SIERRA LEONE
Progress Assessment
Global Fund Breaking Down Barriers Initiative

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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. Executive Summary

Since 2017, Sierra Leone has received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria to reduce or remove human rights-related barriers to HIV and TB services through participating in the flagship *Breaking Down Barriers* initiative. As part of the package of assistance to countries to catalyze efforts to remove barriers, the initiative provides matching funding for “comprehensive” programs to remove rights-related barriers, based upon scaling up a set of internationally recognized human rights programs. Countries are also supported to create enabling environments to advance and sustain comprehensive responses.

This progress assessment, completed between August-September 2023, examines achievements and challenges over the 2021-2023 grant implementation period, paying particular attention to changes since the mid-term assessment was completed at the beginning of 2020. The assessment reviewed the status of rights-related HIV and TB programming twenty-seven months into CG6 – at the time of the country visit, nine months remained on the HIV and TB grants, which began in July 2021 and run until June 2024. The assessment found that, overall, Sierra Leone had made some progress in scaling-up programs to remove rights-related barriers to HIV services, with more modest progress on similar activities in the TB response. Generally, however, there have been significant delays to achieve more progress largely due to bottlenecks in grants management and the limited disbursement of available funds.

With regard to progress to reduce or remove human rights-related barriers to HIV services, the assessment noted that the Sierra Leone Human Rights Strategy was launched in 2021 and efforts were made to disseminate it and promote its use with support from UNAIDS and

UNDP. High-level engagements led by the National HIV/AIDS Secretariat were continuing to place a priority on the HIV response and to highlight the challenge of stigma and discrimination for increasing uptake of HIV services, including prevention services, and for sustaining people living with HIV (PLHIV) on anti-retroviral treatment. Important national institutions, such as the Human Rights Commission of Sierra Leone and the Judiciary, were also increasing their engagement to protect and promote the human rights of key populations and PLHIV, and to create a more enabling environment for the ongoing expansion of HIV services. Senior leadership at the Sierra Leone Police was also maintaining an open and responsive stance to address challenges for police behavior in communities that was interfering with the ability of individuals to safely access services and to seek protection when they experienced stigma, discrimination, or violence.

The network of Drop-In Centers and other safe-spaces was expanding for key populations and representatives from these communities were very engaged and visible across the national multi-sectoral response to HIV. An expanded community-led monitoring (CLM) process had been rolled-out during the assessment period, although with challenges to validate and share, in a timely manner, the data that had been collected. Despite the extended implementation delays, at the time of the assessment activities were soon to begin to establish embedded, community paralegals and to engage a legal services provider to fill gaps left in legal literacy and access justice that arose due to changes in implementation arrangements from the previous to the current grant cycle. Finally, despite a reduction in the amount of matching funds available for the Grant Cycle 7 (GC7) allocation period, a comprehensive set of investments was proposed to sustain progress to reduce human rights-related barriers throughout 2024-2026.

With regards to programs to reduce human rights-related barriers to TB services, there was more limited progress since both the baseline (2017) and mid-term (2020) assessments were conducted. The national TB response in Sierra Leone remains significantly underfunded meaning that all available technical and operational resources are strained to provide a core package of TB services in a high burden setting, including components related to reducing human rights-related barriers. The assessment found that some modest progress had been achieved regarding eliminating TB-related stigma and discrimination, to improve legal literacy and access to justice, and to support community mobilization and engagement. The Civil Society Movement Against Tuberculosis (CISMAT) remained the most prominent civil society entity advocating for the removal of human rights-related barriers and was continuing to have a leadership role in the TB component of CLM. It was a strong partner of the National Leprosy and Tuberculosis Control Program which, amongst other joint achievements, had established a TB Caucus of Parliamentarians to galvanize stronger institutional support and domestic investment for the national TB response, as well as to review and revise the legislative and policy frameworks. However, beyond these achievements, progress was modest or limited. Significant additional effort is still needed, including from HIV-focused allies, to accelerate and strengthen human rights-related responses to TB for the country.

The scorecard results for the progress assessment (including the KPI E1 values), by disease component and program area, are shown below (see **Annex 2** for the scorecard methodology).

HIV component

Program Area	Baseline (2018)	MTA (2020)	Progress and KPI E1 Baseline (2023)
Eliminate stigma and discrimination in all settings	1.0	3.1	3.3
Ensure non-discriminatory provision of health care	0.0	0.8	2.6
Ensure rights-based law enforcement practices	0.0	1.1	2.3
Improve legal literacy ("know your rights")	1.0	2.0	2.6
Improve access to justice (HIV-related legal services)	0.7	3.4	2.6
Improve laws, regulations and policies related to HIV and HIV/TB	0.0	2.3	2.6
Reducing HIV-related gender discrimination	0.0	2.2	3.0
Support community mobilization and engagement	*	*	3.3
Average Score	**0.4**	**2.1**	**2.7**[#]

*: no score assigned in previous assessments.
[#]: Note that the average scores only consider the first seven indicators to ensure consistency.

TB component

Program Area	Baseline (2018)	MTA (2020)	KPI E1 Baseline (2023)
Eliminate TB-related stigma and discrimination	1.0	1.4	2.2
Ensure people centered and rights-based TB services at health facilities	0.0	0.6	2.0
Ensure rights-based law enforcement practices for TB	0.0	0.0	0.0
Improve TB-related legal literacy (“know your rights”)	0.0	0.0	2.3
Improve access to justice in the context of TB	0.0	0.0	1.0
Improve laws, regulations and policies related to TB	0.0	0.0	1.0
Reduce TB-related gender discrimination	0.0	0.0	1.0
Support community mobilization and advocacy	1.3	0.0	3.0
Address needs of people in prisons and other closed settings	0.0	0.0	3.0
Average Score	**0.23**[##]	**0.24**[##]	**1.72**

[##]: 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. Introduction

Since 2017, the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) has provided more than US$85 million in catalytic matching funds to scale up evidence-based programs to reduce human rights-related barriers to HIV, TB and malaria services through the *Breaking Down Barriers Initiative*. This ground-breaking, global effort has further catalyzed additional investments through requiring participating countries to commit matching financial support from within their main Global Fund allocations thereby increasing overall efforts to reduce or remove human-rights related barriers to services. To track progress in each of the 20 countries that participate in the initiative, the Global Fund undertook baseline and mid-term assessments in 2017 and 2020, respectively. In 2023, it supported a further round of progress assessments to examine evidence of emerging impact and to inform further catalytic support as part of the Grant Cycle Seven (GC7) allocation period for 2024-2026.

Breaking Down Barriers aims to support countries to have "comprehensive" programs to remove human rights-related barriers to health services. "Comprehensive" programs are those that: (a) comprise a set of activities that are internationally recognized as effective in reducing human rights-related barriers to health (see **Box 1**); (b) are accessible or serve the majority of the estimated numbers of people living with HIV (PLHIV) and other key and vulnerable populations affected by such barriers; and (c) are adequately resourced to move from non-existence or once-off/small-scale activities to a level of implementation likely to significantly reduce human rights-related barriers to services (a sustained, mutually-reinforcing, broadly protective package of interventions at scale).

Box 1 -- Programs to Remove Human Rights-related Barriers to HIV and TB Services
For HIV:

- Eliminating HIV-related stigma and discrimination in all settings
- Ensuring non-discriminatory provision of health care
- Ensuring rights-based law enforcement practices
- Legal literacy ("know your rights")
- Increasing access to justice
- Improving laws, regulations and polices relating to HIV and HIV/TB
- Reducing gender discrimination, harmful gender norms and violence against women and girls in all their diversity
- Community mobilization and advocacy for human rights

For TB:

- Eliminating stigma and discrimination
- Reducing TB-related gender discrimination, harmful gender norms and violence
- Legal literacy ("know your rights")
- Increasing access to justice
- Ensuring people-centred and rights-based TB services at health facilities
- Ensuring people-centred and rights-based law enforcement practices
- Community mobilization and advocacy, including community-led monitoring
- Addressing the needs of people in prisons and other closed settings

2.1 *Breaking Down Barriers' Theory of Change*

The theory of change for the *Breaking Down Barriers* initiative is based on evidence from the HIV and TB epidemics that human rights-related barriers to health services[1] increase vulnerability to infection and negatively affect access to, uptake of and retention in HIV and TB services, particularly for certain key and vulnerable populations. To effectively reduce these barriers, countries should implement – at appropriate scale and with high quality – a set of internationally-recognized, evidence-based, human rights and gender-related interventions (see **Box 1** above). This will, in turn, accelerate country progress towards national, regional, and global HIV and TB targets. Efforts to remove rights-related barriers will also protect and enhance Global Fund investments and will strengthen health and community systems.

1.1. Breaking Down Barriers in Sierra Leone

Since 2017, Sierra Leone has participated in the *Breaking Down Barriers* initiative, receiving US$1.8 million as human rights catalytic matching funds in GC5 (2018-2020) and US$1.5 million in GC6 (2021-2023). The country fully matched both amounts and for GC6 reached

[1] The main categories of human rights and gender-related barriers to HIV and TB services include: Stigma and discrimination, including within the provision of health services; Punitive laws, policies, and practices; Gender inequality and gender-based violence; Poverty and socio-economic inequality; and Harmful working conditions and exploitation (mainly for TB).

a total of US$3 million invested in programs to reduce human rights-related barriers to HIV and TB services. For Grant Cycle 7 (GC7), Sierra Leone will have access to US$0.8 million in matching funds for programs to remove rights-related barriers and will be required to maintain or increase the level of investment from the 2021-2023 allocation in human rights programming. Furthermore, it must (a) determine the baseline scores for the KPI E1 indicator[2] (which measures the percentage of countries receiving human rights matching funds with increases in scale of programs to reduce human rights-related barriers); (b) review and update its multi-year plan to remove rights-related barriers to HIV services; and (c) ensure that its GC7 submission considers the findings of this most recent assessment of progress and addresses the Global Fund's new requirement regarding program essentials.

