputo, 2018. <https://namati.org/resources/guia-de-levantamento-dos-desafios-das-unidades-sanitarias/>

³⁸ Interview with Feinglass and Gomes, op.cit.

³⁹ See Namati Moçambique, CCS, FDC. Manual de Formação de Paralegais, Defensores de Saúde e Agentes Comunitários: Direitos humanos para a saúde e acesso à justiça. Maputo, 2020.

⁴⁰ Progress assessment interview with FDC staff, February 2023.

CLM data from FDC in the first half of 2022 on barriers to health services is disaggregated by key population group,⁴¹ and shows a range of barriers experiences by all key population members, such as stigma and discrimination, bribery or illicit charges, extortion, and failure to provide information on the available services. According to FDC, this data is fed into the Ministry of Health’s DHIS2 open-source platform (used for tracking healthcare logistics and supplies, particularly for monitoring supply-chain of medicines, with Global Fund and USAID support).⁴²

Namati has also used its data to influence health policy in Mozambique, including the *National Strategy for Improvement of Quality and Humanization of Health Care*. Namati’s work also helped to shape the ministry’s policy against bribery in health services. The organization has also worked intensively with provincial authorities and influenced provincial policy in the provinces where its health advocates are located.

There are plans to develop standard indicators to analyze all national CLM-generated information to support S&D reduction efforts and facilitate evidence-informed advocacy (noted in PEPFAR Country Operational Plan (COP) 2022 and by several key informants⁴³). However, additional specialized personnel would presumably be needed to analyze data fed into the DHIS2 system, which is generally used for health system administration and logistics.

Evaluations of S&D reduction in health care linked to CLM has been mostly positive. A 2022 Global Fund-supported human rights “spot-check” found that PEPFAR and the Global Fund have generally coordinated well, ensuring good coverage of districts or health facilities with minimal overlap.⁴⁴ Both the Global Fund and PEPFAR view CLM as key to strengthened advocacy, especially around stigma and discrimination in health care, and the 2022 PEPFAR COP also classified CLM as a principal tool for addressing stigma and discrimination beyond the health sector.⁴⁵ However, the application of CLM to reduce stigma and discrimination at the family and community level is unclear. This requires that *activistas*, who may be the first contact for people with conflicts, have the capacity to deal with a range of complaints. The human rights “spot check” noted this as a possible gap in the training of *activistas*.⁴⁶

During the “People’s COP22”, 17 civil society organizations (all but 3 based in Mozambique) concluded that PEPFAR’s pilot CLM activity “holds important promise for improving the quality and accessibility of services”.⁴⁷ However, they found that CLM efforts were not sufficiently led and owned by people living with HIV and key population members in an independent and sustainable structure.⁴⁸ The People’s COP22 recommended sustained direct funding of PLHIV- and key population-led groups to enable them to generate evidence “in service of advocacy” and increasing

⁴¹ FDC, Human rights component, op.cit.

⁴² DHIS2. Harnessing the interoperability capabilities of DHIS2 to deliver life-saving logistics systems in Mozambique (online report), undated. <https://dhis2.org/mozambique-logistics-integration/>

⁴³ See, e.g., interview with Feinglass and Gomes, op.cit.

⁴⁴ GFA Consulting Group. Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level”. Final report. Maputo, Sept. 2022.

⁴⁵ Ibid.

⁴⁶ GFA Consulting Group, op.cit., p 3.

⁴⁷ Kuyakama, Lambda, MozPUD et al. People’s COP22 Mozambique: Community priority interventions for PEPFAR in Mozambique in 2022. Maputo, 2022. <http://pepfarwatch.org/wp-content/uploads/2022/03/Peoples-COP22-Mozambique.pdf>

⁴⁸ Ibid., p 7.

the amounts of the small grants that fund CLM.⁴⁹ In 2022, PEPFAR committed to raising the small-grant ceiling from US \$25 000 to US \$50 000 and that it would add an additional US \$1 million for CLM in 2022 to be managed by a Mozambican NGO rather than by CNCS.⁵⁰

In the workplace, the Labor Law no. 23 of 2007 provides for non-discrimination and privacy protections for all workers regardless of actual or suspected HIV status, sexual orientation or race.⁵¹ The law also mandates basic measures of workplace safety with respect to HIV transmission. The International Labor Organization reported in 2022 that the Mozambican government had made progress in ensuring rights-friendly workplaces for people living with HIV.⁵² ILO supports a project called VCT@Work that is meant to create an “enabling environment” for workers to seek voluntary counselling and testing with a link to HIV services and to ensure a non-discriminatory workplace. The project underscores that testing and knowledge of HIV status should never affect opportunities for promotion and other benefits on the job. As of 2022, ILO reported that through this project 130,000 workers and surrounding community members were provided with testing and other services, including HIV self-testing kits for over 10,000 workers.⁵³

However, discrimination against key populations remains, with LAMBDA reporting that Mozambican workplaces remain an environment “characterized by joking comments, looks and laughter that lead them to isolate themselves and keep their sexual orientation a secret”.⁵⁴

For LGBT persons, LAMBDA Mozambique has been a leading force in addressing stigma and discrimination, including internalized stigma, despite the fact that it has, to date, been denied registration as an NGO. LAMBDA uses a multisectoral strategy to reach service providers in all sectors to raise awareness and fight stigma and discrimination.⁵⁵ It conducts this work in 42 districts under the ViVa+ Project (with indirect Global Fund support) and has also received support for this work from the Government of Canada and the United Nations Population Fund (UNFPA). LAMBDA reports reduced stigma and improvements in community-level acceptance of LGBT people in their areas of work, as well as an increase in LGBT-friendly health services they are able to refer members to, for health services.

Some scholars have suggested that Lambda’s emergence to work on HIV issues related to men who have sex with men was less threatening to social values because MSM was a behavior and not an identity.⁵⁶ LAMBDA attributes its progress partly to the decriminalization of same-sex sex, with the revision of the Penal Code of Mozambique in 2014-15, but more importantly to the scale-up of mass media, social

⁴⁹ Ibid.

⁵⁰ PEPFAR Mozambique COP 2022, op.cit.

⁵¹ UNDP, op.cit.; International Committee of Jurists. SOGI legislation country report – Mozambique. Geneva, 2013.

<https://www.icj.org/sogi-legislative-database/mozambique-sogi-legislation-country-report-2013/>

⁵² International Labour Organization (ILO). ILO at a glance and its work in Mozambique. Lusaka, 2022.

https://www.ilo.org/wcmsp5/groups/public/---africa/---ro-abidjan/---ilo-lusaka/documents/publication/wcms_820558.pdf

⁵³ Ibid., p 8.

⁵⁴ Lambda Facebook post, 20 Feb. 2023, <https://www.facebook.com/LambdaMoz/>

⁵⁵ Lambda Mozambique, “Temos boas relações com as autoridades estatais na província do Niassa” (Facebook post), 25 Jan. 2023. <https://www.facebook.com/LambdaMoz/>

⁵⁶ Gomes da Costa Santos G, Waites M. Analysing African advances against homophobia in Mozambique: how decriminalisation and anti-discrimination reforms proceed without LGBT identities. *Sexuality and Culture* 2022; 26(2):548-567.

media and other awareness-raising work, as well as extensive work with police as well as other public servants – social workers, health workers, justice and education officials and other local authorities. The Global Fund-supported human rights “spot check” attributed success with stigma and discrimination reduction, including internalized stigma, also, to its forming and working with community committees that meet regularly with gay men or other men who have sex with men, discuss and find ways to address issues of stigma and discrimination.⁵⁷ Lambda *activistas* are trained not only to give basic information about HIV and knowledge of rights, but also to help them to accept and overcome fear of disclosure of their sexual orientation. Interviews with men in self-help groups - run by gay or bisexual men - or dialogues convened by Lambda expressed feeling unashamed and able to seek health services without fear, for the first time in their lives.⁵⁸ The “spot check” team noted that they could not find an analogous practice to interest community committees in the stigma faced by sex workers or young people.

However, the legal and policy environment continue to pose challenges. The denial of NGO registration to LAMBDA under the Law on Association (Law 8/91) - which may deny registration to organizations if they “offend public morals”⁵⁹ – hampers the organizations ability to operate and limits resource mobilization. LAMBDA staff reported being denied permission to work in some districts because they are not a legally registered NGO, and lacking resources for adequate evaluations. Additionally, sexual orientation and gender identity are not explicitly included as protected grounds in anti-discrimination law (except in labor law - see section 5 below). In addition, social tolerance towards LGBTI, while perceived to be better than other parts of sub-Saharan Africa, arguably holds when behaviors and expression remain behind closed doors but is strained when same-sex relations and non-conforming gender identities are overt.⁶⁰

Sex workers do not have the long experience or organizational depth of LAMBDA, but they have also built their capacity for awareness-raising on their rights and addressing stigma in recent years.

It was difficult to uncover activities specifically related to reducing stigma and discrimination by people who use drugs at the community level. In many countries, sustained harm reduction and other services for people who use drugs have sometimes served as a base for developing anti-stigma activities in the community. MozPUD, the Mozambican network of people who use drugs, seems to be focused largely on fighting the many barriers and setbacks to establishing harm reduction services in the country. Pilot harm reduction services supported by Médecins Sans Frontières in the Mafalala neighborhood of Maputo, for example, have been discontinued, and authorities in Maputo have banned needle and syringe exchange programs.⁶¹

Recommendations

⁵⁷ GFA Consulting Group, op.cit

⁵⁸ GFA Consulting Group, op.cit.

⁵⁹ Rosario and Gianella, *ibid*.

⁶⁰ Rosario C, Gianella C. Progressive legislation in the context of generalized conservative public opinion: the case of LGBT rights in Mozambique. In [Juuko A](#), [Gloppen S](#), [Msosa A](#), [Viljoen F](#), eds. *Queer lawfare in Africa: Legal strategies in context of LGBTIQ+ criminalisation and politicization*. Pretoria: Pretoria University Law Press, 2022, pp. 57-80.

⁶¹ Interview with representatives of MozPUD and UNIDOS, 8 Feb. 2023.

In Mozambique, stigma and discrimination reduction, linked with CLM, is seen as an essential human rights intervention and as a strategy for addressing HIV-related stigma and discrimination in the health sector, particularly for strengthening evidence of and informing advocacy for stigma reduction. An integrated, collaborative approach, including the work of both Global Fund- and PEPFAR-supported organizations, has led to successful scale-up and supported resolving incidents of stigma and discrimination, particularly in the health care sector. The Assessment found that S&D reduction activities focused on the rights violations in the health sector, integrated with other human rights programs to undertake community-led monitoring (CLM), legal literacy and to provide legal support services, has been scaled up considerably. Both the Global Fund Principal Recipients (PRs) and PEPFAR consider CLM to be an essential element of programmatic responses, and have collaborated effectively to conduct CLM. This work has increased evidence of S&D, supported reducing and resolving instances of stigma and discrimination, and CLM data has been important for advocacy efforts to review and reform law and policy.

Stigma and discrimination reduction interventions in the workplace are also reported to have shown success in reducing HIV-related stigma and discrimination, although less so for key populations. Key population-related stigma remains a critical barrier to HIV services in Mozambique. Strides have been made to address it by key population-led groups; and more so for LGBTI persons. However, challenges such as the lack of well-resourced key population organizations and networks to support this work, and the discriminatory legal and policy environment, hamper progress. S&D reduction interventions for sex workers and people who use drugs, in particular, need increased support.

The combination of scaled-up CLM together with other stigma and discrimination reduction activities has certainly strengthened stigma and discrimination reduction programming in Mozambique. This will hopefully be illustrated by the results of the HIV Stigma Index 2.0 which is currently being undertaken in the country.

It is recommended that:

- Further efforts are made to strengthen truly community-led and community-owned monitoring, linked to stigma and discrimination reduction, in health care.
- Donors and government entities supporting CLM urgently fund an evaluation of the extent to which CLM, linked to community education by *activistas* and paralegals, is able to address community-related stigma and discrimination. The evaluation should be conducted with the meaningful participation of people living with HIV and key population members, supported by evaluation experts. It should also include consultations with FDC and CSS *activistas* about the range of cases they face and identify possible capacity-building needs to be further addressed in training.
- An independent evaluation of LAMBDA's stigma reduction work be undertaken to assess its effectiveness and draw out lessons learned. Similarly, an assessment of efforts to reduce stigma amongst sex workers be undertaken in consultation with sex worker organizations and networks in Mozambique, Aidsfonds, Frontline AIDS, the Global Fund, Pathfinder International and other interested donors. Lessons learned from these consultations should inform a broader strategy for building on existing efforts and strengthening S&D reduction among all key populations.

- Private and public sector employers provide anti-discrimination training on sexual orientation and gender identity linked to existing S&D reduction efforts.
- Standard indicators be developed for collating and analyzing all CLM data at a national level.
- A unit within CNCS should be provided with adequate human and other resources to analyze all CLM data across the country to discern trends, geographical patterns, spikes in certain types of abuses, etc. This analysis would optimize the use of CLM data to contribute to reprogramming, to ensure a comprehensive response to human rights-related barriers to HIV services, as well as to inform advocacy.
- Donors and government entities supporting CLM should engage Namati to support further learnings on the use of CLM data for advocacy, including refresher trainings of *activistas*, paralegals and other forums where use of CLM data to inform advocacy may be discussed.
- Additional investment should be made in key population organizations and networks to support stigma and discrimination reduction work, including on internalized stigma, for members of key populations.
- Increased support is required for programming for law reform in respect of the criminalization of certain aspects of sex work and drug possession for own use, which exacerbates stigma and discrimination against sex workers and people who use drugs.
- The results of HIV Stigma Index 2.0 should be used to inform adjustments in national programming to reduce stigma and discrimination to respond to the results.

(b) Ensure non-discriminatory provision of health care

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Ensure non-discriminatory provision of health care	1.2	1.7	2.3

Health care settings are one of the priority settings for the elimination of all forms of stigma and discrimination and have been identified as a Global Fund “program essential” for the countries where it invests. Health care provision should occur in settings that are welcoming, accepting, caring and supportive for all, including those at risk of and affected by HIV, in all their diversity. Health services wherever they are offered should be free from any form of stigma or discrimination based on health condition, ability, socio-economic status or any other individual or group characteristic. In Mozambique, efforts continue to be made, through the Ministry of Health (MISAU) and CNCS and their many partners, including through key population led CSOs in communities, to achieve and maintain non-discriminatory provision of HIV and other related health care services.

The MTA found that training of health care workers on human rights and medical ethics had improved slightly in terms of scope and scale. The Ministry of Health (MISAU) is responsible for taking the lead on this program area; training health care workers in

human rights and medical ethics falls within MISAU's quality improvement department's mission to deliver "humanized" care.

In association with Namati, MISAU disseminated charters of rights and responsibilities for both patients and professionals. From September 2020, MISAU conducted joint trainings on the National HIV Strategic Plan with HIV and TB service providers, including training on reducing stigma and discrimination against all patients, and specific modules related to HIV and TB, working with key populations and issues related to GBV. It reached 300 health facilities from across the country with the lowest retention rate (less than 85%). Namati's work with activists, local health committees and client service officers was also recognized as a sustainable mechanism to identify and resolve human rights-related barriers to care.

The MTA found remaining challenges. Due to limited resources, training of health facility administrative staff was limited. Also, the scale of training - reaching 300 clinics - represented a fraction of the 1800 health facilities in Mozambique. Pre-service training for providers was not in place. Moreover, the MTA found the need to ensure that training of health care workers in human rights and medical ethics is institutionalized in national plans for HIV, TB and human rights, to ensure long-term commitment.⁶²

The current Assessment found that there continues to be progress on training of health care providers on human rights and medical ethics since the MTA.

The position of HIV and TB Human Rights Advisor has been established within the Humanization Department of MISAU, with support from the Global Fund. The Advisor is responsible for, amongst other things, strengthening co-ordination of the HIV and TB- human rights programming within MISAU and ensuring the development and co-ordination of training on HIV, TB, the law and human rights for health care workers. However, there is a sense that the importance of human rights and gender-related HIV and TB programming is less well understood, and as a result less prioritized, outside of the Department of Humanization.⁶³

There are plans to scale up in-service training of health care workers to reach medical practitioners as well as the head of each facility, the health care workers responsible for mental health, HIV and TB and the focal point for humanization of health in 300 health care facilities. In-service training for health care workers is conducted by trainers employed by MISAU, in collaboration with CSOs such as Namati. As at December 2022 however only 185 of the 300 health care facilities had been reached.

Pre-service training is not yet institutionalized by means of formal Memoranda of Understanding (MOUs), although does take place, albeit informally, in some training institutions. Key populations in an FGD during the Assessment noted that the result of this is that when quality, well-trained staff who are trained in-service are transferred

⁶² MTA p 21-22

⁶³ KII 31 January 2023

from one facility to another, repeated in-service training is required at a particular facility.⁶⁴

Customer care units have been established at all health care facilities, tasked with receiving and resolving customer complaints about health service delivery. However, there appears to be insufficient co-ordination between these units and the community health committees in all facilities, undermining their usefulness.

As with many of the human rights- and gender-related HIV and TB programs, effective monitoring and evaluation remains a challenge and is limited to quantitative rather than qualitative data. To address this, MISAU has developed an online monitoring and evaluation (M&E) tool to evaluate the quality and impact of the training on health care workers. Trainees can complete both pre- and post- training assessments online. However, the tool is not yet operational due to bureaucratic delays within MISAU.