The purpose of this assessment was to understand the progress of programs to remove rights-related barriers to HIV and TB services in Sierra Leone, as well as to probe the emerging impact of these interventions on uptake, access and retention in HIV and TB services, with specific attention to program quality, the extent of scale-up and efforts to build in sustainability (see **Box 2**). It also aimed to capture and document lessons learnt and best practices related to human rights program implementation.

Box 2 -- Guiding questions for the progress assessment

The progress assessment essentially asked three questions (output, outcome and impact):

1. Has Sierra Leone made measurable progress since 2021 to scale-up **comprehensive, quality-assured and sustainable** interventions to reduce or remove human rights barriers to HIV and TB services (output)?
2. Have these interventions reduced or removed human rights barriers (outcome)?
3. Has the reduction of barriers improved access and uptake of services (impact)?

1.2. Methods

The progress assessments for all 20 countries took a differentiated approach based on two tiers: those that received a focused assessment, and others that received an in-depth assessment. While the methods used are the same between focused and in-depth assessments – i.e., they all included document review, key informant interviews, site visits and the use of case study analysis -- focused assessments included a smaller number of interviews and other assessment requirements than in-depth evaluations.[3]

The approach for Sierra Leone was a **focused progress assessment**. It began with a desk review of relevant documents from the Global Fund and other key stakeholders. The review

[2] This is a continuation of the KPI 9A indicator but will be a country-owned process that assesses country progress on an annual basis.
[3] The detailed protocol guiding all of the assessment is available on request.

identified that there was limited documentation of results of programs to reduce barriers, meaning that the assessment subsequently relied on key informant interviews, focus group discussion (FGDs) and site visits for the data to inform the findings. An initial round of interviews was conducted remotely which was followed by a ten-day intensive data collection period from August 28 – September 8, 2023. During this period, the research team interviewed key implementers, government agencies and beneficiaries (adult and older adolescent PLHIV; members of key populations communities including sex workers of all genders, men having sex with men, transgender persons, people who use or inject drugs; key populations living with HIV; health care workers of all cadres; ex-inmates; and people with disabilities, among others). They also went on site visits in Freetown, Waterloo and Bo, particularly to Drop-In Centers (DICs) and health facilities where HIV and TB services were provided (see **Annex 4** for the list of informants and locations). In total, 16 FGDs were convened with different beneficiary groups involving 104 participants; through the site visits and key informant interviews an additional 150 individuals participated in the assessment. Following the end of data collection, the assessment team reviewed and synthesized the data to develop the draft report. Key points from the draft report, including the proposed KPI E1 scores, were shared with stakeholders during October-November 2023. The assessment report, including the KPI E1 values, were review and validated by the Sierra Leone Country Coordination Mechanism in December 2023.

1.3. Limitations

During the data collection period, the assessment team sought to engage a full range of stakeholders representative of the broad diversity of actors and locations where the national, multi-sectoral responses to HIV and TB unfold in Sierra Leone. However, this engagement was limited by geography (face-to-face encounters took place only in Freetown, Waterloo and Bo) as well as time (only two weeks were available for intensive data collection). As a result, the full range of diverse experiences and perspectives may not be fully represented in the assessment results.

In addition, there has been only limited efforts to document or monitor achievements related to reducing or removing human rights-related barriers (this is addressed in the assessment findings). The assessment team heard many verbal or anecdotal accounts of progress and achievements, as well as ongoing challenges and gaps. As important as these inputs were, not all of them could be further verified or analyzed in the absence of other sources such as written reports or programmatic data. Focus groups discussion with KPs and PLHIVs typically involved between 6-8 participants. While these individuals shared candid and complete views on their experiences and challenges with regards to reducing or removing barriers, they cannot always be taken to reflect the entirety of experiences for all KPs or PLHIVs in all locations or circumstances in the country.

Finally, the collective efforts to remove human rights barriers were very much in motion during the time of the assessment, despite limited progress on several fronts. It could be that, had the assessment been done at a later period, more progress would have been achieved as many activities appeared to be only just beginning, or were about to start, and to accelerate in the remaining months available before the end of the current allocation period in June 2024. This situation is discussed in more depth throughout the findings under the specific program areas.

2. Background and Country Context

It is important to situate the findings of the progress assessment within the larger country context, particularly current progress to address the linked epidemics of HIV and TB in Sierra Leone. The following sections summarize key trends and ongoing gaps.

2.1. Overview of HIV Epidemiology

The HIV epidemic in Sierra Leone is considered as mixed, generalized, and heterogenous. The epidemic is concentrated among specific key populations, especially men having sex with men, transgender individuals, sex workers of all genders, and people who use and inject drugs. Other population groups are highly vulnerable, particularly children, adolescent girls and young women, people with disabilities, inmates, uniformed forces, miners, and okada drivers, among others.[4] The national adult HIV prevalence was most recently estimated at 1.7%.[5] In 2022, of the 76,600 adults and children living with HIV, it was estimated that less than two-thirds (61%) of PLHIV were aware of their status, of which 78% of those that knew their status were on anti-retroviral treatment (ART), and 45% were virally suppressed.[6] HIV infections were twice as high among women (2.2%) than men (1.1%) and thrice as high among adolescents and young women aged 15-24 years (1.5%) than boys and young men (0.5%) of the same age group. Key populations are disproportionately affected by HIV. In 2021, HIV prevalence among the estimated 27,990 female sex workers (FSW) was 11.8%; for the 16,126 men having sex with men (MSM) it was 3.2%; for the 1,364 transgender individuals it was 4.2%; for the 3,938 people who use or inject drugs (PWID) it was 4.2% (16.9% for females, 2.9% for males); and for inmates (4,600 males and 200 females) it was 3.4% (12.1% for females, 2.3% for males).[7] Data for 2022, as included the country's GC7 submission, showed significant ongoing coverage and uptake gaps for KPs along the entire HIV care continuum.

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[4] National HIV/AIDS Secretariat. 2023. Sierra Leone National Strategic Plan on HIV/AIDS 2021-2025 (2023 Revised Version).
[5] Ministry of Health and Sanitation and Stats Sierra Leone. 2020. Sierra Leone Demographic and Health Survey 2019.
[6] UNAIDS Spectrum Estimates for 2023.
[7] National HIV/AIDS Secretariat. 2021. Sierra Leone Integrated Bio-Behavioural Survey and Size Estimation Among Female Sex Workers (FSWs), Men who Have Sex with Men (MSM), Persons who Inject Drugs (PWID), Transgender (TG) and People in Close Settings (PCS). Estimated number of male and female inmates is taken from the Sierra Leone Correctional Service website (https://slcs.gov.sl).

2.2. Overview of TB Epidemiology

Sierra Leone is one of the 30 high TB burden countries globally due to the high number of estimated TB cases.[8] Based on the WHO estimates, in 2021 TB incidence was 289 per 100,000 population for a total population of approximately 8.4 million. This translated to 24,000 TB cases in 2021, 3,300 or 14% occurring among children, 660 being drug resistant TB cases, and 2 900 or 12% also co-infected with HIV. Mortality for all forms of TB was estimated at 3,300 or 15%. TB remained the leading cause of AIDS-related mortality. The country has a predominantly young population with approximately 60% below the age of 25 years. Though 32% of the population is between 25 and 54 years, this group accounted for almost 60% of the total TB cases notified in 2019. In 2022, over 98% of PLHIV were screened for TB and 100% of TB patients diagnosed with HIV were started on ART. TB treatment coverage reach 77% in 2022 and the treatment success rate was 91% for the 2021 treatment cohort. However, as many as 4,000 individuals acquiring TB in 2022 were undiagnosed. Treatment coverage for Drug resistant (DR)-TB (all forms) reached only 31% of the estimated number of cases. The treatment success rate for the 2020 cohort was 75% with a mortality rate of 23%.[9]

2.3. Legal and Policy Context

There have been some recent improvements in the legal and policy environment for programs to reduce human rights-related barriers. In October 2021, stakeholders convened to launch the *Sierra Leone Human Rights Strategy: A Multi-year Plan to Remove Human Rights--Related Barriers to HIV and TB Services (2021-2024)*. The plan is comprehensive and contains one overarching objective and eight corresponding goals (**Table 1**):

Table 1: Summary of Human Rights Strategy

Overall objective	**An HIV and TB-free Sierra Leone through protecting human rights, achieving gender equality, and improving health equity for all people in Sierra Leone**
Goal #1	To eliminate stigma, discrimination and violence related to HIV and tuberculosis in all settings.
Goal #2	To eliminate stigma and discrimination related to HIV and tuberculosis and create an environment that facilitates access to health services for all
Goal #3	Legislators, law enforcement officials, judges, prosecutors, and members of the Human Rights Commission understand and fulfil their role in respecting, protecting, and promoting health, rights, and gender equality

[8] WHO. 2022. World Tuberculosis Report. All data in this paragraph is taken from the Sierra Leone country page in the report annexes.
[9] MOHS. 2023. Mid-Term Review of the TB National Strategic Plan (2021-2025). May 2023.

Goal #4	All members of key and vulnerable populations are aware of their rights and can claim them whenever necessary
Goal #5	All members of key and vulnerable populations, including inmates, have access to an effective remedy for violations of their rights, including mediation or judicial proceedings
Goal #6	Laws, regulations and policies, and their implementation, are monitored routinely and respect the rights of key and vulnerable populations and facilitate rather than compromise their access to and retention in health services
Goal #7	Women, girls, LGBT individuals have access to health services without gender-related barriers; gender-based violence is significantly reduced, and populations have access to an effective remedy for gender-based violence
Goal #8	The multi-year plan is implemented in a coordinated and strategic manner; challenges to its implementation are identified promptly, and the plan is adapted for changes in its context.

Subsequently, in 2022, NAS mobilized support from the West African Health Organization (WAHO) to print and distribute copies of the Strategy, and to organize training and sensitization sessions delivered by KP-led CSOs in communities on both the Strategy and the results of the *2020 PLHIV Stigma Index*. The report on these activities indicates that 128 representatives from the main PLHIV and KP-led networks and CSOs completed the initial training and orientation. These partners were subsequently able to reach over 1,800 of their peers through community-level sensitization and engagement activities.

As part of the preparations for the country's GC7 submission, the national strategic plans (NSPs) for HIV and TB were reviewed and updated. The review of the HIV NSP noted that, despite the comprehensive component on reducing human rights and gender-related barriers to HIV services, little progress had been made since the NSP was launched in 2021. With regard to the TB NSP, the review noted the absence of substantive content on reducing human rights and gender-related barriers in the context of TB and recommended that the NSP be revised accordingly.

The most recent Legal and Environmental Assessment for HIV was completed in 2017.[10] Its findings regarding criminalization of same-sex sexualities, gender diversity, aspects of sex work, and of drug use remained largely unchanged during period covered by the progress assessment, although it was the view of key stakeholders that the overall rule of law and the administration of justice was improving. And while the National HIV and AIDS Commission (NAC) Act of 2011 provides for comprehensive protections against stigma and discrimination linked to HIV, knowledge and awareness of its provisions remained inadequate along with effective mechanisms for seeking redress in line with the provisions of the Act. To the extent that institutions such as the Human Rights Commission of Sierra

[10] NAS and UNDP. 2017. Assessment of Legal Environment for HIV and AIDS in Sierra Leone. Available: https://hivlawcommission.org/wp-content/uploads/2019/10/UNDP-Reports-LegalEnvironmentAssessments-Sierra-Leone.pdf

Leone and the Legal Aid Board offer such pathways for redress, for PLHIV, KPs and other vulnerable populations, there was limited evidence to suggest they were utilized.

2.4. Effects of COVID-19 Pandemic

The country's response to the COVID-19 pandemic led to significant disruptions in HIV and TB programming as well as increasing the already significant socio-economic vulnerability and exclusion of PLHIV and KPs. By 2023, much of the service disruptions had been addressed, with a strong recovery of the HIV and TB programs, for example. However, for PLHIV and KPs who were negatively affected, recovery had been more modest with many individuals undergoing daily struggles for any form of income, adequate shelter, and adequate food and nutrition.[11] Poverty and food insecurity remain cross-cutting challenges for Sierra Leone with additional impacts for sub-populations such as PLHIV, people affected by TB, and KPs who face additional forms of exclusion and disadvantage linked to their health status or their social characteristics. A social vulnerability study from 2021 found that 94% of the 3,100 PLHIV participants (76% of all participants were female) were either vulnerable (52%) or highly vulnerable (42%) based on standard indicators measuring food security, socio-economic status, and access to shelter.[12]

3. Towards Comprehensiveness: Achievements in Scope, Scale and Quality for Programmes to Reduce Human Rights-Related Barriers to HIV and TB Services

The more detailed findings of the progress assessment are presented in the following sections, beginning with an overview of current programs and investments to reduce human rights-related barriers to HIV and TB services.

3.1. Overview of Investments and Implementation Arrangements

For the 2021-2023 allocation period, Sierra Leone allocated US$3 million to scale-up programs to reduce human rights-related barriers to HIV and TB services. The original distribution of the funds by program areas is shown below (**Table 2**):

Table 2: Allocation of funds by program area

Program Areas for HIV/TB	Amount (US$)	%

[11] World Food Program, NAS and UNAIDS. 2021. Profiling Assessment of People living with HIV (PLHIV) in Sierra Leone
[12] Ibid.

Eliminate stigma and discrimination in all its forms	1 060 845	36%
Ensure non-discriminatory provision of medical care	13 378	0%
Ensure human rights-based law enforcement practices	38 081	1%
Legal literacy ("know your rights")	245 723	8%
Access to legal services	556 849	19%
Improving laws, regulations and policies on HIV and TB	-	0%
Reducing HIV and TB-related gender discrimination	903 480	30%
Community mobilization and human rights advocacy	156 554	5%
Total	**2 974 909**	100%

In addition to these funds, US$1.75 million was allocated to support the scale-up of community-led monitoring (CLM) to all 16 districts of the country. The CLM concept was inclusive of indicators to monitor efforts to reduce human rights-related barriers (see **Section 3.2.8**).

The implementation arrangements for programs to reduce human rights-related barriers included the Principal Recipient (PR), the Ministry of Finance, two national disease programs, the National AIDS Control Program (NACP) and the National Leprosy and Tuberculosis Control Program (NLTCP), and eight civil society organizations (CSOs) leading the implementation of PLHIV and key-population focused programming for HIV and TB. These are listed below along with their respective allocations for human rights-related activities (**Table 3**). Total expenditure as of June 30, 2023 is also indicated.

Table 3: Allocation of funds by SR and expenditure as of June 30, 2023

SR	Budget (US$)	Expense (US$)	%
Dignity Association (MSM)	599 607	90 628	15%
Kakua Hospice (FSW)	214 304	18 961	9%
Network of HIV Positives in Sierra Leone (NETHIPS) (PLHIV)	990 976	16 251	2%
Prison Watch (People in closed settings)	152 101	2 779	2%
Rofutha Development Association (RODA) (FSW)	226 226	15 738	7%
Social Linkages for Youth Development And Child Link (SLYDCL) (PWUID)	100 235	0	0%
Society for Women and AIDs in Africa *Sierra Leone*(*SWAASL*) (FSW)	219 517	4 509	2%
Women in Crisis Movement (WICM) (FSW)	218 612	18 087	8%
Total	**2 721 579**	**166 952**	**6%**

The implementers for CLM included Catholic Relief Services as the PR and two SRs, the Consortium for the Advancement of Right for Key Affected Populations (CARKAP) and the Civil Society Movement Against Tuberculosis (CISMAT). As a significant change from the previous allocation period (2018-2020), discussed below, NAS and the Legal Aid Board

were not included in the grant implementation arrangements for the 2021-2023 period. Despite this, NAS was still working to play a leadership role to coordinate interventions to reduce human rights-related barriers. Using Global Fund resources, a Senior Technical Advisor on Human Rights had been deployed to NAS to guide and support this work and was widely regarded to be effective in the role.

As **Table 3** indicates, at the time the assessment took place, there had been significant delays to implement planned activities utilizing Global Fund resources (there was still an intention to accelerate implementation). All of these funds were lodged under the Integrated Health Project Administration Unit (IHPAU) in the Ministry of Health and Sanitation (MOHS). The main explanation given was the complexities of public financial administration procedures governing IHPAU as well as additional risk mitigation measures imposed by the Fiscal Agent and the Local Funding Agent (LFA) following grants management irregularities identified in previous allocation periods.[13] A reprogramming request had been submitted and approved in 2022 to address acceleration. However, implementation of the reprogrammed activities had not yet started when the assessment was conducted. Other implications of these delays are discussed under the specific program areas in the following sections.

3.2. Progress to Remove Barriers to HIV Services

Overall, since the mid-term assessment (MTA), there has been some progress to reduce human rights-related barriers to HIV services. All stakeholders were of the view that there had been increased uptake and retention in HIV services across the continuum, from HIV prevention services, including pre-exposure prophylaxis (PrEP), through to enrolment and retention on ART. This was attributed to tangible, if incremental, changes in the program environment as well as the ongoing scale-up of HIV services themselves, including those specifically focusing on KPs and other priority populations for the national HIV response. Not all of this progress was linked to Global Fund-supported activities, however, due to implementation delays noted above. Interventions supported by other partners, including the United States President's Emergency Plan for AIDS Relief (PEPFAR), UNAIDS and UNDP, as well as the volunteer and unfunded efforts of a range of stakeholders, made more substantive contributions to these shifts.

(a) Eliminate stigma and discrimination in all settings

HIV program area	Score		
	Baseline	Mid-Term	Progress
Eliminate stigma and discrimination in all settings	1.0	3.1	3.3

[13] Sierra Leone is categorised as a challenging operating environment by the Global Fund and has also been placed under the Additional Safeguards Policy.

While efforts to reduce or eliminate HIV-related stigma and discrimination may not be well-coordinated or coherent in terms of linkages and synergies, many participants in the assessment stated that, in general, HIV-related stigma and discrimination was waning in Sierra Leone, although not for all populations or in all locations in the country. Several activities had contributed to this change, including the following:

- NETHIPS continued to be active on several fronts, regardless of the extent to which it had specific funding for its activities. This included continuing to promote the results of the *2020 PLHIV Stigma Index*, empowering members of support groups to be active in their communities to confront HIV-related stigma and discrimination, and to work with PLHIV themselves to build resilience to stigma and to reduce levels of internalised or self-stigma. There was no comprehensive monitoring of this work, however, to determine its full scale or scope, or to measure the extent to which HIV-related stigma and discrimination was reducing as a result. A new stigma index is planned under the country's GC7 submission and there is a commitment to repeat the exercise every three years in future periods.