In addition to this progress and ongoing challenges, there continue to be reports of stigma and discrimination within health care. Participants in an FGD held during the course of this assessment expressed their concerns about the attitudes of some health care workers, breaches of confidentiality, limited understanding of their needs and limited access to services, when accessing health care.

“Health care workers are trained but this doesn’t make much of a difference. They are not respectful and there is no privacy. When you go for HIV testing you are supposed to go in one door and exit through another to protect your privacy and confidentiality but in practice this does not happen. Everyone waits for an HIV test in one room and you have to exit through the same room once the test has been done. There is no understanding on the part of health workers that privacy is important. There should be a poster in each health facility that explains patient’s rights”⁶⁵.

Transgender people face a range of both health care and legal challenges: *“As a transwoman I face many barriers – when I go to the health center the health care workers attitudes are “Oh there she is again...” I get so stressed that I cannot even ask for the services that I want. There is no hormone therapy for transgender people. The only access to this is outside the country and it is expensive and beyond the reach of most. Health care workers insist on calling you by your name on your ID document and not by your chosen name and doctors are not familiar with our health needs. It is not possible to change your gender marker on your ID documents. We need to advocate for access to hormone therapy and for a change of law to allow us to change our gender markers and names on our ID documents – this would help with reducing stigma and discrimination against TG in health facilities”⁶⁶.*

Sex workers also reported facing stigma and discrimination and well as breaches of confidentiality at the hands of health care workers: *“As sex workers living with HIV, we face stigma and discrimination from health care workers when we go to get our ART.*

⁶⁴ ibid

⁶⁵ Focus group discussion KPs, 9 February 2023

⁶⁶ ibid

If the health care worker lives in the same area as I do, she will tell her colleagues and our neighbors that I am a sex worker living with HIV. In the health facilities this means that we are kept waiting for long periods of time before being attended to and in our neighborhoods, we are shunned. We face double discrimination – for being a sex worker and living with HIV. I have had to change health facilities a number of times because of this and change my name every time I go to a new facility”⁶⁷.

All participants noted that in general, services for all key populations are better at health care facilities where peer activists are based, and where health care workers have been well trained.

Sex workers reported that some health facilities where peer activists work are more accommodating, for example in Maputo port: *“I find my peers there, so I feel more comfortable there. As an activist I come across many sex workers who want to come to facilities that are more sex-worker friendly but they are few and far between. The ones that are friendly are the ones that have CSOs who have peer activists based at the health facilities”⁶⁸.*

Representatives of people who use drugs reported not only discriminatory treatment by health care workers but also a lack of understanding of the impact of drug use on their ability to access the health services that they need: *“I had a client who uses drugs who was run over by a car. I took him to the hospital where he was admitted but he ran away as he was in withdrawal, and he needed to use. We took him back, but the doctors refused to give him proper treatment as he had run away the first time. Doctors will not prescribe methadone for people who use opioids and who need to be treated as an in-patient”⁶⁹.*

FGD participants attributed stigma and discrimination to deficiencies in training, with insufficient emphasis e.g. on issues of gender identity and sexual orientation, and inadequate monitoring on the content and quality of training, which varies significantly.⁷⁰ They recommended expanded CLM in health facilities by peer activists, improved monitoring of the quality of the training, and strengthened accountability for violations in the health care setting. They also recommended improved efforts to institutionalize HIV, TB, human rights and ethics training within health care worker pre-service training.⁷¹

Case Study: Challenges with community-led monitoring and customer care units within health care facilities

In the past, many locals avoided going to Machava General Hospital. Rumors, misinformation, and its focus on both HIV and TB – MDR and extensively drug-resistant TB in particular – led

⁶⁷ ibid

⁶⁸ ibid

⁶⁹ ibid

⁷⁰ ibid

⁷¹ ibid

to the complaints that “If you go there, you’ll never come back”, according to Christina Rafael, a volunteer community worker at the hospital.

Christina Rafael is the link between the hospital and some of the local villages, where mistrust of the nearby health care facilities can run high. She collaborates with the staff at the hospital, as part of a Co-Management Committee, working to educate communities, and to bring forward community complaints and fears. So she works on the one hand to alleviate fears and to encourage people to in her community to go for testing and treatment, and on the other hand to help make sure that people’s concerns and rights violations are identified, discussed and addressed.

The nurses and the doctors at Machava General Hospital have been trained on HIV and human rights to ensure that patients are able to access effective, reliable and accountable health care services. In addition, the hospital has established a complaints system to record experiences of stigma, discrimination, and other health rights violations at the hospital, even with the limited means available to them. The hospital entrance has a cardboard suggestions box, with post-it pads for writing suggestions, and a large ledger complaints book for patients and their relatives to handwrite (anonymous, if they wish) complaints. Posters on the walls increase awareness about the hospital’s Client’s Office, and the rights of the patients. The complaints office staff person goes through the various complaints books placed throughout the hospital every Friday, to identify and follow up on complaints. The idea is that these Client’s Offices work in coordination with the community through the Co-Management Committees. In some health facilities, however, Co-Management Committees are not aware of the Client Offices and how to work with them, leading to breakdowns in the planned system.

According to the staff and the volunteer community workers, their efforts to protect and promote patients’ rights and to build trust in the health care system have led to a greater willingness amongst members of the local communities to go to Machava Hospital, increasing access to health care services. “I’m saving lives in my family, in my community and that makes me proud,” says Christina Rafael, when asked why she is prepared to walk the one and half hour distance to the hospital, to volunteer her time on the community committee.

However, while there is high level of engagement and enthusiasm amongst the volunteer and medical staff, their efforts and the outcomes are not well recorded, monitored or evaluated. E.g. patients’ and relatives’ complaints are noted down and reviewed, but the follow-up mechanisms are not systematic, particularly for those that can’t be addressed at the health facility. There is limited capacity to collate and analyse data in the handwritten ledgers e.g. to determine the number and type of complaints, whether they are resolved, and trends over time. Additional support and resources are needed to develop a strong, sustainable human right-based complaint system.

Ongoing challenges they cite include the fact that community workers are volunteers, with no remuneration, and they and the Client’s Offices staff receive inadequate training in HIV- and TB-related human rights violations. Communities still need further awareness about their rights, and the complaints mechanisms, in order for the system to work effectively. Additionally, not all health workers have been trained in all facilities, with priorities given to those with high records of patients with HIV and TB. Also, trained health workers are frequently transferred due to ongoing budget cuts, leading to loss of sensitized personnel.

Recommendations

While in-service health care worker training on HIV, TB, human rights and medical ethics continues to be scaled up, this work is taking place at a limited pace, is still inadequate to meet needs, and is insufficiently monitored and evaluated. Pre-service training requires institutionalization to deal with loss of trained staff within facilities. The Assessment recommends:

- MoUs between MISAU and all health care worker training institutions and university medical schools are prioritized, to support integration of human rights and medical ethics module into health worker pre-service training curricula.
- Initial and follow up in-service training on human rights and medical ethics is scaled up across the country, potentially using an online training platform, and broadens its reach to include administrative staff at health care facilities.
- Ensure that both pre-and in-service training curricula for health care workers includes information on the specific needs of key populations, including, for example, access to methadone for people who inject drugs who require hospitalization.
- Training of health committee members and customer care service officers in human rights and medical ethics be prioritized, to ensure sustainability of mechanisms to identify and resolve human rights-related barriers to care.
- The development and roll out of the online M&E tool for health care worker training is completed, with a view to monitoring the quality of training and the impact of training on levels of knowledge and understanding on the part of health care workers.
- CLM data on rights violations, and data gathered from the training M&E tool, be used to address training quality shortfalls and to inform the focus of updated training materials, including around S&D against key populations.
- A system for conducting spot checks on training, to monitor the competence of trainers and the quality of training, be considered.
- M&E of complaints regarding service delivery at health care facility customer care units and the resolution of complaints, be improved.
- Given the reported improvement of services at health facilities where peer activists are present, conduct an assessment of the impact of peer activists on uptake and retention in HIV services, particularly by key populations.

(c) Improve legal literacy ("know your rights")

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improve legal literacy ("know your rights")	1.2	3.0	4.3

The lack of awareness of human rights in the context of health among key populations, the broader communities and duty bearers is a key challenge in Mozambique. The MTA found that, since the baseline assessment, legal literacy programs had expanded in both scope and scale, ranging from “Know Your Rights” radio spots and debates, dissemination of patients’ rights charters and widespread legal literacy activities for girls, young women, sex workers and others. The Viva+ project reached 100 000 women, girls, transgender women and gay men and other men who have sex with men with human rights education sessions that included modules focused on sexual and reproductive health and gender-based violence. Implementers consistently reported progress in what they called “demand creation” - the awareness among beneficiaries and duty bearers that access to health care and to justice were not favors to be bestowed by were entitlements as a matter of law.⁷²

The MTA noted the importance of the integrated approach towards legal literacy used by FDC, CSS, Namati and other implementers, where legal literacy programs involve a broad range of stakeholders and programmatic approaches. Programs included community dialogues and also involved health officials and law enforcement. They were followed up by discussions with health committees and referrals to paralegals and advocates to resolve issues arising. Although time-consuming and requiring sustained engagement within a community, this evidence-informed approach appeared to be producing positive results, and had translated into impact on health outcomes, particularly in reconnecting people to treatment. For example, CCS reported that from January to March 2020, 696 of 875 patients (79%) were reintegrated into HIV care by health advocates, including paralegals who provided assistance in cases involving violations of human rights.

The MTA noted that geographic coverage, reaching only 63 of 129 districts in all 11 provinces, was limited and appeared to be concentrated in more urban areas. Implementers also reported a need for additional written materials and resources in order to improve the quality of training for community leaders and to equip them to train others.

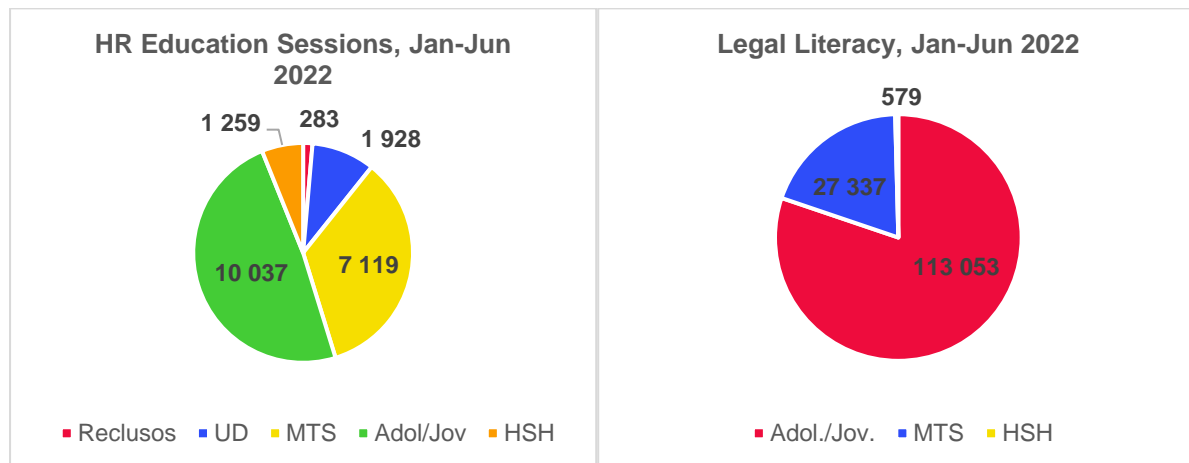
Progress on legal literacy programming since the MTA includes the following:

Coverage of integrated legal literacy programs has increased significantly, using similar, integrated methodological approaches. By the end of 2022, CCS was reaching 86 districts (Maputo Province, Maputo City, Gaza, Inhambane, Manica, Sofala, Niassa, Cabo Delgado) and FDC was reaching 96 districts of the total 129 districts in Mozambique. Both FDC and CSS continue to use an integrated approach, using similar interventions undertaken by *activistas*, paralegals and community committees, with FDC targeting AGYW, female sex workers, men who have sex with men and people who use drugs and CSS targeting adherent and non-adherent HIV and TB patients.

⁷² MTA Report pp 23-26

For instance, during the period January to June 2022, legal literacy and legal empowerment actions carried out by FDC paralegals and activists reached a total of 161 595 adolescent girls and young women, female sex workers, men who have sex with men, people who use drugs, prisoners, parents and guardians, teachers, community and religious leaders.⁷³

FDC Results by population



During the period January to June 2022, FDC conducted 197 radio debates across all 11 provinces using data from CLM and consultation with community committees to determine legal literacy topics for discussion. Topics included child marriage, sexual harassment, stigma and discrimination, assault, sexual orientation, sexual violence, and the Patients Charters of Rights, as well as information on where to seek assistance when a person’s human rights are violated. FDC reports that radio debates and television programs have contributed to the dissemination of information and to improved observance of the human rights of AGYW and key populations by the communities.

FDC continues to use community dialogues, involving community authorities and influential local leaders, parents, caregivers and guardians, people living with HIV and key population members as well as service providers in the health, education, justice and gender sectors. The dialogues provide a safe space to discuss rights and develop local solutions to improve legal literacy remove human rights barriers to access to health and other services. During January to June 2022, FDC conducted 1 108 community dialogues, reaching 16 326 people including AGYW and key populations to discuss rights and barriers to accessing health and other services, including access to education and justice. As with radio slots, data from CLM informs themes for discussion and included GBV, stigma and discrimination in the family, increased vulnerability to HIV by AGYW, lack of confidentiality and poor service provision in health care facilities. Action plans are developed based on the outcomes of the

⁷³ FDC Progress Report January to June 2022

community dialogues and the implementation of these plans are monitored by service beneficiaries.

FDC works with Community Committees (with representation from the Health committee, Child Protection Committee, Community Safety Council, community courts, the school board and representatives of the Family and Child Victim Support Sectors, based in the district police stations and commandos) to sensitize a range of sectors within communities about their rights and to mobilize communities to protect and respond to barriers to access to health services. FDC strengthens their capacity with training on various human rights issues. During the period January to June 2022 FDC conducted 448 technical support meetings with Community Committees in 96 districts, involving around 4 000 members.

These legal literacy and rights awareness interventions have resulted in an increase in cases of reported human rights violations for referrals to legal support. FDC reported receiving 1911 cases relating to barriers to access to health services during the period January to June 2022 - an increase of 70% in comparison with the same period in 2021.⁷⁴

In addition to FDC and CSS, the National Human Rights Commission also conducts a limited amount of “Know your rights” sessions with communities, primarily in rural areas.

A 2022 Global Fund-supported human rights “spot check” identified gaps in the training of the *activistas* and paralegals who carry out legal literacy programs that may negatively impact on the quality of information.⁷⁵ In addition, current training materials for *activistas* and paralegals are reported to contain limited information on harm reduction for people who use drugs.⁷⁶ This will be dealt with in more detail in the following section of access to legal services.

Recommendations

The provision of integrated HIV and TB legal literacy programs at community level, involving a range of stakeholders, continues to be a useful model, reaching greater numbers in more districts and showing impact in improved awareness, increased reporting of rights violations and improved access to and retention in care. The quality of training, particularly with respect to specific populations such as people who use drugs, may need review and improvement. It is recommended that:

- The integrated model of conducting legal literacy, combined with other human rights programmatic responses and using community-led approaches with a range of stakeholders, continue to be scaled up.

⁷⁴ *ibid*

⁷⁵ GFA Consulting Group: Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2022

⁷⁶ FGD with PWUD 8 February 2023

- The training of paralegals and *activistas* be monitored and evaluated to ensure that they have adequate knowledge of common human rights and gender related barriers to access to HIV services for people living with HIV, people with TB and key and vulnerable populations.

(d) Improve access to justice (HIV-related legal services)

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improve access to justice (HIV-related legal services)	2.0	3.0	4.0

The MTA found that since the baseline assessment, paralegal programs had expanded significantly, with three NGOs training and deploying paralegals to reduce human rights-related barriers to access to health care in 11 provinces. Namati had provided strong institutional support and technical assistance and training of paralegals to expand access to justice, and their proven model for integrating legal literacy and paralegal programs with robust community engagement had been adopted by Global Fund implementers.⁷⁷

The MTA noted remaining challenges, including a concentration of services in urban areas, and inadequate rates of resolution (with only 1 600 of 5 000 reported cases having been resolved by Global Fund-supported paralegals) which pointed to the need for improved alternative dispute resolution training for paralegals as well as the need for stronger legal support and strategic litigation for broader impact. It also noted inadequate law enforcement engagement and awareness, which impacted in resolving cases for key populations, particularly female sex workers.⁷⁸ Additionally, the MTA noted the need for improved M&E to measure impact on access to health outcomes.⁷⁹

Progress on improving access to justice since the MTA includes the following:

There has been continued expansion and coverage of integrated legal support services, with FDC and CCS employing more paralegals and lawyers. FDC employs 300 paralegals through its sub-recipients in 96 of the 129 districts in the country, compared to 200 paralegals in 63 districts under GC5 and 1 part time lawyer per province. CCS employs 164 paralegals and 8 legal technicians in 86 districts in 8 provinces. The approach is showing a positive impact on access to justice and access to health, as described in the case study below.