- At the time of the assessment a number of high-level engagements were ongoing, or planned to move forward, to continue to raise the profile of HIV country-wide, and to change public attitudes and behaviours as a result. NAS and UNAIDS were the leaders in this regard. This work, largely implemented by NAS, has included country-wide participation in World AIDS Day, for example, where the Chief Justice was the key note speaker in 2022; the development of a '100 days' plan to be lead by the Office of the President in order to galvanise stakeholders towards achieving 98-98-98 targets for the national HIV response; engagement with the media on non-discriminatory coverage of HIV-related topics; and ongoing engagement with members of the Cabinet and other Parliamentarians, including the Minster for Youth Affairs, the Minister of Gender and Child Affairs, and the Minister of Labour, among others.

- With regard to this last Cabinet member, at the time of the assessment, the Ministry of Labour was completing a review and revision of the National Workplace Policy on HIV/AIDS, first developed in 2006. As part of the revision, the Ministry was intending to intensify its monitoring of workplaces for compliance with the revised policy, as well as with prevailing laws, including the NAC Act of 2011, for preventing discrimination on the basis of HIV-status in workplace settings.

- CARKAP and its members were continuing to work in districts and communities, often with limited resources, to promote recognition of HIV and KPs and to create enabling environments for Drop-In Centres (DICs) and other outreach programmes, as well as to reduce levels of stigma, discrimination, and violence. Some of this work was supported through Global Fund resources; more of it was done solely on the basis of volunteer commitments and the dedication of KP-led CSOs to achieve change for their members. There is no comprehensive tracking of this work, however, making it challenging to assess how far it reaches and the extent of change that has occurred.

- CARKAP members, supported by strategic partners such as NAS, UNAIDS, UNDP and Jhpiego, had developed and launched a Community Charter to intensify and align their joint efforts to support the goal of ending HIV and AIDS as public health threats by 2030 in Sierra Leone. Target 6 specifically addressed eliminating stigma and discrimination in all settings (see **Box 3**).

Box 3 -- The Sierra Leone Community Charter - Target 6 - Less than 10% experience HIV and TB-related stigma and discrimination

We [the community] will:

- Conduct and disseminate the results of the PLHIV stigma index every three years;
- Hold regular engagements with the relevant parliamentary oversight committees on HIV, human rights and the law;
- Work with religious and other community leaders to address HIV and TB-related stigma, discrimination and violence;
- Promote the greater involvement of PLHIV/TB and KPs in the national responses to HIV and TB;
- Carry out the Know- Your-Rights Campaign for PLHIV and KPs in communities;
- Work with religious and other community leaders to address stigma, denial and improve treatment uptake and retention in care for PLHIV/TB and their families in communities;
- Advocate for the institutionalization of human rights training for the Sierra Leone Police, Sierra Leone Correctional Service, and the Judiciary.

- The Disability Rights Movement (DRIM) in Sierra Leone noted in its annual report for 2022 that it had undertaken sensitisation activities with people with disabilities in communities on HIV, TB and human rights-related topics. These activities took place in several locations, including Bo, Bonthe, Tonkolili, Moyamba, Freetown, Koinadugu, Kenema, Kono, Pujehun and Kailahun according to the report. No specific data was captured on how many individuals these activities reached (the report states only 'the whole community' as the target reached).

In general, however, there was an absence of a comprehensive approach to eliminating stigma and discrimination in all settings, primarily due to limited resources and not the lack of a collective will to do more. The results of the 2019 DHS, released in 2020, give an indication of the magnitude of the challenge to be addressed with 80% of women and 71% of men expressing one or more negative attitudes towards HIV as well as people living with or affected by the disease.[14] Not surprisingly, during focus group discussions, PLHIV continued to report high levels of stigma in their interpersonal and community environments, either as actual experiences or as ongoing anxieties about the risk of such experiences. For this reason, PLHIV continued to keep their HIV status private and to express concerns about certain environments, including the way that HIV services were organized in public health facilities, where their HIV status could be inadvertently disclosed to others.

[14] Ministry of Health and Sanitation and Stats Sierra Leone. 2020. Sierra Leone Demographic and Health Survey 2019. p.222

Poverty, and limited opportunities for economic upliftment, and food insecurity continue to be the greatest preoccupations for a substantive proportion of PLHIV and KPs. For young PLHIV, including children and adolescents, there were ongoing challenges in the educational environment (high school and tertiary settings) to the extent that they kept their HIV status secret or reported negative experiences once their status became known. Participants in focus group discussions who were older adolescents and young PLHIV shared troubling accounts of being excluded or rejected from families once their HIV status was known, adding to an already high burden of socio-economic vulnerability for children and young people more generally throughout the country. All of this was occurring despite clear and comprehensive provisions within the NAC Act of 2011 regarding protections against HIV-related stigma and discrimination, much of which is known by PLHIV but considered to be not practically useful to them in the absence of readily available redress mechanisms to pursue claims (see below).

The burden of stigma, discrimination and violence was generally heavier for members of KP groups, including KPs living with HIV and people with disabilities, according to the different focus group participants. While DICs, where they were functional and available, provided safe spaces within which to avoid stigma and discrimination, or to receive support when such experiences occurred, there was limited progress in the overall social environment to prevent stigma, discrimination or violence, and to limit the social and economic exclusion experienced by many KPs who participated in the assessment.

KPs living with HIV experienced additional risks. While there was appreciation for the efforts to protect their privacy and confidentiality as they accessed services through DICs, for example, few were of the view that DICs and their fellow KPs that utilized them were accepting and supportive of PLHIV amongst them. Many had not disclosed their status other than to their PLHIV peers who were also KPs. Some efforts were being planned to address this, particularly in the DICs supported by Jhpiego, but had not been implemented at the time of the assessment. When the activities do move forward, they will include renewed promotion of HIV treatment as prevention and U=U (undetectable=untransmissible) messaging to be fully inclusive of KPs on ART as important contributors to HIV prevention and risk reduction, and to promote greater acceptance and support of KP PLHIVs within KP communities.[15]

Finally, the expanded CLM project is meant to track trends in stigma, discrimination, and violence. The revised data collection tools are comprehensive and have the potential to provide a highly sophisticated and fully disaggregated account of experiences of stigma, discrimination, and violence, and to link these data with data on the core elements of HIV and TB care, including access, uptake and retention in services. The data, once compiled, will also allow for population and location specific trend analysis.

[15] Aligned to global shifts, PLHIV on ART are now referred to as 'recipients of care' in Sierra Leone.

Recommendations

- Develop a comprehensive action plan to eliminate stigma in all settings in line with the 10-10-10 commitments. Link the action plan to the Human Rights Strategy.
- Accelerate the roll-out of tools and materials to reduce HIV-related stigma in DICs and other settings for KPs;
- Routinely monitor progress to reduce/eliminate HIV and TB stigma, discrimination, and violence (routinely analyse and share CLM data on these topics).
- Undertake rapid assessments to measure HIV-related stigma and discrimination in education, workplace and humanitarian settings. Use the results to scale up relevant interventions.
- Fully integrate the needs and concerns of people with disabilities living with or at risk for HIV into comprehensive interventions to reduce HIV-related stigma and discrimination.
- Undertake tailored stigma and discrimination reduction interventions of children and adolescents living with HIV or at high risk for HIV acquisition.

(b) Ensure non-discriminatory provision of health care

HIV program area	Score		
	Baseline	Mid-Term	Progress
Ensure non-discriminatory provision of health care	0.0	0.8	3.0

There has been some progress to address stigma and discrimination in health care settings, but not for all groups, or in all locations where HIV services are provided. The NACP has limited overall resources to provide training to health care workers (HCWs) meaning that opportunities to engage these individuals on human rights and medical ethics in the context of HIV or TB is equally curtailed. During site visits to ART centers, conducted as part of the assessment, HCWs were engaged by the assessment team on topics related to human rights and medical ethics. Most showed an awareness of the high risk of stigma and discrimination in the context of HIV, particularly through the experiences of the PLHIV they cared for, and the need to emphasize confidentiality and privacy, for example, even though they may not have received formal training on such topics. They also raised the challenges they have in this regard, particularly the challenges for the physical environments in ART centers (Lumley, for example) which lacked sufficient space for privacy.

ART services in four districts are supported by Jhpiego which is funded through the regional PEPFAR program. Jhpiego also supports a KP technical advisor situated within the NACP. In all its training and mentoring activities, Jhpiego includes content on human rights, and sexual and gender diversity, in order to equip HCWs to provide stigma-free services, particularly to KPs. Expert patients are also part of health teams at ART centers and work to address any perceptions of stigma and discrimination that may arise amongst the Recipients of Care (PLHIV on ART) who use the services. Jhpiego also supports DICs

(complementing but not duplicating support provided through the Global Fund). At the time of the assessment, Jhpiego was beginning to work with DICs to include ART services (DICs already offer HIV testing, PrEP access and screening and referral for STI treatment). These adjustments were seen, nationally, as a strategy to mitigate the risk of stigma and discrimination for KPs in general health services and to improve uptake and retention in HIV programs, particularly PrEP and ART.

Jhpiego's support is aligned to the country-wide effort in Sierra Leone to roll-out a comprehensive differentiated service delivery (DSD) strategy. The overall aim of the strategy is improving uptake and retention in HIV services across the cascade, from HIV testing and diagnosis to long term viral suppression.[16] The DSD guidelines have a specific component for KPs for whom differentiated models of service delivery provide more opportunities to engage in the HIV continuum through expanding services in safe and trusted environments, such as DICs or specific KP-friendly health facilities. Measures to monitor the roll-out of DSD for both PLHIV and KPs have been included in the revised CLM tools. At the time of the assessment, however, this data was not yet available for review and analysis.

In mid-2023, with support from UNDP, a Patients' Charter was launched setting out both rights and responsibilities for health service provisions for service users and service providers. NAS is continuing to promote the Charter through subsequent training and sensitization activities as well as through the distribution of printed copies to be displayed in health care settings. The revised CLM tool has indicators linked to the Charter to be able to monitor its influence on the quality of care received by PLHIV, and specifically KPs.

At the time of the MTA, through the PLHIV Stigma Index, PLHIV reported low levels of stigma and discrimination in the provision of health services (4% reported denial of health services and 5%-7% reported different challenges with the quality of HIV services they received).[17] During the progress assessment, those PLHIV who participated reported limited challenges in accessing HIV services through ART centers, although concerns related to privacy and confidentiality linked to the physical arrangement for services were consistently raised. Some PLHIV reported ongoing challenges in other health services (laboratory, for example) or from administrative or security personnel working at health facilities (demanding to know the reason for their visit, for example, and thereby compelling disclosure of their status as a Recipient of Care). PLHIV were more concerned regarding transport costs (since ART services are not provided in all health facilities) as well as ancillary services, particularly food and nutrition support.

Challenges were still evident for KPs in health care settings, however, including at ART centers. Outside the limited number of facilities known or designated as KP-friendly,

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[16] MOHS and NAS. 2022. Sierra Leone Differentiated Service Delivery Operational Guide.
[17] NETHIPS and others. 2020. The PLHIV Stigma Index Sierra Leone. April 2020. p45.

experiences were generally negative. Individuals had had different experiences, including being forced to wait until all other individuals had been served, or facing different direct or indirect forms of stigma and abuse. KP implementers support peer navigators to accompany individuals to health centers as a way to encourage service uptake and retention, and to mitigate the risks of stigma and discrimination, including from providers of HIV services. However, the reach of these efforts is limited and even peer navigators could experience barriers related to stigma and discrimination when they accompanied their peers to health facilities. There was a cross-cutting call for the acceleration of DSD, particularly the provision of ART services through DICs, so that KPs could avoid general health services altogether.

Recommendations

- NACP should pilot and roll-out a 'facility-wide' stigma and discrimination reduction intervention, prioritising high volume ART sites and those accessed by KPs.[18]
- Scale up and sustain efforts to promote the Patients Charter and to monitor the provision of health services considering its provisions.
- Create opportunities for KPs to raise quality of service complaints and to have them addressed.
- Review and revise training materials for all cadres of HCWs to ensure specific and robust content on human rights and medical ethics (including scaling-up the components on sexual and gender diversity developed by Jhpiego).
- Accelerate efforts to modify pre-service training materials and curricula to include content on human rights and medical ethics and the elimination of all forms of stigma and discrimination in health care settings.
- Address and resolve the concerns of people with disabilities for unimpeded access to comprehensive HIV and TB services.
- Sustain and scale up current efforts to support children and adolescents living with HIV at access and be retained in HIV services.

(c) Ensure rights-based law enforcement practices

HIV program area	Score		
	Baseline	Mid-Term	Progress
Ensure rights-based law enforcement practices	0.0	1.1	2.3

Over the assessment period, there continued to be efforts to engage the Sierra Leone Police (SLP) as a key stakeholder in the rights-based, public health response to HIV and TB. A senior level focal point remains in place and is responsive to different stakeholders when challenges involving the police arise, including instances of unlawful arrest or detention, as well as other forms of harassment and abuse in communities. There is a commitment to

[18] See, for example, Nyblade et al. 2020. A total facility approach to reducing HIV stigma in health facilities: implementation process and lessons learned. *Aids*, *34*, pp.S93-S102. This model is currently implemented in Ghana using resources from the Global Fund and other partners.

revising the training curricula for police recruits to include information on HIV, TB and human rights, and on the role of the police in supporting (rather than hindering) public health responses.

At the local level, in communities, implementers worked to engage police officers as part of sensitization activities to create enabling environments, or through more direct efforts made by Complaint Desk Officers (CDOs), for example.[19] The success of these efforts was uneven, according to community stakeholders, and relied very much on the willingness of local police leadership to support HIV responses and to reduce the frequency of harassment and abuse against individuals. A frequent challenge was turnover when local officers were posted elsewhere and the engagement process needed to start again from the beginning with newly installed incumbents.

Despite these limited efforts, significant challenges remain according to many of the KPs that participated in the assessment. In their view, the SLP remain a daily risk or 'menace' to individuals in communities, particularly for sex workers and PWUIDs.[20] Raw, unverified data from CLM suggested that the magnitude of this challenge remains significant. There were accounts in all locations visited during the assessment of abuse of sex workers by local officers, either to extort money or to demand for sex. The country is in the midst of rapidly expanding drug use (this is also occurring at the regional level) and this is leading to an escalation in police actions against PWUIDs in local communities. This has led to disruptions in programming for PWUIDs, including needle and syringe exchange, and severed hard-won relationships between local CSOs and a highly mobile and difficult to engage drug-using community. While SLYDCL works to sensitize and build relationships with SLP to prevent such mis-steps, these frequently occur as reactions to raids and other abuses forcing local actors to begin from the start to reengage with local PWUIDs and their networks. There has been little progress to prevent these actions in the first place.

In addition, it was evident through the focus group discussions that levels of confidence are extremely low in the protective function of the SLP. Individuals either do not report instances of violence or abuse or, when they do, struggle to have cases lodged and to receive appropriate responses. It was stated that, often, money must change hands if cases are to progress. As further evidence of this challenge, the recently completed IBBS found, for example, that of the 8% of sex worker participants reporting having been sexually assaulted, 72% did not seek assistance from the police. Although there is a national effort to address sexual violence against women and girls, including through the SLP's Family Support Units

[19] At the time of the assessment, seven KP organizations employed 8 CDOs, working in 8 districts of the country. 4 CDOs focus on sex workers, 2 on people who use drugs; 1 on MSM and 1 on inmates. 6 CDOs cover 10 of Sierra Leone's 16 districts, including the 7 high burden districts. CDOs are meant to provide a range of counselling and mediation services related to human rights violations, including physical and sexual violence and harassment. Most incumbents have training in counselling or social work, but no specific qualifications in law or human rights. Resources to support their work are constrained. During a focus group discussion, CDOs expressed frustration with limited budget and tools available to them to effectively support and protect the KPs with whom they work on a daily basis.

[20] Indeed, challenges with the SLP may be more systemic light of the fact that, in 2021, the Human Rights Commission of Sierra Leone completed a special review of SLP practices given the high volume complaints of abuse it was receiving from citizens.

(FSU), there was little evidence that KPs utilized this support. Evidently, a more comprehensive, longer-term approach is needed that goes beyond once-off engagement activities or reactive responses once abuses have occurred. While many key stakeholders acknowledge this need, progress to move in this direction has been limited to date despite this willingness.

For more than two decades, Prison Watch has been supporting inmates in Sierra Leone to promote and protect the human rights of incarcerated persons. Prison Watch also collaborates with Sierra Leone Correctional Service to improve the technical capacity of prison staff on rights-based approaches detention management. During the 2021-2023 period, it is receiving Global Fund support for some of its work to promote uptake of HIV and TB services and to support broader institutional change and improvement regarding the health and welfare of inmates. Its current priorities include participating in law and policy reform (supported by UNDP), specifically a new legislative framework for correctional institutions, and the review and revision of the prisons health policy. Global Fund supports a Chief Detention Monitor based in Bo to provide advice and support to inmates and to generally monitor rights-related trends. The work of this individual also includes organizing legal assistance through the Legal Aid Board.

Recommendations

- Design and institutionalise a training programme adapted from best-practice models (Ghana, for example). This programme should include a version of the training curriculum for deployed officers. The programme should be inclusive of representatives from PLHIV and KP communities.
- Using results from CLM and other sources, there should be routine accountability sessions with SLP leadership to monitor institutional behaviour changes as the training is rolled out.
- NAS should engage the leadership of the FSU arm of SLP to undertake internal advocacy and sensitisation so that this service can be available to all KPs who experience sexual violence.
- Use the evolving engagement with the Judiciary to create a platform for all law and justice stakeholders to strengthen efforts to reduce or remove barriers.

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

HIV program area	Score		
	Baseline	Mid-Term	Progress
Improve legal literacy	1.0	2.0	2.6

There has been some progress since the MTA to maintain legal literacy interventions for PLHIV and KPs. Over the 2021-2023 period, trainings for peer educators and peer navigators, for example, have routinely included content on legal and human rights literacy. For all of the KP-led SRs, such trainings had occurred at least once since 2021, if not more frequently. The number trained and the frequency varied from group to group, however.

Larger trainings, convened by NAS, had occurred in 2023 on treatment literacy, CLM, human rights literacy, and both the Patient and Community Charters, using resources from WAHO and UNDP. By August 2023, these events had involved over 200 participants from four districts, according to the activity report. The participants were drawn from a range of groups, including KP representatives, health care workers, Recipients of Care and other local stakeholders.