⁷⁷ MTA p24

⁷⁸ Op cit p27

⁷⁹ *ibid*

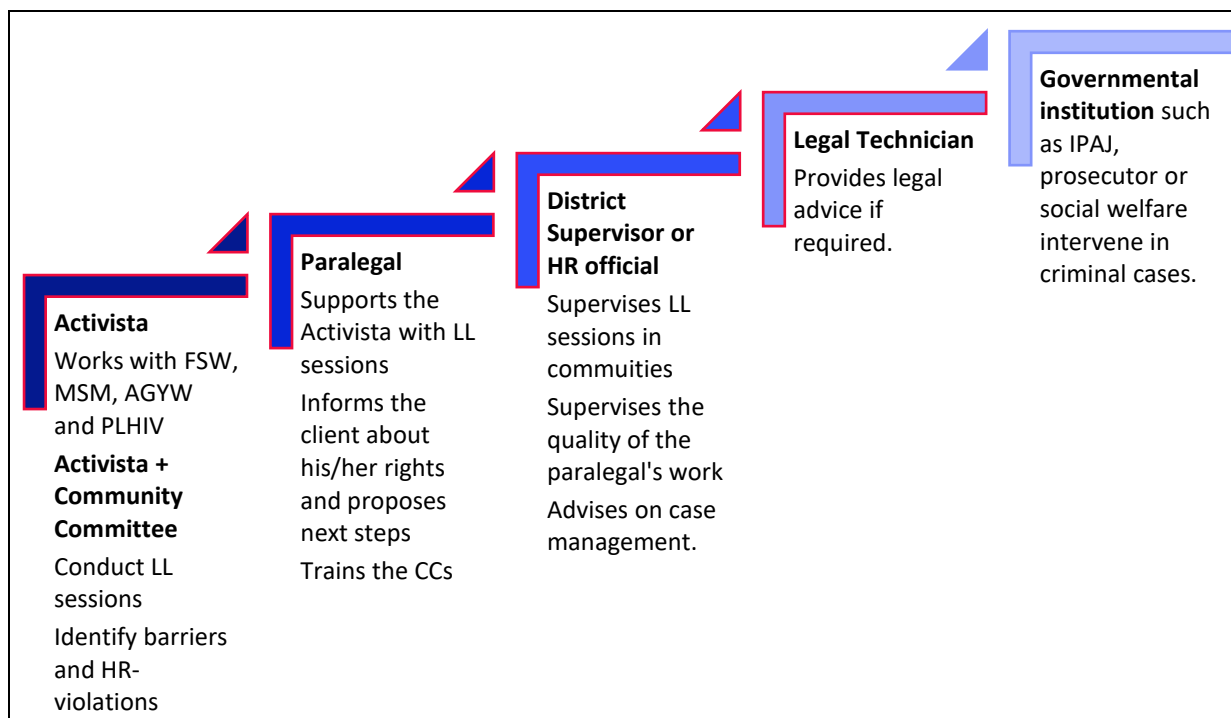
Case Study: Impact of Integrated Legal Support Services on Access to Justice and Health

Integrated legal support services provided by GF-supported implementers are described in full below, as a promising practice that has been well evaluated. The roles, responsibilities and training provided to various role players are described, as well as the impact and remaining challenges to be addressed to strengthen these services further.

Integrated legal support services provided by PRs and their SRs generally include the following role players working together:

- *Activistas* as the first contact point being in daily contact with beneficiaries, with the principal responsibility for identifying violations.
- *Paralegals* to provide further expert support to *activistas*.
- *Community committees and local community leaders* trained by the *activistas* and/or paralegals to identify rights violations.
- *District Supervisors and Provincial Human Rights Officers* where a case requires the involvement of further legal support.
- *Lawyers* where available at PR level.
- *Government legal support structures* e.g. the governmental legal aid institute “Instituto do Patrocínio e Assistência Jurídica” (IPAJ) or the prosecutor.⁸⁰

The response and referral structure is explained in the graphic below.



⁸⁰ GFA Consulting Group, Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2022, p21

Activistas, who are themselves lay community members and representatives of key population groups, have been working for the different SRs for many years in both Global Fund-funded and other programs, responsible for community outreach activities. They now take on additional human rights-related activities, educating beneficiaries about their rights, identifying violations, informing complainants about referral structures and referring them, where necessary, to the paralegal.⁸¹ They are also responsible for working with community leaders to identify participants and key issues for community dialogues and supporting community mobilization.

The *activistas* receive 3-5 days training, tailored to their specific work with target populations. In addition to information on HIV and TB, prevention, counselling and communication skills, they now also receive training on human rights-related topics. They have weekly information and case management meetings with the paralegals and supervisors.⁸²

Paralegals employed by FDC and CCS are expected to have completed secondary education (grade 12) at minimum, be familiar with the community they work in, and be good communicators who are interested in human rights issues.⁸³ They are responsible for awareness raising and legal literacy, identifying and responding to relevant human rights violations; including through extra-judicial means such as mediation; and referring and accompanying people to court to support them with regard to court language and procedures.

Paralegals receive one to three weeks of training (CCS partners with NAMATI to provide one week of theoretical training, one week of practical training, and a third week evaluating and discussing the practical experience; FDC provides one week of training). Thematic areas for training include information on the legal system in Mozambique, and various kinds of conflict resolution; human rights, including the right to health; stigma, discrimination, violence including GBV, and other common rights violations and barriers to access to health care for people living with HIV, people with TB and key populations; protective laws and policies such as the HIV Law 19/2014 and the Patients Charter; and the role of paralegals in providing access to justice⁸⁴.

Lawyers are engaged by FDC and CCS to assist with cases that require referral to the courts. FDC employs 1 lawyer per province on a part-time basis and supports legal costs (e.g. notary fees), despite not having a budget for this. CCS employs 8 lawyers (1 in each province in which they work).

⁸¹ *ibid*

⁸² *ibid*

⁸⁴ CSS progress report 2021

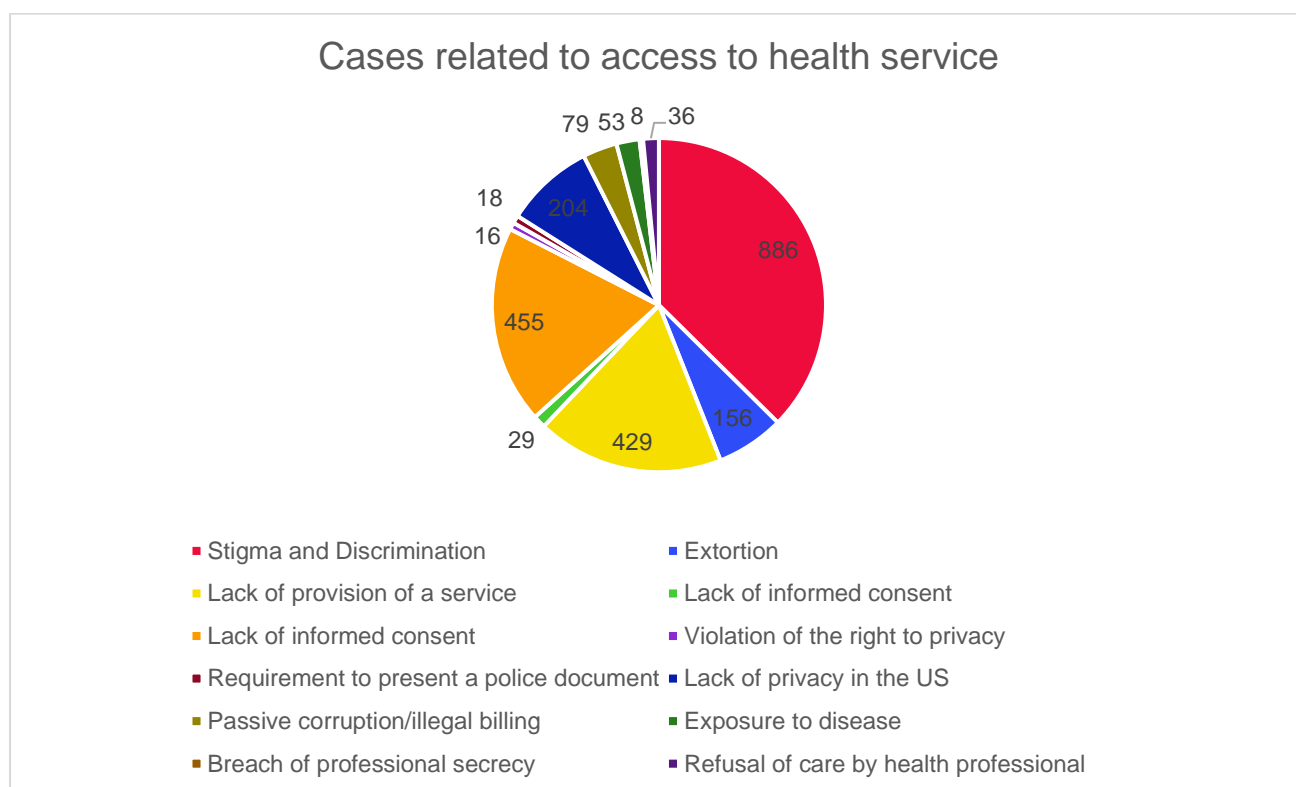
Notably, data from CSS shows that the majority of cases taken on by *activistas* and paralegals were resolved through alternative dispute resolution.

Cases referred and solved 2020 and 2021 CCS

Cases	2020	Jan-Oct 2021
Submitted for extralegal treatment	4236	1782
Solved outside the judiciary system	3684	1757
Referred for legal support	31	89

From July 2021, CCS started evaluating and reporting on the impact of legal support on access to HIV and TB treatment, including return to ART and initiation of children, in particular, on isoniazid preventive therapy (IPT). From July to October 2021, paralegal interventions and support resulted in 591 people being reintegrated into ART, 6 people who started TB treatment and 297 children under the age of 15 who were started on preventive therapy.⁸⁵

Of the 7381 human rights violations reported to FDC during the period July to December 2022. 32 % (2369 cases) related to human rights violations in health care facilities. As indicated in the graphic below, the majority of these related to stigma and discrimination in health care facilities⁸⁶.



Source: FDC Progress Report July to December 2022

⁸⁵ CCS data July to October 2021

⁸⁶ FDC progress report July to December 2022.

Community members interviewed in the course of the Global Fund-supported human rights “spot check” all expressed their satisfaction with the paralegals’ services and the resolution of disputes.⁸⁷ The main reasons for their satisfaction are:

- *The availability of the paralegals*, who distributed their phone numbers widely and were available to help beyond “normal” office hours. This was especially relevant for key populations such as sex workers.
- *Their non-judgmental attitudes* made clients feel accepted.
- *The accessibility of legal aid through paralegals* which are often the only form of free legal support still available to communities, and with whom they could freely discuss matters. Vulnerable populations and those with limited formal education were hesitant to present cases to the police or IPAJ, due to uncertainty about rights violations or out of fear of illicit charges, poor service or ill-treatment.
- *Improvements in relationships with law enforcers for key populations* such as sex workers, as a result of interventions of paralegals. A sex worker from Gondola reported “*Here too the cops have been emptying us for a long time. But we called the paralegals again, they went to complain and now we are walking at ease, no cops or anything that threatens us on the road anymore.*” In Nampula, however, the sex workers still are very much afraid of the violent police and military.
- *Increased self-esteem due to resolution of disputes and referrals to services.* A young man from Chibuto explained during the interview: *In the beginning I was discriminated against and it got to the point that I was thrown out of home, my parents didn't accept me when they found out that I was homosexual. So, from there I went to the authorities and I also had a conversation with “brother” Tomas who introduced me to the paralegal Igor. He was the one who went home, talked to my parents just to open their minds, to make them understand the situation. They accepted me back and I resumed my classes. I stopped for a while because of discrimination, at home and at school. After I met Lambda, I can say that my life really changed, it changed a lot. They opened my mind, they taught me to accept myself first. So, I managed to overcome all the difficulties, and now I am also happy, I am free, I really feel free and I accept myself the way I am and I also sometimes make other people accept me, and I explain to people who and what I am.”*

There are remaining challenges to be addressed to strengthen legal support services. A 2021 analysis⁸⁸ noted several shortcomings in the training of CSS and FDC paralegals, resulting in several knowledge gaps that may negatively impact on the quality of paralegal / legal services provided:

- There is an inadequate understanding of what constitutes a human rights violation and what constitutes a criminal offence. E.g. some paralegals misunderstand what acts constitute a criminal offence, requiring the state to prosecute the offender (*crimes officiais*), and those offenses which cannot be prosecuted in the absence

⁸⁷ *ibid*

⁸⁸ *ibid*

of a complaint by the victim. E.g. some paralegals mistakenly regarded a husband's prohibiting his wife from taking ART as a criminal offence, whereas a case of this nature requires the wife to lodge a complaint in order for a prosecution to take place. A case was cited of a paralegal advising community members that it is against the law to become pregnant before the age of 18. Another is reported to have stated that a wife's refusal to engage in sex with her husband living with HIV is a violation of the husband's rights.

- There is an inadequate understanding of what types of human rights violations constitute barriers to access to HIV and TB services, and which are beyond the scope of the program. E.g. questions were raised about a paralegal supporting a case of a sex worker who was not able to secure a place in school for her child – unrelated to her sex work.
- Paralegals are not provided with any theoretical or practical training on mediation and/or conducting solution-orientated dialogues, despite the emphasis on extra-judicial resolution of conflicts.

Other challenges include insufficient clarity on the division of tasks between the paralegal and the *activista*, particularly in HIV/TB cases where data suggest an increased need for counselling and mediation skills, rather than paralegal support, so that patients start with or remain in treatment, than for legal advice.⁸⁹ The lack of funding for legal costs within the current grant (e.g. court process fees, transport and accommodation) and the limited availability of lawyers are further challenges. In many cases the paralegals are paying transport and accommodation costs for clients out of their own pockets.⁹⁰ Whilst it would be more sustainable to use government IPAJ staff, many are not yet qualified and lack the expertise and experience to take on such cases. CCS has yet to enter into an MoU with IPAJ for legal services, and has had to engage alternative lawyers to provide this service.⁹¹ Some lawyers are unwilling to take on the cases that are referred to them by paralegals. An MSM paralegal reported as follows: *"I had a client who was assaulted- I took him to the police station to lodge a complaint of assault and the police didn't want to take up the case. I also prepared papers for the lawyer but the lawyer didn't want to take up the case either"*.⁹²

With the exception, to some extent, of CCS, the M&E system currently focuses on quantitative data, making it difficult to accurately measure the impact of the work of activists and paralegals on access to HIV services.

Recommendations

An integrated approach to improving access to justice continues to be one of the successes of the Mozambique program and has been scaled up. In reality, many conflicts are resolved without legal support, and access to qualified, sensitized lawyers

⁸⁹ *ibid*

⁹⁰ Interview with FDC representative

⁹¹ Interview with CCS representative

⁹² Focus group discussion KPs 9 February 2023

remains a challenge. In order to strengthen this approach, the following is recommended:

- Continue and scale up existing integrated programming utilizing *activistas*, paralegals and lawyers to reach remote and rural areas.
- Fund a thorough assessment, including of CLM data, to determine the particular human rights violations faced by the target groups, to clarify areas of focus with staff.⁹³
- Review and update the training materials of paralegals based on the assessment; and on alternative dispute resolution and mediation skills.
- Provide refresher training, mentoring and follow up to all existing paralegals.
- Ensure an adequate budget in Global Fund and other funding requests for ancillary costs associated with litigation, including court fees and transport for pro bono lawyers.
- Ensure the implementation of the MoU with IPAJ to provide legal services and provide IPAJ lawyers with the necessary capacity strengthening to do so.
- Strengthen M&E to measure outcomes and impact in addition to outputs, for example by pre and post training evaluations, user surveys and health data.

(e) Ensure rights-based law enforcement practices

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Ensure rights-based law enforcement practices	0	0.5	2.6

The MTA noted that government had made some, albeit limited, progress in ensuring rights-based law enforcement practices. However, the lack of cooperation and coordination between CNCS and the Ministry of the Interior, IPAJ and the Judicial Training Centre (CFJJ), with whom CNCS had concluded Memoranda of Understanding,⁹⁴ meant it remained sporadic and localized. Local efforts by other organizations to educate and collaborate with law enforcement - such as the work of Pathfinder International’s Bridging the Gaps and PITCH programs, supported by Aidsfonds, with key populations and the police – were limited in scale and resources. The MTA identified the lack of police awareness and response as a significant obstacle to achieving successful dispute resolution and redress.⁹⁵

The situation continues, showing signs of some good, albeit limited, progress since the MTA. The Mozambique Republic Police (PRM) has updated and strengthened its training manual for police members to include more comprehensive information on issues faced by all key populations. In 2022, PRM has provided in-service training for

⁹³ (GFA Consulting Group, Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2023)

⁹⁴ MTA p21-22

⁹⁵ *ibid*

13 000 police members in all districts and provinces on HIV, human rights and key populations (men who have sex with men and sex workers) as well as on people who use drugs and harm reduction.⁹⁶ Regular monitoring of quality takes place, through observation and supervisory participation in the trainings.⁹⁷ With the exception of training of police members on sexual orientation and gender identity by LAMBDA (see below), it is not clear to what extent PRM actively involve PLHIV and members of key populations in police in-service training. PRM also work with communities, training community leaders to conduct trainings at community-level; focused primarily on GBV with current initiatives to expanded to include a broader range of human rights topics.⁹⁸

Pre-service training and integration within the curriculum remains difficult due to challenges with command-level commitment and resistance from management of police academies, who view the subject matter as beyond the scope of traditional police training. To address this, the PRM continues to work on getting buy-in at command level. They also continue to work with police academy trainers to review and increase understanding of the materials, and these efforts are now beginning to show results.⁹⁹

Evaluation of the impact of the training on participant experiences, has not taken place. A formal assessment is planned for 2023. However, PMR report seeing substantive changes as a result of in-service training and sensitizing the management cadres of the PMR. They report seeing a steady increase in reports by key populations to the police, which they see as indicating an increased trust in the police. E.g. in the past sex workers were reluctant to report cases of violence perpetrated against them by clients and preferred to go to the hospital and not to the police. More sex workers are reporting cases to the police, even in cases where the perpetrators of violence are the police themselves.¹⁰⁰

They also report an improvement in the responses to cases of client and police violence against key populations. E.g. in 2022, perpetrators were apprehended and prosecuted in 13 cases of homicides of sex workers in Beira. Previously, police members would not always treat sex workers' reports of violence seriously, but they now have a better understanding of the issues and take them seriously. Internal disciplinary measures are taken in cases of police abuse, with dismissals in the case of abuse. In Matola, special force members were prosecuted and sentenced for abusing sex workers.

PMR also reported changed attitudes on the part of police management and members towards key populations, including towards police recruits (including men who have sex with men and transgender people) wishing to become police, citing examples of

⁹⁶ Kll Egor Borges, Jorlino Tembe, PRM 2 February 2023

⁹⁷ *ibid*

⁹⁸ *ibid*

⁹⁹ *ibid*

¹⁰⁰ *ibid*

both MSM and transgender people participating in basic police training and being employed as police members.¹⁰¹

LAMBDA also sensitizes police members on sexual orientation and gender identity, and report an increased number of police members willing to address rights violations against LGBTI people. A LAMBDA representative spoke of a case where a woman reported to police that her son's friends were "teaching" him to be gay. The police member declined to take the complaint and explained to the woman that it is not possible to "be taught to be gay" and proceeded to sensitize the complainant on sexual orientation and gender identity.¹⁰²

Aidsfonds, Frontline AIDS and Pathfinder International have supported a National Platform on Sex Workers' Rights, which undertakes CLM of policing practices in all 11 provinces.¹⁰³ Sex workers are trained and supported to document violence, police misconduct and discrimination against sex workers and to report these to the platform.¹⁰⁴ The Platform has shown success; however, it also requires police counterparts to participate effectively with sex workers. If this does not take place, the Platform cannot be effective.¹⁰⁵

Pathfinder also supported the development of a sensitization manual that the police directorate and the Ministry of the Interior have accepted for further police training.¹⁰⁶ Sex workers have also worked to sensitize healthcare providers, with some success, though discriminatory and abusive behavior on the part of health workers remains a concern.¹⁰⁷

The National Platform notes progress since sex workers have been organized in all provinces but identifies key challenges as being the 'legal limbo' within the current legal framework, and the need for sustainable funding for community-based advocates.¹⁰⁸ They have submitted a shadow report to the UN CEDAW Committee, documenting continued discrimination and calling for comprehensive decriminalization of sex work in Mozambique.¹⁰⁹ Paid sexual transactions themselves are not illegal in Mozambique, but many activities associated with sex work are prohibited, and "public decency" ordinances may also be used to arrest and prosecute sex workers.

CFJJ, which has an MoU with CNCS, has started developing training materials and curricula on HIV, TB and human rights and key populations for judges, prosecutors

¹⁰¹ *ibid*

¹⁰² KII Roberto Paulo LAMBDA 1 February 2023

¹⁰³ Aidsfonds, Frontline AIDS et al. Gaining power: How sex workers in Mozambique made their voices heard. 2021.

<https://aidsfonds.org/story/how-sex-workers-in-mozambique-made-their-voice-heard>

¹⁰⁴ Aidsfonds. Interview: Data collection advances advocacy for sex worker rights. 24 February 2023.

<https://aidsfonds.org/work/hands-off-reducing-violence-against-sex-workers/news/interview-data-collection-advances-advocacy-for-sex-worker-rights>

¹⁰⁵ *ibid*

¹⁰⁶ Pathfinder International. Encouraging respect for sex workers' rights in Mozambique. Undated,

<https://www.pathfinder.org/encouraging-respect-for-sex-workers-rights-in-mozambique/>

¹⁰⁷ Aidsfonds, Frontline AIDS et al. Gaining power, *op.cit.*

¹⁰⁸ Aidsfonds, Frontline AIDS et al. Gaining power, *op.cit.*

¹⁰⁹ Tiyane Vavasate. Submission to the Committee on the Elimination of All Forms of Discrimination Against Women. 73rd Session, 2019.

and other justice sector institutions, including the national Directorate on Human Rights and Citizenship, the Correctional Services and IPAJ (Legal Aid Board). The training activities, generally implemented by CFJJ Trainers, will now involve co-facilitation by members of key populations. A CFJJ representative reported however that the trainings are yet to commence due to delays in the disbursement of funds to CFJJ from CNCS.¹¹⁰ LAMBDA is also working with magistrates to provide sensitization on sexual orientation and gender identity¹¹¹ and FDC, a PR, has entered a partnership with the Mozambican Association of Judges and the Mozambican Association of Prosecutors which has enabled them to contribute to the upgrading and training of magistrates to improve their performance in the area of human rights.¹¹²

FDC has also been engaged with sensitization of Magistrates on HIV and human rights. During the period July to December 2022 eight workshops were conducted in eight Provinces (Maputo City and Province, Manica, Tete, Sofala, Zambezia and Niassa), attended by 197 Magistrates. The objective of these workshops is to strengthen the technical competencies of the magistrates to handle cases relating to stigma and discrimination against people living with HIV, violation of the rights of women and young girls and key populations. FDC has adopted an innovative methodology for these workshops in terms of which magistrates, paralegals, prosecutors and representatives of PLHIV, women and young girls and key populations sit together in working groups where they discuss common human rights violations faced by these groups, including stigma and discrimination, sexual and gender-based violence, sexual harassment and child marriage.

In each group, each beneficiary tells her/his story about human rights violations and the barriers encountered in resolving them. From this *story telling*, questions for reflection emerge and magistrates and prosecutors hear firsthand about the problems faced by these groups. They agree on key actions that need to be taken to ensure that people are held accountable for these human rights violations.

The workshops have yielded positive results. For example, in the city and province of Maputo during the period July to December 2022 there was an increase the number of these cases finalised in court to 17 from 7 in the preceding six months. Similarly in Sofala province the number of cases resolved increased to 38 during the period July to December 2022 compared to 18 in the preceding six month period.

FDC reports that these workshops have contributed to:

- Increased procedural speed in cases involving minors;
- Increased openness, communication and flexibility by Magistrates in FDC-related human rights violation cases;
- Increased number of cases finalized in court;
- Improved collaboration and coordination between the different organs of

¹¹⁰ KII Sérgio Baleira, CFJJ 28 February 2023

¹¹¹ KII Roberto Paulo op cit

¹¹² KII Guilamba Casimiro FDC 7 February 2023

administration of justice¹¹³.

Challenges remain, with key populations still reporting discrimination, violence and a lack of cooperation on the part of some police members. One sex worker stated that *“Police take away our ID documents and chase our clients away. Sometimes they arrest and detain us and make us clean their toilets – sometimes they beat us and demand sex in exchange for our release. The training on human rights that the police receive does not reach the police members on the ground. The law on sex work is not clear and sometimes the police see us as illegal.”*¹¹⁴ Another reported that *“If you go to them to lay a complaint against a client who has assaulted you or not paid you they will not take the case forward as the client against whom you are complaining pays the police off with the money they should have used to pay me.”*

A person who uses drugs reported that *“ We face lots of violence at the hands of the police – even if they only find us in possession of a syringe. If the police come to a hotspot and find one person with drugs they arrest everyone there and keep them in custody. Many PWUD are car guards so that they can earn some money for drugs. They are generally very protective of cars parked in their “spot” as they know that if anything happens, they will not get paid to guard cars again in that area. In one case a woman who parked her car left her door unlocked by mistake. The car guard followed her to tell her that she had left the door unlocked. Her response was to go to the police and to tell the police that her phone had been taken out of her car and blamed the car guard. The police came and arrested the car guard and his colleague and assaulted them and arrested them. The next morning the same woman came to the police station with her husband and told the police that she had subsequently found her phone and asked that they be released. The car guard and his colleague were too scared to open a complaint against the police”*¹¹⁵.

Additional challenges in training of police include inadequate M&E, which currently focuses on quantitative outputs rather than qualitative impact, and 8-month delays between the signing of MOUs and the disbursements of funds from CNCS to both PMU and to CFJJ, delaying the implementation of training programs for both police members and judicial officers.¹¹⁶

Law makers and correctional service officers have been left behind: there appears to be limited programming for the training and sensitization of both lawmakers and correctional service officers, beyond the work of some work of CSOs who provide educational activities on HIV, TB and human rights for correctional service officers.¹¹⁷

Finally, whilst the integrated approach to community led monitoring, legal literacy and access to legal services using paralegals and *activistas* is used extensively in relation

¹¹³ FDC Progress Report July to December 2022

¹¹⁴ KP FGD 9 February 2023

¹¹⁵ *ibid*

¹¹⁶ KII Sérgio Baleira CFJJ 28 February 2023; KII Egor Borges, Jorlinho Tembe, PRM 2 February 2023

¹¹⁷ KII Laurence Saubame, Association for the Rehabilitation and Social Integration of Prisoners 14 February 2023.

to the provision of health services, with good results, there is no wide-scale similar approach towards CLM of policing practices.

Recommendations

There continues to be some progress in the training and sensitization of law enforcers, and monitoring of violations against key populations such as sex workers. However, the Global Fund support to integrate training within pre-service training of police continues to have limited success, and various challenges remain. In addition, the impact of the in-service training efforts is not well evaluated, with anecdotal reports serving as evidence of impact across various sectors.

To achieve comprehensive programs to ensure rights-based law enforcement practices, the following steps are recommended:

- Fully investigate the barriers to integrating the module on HIV, TB, human rights and key populations into PRM pre-service training at police training colleges, with high-level police management consultations. Conduct similar consultations with correctional services management.
- Scale up in-service training of PRM members and actively engage PLHIV, people affected by TB and members of key populations in these trainings.
- Integrate the module on HIV, TB and human rights and key populations in the pre-service training of members of the judiciary and prosecutors offered by CFJJ, and expand coverage of this training to community court members.
- Scale up programming for the meaningful involvement of KPs in the training of PRM members and the sensitization of law makers.
- Scale up programming for pre-service and in-service training for correctional services staff on HIV, TB, human rights and key populations.
- Develop and roll out an M&E strategy and tools for adequately evaluating the impact of law makers and law enforcers sensitization and training on both police members and key populations.
- Develop and implement programs for peer learning and dialogue between members of the judiciary on HIV, TB, human rights and key populations.
- Scale up and expand the use of the integrated approach to community led monitoring, legal literacy and access to legal services using paralegals and *activistas*, to monitor and address violations of rights by people living with HIV and key and vulnerable populations (with a focus on FSW and PWUD) at the hands of police members.

(f) Improve laws, regulations and policies related to HIV and HIV/TB

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improving laws, regulations and policies related to HIV and HIV/TB	0	1.5	2.3

The MTA found that the legal environment supporting the HIV response had been improving in Mozambique. In 2014 an amended HIV law, the Law for the Protection of Persons, Workers and Job Candidates Living with HIV (Law 19/2014, was passed that includes non-discrimination protections for people living with HIV in both the public and private sectors, mandates informed consent for testing and confidentiality for HIV status and removes provisions in the previous law that criminalized non-disclosure of HIV status and non-intentional transmission.) The law includes prohibitions against discrimination based on HIV status in the health sector, in educational institutions, in markets and restaurants and other public places, in the conduct of police, in housing, in civic participation, in social assistance programs, and in employment. Moreover, in 2015, Mozambique decriminalized consensual same-sex sexual relations.¹¹⁸

Despite these improvements, elements of a challenging legal environment remain. The 2021 UNDP-supported Legal Environment Assessment (LEA) identified the need for improved implementation and development of regulations for the HIV law, the addition of non-discrimination protections for key populations, and provisions to protect women from gender-based violence and to increase access to sexual and reproductive health and rights, review of workplace policies on HIV and reform of punitive drug laws and policies.¹¹⁹ The MTA recommended that the LEA recommendations be implemented, and that technical support be provided to civil society and key population organizations who lacked capacity for national-level advocacy.¹²⁰

The Assessment found that there has been some progress on the monitoring and reform of laws and policies since the MTA. In 2019 Article 30 of the Family Law Act Number 10/2004 of 25 August 2004 was amended to prohibit marriage before the age of 18, with or without the consent of the person.¹²¹ In terms of the amended law the arrangement of such a marriage is a criminal offence punishable with a sentence of up to 12 years imprisonment. Whilst implementers under GC6, for example FDC paralegals, are engaged in raising awareness about and enforcing this law, cultural norms and tradition still support the practice of early marriage, particularly in rural areas. The enforcement of this law is being undermined by ongoing internal displacements due to terrorism in the north of the country, poverty, entrenched patriarchy and gender inequality and lack of support for CSOs to monitor and enforce the implementation of the law.¹²²

Work is also ongoing on the review and updating of Law No. 19/2014 as well as on Law No. 03/97 on drugs in order to facilitate the provision of needle and syringe exchange, in line with the recommendations of the LEA. In addition, regulations for the effective implementation of the HIV Act have been finalized and are awaiting

¹¹⁸ BDB Mid-term Assessment Report p.25

¹¹⁹ UNDP Mozambique HIV Legal Environment Assessment 2021 available at <https://hivlawcommission.org/wp-content/uploads/2021/11/UNDP-Policy-Brief-LEA-Mozambique-Portuguese-D4.pdf>

¹²⁰ BDB Mid-term Assessment Report op cit

¹²¹ "Early marriages are now a crime in Mozambique." World Vision, July 30, 2019.

<https://www.wvi.org/stories/mozambique/early-marriages-are-now-crime-mozambique> available at <https://ehs.se/en/wp-content/uploads/sites/2/2022/05/mozambique-child-marriage-report-5mr445.pdf>

¹²² E. Heinonen, L. Lindfors & S. C. Sammy, Child Marriage in Mozambique, March 2022

approval.¹²³ The promulgation of these regulations may improve the implementation of the law, which is currently seldom used to bring forward cases of HIV-related discrimination, with the exception of workplace-related cases.¹²⁴

There are however a number of additional LEA recommendations that are yet to be actioned.

As many of the laws and policies that require reform fall under the jurisdiction of Ministries other than the Ministry of Health (for example, the law that regulates the possession and use of narcotic drugs), CNCS undertakes high-level engagement and sensitization with other Ministries and sectors to raise awareness about and to seek to develop consensus on the need to reform specific laws and policies that act as barriers to an effective HIV response.¹²⁵

Aside from this, there appears to be a little in the way of civil society advocacy for the reform of laws and policies as recommended in the Legal Environment Assessment.

Recommendations

Strengthened efforts are required to support civil society advocacy and multi-sectoral government commitment to reviewing and reforming all laws, regulations and policies identified as challenging by the LEA, and to support the implementation of current protections in law. Recommended actions include:

- Increase investment in CSOs and community-led organizations to engage in advocacy for law and policy reform.
- Strengthen the capacity of CSOs, particularly those led by key populations, for advocacy at a national scale, including through including the provision of technical assistance for the development of advocacy training materials and policy briefs to support advocacy.
- Support the establishment of a national platform for engagement between civil society and relevant government ministries on policy and law reform required for an enabling environment for an effective HIV response.

(g) Reducing HIV-related gender discrimination and GBV

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Reducing HIV-related gender discrimination and GBV	1.5	3.0	4.3

The MTA found that while there have been some successes in gender-focused programming, there have also been many challenges. Overall, respondents highlighted the need for strengthened technical assistance and support for the M&E

¹²³ KII Dr Filimino Mujovo, Rosalina Cossa, Ministry of Justice, 8 February 2023

¹²⁴ Interview with Nadja Gomes, op.cit., 15 Feb. 2023.

¹²⁵ KII Paulo Raimundo, CNCS 1 February 2023

of the impact of the legal literacy and paralegal programs supporting women, girls, and sex workers, and challenges with redress for violations of sex workers' rights, from law enforcement officers.