Other legal literacy activities were less direct or specific. NETHIPS, for example, continues to sensitize PLHIV on the provisions of the NAC Act of 2011, particularly its protections for PLHIV against discrimination, non-consensual disclosure of HIV status, and the circumstances when PLHIV may be required to disclose their HIV status to others (including exemptions and mitigating factors). KPs who are PLHIV were also sensitized on these topics as part of the support they received through DICs. Prison Watch also includes a component of legal and human rights literacy in its work with inmates and through its support of training programs for Correctional Officers.

While legal and human rights literacy was appreciated by many, and the content and resulting knowledge considered both helpful and personally empowering, there were limitations according to key informants. When legal or human rights violations occur for individuals, the means for redress remain limited, a gap left by the non-reengagement of the Legal Aid Board and one that was not yet filled at the time of the progress assessment (although a procurement process for another legal services provider was in an advanced stage). These informants were of the view that, without such routes for seeking redress, the impact of legal literacy interventions was limited. Many KPs spoke about the reality of socio-economic exclusion, including being denied family support, being forced out of the family home, and being unable to find employment or other ways to generate income in order to be independent. These challenges were just as compelling to them as other legal or human rights violations. However, there were few legal provisions or other routes that provided for redress in these instances.

At the time of the assessment, a plan had been developed to reprogramed Global Fund resources to increase the scale and scope of legal literacy interventions and to link them to access to justice through the engagement of paralegals and a legal services provider. This included the engagement of community paralegals and providing more technical and operational support to CDOs. This demonstrated that there was an awareness of the importance of scaling-up and sustaining interventions to support legal and human rights literacy. However, as already noted, implementation had not moved forward, although it was expected to start before the end of 2023. A more comprehensive approach had been included in the GC7 request for Sierra Leone.

Recommendations

- Accelerate the implementation of the plan to train and deploy community paralegals.

- Accelerate the implementation of the plan to strengthen the role of CDOs.
- Including within the CLM tools indicators to monitor levels of legal and human rights literacy.
- Continue to integrate components on legal and human rights literacy within core HIV interventions for PLHIV and KPs.

(e) Improve Access to Justice

HIV program area	Score		
	Baseline	Mid-Term	Progress
Improve access to justice	0.7	3.4	2.6

Progress since the last assessment has declined for this program area. As already noted, while during the 2018-2020 allocation period the Legal Aid Board had functioned as an SR to provide legal services for PLHIV and KP, it did not continue in this role for the 2021-2023 period. Although the Board, as part of its statutory mandate to service all Sierra Leonians, remains available to provide legal support in the context of HIV and TB, it can no longer prioritize this work, nor can it specifically track cases that involve PLHIV, KPs or people living with TB, both due to limited resources. As already noted, the plan for the 2021-2023 period included engaging a new legal services provider that was not yet in place at the time of the assessment.

The HRCSL continued to be available to PLHIV and KPs for human rights related concerns that fall within its mandate. However, no examples of current cases were available. While the annual reports for 2021 and 2022 contain a section on Vulnerable Groups that makes mention of PLHIV and KPs, the reports themselves have little to no content on issues affecting these populations. According to the HRCSL, the report for 2023 may address this gap. A plan had been developed to reprogramed Global Fund resources to support the HRCSL to facilitate district level engagements to create stronger ties with PLHIV and KP communities and to improve the confidence of these communities in the services it provides, including a web-base platform for reporting human rights violations. However, at the time of the assessment, the Global Fund support had not been released. The HRCSL was also unable to determine or track how many HIV or TB related complaints it had received or was currently processing.

In the midst of these gaps, CDOs make efforts to support PLHIV and KPs to seek justice and redress where required. This may include making their own arrangements with lawyers, including for pro-bono services, or providing conflict mediation support depending on the nature of the violation being addressed. However, there is no centralized tracking of the support that CDOs provide, including the number and type of cases they take on and to what extent they obtain favorable outcomes. In the previous implementation period (2018-2020), the Legal Aid Board supported paralegals to work in communities to support PLHIV and KPs to access justice. These paralegals are part of the structure of the Board and are recruited and accredited using its own processes. Global Fund resources under GC5 had enabled

the Board to increase the number of paralegals to work specifically on the needs of PLHIV and KPs. For the 2021-2023, an alternative plan has been put in place to establish a separate cadre of community paralegals drawn from PLHIV and KP communities themselves. At the time of the assessment, a service provider (an international NGO specializing in health and human rights advocacy) had been identified to train and equip community paralegals. Some CSOs had also gone as far as identifying candidates to be trained. However, delays were occurring to finalize the arrangement although it was expected that this activity would move forward before the end of the year.

NAS has been able to gain a commitment from the Judiciary, through the Chief Justice, to examine the responsiveness of the justice system in the context of the national HIV and TB responses. At the time of the assessment, preparations were being made for district level engagements between judges, magistrates and local PLHIV and KP stakeholders. This was a part of a program of activities, to be supported by UNDP, that also included enhanced judicial training and education on HIV and human rights, study visits to other countries with effective mechanisms, a review of laws inhibiting the public health goals of the HIV and TB responses, and the potential to establish more focused and responsive judicial mechanisms for HIV or TB-specific cases. This was a promising development.

Finally, it was noted by a number of stakeholders that there is no system in place to routinely and systematically track HIV or TB-related cases on a real-time basis to ensure that they are dealt with and resolved appropriately and expeditiously. While CLM does include some indicators on stigma, discrimination and violence and whether individuals sought redress, it was not designed as a case management system. Discussions were ongoing on how to rapidly roll-out a tracking and case management system. Some reprogrammed Global Fund resources had been identified to support further consultation and, potentially, the design of a system. However, at the time of the assessment, this activity had not moved forward beyond the initial discussion stage.

Recommendations

- Accelerate the engagement of a qualified legal services provider.
- Accelerate the engagement of the HRCSL to more proactively promote and protect the human rights PLHIV and KPs in communities.
- Monitor the engagement with the Judiciary to ensure it produces tangible results.
- Deploy a monitoring/case management system. Benefit from the experience of other BDB countries in the region that have already put something in place.

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

HIV program area	Score		
	Baseline	Mid-Term	Progress
Improve laws, regulations and policies related to HIV and HIV/TB	0.0	2.3	2.6

As previously noted, in 2021, stakeholders convened to launch the Sierra Leone Human Rights Strategy. As part of the development of the GC7 funding request, the HIV and TB programs were reviewed along with their respective NSPs. The HIV NSP was subsequently revised, and a corresponding National Integrated Operational Plan was developed covering the 2023-2027 period. Both the Strategy and the Plan maintain "Strengthening of Critical Enablers" as one the main strategic objectives. Outcome 9 specifically addresses reducing or removing human rights-related barriers and creating and maintaining an enabling environment. The proposed activities are comprehensive. The challenge has remained to implement the prioritized activities, even when funding has been secured. Linked to the HIV NSP and other guiding frameworks, at the time of the assessment, guidelines and SOPs supporting KP services were being revised with, among other changes, more comprehensive content of human rights.

In its engagement plan with NAS, the Judiciary has committed to identifying and addressing problematic aspects of the legal framework and legal system (this component was not yet implemented at the time of the assessment). A review of the NAC Act of 2011 has also been proposed. A national discussion was ongoing to create a more enabling environment for harm reduction through both legal reform and policy development, with a goal of achieving at least policy related changes by the start of the GC7 grant. In addition, as already noted, the Ministry of Labor was revising the Sierra Leone Workplace Policy on HIV/AIDS, originally developed in 2006 and was intending to produce a revised draft policy before the end of 2023. Also of note was the effort made by the National Commission on Social Action (NaCSA) to include PLHIV and people affected by TB as part of the category of vulnerable populations to be prioritized for social protection support. As the assessment was underway, NaCSA was organizing to begin its engagement with PLHIV on how to move forward on its commitment. A WFP study, quoted above, on the social vulnerability of PLHIV provided compelling evidence of the urgent need for social protection support for a majority of such individuals, including those who are KPs.

The assessment found that no active efforts were underway to address criminal laws for KPs, including the persistent use of 'public nuisance' laws as the basis for harassment and arbitrary arrest and detention of individuals. There was, however, strong awareness amongst key stakeholders that this work needed to be prioritized and to move forward. Presumably, these problematic aspects of the legal framework will be included in the scope of work proposed by the Judiciary in its collaboration with NAS, UNDP and UNAIDS, but no clear commitment had been made at the time of the assessment. NAS also intends to pursue a more intensive engagement with Parliamentarians regarding the need for legal reform. In addition to repealing or amending criminal statutes, it was also acknowledged that more comprehensive protective provisions needed to be introduced to prevent legal and human rights abuses against KPs.

Recommendations

- Sustain the engagement with the Judiciary and monitor and report on outcomes for law and policy change.
- Develop and roll-out an advocacy plan for law reform, prioritising 'public nuisance statutes', drug laws that impede harm reduction, and criminal provision regarding sexual and gender diversity, and sex work.
- Consider commissioning the HRCSL to undertake a special report on HIV, TB, and human rights to inform the development of the advocacy plan.