Moreover, the MTA found that some populations were not sufficiently prioritized. Although male engagement programs are recognized in national HIV policy as key to reducing HIV risk among men as well as among women and girls, they remained limited in scope and scale¹²⁶. Transgender people remained largely invisible in the national HIV response, with limited data on HIV and population size among transgender people hampering informed program development for reducing human rights-related barriers to services, and a clear need for broader support beyond the work of LAMBDA .¹²⁷

Progress since the MTA has been notable. The provision of integrated legal literacy and access to legal services through *activistas*, paralegals, *pro bono* lawyers and community committees, primarily by FDC and CCS, has scaled up significantly, and includes training and responses to issues of gender equality and GBV. Cases of gender-based violence are generally detected by the *activistas* as well as the community committees. Paralegals accompany the client from the moment the case is detected to its closure, either at a police station, extrajudicial settlement or through court.¹²⁸ The highest number of sexual violence cases reported to FDC by AGYW in 2021 were amongst the 10-14 year age group (32% of all human rights violations reported by AGYW).¹²⁹

In Mozambique cases of gender based violence continue to increase;¹³⁰ from 2017 to 2019 the number of cases rose by 19 per cent.¹³¹ In 2019, the most cases were reported in the province and city of Maputo, with 3 803 in the city and 2 686 in the province.¹³² Since cases are often heard by the community courts, they have been targeted for training on gender equality, GBV and harmful traditional norms and practices. In addition, efforts to promote the model of integrated care for GBV survivors have been undertaken, bringing PMR members and health care providers together for training on HIV, gender, human rights, gender identity and sexual orientation and on how to respond to women and key population survivors of GBV. There has also been an increase in the number of GBV Integrated Care Centers through the establishment of additional centers in 4 provinces (Zambezia. Tete, Niassa and Cabo Delgado)¹³³.

Case Study: Male engagement at Nkobe Health Facility, Matola, Maputo Province

¹²⁶ MTA p26

¹²⁷ *ibid*

¹²⁸ Human rights spotcheck at 35

¹²⁹ Human rights spot check at page 56

¹³⁰ See data available from National Institute for Statistics. Available at: <https://bit.ly/3uewqvw>

¹³¹ Instituto Nacional de Estatísticas (2019) *Estatísticas de violência doméstica, casos criminais e cíveis 2019*, p. 10. Available at: <https://bit.ly/3g8Boma>

¹³² *op cit* at p 11

¹³³ *Ministry of Gender, Children and Social Action (MGCAS) 2021*

The Progress Assessment team visited Nkobe health facility, a site that provides health information and services to pregnant and breastfeeding mothers to reduce vertical transmission, as well as to provide ART to infants. The site illustrates the way in which PRs have *comprehensively integrated human rights, gender-transformative support with health services at both health facility and community level*, engaging women and their male partners, and the positive impact this has had on reducing discrimination and improving access to and retention in services for both AGYW and their male partners.

At Nkobe, CCS paralegals and *activistas*, 'Mother Mentors' and 'Champion Men' (peer women and men who have successfully dealt with and prevented vertical transmission of HIV with their partners) work together with staff of the health care facility to support clients. They provide health information, positive living support and advice to pregnant mothers and their male partners and follow up regularly, including with home visits. They also provide information on rights, harmful gender norms and GBV, and document and refer instances of stigma, discrimination and violence to the *activistas* and paralegals to support resolving disputes. They do this work both at the health facility and as part of community dialogues in the surrounding communities.

CCS staff reported how fear of stigma and discrimination discourage couples from wanting pregnant and breastfeeding to take ART, or to want home visits from the facility. Mentor Mothers, Champion Men and the paralegals talked about how they were seeing reduced stigma and discrimination amongst couples and within communities, which made women more willing to take ART. The engagement of men is a core part of the work. When they first started the work, in 2021, they had around 18 cases per month, now they were reporting around 4 cases per month. The health facility reported on the positive impact of the integrated approach and the gains this has had for 'humanizing' health services. They report having a good, close relationship with the pregnant and breastfeeding mothers at their facilities, and high levels (90%) of retention in services.

Ongoing gaps and challenges include ongoing difficulties with cooperation from law enforcers, particularly for key populations,¹³⁴ high rates of child marriage despite the 2019 law outlawing child marriage (attributed to a general lack of knowledge about the 2019 law, and ongoing conflict in the Cabo Delgado region where internal displacement of families and children have led to an increase in the rates of early marriage)¹³⁵ and ongoing GBV. In addition, no HIV Gender Assessment has been done to date, to support a thorough understanding of gender transformative, equitable and rights-based responses to HIV and TB, despite the fact that gender inequality and GBV are still one of the contributing factors to loss to follow up and retention in care for women¹³⁶.

Additionally, as with other programs, M&E of the impact of interventions is limited. There are also still no accurate data on transgender people, either for HIV surveillance

¹³⁴ KP FDG 9 February 2023

¹³⁵ Between January and March 2022, the agency recorded 108 cases of child marriage in the Pemba, Metuge, Chiure, and Montepuez districts of Cabo Delgado, compared to 65 cases between October and December 2021. Between January and March, the number of children newly married steadily increased, from 6 children in January, 32 in February and 70 in March. Save the Children 19 May 2022 available at <https://www.savethechildren.net/news/rates-child-marriage-double-amongst-thousands-children-displaced-conflict-cabo-delgado>

¹³⁶ GFM Consulting Group: Porque parou? Study Report on the patient-related reasons for abandoning or remaining in antiretroviral therapy 2021

or population size, hampering informed program development for reducing human rights-related barriers to services for transgender people.

Recommendations

Progress in programming for gender inequality, reducing harmful gender norms and addressing GBV has benefitted from broader, integrated programs to increase legal literacy and access to legal support services, as well as efforts to sensitize law enforcers. However, critical and specific gendered issues facing people living with HIV, people with TB and key populations remain less well understood and addressed. In addition to continuing existing work, it is recommended that:

- A comprehensive HIV Gender Assessment be undertaken, to inform targeted programming to address gender inequality and gender-based violence.
- Legal and policy literacy on children’s rights, including laws and policies related to early child marriage, sexual and reproductive health and rights, be undertaken at community level.
- Continued scale up of sensitization and engagement, including with community, traditional, religious and opinion leaders on GBV and harmful gender norms and traditional practices, be prioritized.
- The expansion of the provision of integrated services for GBV survivors be prioritized.
- Improved support and capacity strengthening for TG led organizations to engage in advocacy for health and human rights for transgender people in Mozambique.

(h) Community mobilization and human rights advocacy

HIV program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Community mobilization and human rights advocacy	*	*	2.0

Both CCS and FDC work with and through different structures at community level. CCS works with the already existing health and co-management committees. CCS SRs’ paralegals participate in those committees to discuss the main problems related to HIV / TB retention with health committees, co-management committees and entities of district health services to ensure an enabling environment and provision of humanized health services¹³⁷.

FDC SRs establish their own committees; each district has at least one for FSW, MSM and AGYW.

The objective of these committees is to strengthen the communities on legal literacy and empowerment to ensure local monitoring of HIV, GBV related laws, regulations, protocols and policies. Each committee comprises representation from the health

¹³⁷ GFA Consulting Group: Final Report, Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2022, p40

committee, the co-management committee, the child protection committee, the community safety council, and the school council.

All committees are trained by the paralegals. It would appear that there are no standardized training materials for these committees but AGYW and FSW committees reported that they received a 1-day training by the paralegals on human rights violations, especially GBV, early marriage and physical and economic violence in general.

Despite having the same ToR, the MSM committees function differently from the AGYW and FSW committees. The table below illustrates these differences.¹³⁸

	MSM	FSW and AGYW
Composition	At least one member of the CC is an MSM. He is in the group to talk about his own experiences of discrimination, sensitize the other members about the stigmatization that MSM face in the communities and give advice on how to deal in the most appropriate ways with stigma and discrimination related to MSM. In addition to the MSM, one member of the Chamankulo CC was a clinical psychologist who also tried to develop empathy and understanding for the situation of MSM.	Neither the FSW nor the AGYW CCs included any representative of their target population; they spoke about the FSM and AGYW but not with them. Consequently, many CC members didn't feel connected at all to the "target group" of the CC.
Focus	The MSM CC focus is entirely on reducing HR violations related to MSM. This can be discrimination, expulsion from home or physical violence when discovering the sexual preference of the client.	No specific focus related to their target group has been identified, but a rather general one on identification of cases of GBV, early marriage and violence in general within the communities.
Activities	Members of the CC sensitize their fellow colleagues. Policemen, for example, sensitize during their daily activities their colleagues on the rights and special problems of the MSM. They intervene as CC-member only when the rights of a MSM is being violated. For example, they support men who are expelled	These CCs perceive themselves as "the eyes of the community". Both FSW as well as AGYW CCs report cases of GBV, early marriage and physical and economic violence to the paralegal. The FSW CC particularly seem to have little understanding for "their" target group.

¹³⁸ *ibid*

	<p>from home or a MSM who has been discriminated publicly. Their approach is to mediate between the conflicting parties, sensitizing the offender on the needs and rights of the victim.</p>	
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Both CCS and FDC and their respective SRs also conduct community dialogues. According to FDC’s strategy paper, “*the community dialogues are an opportunity for beneficiaries (Girls; Young Women; Sex Workers; Men who have Sex with Men) to have an appropriate, private, confidential, friendly and welcoming space to address relevant issues around their human rights; raise barriers and challenges that prevent or hinder access to services or care and take concrete actions for their resolution. The providers of the different services related to the satisfaction or enjoyment of these rights also participate in these dialogues.*”¹³⁹

Examples of these are MSM community dialogues facilitated by LAMBDA. During these meetings, the MSM meet to discuss one theme that has been introduced by the paralegal. Apart from discussing legal aspects related to the topic of the day they debate about their situation as MSM within the communities and issues related to stigma and how to cope with it. These dialogues generally do not include service providers such as health care providers, due to concerns about confidentiality.

CCS defines community dialogues as dialogues with community members about various human rights and health related topics which are “mobilized and prepared by *activistas* in collaboration with community leaders, paralegals and with the support of health and human rights experts”¹⁴⁰.

FSW, AGYW and HIV/TB community dialogues convened by CCS and its SRs generally involve between 20 and 30 community members who have been mobilized by the *secretário do bairro* as well as the *activistas*. Generally, the greater part of these dialogues are taken up by a talk by the paralegal on the topic of the day and dialogue part of the meeting is confined to a few questions posed to the participants prior to the talk about whether they had ever heard of the topic of the day, what they heard and what they knew about it. The focus of these dialogues is primarily on early marriage/pregnancy, GBV/domestic violence/rape regardless of the target group (HIV/TB, FSW or AGYW), and rarely on other HIV-related human rights violations. In addition, paralegals focus more on the need for punishment of perpetrators of GBV than on addressing the need for programming to reduce GBV in the community, which is frequently met by resistance from women participating in the dialogue who state that they do not want their husbands to go to jail but to stop being violent at home¹⁴¹.

¹³⁹ FDC. (2020). *Estratégia de Implementação das atividades de Direitos Humanos 2021 – 2022*. Maputo

¹⁴⁰ CCS. (2018). *Pacote de direitos humanos*

¹⁴¹ GFA Consulting Group: Final Report, Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2022, p42-43

In addition to community dialogues facilitated by LAMBDA, people living with HIV and affected by TB as well as members of key populations are engaged as activists and peer supporters and paralegals, who also undertake CLM at health facilities. Unfortunately, however, current investment in and support for true community-led programming to address human rights-related barriers to access to HIV services is limited and in the case of key populations, funding is rather provided to larger implementing partners who have no track record in KP service delivery. The same applies to CLM.

Recommendations

- Priority should be given to funding KP programs that are designed and implemented by key populations themselves, rather than funding large IPs that have no track record in KP service delivery and typically use small community organizations to deliver against their program targets, providing extremely limited funding, unrealistic timelines, and no commitment to fund capacity transfer to indigenous KP networks.
- Support should be provided for an independent, robust, PLHIV- and KP-hosted, owned and led CLM program providing sufficient, ongoing monitoring with a focus on poorly performing facilities and underserved populations such as KPs. Funding for CLM should be prioritized for direct investment in PLHIV- and KP-owned and led independent models that will generate community evidence in service of advocacy to resolve chronic problems uncovered during monitoring. This program must be hosted and coordinated by PLHIV- and KP communities themselves, with direct funding to them for this work.
- Support should also be provided to community-led organizations to undertake human rights literacy, stigma reduction, community-based monitoring, law reform efforts and human rights advocacy for their constituents.
- Cores support should be provided to community-led organizations for recruitment, training, management and monitoring and evaluation activities relating to human rights goals as well as for developing peer expertise to enable the deployment of peer human rights educators and peer paralegals.
- Ensure that community committees currently supported by CCS and FDC include effective representation from PLHIV and members of key and vulnerable populations.
- Ensure that paralegals responsible for facilitating community dialogues are sufficiently trained in participatory facilitation skills.

3.3 Progress to remove barriers to TB services

While there have been efforts to expand TB screening, diagnosis, and treatment for vulnerable populations, and the National TB Program (NTP) has established a Prison Health Technical Working Group and expanded TB screening for health workers, there continues to be a limited number of programs in Mozambique to remove human rights- and gender-related barriers to TB services.

(a) Eliminating TB-related stigma and discrimination

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Eliminating TB-related stigma and discrimination	0	1.0	2.6

Few, small-scale specific programs on TB stigma and discrimination were identified during the MTA. However, programs did appear to be strengthening human rights components and expanding the range of individuals reached. E.g., the Associação Ajuda ao Desenvolvimento de Povo para Povo (ADPP) OneImpact pilot project was supporting individuals with TB to report S&D, but was only operating in four health facilities, all in Maputo. An expansion of the project, with support from Namati, was initiated in October 2020 in Gaza Province using quarterly broadcasts in four communities via local radio stations.¹⁴²

Stigma and discrimination reduction and legal literacy was also a component of the US\$20 million USAID-funded “TB Response” project, also implemented by ADPP in association with FHI360, COMUSANAS, DIMAGI, and KUPULUMUSSANA, in four provinces (Nampula, Sofala, Tete and Zambézia) in partnership with the NTP.¹⁴³

Since the MTA there has been further progress. Evidence of human rights and gender-related barriers to TB has improved; and integrated S&D reduction, legal literacy and legal support service programs have been scaled up. However, TB-related stigma continues to be a deterrent to both initial access to and adherence to HIV treatment,¹⁴⁴ and people with TB continue to lack sufficient awareness of their health rights. Programs have yet to reach national coverage and still tend to focus more on HIV.

In line with the MTA recommendations, the NTB has conducted a community-level study on TB-related human rights and gender issues and has recently finalized a study on human rights and gender-related barriers at health facility level.¹⁴⁵ The findings and recommendations of this assessment inform the Community, Rights and Gender Action Plan for Tuberculosis 2023 – 2026, which is currently under development.¹⁴⁶ In

¹⁴² ADPP implements innovative project to combat TB in Gaza. (2020). ADPP Mocambique. <https://adpp-mozambique.org/2020/10/02/adpp-implements-innovative-project-to-combat-tb-in-gaza/>

¹⁴³ USAID. (2019). *Mozambique: TB response*. https://www.usaid.gov/sites/default/files/documents/1860/TB_Response_Fact_sheet_November_2019.pdf and ADPP Mocambique. (2020). *ADPP Mocambique*. <https://adpp-mozambique.org/>

¹⁴⁴ De Schacht C, Mutaquiha C, Faria F, Castro G, Manaca N, Manhica I, et al. (2019) Barriers to access and adherence to tuberculosis services, as perceived by patients: A qualitative study in Mozambique. *PLoS ONE* 14(7): e0219470. <https://doi.org/10.1371/journal.pone.0219470>. See also Daftary A, Frick M, Venkatesan N, et al/ Fighting TB stigma: we need to apply lessons learnt from HIV activism *BMJ Global Health* 2017;2:e000515; MISAU & The Global Fund (2023). *Assessment Of Human Rights- And Gender-Related Barriers To Accessing TB Services In Mozambican Health Facilities*. Maputo, Mozambique.

¹⁴⁵ MISAU & The Global Fund (2023). *Assessment Of Human Rights- And Gender-Related Barriers To Accessing TB Services In Mozambican Health Facilities*. Maputo, Mozambique.

¹⁴⁶ PNCT, CCS & The Global Fund (2023). *Mozambique Community, Rights and Gender Action Plan for Tuberculosis 2023 – 2026*. Maputo, Mozambique (draft).

addition, a Stigma Assessment is being planned by the National TB Program in partnership with CCS.

The 2023 NTB assessment of human rights- and gender-related barriers in health facilities collected data was collected from 12 sites in 6 provinces. The assessment found the main barriers to access to TB services included long distances to health facilities, lack of transport, and lack of food during treatment.

Participants also raised human rights-related barriers to access, including stigma and discrimination, isolation by families and lack of access to information about their TB-related health rights. In 5 sites (42% of the sample) people mentioned stigma and discrimination as a barrier to access to services. In 50% of the sites, participants said their rights – such as rights to confidentiality – were violated. There was less awareness and understanding of the gendered impact of TB, and gender-related barriers.

TB-affected communities were all aware of the health complaints box and generally, expressed being aware of how to use these complaints mechanisms. However, the health committees did not include TB affected communities. The assessment also found that affected individuals felt that TB activists played an important role in addressing these barriers, and recommended strengthening and increasing the number of TB activists. None of the 193 healthcare workers participating in the assessment had ever received human rights and medical ethics training and all 43 facility management staff agreed on the need for training.

Integrated TB S&D reduction interventions, including community dialogues, radio debates and combined work on legal literacy, CLM and legal support, have been scaled up alongside HIV-related work as has been described above, with CCS now supporting 164 paralegals in 87 districts and FDC supporting 300 paralegals and *activistas* in 96 of the 154 districts.