(g) Reducing HIV-related gender discrimination, harmful gender norms and violence against women and girls in all their diversity

HIV program area	Score		
	Baseline	Mid-Term	Progress
Reducing HIV-related gender discrimination	0.0	2.2	3.0

Gender inequalities and related human rights violations, including sexual and gender-based violence (SGBV), remain cross-cutting, complex challenges for Sierra Leone. The 2019 DHS found, for example, that 62% of girls and women aged 15-49 had experienced physical or sexual violence, stark evidence of the magnitude of the challenge the country faces.[21] Ending SGBV and promoting women's equality are key priorities for the government and its many partners. In January 2023, the Gender Equality and Women's Empowerment Act of 2022 came into force. Its provisions are far-reaching in terms of transforming the position of women and girls in Sierra Leonean society moving forward. Through domestic, bilateral and multi-lateral investments, a range of interventions are underway to address critical human rights challenges, including early marriage, female genital mutilation (FGM), and SGBV. UNICEF and UNFPA, for example, have close partnerships with the Ministry of Gender and Children's Affairs to provide emergency support to survivors, through toll-free lines and one-stop centers. As part of this partnership, a Gender-Based Violence Management Information System (GBVMIS) was recently launched to provide more comprehensive, real-time data on efforts to end this ongoing human rights violation for women and girls. Partners also support the SLP to maintain Family Support Units (FSUs) as a dedicated service to address SGBV. Efforts are also being made to engage men as champions in communities to end harmful gender norms and practices, including physical and sexual violence, early marriage and FGM.

In the context of these efforts, Global Fund investments through BDB support are modest but no less significant. As shown above in Table 2, 30% of the total investment in programs to reduce human rights related barriers to HIV and TB services was initialed allocated to this program area although it was difficult to track more precisely which activities were supported or implemented from the limited information provided to the assessment team. Information on what this investment has generated was also not made readily available. As part of the package of services provided to PLHIV and KPs, screening and support for GBV is included,

[21] Ministry of Health and Sanitation and Stats Sierra Leone. 2020. Sierra Leone Demographic and Health Survey 2019. pp. 298-299.

including medical care, psycho-social support and legal referrals. Data on the number of cases that are detected and managed were not available, however. Related indicators have been included in the revised CLM tool. When the data is finally released, this gap may be addressed. CDOs also provide support for survivors, including encouraging them to report cases to police. However, the success of these efforts has been limited. In general, PLHIV and KPs who experience gender-related violence and abuse did not regard the available redress mechanisms, such as the FSUs or the HRCSL, as being responsive and available to them. Individuals fear reprisals and other negative consequences given the general lack of protection for KPs in communities.

During focus group discussions with KPs, there was a high frequency of accounts of experiences with GBV in different forms. This only highlighted the gap that still exists for providing comprehensive responses. DICs supported under Jhpiego are equipped with some additional resources to provide more effective and timely responses, including trained staff as well as resources for emergency support. Jhpiego is intending to scale-up this support to additional DICs under its next implementation period (October 2023-September 2024). More responsive and proactive support is also meant to be part of the deployment of paralegals and the engagement of a legal services provider. Continuation of community-level engagements to address and transform harmful gender norms affecting PLHIV and KPs is also planned under GC7.

Recommendations

- CLM data on gender-based violence for KPs and PLHIV should be validated and shared. This data should be routinely monitored to track trends in violence and redress mechanisms, particularly once paralegals are deployed and the legal services provider is engaged.
- Conduct high-level engagements with SLP to address the lack of trust of KPs to use their protection services for those experiencing GBV.

(h) Support HIV-related community mobilization and human rights advocacy

HIV program area	Score		
	Baseline	Mid-Term	Progress
Support community mobilization and human rights advocacy	*	*	3.3

During the 2021-2023 period, CLM in Sierra Leone was scaled up to be inclusive of HIV, TB and malaria components. CLM is a collective effort involving CSOs and networks representing KPs, PLHIV and people affected by TB. CLM is currently managed by CRS as the PR for this component of the grant. A plan to transition this responsibility to CARKAP is in place. However, stakeholders have agreed that CARKAP should undergo some

institutional strengthening and renewal before this transition takes place (it is proposed as part of the GC7 submission). The performance of CLM under the current arrangement has been mixed. While monitors have been identified by the different partners, tools have been revised and validated, training provided and equipment made available (with contributions from Global Fund, PEPFAR and UNDP), the CLM data that has been collected to date has not been validated and remains unavailable to guide program quality improvement, including programs to reduce barriers. Given the range of data collected, the CLM data set can, potentially, be a powerful tool to monitor human rights-related trends and to link these to trends in service delivery. However, for this to happen, the ownership and overall management of the CLM process needs to be clarified. In addition, clearer and more proactive arrangements and platforms should be put in place to routinely examine and use CLM data to address and resolve systemic challenges, including reducing human rights-related barriers.

Despite the significant underspending of Global Fund resources for programs to reduce human rights related barriers, community partners in Sierra Leone remain active and committed to human rights advocacy and to protecting and promoting the human rights of PLHIV and KPs to the extent that is feasible. Much of this work remained unfunded during the 2021-2023, in many respects because of the lack of disbursement of Global Fund resources allocated to support this work. As a way to improve the coherence and coordination of community engagement and advocacy on HIV, in July 2023, community stakeholders launched the Community Charter to clarify and catalyze their collective commitment to ending HIV as a public health threat in Sierra Leone by 203o. The Charter is comprehensive with specific objectives, strategies and targets for accelerating the progress of the HIV response and for reducing and resolving lingering inequalities that threaten to impede this work.

CARKAP has the mandate for coordinating the main community actors in the HIV and TB responses. With support from USAID and guided by NAS, CARKAP underwent a comprehensive organizational capacity assessment which informed an institution strengthening and renewal plan. Moving forward on the plan requires some investment, however, and at the time of the assessment, sources for this funding had not yet been fully identified (USAID had committed some additional support and UNAIDS was also preparing to make a contribution). It was intended that through an accelerated process of renewal, CARKAP would be positioned for an expanded role in Global Fund implementation by the beginning of the GC7 allocation period in July 2024.

Finally, it was noted by the assessment team that, across the different KP communities, sex workers remain without a sex-worker-led entity, similar to their MSM or PWUID peers. This gap was noted in previous assessment and was raised again in focus group discussion with sex workers during the assessment. Robust sex-worker led CSOs and networks exist throughout the region to serve as models or mentors for Sierra Leone. A concerted effort should be made, moving forward, to address this gap for the country.

Recommendations

- Urgently resolve the challenges preventing the dissemination and utilisation of CLM data.
- Accelerate the strengthening and renewal of CARKAP.
- Ensure that, by the beginning of the GC7 allocation period, the ownership and leadership for CLM is clarified and that CLM itself is situated within a technically competent and responsive host organisation with full ownership and accountability on the part of communities.
- Put in place clearer and more proactive systems and platforms to routinely analyse and use CLM data to reduce human rights-relate barriers and to promote quality improvements for HIV and TB services.
- Develop a time-bound action plan to build the capacity of sex workers to form their own sex-worker-led CSOs and to play an ownership role in the delivery of HIV and TB programmes for their peers in communities.

3.3. Progress to Remove Barriers to TB Services

Progress since the MTA to remove human rights-related barriers to TB services has been more limited than for HIV. As was noted in the MTA, the national TB response remains significantly underfunded in Sierra Leone with an estimated annual funding gap of as much as 50% over the 2021-2023 period.[22] Aside from limited domestic support for the NLTCP, the Global Fund is the primary external funder. The national TB response contends with gaps and challenges across all programmatic areas creating significant pressures for the prioritization of available resources. As a result, programs to address human rights or gender-related barriers receive only limited support (some program areas receive no direct support).

One of the strategies available to overcome this gap is through integration with HIV programs; however, here too only limited progress has been achieved. The lead national civil society organization addressing TB priorities remains the Civil Society Movement Against Tuberculosis in Sierra Leone (CISMAT) and although it is a member of CARKAP, for example, this has not led to cross-cutting integration of TB-related priorities within the human rights activities of its other more HIV-focused members. Similarly, while there is a high-level of commitment to achieve greater overall integration of the HIV and TB responses (particularly given the rate of HIV/TB co-infection), only initial steps have been taken to date to make this change. A more detailed analysis of progress to reduce human rights-related barriers to TB services is presented below.

[22] Sierra Leone was allocated US$15.2 million under CG6; the TB NSP estimated a need of US$29.8 million over this same period.

(a) Eliminate TB-related stigma and discrimination in all settings

TB program area	Score		
	Baseline	Mid-Term	Progress
Eliminate stigma and discrimination in all settings	1.0	1.4	2.2

Comprehensive data on the extent of TB-related stigma and discrimination in Sierra Leone remains unavailable. Although CISMAT participated in the development and launch of the Stop TB Partnership's TB Stigma Assessment Toolkit in 2019, as was noted in the MTA, the country has not yet used the toolkit to conduct a stigma assessment. CISMAT has planned to undertake a country-wide 'stigma mapping' exercise using the tools; however, the funding available is insufficient and this initiative has been paused while there is a search for additional resources, including through reprogramming.

During the progress assessment, TB survivors and other community stakeholders gave anecdotal accounts of TB-related stigma, particularly in community and family settings. There is no consolidation of these accounts, however, to determine their magnitude or to track progress to address and reduce TB-related stigma. The MTR of the TB NSP reported finding high levels of TB-related stigma driving individuals with TB to hide their diagnosis from others, even seeking care at some distance from their communities to avoid being identified as a person undergoing TB treatment. In addition, individuals often gave incomplete personal information at the time of diagnosis to avoid contact tracing and being found out as someone on TB treatment by their families or communities. What was also evident from the accounts of TB survivors was that myths and misperceptions remain strong in communities and frequently result in delayed diagnosis and care as individuals seek out different reasons and explanations for their ill health until they are finally screened and diagnosed with TB once the disease is well advanced.