During the period January to June 2022 FDC facilitated 1108 community dialogues reaching 16,326 people (AGYW, MSM, PWUD and FSW). They also held 197 radio debates in 11 provinces to address stigma and discrimination, gender inequality and GBV. During a similar period, CCS broadcast 40 radio spots in 8 provinces in 15 local languages.

Recommendations

TB-related human rights programs continue to be strengthened. However, efforts are far from reaching national-level coverage, tend to focus more, and reach more people affected by HIV than TB and fail to adequately monitor and evaluate the impact on access to treatment, care and support. Efforts need to build on improved evidence and current, integrated approaches to strengthen responses. Current recommendations, informed by the 2023 TB CRG Health Facilities Assessment,¹⁴⁷ include:

¹⁴⁷ *ibid*

- Finalizing the TB Stigma Assessment and using the results to inform S&D reduction programming in healthcare facilities, families and communities.
- Popularize and implement the recently finalized Community, Rights and Gender Action Plan for TB 2023-2026.
- Continue to expand integrated stigma and discrimination reduction programs working with paralegals and TB *activistas*, with renewed efforts to reach out to people with TB.
- Ensure that the enrolment and training of *activistas* and paralegals include peers affected by TB and include a strengthened focus on TB S&D, CLM, and legal literacy.
- Strengthen healthcare workers' training on the rights of patients with TB, including the rights to medical confidentiality.
- Scale up training for healthcare workers and information sessions for TB-affected communities on the gendered aspects of TB and how TB services can be made more gender-responsive.
- Support TB-affected communities to participate meaningfully in health facility committees and other governance structures related to TB services.
- Support scale up and improved community leadership of community led monitoring of TB services, through, for example, ensuring funds are received by community-led organizations and networks.
- Develop an improved M&E system that looks at the impact as well as outputs of stigma and discrimination reduction interventions.

(b) Ensure people centred and rights-based TB services at health facilities

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Ensuring people-centered and rights-based TB services at health facilities	1.3	1.6	2.3

As is the case with training of health care workers on human rights and medical ethics related to HIV, the Ministry of Health (MISAU) has been responsible for taking the lead on training health care workers in human rights and medical ethics as a part of their broader quality improvement mission to deliver “humanized” care. The MTA found that these efforts had expanded somewhat since the Baseline Assessment, including (with the support of Namati) the dissemination of a charter of rights and responsibilities for both patients and professionals. MISAU had also conducted trainings with HIV and TB service providers that include attention to stigma and discrimination, and a specific module related to TB and working with key populations.

Subsequent to the MTA there has been further progress on in-service training of health care providers on human rights and medical ethics. The appointment of a HIV and TB Human Rights Advisor within the Department of Humanization in MISAU has

contributed to a stronger focus on human rights in the context of HIV and TB within MISAU as well as to strengthened co-ordination of HIV and TB – human rights related activities undertaken by MISAU. There has also been some scale up of in-service training by trainers employed by MISAU, in collaboration with CSOs such as Namati, using a training toolkit developed by MISAU in collaboration with Namati and others.¹⁴⁸ Training has also been provided for health care workers on sign language with a view to making both HIV and TB services more accessible for people with impaired hearing. In addition, measures are being developed to evaluate the quality of training for health care workers through the establishment of an online monitoring and evaluation tool, as set out above.

Despite this progress, TB-related stigma continues, as noted above, to be a deterrent to both initial access to and adherence to HIV treatment,¹⁴⁹ to some extent perpetuated by the attitudes of health care workers towards people with TB. In a Knowledge, Attitudes and Practices (KAP) assessment carried out amongst health care workers in the district of Manhica, a high tuberculosis and HIV burden rural area in Southern Mozambique, 70% of respondents agreed that there was a stigma associated with TB and 48.2% of them believed that this stigma was greater than that with HIV. Disturbingly only 35% of the sample disagreed with the assertion “*The way I interact with TB patients contributes to TB-related stigma.*”¹⁵⁰

As set out above, challenges remain with both the commitment towards human rights programming,¹⁵¹ the scale-up on in-service training (only 185 of the 300 health care facilities had been reached at the time of this Assessment) and formalized MoUs for the inclusion of HIV, TB, law and human rights and medical ethics in the pre-service training curriculum for health care workers at medical schools and nurse training institutions. Until such time, pre-service training for health care workers on HIV, TB, law and human rights and medical ethics is reported to take place, albeit informally, in some training institutions.

The 2023 CRG TB Assessment found that none of the 193 healthcare workers consulted in 12 sites had ever received human rights and medical ethics training, with all 43 facility management staff consulted agreeing the need for such training. There was limited understanding of the gendered nature of the TB epidemic and how to address this within TB-related health care. Healthcare workers in a few sites said that TB services could be made more gender-sensitive by implementing a gender training (1 site) and engaging men in TB services (3 sites).

¹⁴⁸ Whilst the aim was to train 4-5 medical practitioners in 300 health facilities, including head of facility, person responsible for mental health, HIV, TB and the focal point for humanization of health, MISAU had, by December 2022, only managed to cover 185 health care facilities across the country.

¹⁴⁹ De Schacht C, Mutaquiha C, Faria F, Castro G, Manaca N, Manhica I, et al. (2019) Barriers to access and adherence to tuberculosis services, as perceived by patients: A qualitative study in Mozambique. PLoS ONE 14(7): e0219470. <https://doi.org/10.1371/journal.pone.0219470>. See also Daftary A, Frick M, Venkatesan N, et al Fighting TB stigma: we need to apply lessons learnt from HIV activism *BMJ Global Health* 2017;2:e000515

¹⁵⁰ Noé, A., Ribeiro, R.M., Anselmo, R. et al. Knowledge, attitudes and practices regarding tuberculosis care among health workers in Southern Mozambique. *BMC Pulm Med* 17, 2 (2017). <https://doi.org/10.1186/s12890-016-0344-8>

¹⁵¹ Interview with MISAU HIV, TB and Human Rights Advisor 31 January 2023

Similarly with many human rights- and gender-related programs, effective M&E remains a challenge and is limited to quantitative rather than qualitative data, and MISAU's online tool for pre- and post-assessment of health worker knowledge and attitudes is not yet operational. The CRG assessment also found that while customer care units have been established across all 12 assessed health facilities, these need stronger linkages with community health committees. The health committees also need representation of TB-affected communities as active members.

CRG Assessment findings on redress for health care related discrimination:

TB-affected communities mentioned the availability of a complaint box in all 12 health facilities. In 8 sites, they noted that they could call the numbers pasted on the walls of the facility, and in 7 sites they felt empowered to complain directly to health facility staff. In 2 sites, health facility committees were cited as a good vehicle to voice concerns.¹⁵²

Recommendations

Scale-up of in-service training of health workers continues to be modest, and insufficiently evaluated; this program area has not yet addressed a number of the challenges and recommendations cited in the MTA. The development of health-related complaints mechanisms is a welcome sign of progress but requires further work to ensure that TB-related complaints are able to be brought by communities to the attention of health facility management. The Assessment recommends the following:

- Scale up the coverage of initial and follow up in-service training on human rights and medical ethics across the country, potentially using an online training platform, with an initial focus on health facilities in districts hardest hit by TB.
- Prioritize the conclusion of MoUs between MISAU and all health care worker training institutions and university medical schools, to support integration of human rights and medical ethics module into health worker pre-service training curricula.
- Initial and follow up in-service training on human rights and medical ethics is scaled up across the country, potentially using an online training platform, and broadens its reach to include administrative staff at health care facilities.
- Ensure the representation of people with TB on and support training of health committee members and customer care / client officers in human rights and medical ethics, to ensure sustainability of mechanisms to identify and resolve human rights and gender-related barriers to care.
- Complete the development and roll out of the online M&E tool for health care worker training with a view to monitoring quality of training and the impact of training on levels of knowledge and understanding on the part of health care workers. Consider also establishing a system for conducting spot checks on training to monitor the competence of trainers and the quality of training.
- Use the data gathered from the training M&E tool and CLM to monitor the quality of training and address training quality shortfalls where identified.

¹⁵² *ibid*

- Improve the monitoring and evaluation of complaints regarding service delivery at health care facility customer care units and the resolution of complaints.

(c) Improve TB-related legal literacy ("know your rights")

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improving TB-related legal literacy	1.0	3.0	4.3

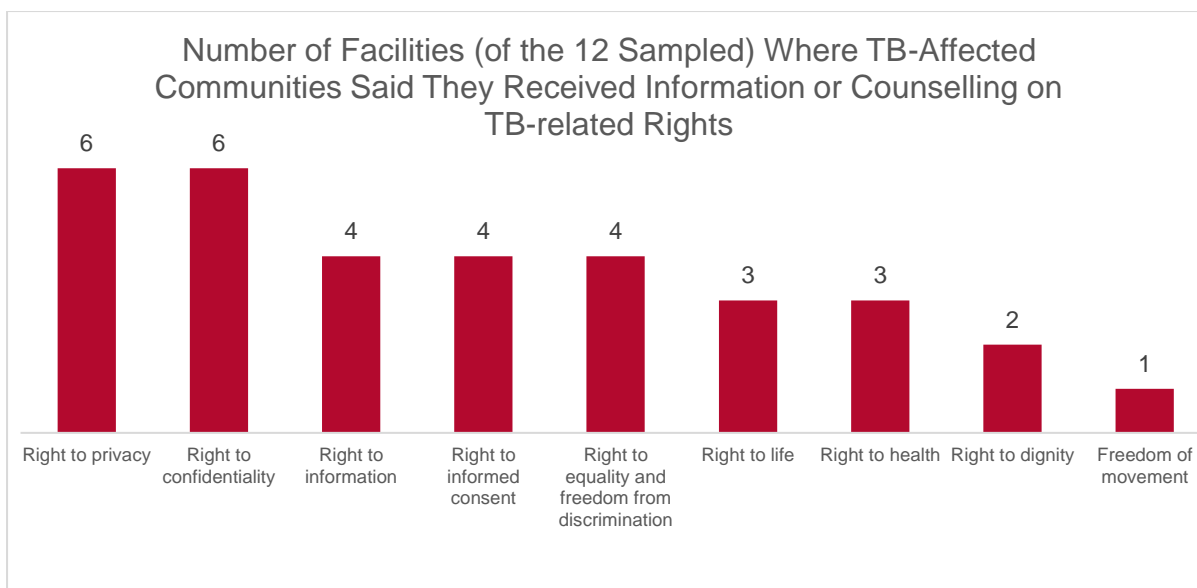
The MTA¹⁵³ found that, since the baseline assessment, legal literacy programs had expanded in both scope and scale, ranging from “Know Your Rights” radio spots and debates, dissemination of patients’ rights charters and widespread legal literacy activities for girls, young women, sex workers and others. Importantly, the integrated approach used by FDC, CCS, Namati and other implementers, with legal literacy being part of a broad network of community-based activities, helped to support increased awareness and identification of human rights-related barriers as well as resolution of disputes, including with health officials and law. Geographic coverage, however, was limited, with legal literacy programs reaching only 63 of 129 districts in all 11 provinces. Moreover, programs tended to be concentrated in more urban areas.

There has been significant progress on legal literacy programming since the MTA, particularly in terms of geographic coverage. As at the end of 2022, CCS is reaching people living with HIV and people with TB in 86 districts (Maputo Province, Maputo City, Gaza, Inhambane, Manica, Sofala, Niassa, Cabo Delgado) and FDC is reaching AGYW and key populations in 96 districts of the total 129 districts in Mozambique. CCS’s focus is more on TB whereas FDC’s focus is more on HIV.

Ongoing challenges remain. Whilst geographic coverage has been increased, it is still not national. Interventions tend to focus more on HIV than TB and appear to reach more people living with both HIV and TB than those with TB only. The 2023 TB CRG Assessment found that TB-affected communities have limited knowledge of their rights, having received counselling or information on just 9 of the 22 rights of people affected by TB. Patients’ rights charters were visible on the walls in 10 of the 12 sites where the assessment was conducted, though none contained specific information on the rights of people with TB. Participants noted that their rights to confidentiality were frequently violated.¹⁵⁴

¹⁵³ MTA Report pp 23-26

¹⁵⁴ Programa Nacional de Controlo da Tuberculose (PNCT) & The Global Fund (2023). Assessment Of Human Rights- And Gender-Related Barriers to Accessing Tb Services In Mozambican Heath Facilities. Maputo, Mozambique. Online at <https://www.dropbox.com/s/pdfp2o4xssiv576/Mozambique%20TB%20CRG%20Health%20Facilities%20Assessment%20%2819%20May%202023%29.pdf?dl=0>



Source: Programa Nacional de Controlo da Tuberculose (PNCT) & The Global Fund (2023). Assessment Of Human Rights- And Gender-Related Barriers to Accessing TB Services In Mozambican Health Facilities.

Recommendations

- Scale up the geographic coverage of integrated legal literacy programs working with paralegals and *activistas* that serve and reach both people living with HIV and people with TB equally.
- Ensure that training of paralegals and *activistas* focuses equally on human rights and gender related barriers to access to both TB and HIV services.
- Expand training of community health workers, paralegals, and traditional, religious and community educators on TB and human rights, including how to combat TB-related stigma and discrimination.
- Develop and disseminate patients’ rights materials specifically related to TB among key populations and disseminate information on workplace protections in workplaces with high TB risk, for example mining.

(d) Improve access to justice in the context of TB

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improving access to justice in the context of TB	1.0	3.0	4.0

The MTA noted progress in the implementation and scale-up of integrated paralegal programs in all 11 provinces, with successful “synergy” among local officials, health committees, and community leaders to promote the identification and resolution of human rights violations. However, geographic coverage remained limited to more urban areas and that paralegals required increased training on alternative dispute resolution to resolve cases outside of court. In addition, similar to the situation with

HIV, lawyers required capacity building and support to engage in large-scale strategic litigation for broader impact on TB-related human rights violations.

Since the MTA there has been good progress in expanding programming for the provision of TB-related legal services, as has been described above. There is anecdotal evidence of the positive impact of the provision of paralegal services on TB-related health outcomes. For example, a 2022 Global Fund-supported human rights “spot check” on programs to reduce human rights-related barriers to HIV and TB treatment at community level found that 99% of the TB-related cases addressed by paralegals related to refusing to allow children to take TPT-medication, and that paralegals have successfully persuaded parents to allow their children to take and adhere to TB treatment.¹⁵⁵

Gaps have been noted in the training of paralegals in respect of the range of human rights violations that negatively impact on access to TB services as well as in respect of alternative dispute resolution.¹⁵⁶ As is the case with HIV, paralegals are trained to identify cases that have no or unclear linkages to TB prevention and retention in care. In addition, they are not familiarized with target-group specific barriers and HR-violations. They also have gaps in their own legal knowledge. While certain relevant information is missing in the training material, other information provided is irrelevant for the tasks of the paralegals. Both the CCS and the FDC training manuals mention that extrajudicial conflict resolution should be preferred. Neither of the training manuals, however, equips the future paralegals with mediation or conflict resolution skills.¹⁵⁷ The lack of funding for court process fees, transport and accommodation required for supporting clients to resolve matter in courts has also been cited above, with paralegals and pro bono lawyers often face having to pay these expenses out of their own pockets.¹⁵⁸ Efforts to work with IPAJ lawyers to provide legal services have as yet to be realized as the MoU between CNCS and IPAJ is yet to be finalized. However, whilst it would be more sustainable to use IPAJ staff, they do not have the required expertise and experience to take on these kinds of cases and many of them are not yet qualified as lawyers and would require capacity strengthening to take on this task.

Recommendations

As is the case with HIV, an integrated approach to providing access to TB-related legal support services continues to be one of the successes of the Mozambique program and has been scaled up. In reality, many conflicts are resolved without legal support, and access to qualified, sensitized lawyers remains a challenge. In order to strengthen this approach, the following is recommended:

¹⁵⁵ GFA Consulting Group, Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2023

¹⁵⁶ *ibid*

¹⁵⁷ *ibid*

¹⁵⁸ KII FDC

- Continue and scale up existing integrated programming utilizing *activistas*, paralegals and lawyers to reach remote and rural areas.
- Fund a thorough assessment, including of CLM data, to determine the particular human rights violations faced by the target groups, to clarify areas of focus with staff.¹⁵⁹
- Review and update the training materials of paralegals based on the assessment; and on alternative dispute resolution and mediation skills.
- Provide refresher training, mentoring and follow up to all existing paralegals.
- Ensure an adequate budget for ancillary costs associated with litigation.
- Ensure the implementation of the MoU with IPAJ to provide legal services and provide IPAJ lawyers with the necessary capacity strengthening to do so.
- Strengthen M&E to measure outcomes and impact in addition to outputs, for example by pre and post training evaluations, user surveys and health data.

(e) Improve laws, regulations and policies related to TB

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Improving laws, regulations and policies related to TB	0	0	0

The MTA was unable to identify any programs to strengthen the monitoring and reforming of policies, regulations and laws that act as barriers to access to and retention in TB services or exacerbate vulnerability to TB infection. The report specifically recommended that support should be provided for advocacy and reform of sentencing and incarceration laws, policies and regulations to reduce overcrowding in closed settings which exacerbates the spread of TB in closed settings such as prisons and police holding cells.

Although the 2020 Community, Rights and Gender TB Assessment¹⁶⁰ sought to explore the impact of the legal environment, and gender relations towards access to health and Tuberculosis treatment among vulnerable groups in Gaza and Maputo Provinces it failed to identify any laws or policies that impact on access to and retention in TB services. Subsequent to the MTA no TB-related legal environment assessment has been conducted and no progress has been noted in programming to strengthen the monitoring and reforming of policies, regulations and laws that act as barriers to access to and retention in TB services.

Recommendations

- Conduct a legal environment assessment specific for TB with special emphasis on a) situation analysis, b) progress, c) challenges and d) recommendations.

¹⁵⁹ (GFA Consulting Group, Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2023)

¹⁶⁰ PNCT & Stop TB Partnership (2020). Community, Rights and Gender TB Assessment in Mozambique. Maputo: MISAU. Online at

<https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Mozambique%20DRAFT.pdf>

- Increase support and technical assistance for building capacity of civil society organizations, particularly community led organizations, for advocacy to reform laws, policies and practices that act as barriers to access to and retention in TB services or increase vulnerability to TB infection at national scale.
- Provide support for the development of advocacy training materials for civil society organizations and policy briefs to support advocacy.
- Support the establishment of a national platform for engagement between civil society and relevant Government departments and Ministries on policy and law reform required for an enabling environment for an effective TB response.

(f) Ensure rights-based law enforcement practices for TB

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Ensure rights-based law enforcement practices for TB	0	0	0.5

The MTA was unable to identify any programs to sensitize law enforcement on human rights and gender related barriers to access to and retention in TB services or exacerbate vulnerability to TB infection.

Subsequent to the MTA, CFJJ has entered into a MoU with CNCS and has begun to design training materials and curricula on HIV, TB and human rights and key populations for judges, prosecutors and other justice sector institutions. This training has however yet to be implemented.

Recommendations

Much work remains to be done on sensitize law enforcement on human rights and gender related barriers to access to and retention in TB services or exacerbate vulnerability to TB infection.

It is recommended that:

- The curriculum on TB-related human rights and ethics for police and correctional service members be strengthened and support and funding for training on human rights and medical ethics for police and correctional service members be increased.
- Expand efforts to sensitize police and correctional service members on TB and human rights-related barriers to access to services.

(g) Support community mobilisation and advocacy

TB program area	Score
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	Baseline	Mid-Term (2021)	Progress (2023)
Support for community mobilization and advocacy	1.0	1.3	2.3

A number of projects were identified at the time of the MTA around mobilizing patients and engaging communities to increase screening and TB treatment adherence¹⁶¹. For example, ADPP launched the “Total Control of TB project” in 7 districts in Gaza province in July 2019. The project has expanded screening in mining communities and sought to reinforce support for individuals with TB through the identification of “supporters”. An older program, the Juntos Pelo Acesso aos Medicamentos (Together for Access to Medicines or JAM) Program, was started by MSF in nine health centers (HCs) in Tete province in July 2015. The program was designed to improve treatment literacy, reinforce adherence, monitor the local supply chain and access to medicines, raise awareness of patients’ responsibilities and their right to access to free healthcare, and empower patients. The initiative also sought to support the Ministry of Health to identify patients that were unable to access treatment and be promptly alerted to where stock-outs of medicines were occurring.

However, no interventions specifically aimed at mobilizing and empowering patient and community groups related to TB were identified.

Some progress has been made subsequent to the MTA. NTP has, for example, developed a manual for support groups of people with TB with a view to mobilizing and empowering patient and community groups related to TB.

Recommendations

Few CSOs focus their work on mobilizing and empowering patient and community groups and those that do have very limited geographic coverage. In addition, difficulties have been experienced in establishing TB support groups as there are issues with bringing people together if they are at different stages of treatment or different kinds of TB. People are afraid of transmitting TB or exposing others to TB. In order to strengthen this program area, the following is recommended:

- Include patient groups in the design, evaluation and modification of TB services to improve their patient-centeredness and quality and to ensure that community mobilization and engagement sufficiently address the needs and realities of people at risk of TB, people with active TB, as well as those undergoing TB treatment.
- Give particular attention to gender equity and prioritize the development of women TB advocates (including paralegal and peer outreach) and support groups.

(h) Reduce TB-related gender discrimination

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)

Progress on reducing TB-related gender discrimination	0	0	1.0
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The MTA was unable to identify any programs in place aimed at reducing TB-related gender discrimination. Subsequent to the MTA there has been no improvement in this situation.

A 2020 Communities, Rights and Gender TB (CRG) Assessment in Mozambique¹⁶² assessed the legal environment, human rights, and gender-related barriers to accessing TB services amongst TB key populations.

The Assessment identified a number of entrenched gender-related power imbalances and disparities that are common barriers to TB service access. Male behaviors including migration, frequent visits to crowded environments and not staying at home are male-linked factors for acquiring TB and related illnesses. In addition, as men are perceived as being stronger and unlikely to visit health services when they are affected by any sign of illness, fueling the limited behavior of seeking medical attention¹⁶³.

A significant number of respondents in the assessment from all vulnerable groups mentioned differences between men and women in accessing TB services. Women have priority in the queue to be seen by doctors and nurses. Another difference is related to the client's preferences in being assisted by male or female health professionals. In general, clients and healthcare professionals belonging to different genders are likely to have better interaction during the medical consultation. Female clients prefer male healthcare providers, while male clients prefer female providers. The reason is that male workers are more attentive, patient, provide good care and create comfortable consultation environments. Participants also expressed a view that "male workers are calm".

Different populations had different views on the gender-related barriers to TB services in the country.

Among the 31 people living with HIV interviewed, 8 (25.8%) felt there were gender differences, while 19 (61.3%) felt there were not. Interestingly, among those who said there were no gender differences in terms of TB services, less than half (48.4%) agreed there were equal rights between men and women. The remaining 4 (12.9%) did not know or did not want to answer. People living with HIV noted that men are in charge of everything in the house and women rely on their male partners to seek medical assistance. This fuels delays in seeking health services at health facilities. Further, if they feel unwell, the first thing to do is consult their husbands rather than seeking health services. In addition, in the provider-client interaction, there is a preference for being attended to by male healthcare workers; 69.4% of women and 54% of men reported that they prefer male health professional¹⁶⁴.

¹⁶² Communities, Rights and Gender TB (CRG) Assessment in Mozambique, MISAU, Stop TB 2021 available at <https://stoptb.org/assets/documents/communities/CRG/TB%20CRG%20Assessment%20Mozambique%20DRAFT.pdf>

¹⁶³ ibid

¹⁶⁴ ibid

Among the 28 sex workers interviewed, 5 (17.9%) felt there were gender differences, while 22 (78.6%) felt there were not. The reasons underlying the differences are attributed to (i) men are seen as decision makers, (ii) men are the father of the family and (iii) women are responsible for taking care of the family. Sex workers also noted that men are more likely to be privileged to attend school than women. Among the groups of sex workers interviewed, 15 (53.6%) women reported having dropped out of primary school, (42.9%) women had dropped out of secondary school.

Among people who inject drugs, about 10% felt there were gender differences while 90% felt there were not. The difference was linked to the fact that men were stronger than women.

Finally, for Miners/Ex-Miners, 22 of the participants (46.8%) felt there were gender differences. The reasons are: (i) men have more voice than women, (ii) men go to work and women take care of the family, (iii) there are specific activities for men that women cannot do. The miners consider that women and children have priority in health care units¹⁶⁵.

Recommendations

- Develop a plan of action to reduce gender discrimination and harmful gender norms in relation to TB.
- Support advocacy projects to obtain government commitments concerning gender equality in the provision of TB healthcare services at national and regional levels.
- Support the implementation of programs to ensure gender-responsiveness in TB service delivery.
- Support the provision of technical assistance on the design of programs to reduce human rights and gender related barriers to TB services.

(i) Address needs of people in prisons and other closed settings

TB program area	Score		
	Baseline	Mid-Term (2021)	Progress (2023)
Addressing the needs of people in prisons and other closed settings	1.0	1.0	1.3

The MTA was unable to identify any programs to address TB in prisons and other closed settings.

TB rates among this population (almost 1,500 per 100,000 Pop.) are still higher than the general population. Factors contributing to this low coverage include obsolete, poor ventilated and overcrowded facilities; low literacy and stigma related to TB.

Subsequent to the MTA a program has been initiated and implemented by the Association for the Rehabilitation and Social Integration of Prisoners (a FDC SR) which provides legal literacy and advice in prisons. There are however still no programs in place to address one of the root causes of increased vulnerability to TB in closed settings, i.e. overcrowding.

¹⁶⁵ PNCT & Stop TB Partnership (2020 op cit)

Recommendations

- Expand efforts to reduce TB-related stigma and discrimination to all prisons.
- Support the NTP and its partners to ensure sufficient technical and operational resources for the Prison Health Technical Working Group.
- Support advocacy for the implementation of non-custodial sentencing to relieve overcrowding in prisons.

4. National Ownership and Enabling Environments to Address Human Rights-related Barriers

This section discussed two cross-cutting components of the progress assessment: improvements in national ownership for reducing or removing barriers, and important trends in the program environment that either enable or impede progress to remove barriers.

Improvements in national ownership for reducing or removing human rights- and gender-related barriers to HIV and TB services are evidenced by the adoption of *Mozambique's National Strategic Plan for HIV/AIDS 2021-2025* (PEN V), as well as the National Strategic Plan To End Tuberculosis in Mozambique 2023-2030 ('the TB NSP'), both of which have a strong emphasis on the removal of human rights and gender related barriers¹⁶⁶. In addition, the country's clear commitment to reducing human rights and gender related barriers to HIV services is outlined in the *Operational Plan: Comprehensive response to human rights and gender-related barriers to HIV services in Mozambique (2023-2025)*. The aim of the Human Rights Plan is to provide a supportive, human rights-based and gender-transformative policy environment for the implementation of HIV programs that reduce new infections, AIDS related deaths and discrimination against people living with HIV and other key and vulnerable populations in Mozambique. It seeks to close the gaps that are preventing progress towards ending AIDS as a public health threat in Mozambique by 2030.

This plan has been developed to set out a comprehensive response to human rights and gender related barriers to HIV services in Mozambique for people living with or affected by HIV with operational activities, as well as a monitoring and evaluation framework, which will facilitate better coordination and strategizing for the effective scale-up of programs to remove human rights and gender-related barriers to an effective HIV response. The plan reinforces and complements commitments under *Mozambique's National Strategic Plan for HIV/AIDS 2021-2025 (PEN V)*, and the *Government Five-Year Program 2020-2024* to follow human-rights-based and gender sensitive principles and approaches that leave no one behind. It further reinforces the country's commitments under *2021 Political Declaration on HIV and AIDS: Ending*

¹⁶⁶ See para 2.4 above for further details on these plans.

Inequalities and Getting on Track to End AIDS by 2030 and the African Union's Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030.

The plan promotes inclusive, multisectoral approaches to HIV to reduce inequalities, protect human rights and strengthen collaboration and synergies between HIV-specific and broader health and development initiatives and systems at all levels. It also seeks to advance a whole-of-government, whole-of society response to HIV and to strengthen inclusive, transparent, accountable and multisectoral governance mechanisms to effectively support inclusive, multisectoral strategic partnerships, coordination and collaboration. One of its specific objectives is to strengthen the leadership, accountability and coordination of human rights and gender transformative responses to HIV, including through strengthening the capacity of the national HIV & Human Rights Technical Working Group (TWG) to (a) enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV services and (b) to continuously monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs.

The HIV and Human Rights TWG was established prior to the development of the GC6 Funding Request and was the coordinating body for the development of the human rights and gender components of the GC6 Funding Request. As noted above the role of the TWG, which is multisectoral in its composition, comprising representatives of state and non-state actors and development partners, is to enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV services, to monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs.

Most key informants interviewed in the course of this assessment were aware of the existence of the TWG and were in fact members of the TWG. Opinions were varied concerning the current effectiveness of the TWG in terms of its coordinating and quality assurance functions.

Key Informants Views on the Human Rights TWG	
Positive Aspects	Challenges
"It benefits different stakeholders, reduces overlap and duplication and promotes complementary working".	"The challenge in participating in the TWG meetings is that these meetings have overlapped with other responsibilities".
"The TWG provides CSOs with opportunity to be involved with government planning".	"There is a lack of awareness of TWG at provincial level".
"It is good that when partners share challenges with implementation of activities and the TWG members help with ideas on how to address the challenge."	"It is often difficult to get all TWG members to participate during TWG meetings and when members do send representatives, they often send different people so there is a lack on

	institutional memory about has been discussed and agreed before”.
“The TWG has the authority and power to bring different sectors, especially government ministries, to the table”.	“There are not enough representatives of people working on TB on the TWG and TB programming is not often on the agenda for discussion”.
	“Invites are not sent out regularly, so often we don’t know when the meetings are taking place”.
	Many participants do not attend to share their contributions to our discussions. At most TWG meetings we only have about half of the members in attendance. When members do send representatives, they often send the wrong people who are not familiar with the issues”.
	“Generally, it is only the PRs who present their work at meetings – SRs and SSRs do not get the opportunity and do not benefit from sharing and learning from each other”.

In general, it appears that while the HIV Human Rights TWG provides a mechanism for co-ordination of implementation, the challenges referred to above compromise the ability of the TWG to be wholly effective in this function. In addition, it would seem that the TWG does not currently play a significant role in quality assurance of programming.

This may be attributable to some extent to the fact that there is a no common set of outcome level indicators and targets, and a comprehensive monitoring and accountability mechanism.

Recommendations

In order to strengthen the capacity of the HIV Human Rights TWG to enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV services, to monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs, the following is recommended:

- Establish a calendar for routine meetings of the TWG linked to monitoring and reporting of progress of interventions to reduce or remove barriers;
- Develop and implement a monitoring and accountability framework for the implementation of the *Operational Plan: Comprehensive response to human rights and gender-related barriers to HIV services in Mozambique (2023-2025)*.

- Develop a digitized system for reporting on progress on programming to reduce human rights and gender related barriers.
- Broaden the membership of the TWG to include representatives from the TB (and malaria) sectors to facilitate the integration of programming to address barriers to HIV, TB and malaria services.
- Strengthen the capacity of the national HIV & Human Rights Technical Working Group (TWG) and secretariat to (a) enhance the coordination of implementers engaged in programming for the reduction of human rights and gender-related barriers to HIV services and (b) to continuously monitor the implementation of the plan and ensure quality of activities and interventions through capacity strengthening on design and implementation and scaling up of programs and on quality assurance and effective monitoring and evaluation of programs.

5. Key Recommendations

5.1 Recommendations for Programs to Reduce Barriers to HIV Services

The following recommendations are proposed to strengthen programs to reduce human rights-related barriers to HIV services.

Program Area	Recommendations
Eliminate stigma and discrimination in all settings.	<ul style="list-style-type: none"> a) Further efforts are made to strengthen truly community-led and community-owned monitoring, linked to stigma and discrimination reduction, in health care. b) Donors and government entities supporting CLM urgently fund an evaluation of the extent to which CLM, linked to community education by <i>activistas</i> and paralegals, is able to address community-related stigma and discrimination. The evaluation should be conducted with the meaningful participation of people living with HIV and key population members, supported by evaluation experts. It should also include consultations with FDC and CSS <i>activistas</i> about the range of cases they face and identify possible capacity-building needs to be further addressed in training. c) An independent evaluation of LAMBDA's stigma reduction work be undertaken to assess its effectiveness and draw out lessons learned. Similarly, an assessment of efforts to reduce stigma amongst sex workers be undertaken in consultation with sex worker organizations and networks in Mozambique, Aidsfonds, Frontline AIDS, the Global Fund, Pathfinder International and other interested donors. Lessons learned from these consultations should inform a broader strategy for building on existing efforts and strengthening S&D reduction among all key populations. d) Private and public sector employers provide anti-discrimination training on sexual orientation and gender identity linked to existing S&D reduction efforts.

	<ul style="list-style-type: none"> e) Standard indicators be developed for collating and analyzing all CLM data at a national level. f) A unit within CNCS should be provided with adequate human and other resources to analyze all CLM data across the country to discern trends, geographical patterns, spikes in certain types of abuses, etc. This analysis would optimize the use of CLM data to contribute to reprogramming, to ensure a comprehensive response to human rights-related barriers to HIV services, as well as to inform advocacy. g) Donors and government entities supporting CLM should engage Namati to support further learnings on the use of CLM data for advocacy, including refresher trainings of <i>activistas</i>, paralegals and other forums where use of CLM data to inform advocacy may be discussed. h) Additional investment should be made in key population organizations and networks to support stigma and discrimination reduction work, including on internalized stigma, for members of key populations. i) Increased support is required for programming for law reform in respect of the criminalization of certain aspects of sex work and drug possession for own use, which exacerbates stigma and discrimination against sex workers and people who use drugs. j) The results of HIV Stigma Index 2.0 should be used to inform adjustments in national programming to reduce stigma and discrimination to respond to the results.
<p>Ensure non-discriminatory provision of health care</p>	<ul style="list-style-type: none"> a) MoUs between MISAU and all health care worker training institutions and university medical schools are prioritized, to support integration of human rights and medical ethics module into health worker pre-service training curricula. b) Initial and follow up in-service training on human rights and medical ethics is scaled up across the country, potentially using an online training platform, and broadens its reach to include administrative staff at health care facilities. c) Ensure that both pre-and in-service training curricula for health care workers includes information on the specific needs of key populations, including, for example, access to methadone for people who inject drugs who require hospitalization. d) Training of health committee members and customer care service officers in human rights and medical ethics be prioritized, to ensure sustainability of mechanisms to identify and resolve human rights-related barriers to care. e) The development and roll out of the online M&E tool for health care worker training is completed, with a view to monitoring the quality of training and the impact of training on levels of knowledge and understanding on the part of health care workers. f) CLM data on rights violations, and data gathered from the training M&E tool, be used to address training quality shortfalls and to inform the focus of updated training materials, including around S&D against key populations. g) A system for conducting spot checks on training, to monitor the competence of trainers and the quality of training, be considered.

	<ul style="list-style-type: none"> h) M&E of complaints regarding service delivery at health care facility customer care units and the resolution of complaints, be improved. i) Given the reported improvement of services at health facilities where peer activists are present, conduct an assessment of the impact of peer activists on uptake and retention in HIV services, particularly by key populations.
<p>Ensure rights-based law enforcement practices</p>	<ul style="list-style-type: none"> a) Fully investigate the barriers to integrating the module on HIV, TB, human rights and key populations into PRM pre-service training at police training colleges, with high-level police management consultations. Conduct similar consultations with correctional services management. b) Scale up in-service training of PRM members and actively engage PLHIV, people affected by TB and members of key populations in these trainings. c) Integrate the module on HIV, TB and human rights and key populations in the pre-service training of members of the judiciary and prosecutors offered by CFJJ and expand coverage of this training to community court members. d) Scale up programming for the meaningful involvement of KPs in the training of PRM members and the sensitisation of law makers. e) Scale up programming for pre-service and in-service training for correctional services staff on HIV, TB , human rights and key populations. f) Develop and roll out an M&E strategy and tools for adequately evaluating the impact of law makers and law enforcers sensitisation and training on both police members and key populations. g) Develop and implement programs for peer learning and dialogue between members of the judiciary on HIV, TB, human rights and key populations. h) Scale up and expand the use of the integrated approach to community led monitoring, legal literacy and access to legal services using paralegals and <i>activistas</i>, to monitor and address violations of rights by people living with HIV and key and vulnerable populations (with a focus on FSW and PWUD) at the hands of police members.
<p>Improve legal literacy</p>	<ul style="list-style-type: none"> a) The integrated model of conducting legal literacy, combined with other human rights programmatic responses and using community-led approaches with a range of stakeholders, continue to be scaled up. b) The training of paralegals and <i>activistas</i> be monitored and evaluated to ensure that they have adequate knowledge of common human rights and gender related barriers to access to HIV services for people living with HIV, people with TB and key and vulnerable populations.

<p>Improve access to justice</p>	<ul style="list-style-type: none"> a) Continue and scale up existing integrated programming utilizing <i>activistas</i>, paralegals and lawyers to reach remote and rural areas. b) Fund a thorough assessment, including of CLM data, to determine the particular human rights violations faced by the target groups, to clarify areas of focus with staff.¹⁶⁷ c) Review and update the training materials of paralegals based on the assessment; and on alternative dispute resolution and mediation skills. d) Provide refresher training, mentoring and follow up to all existing paralegals. e) Ensure an adequate budget in Global Fund and other funding requests for ancillary costs associated with litigation, including court fees and transport for pro bono lawyers. f) Ensure the implementation of the MoU with IPAJ to provide legal services and provide IPAJ lawyers with the necessary capacity strengthening to do so. g) Strengthen M&E to measure outcomes and impact in addition to outputs, for example by pre and post training evaluations, user surveys and health data.
<p>Improve laws, regulations and policies related to HIV and HIV/TB</p>	<ul style="list-style-type: none"> a) Increase investment in CSOs and community-led organizations to engage in advocacy for law and policy reform. b) Strengthen the capacity of CSOs, particularly those led by key populations, for advocacy at a national scale, including through including the provision of technical assistance for the development of advocacy training materials and policy briefs to support advocacy. c) Support the establishment of a national platform for engagement between civil society and relevant government ministries on policy and law reform required for an enabling environment for an effective HIV response.
<p>Reduce HIV-related gender discrimination</p>	<ul style="list-style-type: none"> a) A comprehensive HIV Gender Assessment be undertaken, to inform targeted programming to address gender inequality and gender-based violence. b) Legal and policy literacy on children’s rights, including laws and policies related to early child marriage, sexual and reproductive health and rights, be undertaken at community level. c) Continued scale up of sensitization and engagement, including with community, traditional, religious and opinion leaders on GBV and harmful gender norms and traditional practices, be prioritized. d) The expansion of the provision of integrated services for GBV survivors be prioritized. e) Improved support and capacity strengthening for TG led organizations to engage in advocacy for health and human rights for transgender people in Mozambique.

¹⁶⁷ (GFA Consulting Group, Final Report: Spot-check on the “Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level” 2023)

<p>Community mobilization and human rights advocacy</p>	<ul style="list-style-type: none"> a) Priority should be given to funding KP programs that are designed and implemented by key populations themselves, rather than funding large IPs that have no track record in KP service delivery and typically use small community organizations to deliver against their program targets, providing extremely limited funding, unrealistic timelines, and no commitment to fund capacity transfer to indigenous KP networks. b) Support should be provided for an independent, robust, PLHIV- and KP-hosted, owned and led CLM program providing sufficient, ongoing monitoring with a focus on poorly performing facilities and underserved populations such as KPs. Funding for CLM should be prioritized for direct investment in PLHIV- and KP-owned and led independent models that will generate community evidence in service of advocacy to resolve chronic problems uncovered during monitoring. This program must be hosted and coordinated by PLHIV- and KP communities themselves, with direct funding to them for this work. c) Support should also be provided to community-led organizations to undertake human rights literacy, stigma reduction, community-based monitoring, law reform efforts and human rights advocacy for their constituents. d) Cores support should be provided to community-led organizations for recruitment, training, management and monitoring and evaluation activities relating to human rights goals as well as for developing peer expertise to enable the deployment of peer human rights educators and peer paralegals. e) Ensure that community committees currently supported by CCS and FDC include effective representation from PLHIV and members of key and vulnerable populations. f) Ensure that paralegals responsible for facilitating community dialogues are sufficiently trained in participatory facilitation skills.
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5.2 Recommendations for Programs to Reduce Barriers to TB Services

The following recommendations are proposed to strengthen programs to reduce human rights-and gender-related barriers to TB services.

Program Area	Recommendations
<p>Eliminate TB-related stigma and discrimination</p>	<ul style="list-style-type: none"> a) Finalize the TB Stigma Assessment and using the results to inform S&D reduction programming in healthcare facilities, families and communities. b) Popularize and implement the recently finalized Community, Rights and Gender Action Plan for TB 2023-2026. c) Continue to expand integrated stigma and discrimination reduction programs working with paralegals and TB <i>activistas</i>, with renewed efforts to reach out to people with TB.

	<ul style="list-style-type: none"> d) Ensure that the enrolment and training of <i>activistas</i> and paralegals include peers affected by TB and include a strengthened focus on TB S&D, CLM, and legal literacy. e) Strengthen healthcare workers' training on the rights of patients with TB, including the rights to medical confidentiality. f) Scale up training for healthcare workers and information sessions for TB-affected communities on the gendered aspects of TB and how TB services can be made more gender-responsive. g) Support TB-affected communities to participate meaningfully in health facility committees and other governance structures related to TB services. h) Support scale up and improved community leadership of community led monitoring of TB services, through, for example, ensuring funds are received by community-led organizations and networks. i) Develop an improved M&E system that looks at the impact as well as outputs of stigma and discrimination reduction interventions.
<p>Ensure people-centered and rights-based TB services at health facilities</p>	<ul style="list-style-type: none"> a) Scale up the coverage of initial and follow up in-service training on human rights and medical ethics across the country, potentially using an online training platform, with an initial focus on health facilities in districts hardest hit by TB. b) Prioritize the conclusion of MoUs between MISAU and all health care worker training institutions and university medical schools, to support integration of human rights and medical ethics module into health worker pre-service training curricula. c) Scale up initial and follow up in-service training on human rights and medical ethics across the country, potentially using an online training platform, and broadens its reach to include administrative staff at health care facilities. d) Ensure the representation of people with TB on and support training of health committee members and customer care / client officers in human rights and medical ethics, to ensure sustainability of mechanisms to identify and resolve human rights and gender-related barriers to care. e) Complete the development and roll out of the online M&E tool for health care worker training with a view to monitoring quality of training and the impact of training on levels of knowledge and understanding on the part of health care workers. Consider also establishing a system for conducting spot checks on training to monitor the competence of trainers and the quality of training. f) Use the data gathered from the training M&E tool and CLM to monitor the quality of training and address training quality shortfalls where identified. g) Improve the monitoring and evaluation of complaints regarding service delivery at health care facility customer care units and the resolution of complaints.
<p>Ensure rights-based law</p>	<ul style="list-style-type: none"> a) The curriculum on TB-related human rights and ethics for police and correctional service members be strengthened and support

enforcement practices for TB	<p>and funding for training on human rights and medical ethics for police and correctional service members be increased.</p> <p>b) Expand efforts to sensitize police and correctional service members on TB and human rights-related barriers to access to services.</p>
Improve legal literacy	<p>a) Scale up the geographic coverage of integrated legal literacy programs working with paralegals and <i>activistas</i> that serve and reach both people living with HIV and people with TB equally.</p> <p>b) Ensure that training of paralegals and <i>activistas</i> focuses equally on human rights and gender related barriers to access to both TB and HIV services.</p> <p>c) Expand training of community health workers, paralegals, and traditional, religious and community educators on TB and human rights, including how to combat TB-related stigma and discrimination.</p> <p>d) Develop and disseminate patients' rights materials specifically related to TB among key populations and disseminate information on workplace protections in workplaces with high TB risk, for example mining.</p>
Increase access to justice	<p>a) Continue and scale up existing integrated programming utilizing <i>activistas</i>, paralegals and lawyers to reach remote and rural areas.</p> <p>b) Fund a thorough assessment, including of CLM data, to determine the particular human rights violations faced by the target groups, to clarify areas of focus with staff.¹⁶⁸</p> <p>c) Review and update the training materials of paralegals based on the assessment; and on alternative dispute resolution and mediation skills.</p> <p>d) Provide refresher training, mentoring and follow up to all existing paralegals.</p> <p>e) Ensure an adequate budget for ancillary costs associated with litigation.</p> <p>f) Ensure the implementation of the MoU with IPAJ to provide legal services and provide IPAJ lawyers with the necessary capacity strengthening to do so.</p> <p>g) Strengthen M&E to measure outcomes and impact in addition to outputs, for example by pre and post training evaluations, user surveys and health data.</p>
Improve laws, regulations and policies relating to TB	<p>a) Conduct a legal environment assessment specific for TB with special emphasis on a) situation analysis, b) progress, c) challenges and d) recommendations.</p> <p>b) Increase support and technical assistance for building capacity of civil society organizations, particularly community led organizations, for advocacy to reform laws, policies and practices</p>

¹⁶⁸ (GFA Consulting Group, Final Report: Spot-check on the "Mozambican programs to reduce human rights-related barriers to HIV/TB treatment at community level" 2023)

	<p>that act as barriers to access to and retention in TB services or increase vulnerability to TB infection at national scale.</p> <p>c) Provide support for the development of advocacy training materials for civil society organizations and policy briefs to support advocacy.</p> <p>d) Support the establishment of a national platform for engagement between civil society and relevant Government departments and Ministries on policy and law reform required for an enabling environment for an effective TB response.</p>
Reduce TB-related gender discrimination	<p>a) Develop a plan of action to reduce gender discrimination and harmful gender norms in relation to TB.</p> <p>b) Support advocacy projects to obtain government commitments concerning gender equality in the provision of TB healthcare services at national and regional levels.</p> <p>c) Support the implementation of programs to ensure gender-responsiveness in TB service delivery.</p> <p>d) Support the provision of technical assistance on the design of programs to reduce human rights and gender related barriers to TB services.</p> <p>e)</p>
Support community mobilization and advocacy	<p>a) Include patient groups in the design, evaluation and modification of TB services to improve their patient-centeredness and quality and to ensure that community mobilization and engagement sufficiently address the needs and realities of people at risk of TB, people with active TB, as well as those undergoing TB treatment.</p> <p>b) Give particular attention to gender equity and prioritize the development of women TB advocates (including paralegal and peer outreach) and support groups.</p>
Address needs of people in prisons and other closed settings	<p>a) .Expand efforts to reduce TB-related stigma and discrimination to all prisons.</p> <p>b) Support the NTP and its partners to ensure sufficient technical and operational resources for the Prison Health Technical Working Group.</p> <p>c) Support advocacy for the implementation of non-custodial sentencing to relieve overcrowding in prisons.</p>

Annex 1: Summary of Methods

The assessment was conducted between January and March 2023 following a methodology developed by the Global Fund. Assessment team members included a lead researcher, a second researcher and one national consultant. The steps used to conduct the assessment were the following:

- **Document review**--An extensive review document was completed (January-February 2023). Sources included Global Fund grant documents (grant agreements, budgets, Progress Update and Disbursement Request submissions, implementation letters, and grant performance reports); implementer grant agreements and reports (monthly, quarterly, semesterly and annual financial and programmatic reports); program outputs (activity reports, tools, training manuals, guidelines, policies, etc.); documentation on human rights related barriers (violations reports, press statements, etc.); national plans and strategies for HIV and TB; and other documents and sources related to progress to reduce or remove human rights and gender barriers
- **Data abstraction**--Data was abstracted from routine grant accountability reports (M&E data), community-led monitoring, and community monitoring reports of human rights violations. Financial data was abstracted from routine grant accountability reports, including progress reports and budget documents.
- **Key informant interviews and group discussions**--Key informant interviews (using interview guides) were conducted with 26 stakeholder representatives (March-April 2023). Group discussions were conducted with representatives of key populations (sex workers, people who use or inject drugs [PWUD/PWID], gay men and other men who have sex with men [MSM], transgender people), and others participating in or benefitting from programs to reduce barriers.
- **Site visits**-- Site visits were conducted (February and April 2023) to Mashava General Hospital and TB Centre of Excellence as well as to Beira and Pemba. Sites were selected to represent some of the diversity of settings where programs to reduce barriers are currently implemented as well as where there were opportunities to see synergies between the different programs, implementers and other stakeholders.
- **Sharing of preliminary findings**--Preliminary results for the Progress Assessment were shared with CNCS in March 2023 to inform the development of the GC7 Funding Request.

- **Stakeholder input and validation of KPI 9(a) scores**—The findings, recommendations and score range was shared with all stakeholders in November 2023 with a request for feedback and comments. None were received. Both TA providers have reviewed and agreed on the scores for the purposes of KPI 9(a). A meeting will be convened with all stakeholders in January 2024 to achieve consensus on the KPI E1 baseline scores.

To generate the scorecard results, the following definitions were applied:

Rating	Definition
0	No formal programs or activities identified.
1.0	One-off activities that are time-limited, pilot initiative.
2.0	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching <35% of targeted population.
2.3	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching 35-65% of targeted population.
2.6	Small scale on-going initiative with limited geographic scale (e.g., a single or small number of locations – less than 20% of national scale) and capacity for reaching >65% of targeted population.
3.0	Operating at subnational level (btw 20% to 50% national scale) and reaching <35% of targeted population
3.3	Operating at subnational level (btw 20% to 50% national scale) and reaching 35-65% of targeted population
3.6	Operating at subnational level (btw 20% to 50% national scale) and reaching >65% of targeted population
4.0	Operating at national level (>50% of national scale) and reaching <35% of targeted population
4.3	Operating at national level (>50% of national scale) and reaching 35-65% of targeted population
4.6	Operating at national level (>50% of national scale) and reaching >65% of targeted population
5	At scale is defined as more than 90% of national scale, where relevant, and more than 90% of the population

Program is assessed to have achieved the goal when there is impact on service continuum

Goal

Impact on services continuum is defined as:

- a) Human rights programs at scale for all populations; and
- b) Plausible causal links between programs, reduced barriers to services and increased access to HIV/TB services.

Annex 2: List of Documents Reviewed

The following types of documents were used sources for the assessment:

Global Fund materials

GC6 application materials (funding request forms, detailed budgets, performance frameworks)

Progress Updates (for PRs 1, 2 and 3)

SR financial and narrative reports

Global Fund Technical Guidance Briefs

National documents

National Strategic Plans for HIV and TB

Program Review reports for HIV and TB

Other relevant policies, plans and strategies

Legal Environmental and CRG Assessments

Materials from implementers

Training materials

Training reports

Reports for community dialogues, community engagement events, etc.

Reports and data on human rights violations (FDC, CCS for example)

Meeting reports

Journal articles

Relevant articles from peer reviewed journals

Annex 3: List of Stakeholders

Representatives from the following stakeholders participated in the progress assessment:

Associação Ajuda ao Desenvolvimento de Povo para Povo (ADPP)

Associação Tiyane Vavassate

CDC

Centro de Formação Jurídica e Judiciária – CFJJ

CNCS

CSS

FDC

Human Rights Commission

IPAJ

KUYUKANA

LAMBDA

Ministry of Health

Ministry of Justice

MOZPUD

MULEIDE

National TB Program

PEPFAR

PMR

Provincial AIDS Council

Provincial Network for NGOs Manica Province (VSO)

UNIDOS