While direct programmatic responses to TB-related stigma are not yet comprehensive, there are more indirect efforts to address and reduce TB-related stigma. Different activities were undertaken to increase knowledge and awareness about TB, including monthly radio discussions and community engagement events, some led by the NLTCP and some by TB survivors themselves supported through CISMAT. DRIM, noted above, also stated that it included TB as a topic in their community engagement efforts. There was no monitoring of these efforts, however, to be able to determine their scope and scale, or to measure their success to reduce TB-related stigma. Data on stigma in the context of TB may be captured through the CLM process and this data, when made available, will address some of the ongoing knowledge gap. Finally, although still significant, there was a general perception by participants that TB-related stigma was reducing for the country, particularly as TB services continued to expand (although incrementally) and community engagement

increased through the efforts of CISMAT, Community Health Workers, DOTS volunteers, and others.

Recommendations

- Prioritise the roll-out of the TB stigma assessment before the end of the current allocation period.
- Based on the findings of the assessment, design a multi-year action plan to reduce TB-related stigma in all settings and include components within the programme for GC7.
- Ensure that data on TB-related stigma is included in CLM processes and that such data is routine analysed and utilised to guide stigma reduction efforts.
- In future periods, explore emerging methodologies for undertaking integrated HIV and TB stigma assessments.

(b) Ensuring people-centered and rights-based provision of health care

TB program area	Score		
	Baseline	Mid-Term	Progress
Ensure people-centered and rights-based provision of health care	0.0	0.6	2.0

As noted in the MTR, across the NLTCP, the capacity for human-rights-based provision of TB services is limited. Due to limited resources, training of HCWs on TB prevention and care occurs infrequently curtailing opportunities to include content on human rights and medical ethics in the context of TB. This does not necessarily mean that HCWs are unaware of these issues, however. NLTCP staff and HCWs encountered during data collection affirmed the importance of confidentiality and privacy, for example, but were unable to discuss in any depth the more comprehensive components of rights-based provision of TB services. There was limited awareness, for example, of the extent of TB-related stigma that may affect HCWs, particularly in their community or home environments largely because such issues have not been probed by the NLTCP, and HCWs who may have such experiences have had no opportunities to share their stories. All these items were highlighted in the MTR as significant gaps for the NLTCP. This was also acknowledged by the NLTCP management who emphasized their technical gaps to identify opportunities to have more comprehensive responses despite their willingness to make such changes and their understanding of the importance of addressing and resolving these gaps.

CISMAT through its CLM activities and its community engagement activities has encountered HCWs who experience stigma and discrimination in their workplaces and their family and community environments and, given limited resources, has tried to assist some of them through advocacy and mediation. Such accounts included HCWs being 'labelled' in demeaning ways or being asked not to share food utensils or to sit apart from others. It was not possible, however, to gauge the frequency or magnitude of these challenges.

CISMAT also monitors the experience of individuals with TB services, through CLM as well as its network of support groups (at least those that continue to function in the absence of funding support). Individuals generally have challenges with transport costs to travel to the small number of health facilities offering TB services, to cope with occasional stock-outs of TB medications, to incur additional costs for TB care for diagnosis and treatment monitoring (TB treatment itself is free). Given such challenges, the quality of services from a rights-based perspective may not be a priority whether or not they experience stigma or discrimination. The CLM data, when released, will shed more light on these trends.

Recommendations:

- Expedite the roll-out of the TB stigma assessment, including the module for HCW.
- Based on the results, design and implement an action plan to reduce TB-related stigma in the context of health care and to strengthen other components of rights-based provision of TB services, including confidentiality and privacy.
- Revise all training materials for TB to include content on rights-based provision of TB services for all cadres and for components of TB care.
- Integrate content on TB into programmes to reduce HIV-related stigma and discrimination in health care settings (use one, integrated, facility-wide approach to address all forms of stigma and discrimination).
- Expedite the release of CLM data related to TB-related stigma in health care settings.

(c) Ensure people-centered and rights-based law enforcement practices

TB program area	Score		
	Baseline	Mid-Term	Progress
Ensure people-centered and rights-based law enforcement practices	0.0	0.0	0.0

TB in the context of law enforcement practices is not directly addressed at this time in Sierra Leone. Aside from the fact that TB diagnosis and treatment are part of health services offered to police and for detainees (see below), there has been no engagement with law enforcement stakeholders to date on their role to either facilitate or strengthen rights-based responses to TB. No information was available regarding, for example, the manner of engagement with PWUID who are at high risk of TB, or to the extent that, once individuals are arrested or detained, their access to TB medicines is not interrupted while they are in police cells. Stakeholders spoke about plans to have high level engagements with law and justice stakeholders on their roles to enable and support rights-based responses to public health challenges, but it was not clear to what extent topics related to TB would be addressed (presumably they will be included). Similarly, while discussions were underway

to provide training on HIV and human rights to police recruits, there was no specific mention of including TB. However, since all these activities have yet to be implemented, there is still an opportunity to ensure that TB is also addressed.

Recommendations

- Ensure that content on rights-based responses to TB are included in the proposed training for the SLP.
- Expedite planned high-level engagement with law and justice stakeholders and use this as an opportunity to address the importance of rights-based to both HIV and TB.
- Support SLP to undertake an assessment of TB and TB-related risks, including the risk of stigma and discrimination, amongst its ranks.
- Use the results of the assessment to update health policies and practices to ensure enabling and supportive environments for reducing TB-related risks in all settings for this population.

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

TB program area	Score		
	Baseline	Mid-Term	Progress
Improve TB-related legal literacy	0.0	0.0	2.3

TB-related legal literacy is largely addressed through CISMAT and its partners, including through TB support groups and the work that the volunteer TB Champions undertake in communities. There is no specific program of legal literacy, however, nor are there specific tools to promote legal literacy in the context of TB. CISMAT, through its district coordinators, attempts to promote legal literacy. Previously, in its watchdog role, CISMAT was more proactive in this domain. Since the integration of its CLM activities, however, it has not been able to continue to the same extent as previously. While it may be intended that TB-related topics are included in the plan to revamp legal literacy activities under HIV, this was not clearly stated during the assessment. Considering these limitations, it was not surprising that participants in the assessment, including TB survivors, noted that people living with TB are generally unaware of what rights and responsibilities they have available to them, and what mechanisms exist to be able to seek redress when challenges arise. There is a plan to engage community paralegals to work within KP communities; however, there was no indication that some of the available positions would be focused on TB-specific concerns. Since this activity has not yet been implemented, there is still an opportunity to address this gap.

Recommendations

- Modify the plan for enhanced legal literacy interventions and the engagement of paralegals to more explicitly include components related to TB.
- Ensure that TB survivors and TB champions are equitably represented in legal literacy training and implementation activities.

- Ensure that some paralegals are allocated to CISMAT to promote legal literacy and improve access to justice in the context of TB.
- Design and roll-out legal literacy tools and materials that fully integrate HIV and TB topics.

(e) Improve access to justice

TB program area	Score		
	Baseline	Mid-Term	Progress
Improving access to justice	0.0	0.0	1.0

Similar to legal literacy programs, progress related to access to justice in the context of TB was very limited during the 2021-023 period. Other than what CISMAT can undertake to respond to individuals with challenges, the assessment found that there were no additional interventions supporting access to justice. When individuals reach out, CISMAT will attempt to mediate solutions. While the organization does not formally track the number of individuals and the type of challenges it addresses, representatives estimated it was approximately ten cases per month, although not all will be legal issues per se.

The HRC SL and the Legal Aid Board stated that they remain 'open' and 'accessible' to individuals with TB-related complaints or challenges; however, there was no available data on the extent to which individuals used these opportunities. During 2018-2020, the Legal Aid Board did track these cases for the purposes of monitoring grant implementation. This was no longer the case starting 2021 when it ceased to participate in the grant implementation. Similarly, the HRC SL had no specific data related to TB.

As mentioned above, at the time of the assessment, stakeholders were discussing the concept of a national tracking system for legal and human rights cases for HIV and TB. However, at the time of the assessment, this initiative had not moved forward. It was also not clear whether CLM processes would address this gap. Additionally, the process was advancing to engage a legal services provider to compliment and support the engagement of paralegals. It was not clear to what extent competency to support TB-related legal concerns was a criterion for selecting the provider.

Recommendations

- Ensure that some paralegals are allocated to CISMAT to promote legal literacy and improve access to justice in the context of TB.
- Design and roll-out training materials on TB-specific legal and human rights challenges and use these to equip paralegals and the legal services provider.
- Ensure that the legal services provider, when appointed, can address TB-related challenges.

(f) Monitoring and reforming laws and policies

TB program area	Score		
	Baseline	Mid-Term	Progress
Monitoring and reforming laws and policies	0.0	0.0	1.0

The MTR of the TB NSP included a component on gender and human rights. Amongst other things, it found that the TB NSP only incompletely incorporated the components of human rights and gender. Section 5.4 of the NSP, on social protection and human rights, focusses only on the challenge of catastrophic costs for individuals living with or affected by different forms of TB. It does not comprehensively address human rights or the gendered dimension of the TB epidemic for the country.

It was noted by many stakeholders that a comprehensive assessment of TB-related laws and policies has not been undertaken limiting the knowledge needed to propose interventions to improve laws and policies. The gap for protective provisions for people living with or affected by TB was widely noted, however.

Two positive developments did occur during the assessment period. The NLTCP and CISMAT jointly convened a TB Caucus of parliamentarians to raise the profile of TB and to mobilize law makers to address perceived gaps in laws and policies. However, the caucus was not able to convene beyond its inaugural meeting in 2021 due to lack of funds. Some additional funds were requested as part of reprogramming but at the time of the assessment it was not clear whether the caucus would convene before the end of the allocation period.

As noted previously, Sierra Leone, through NaCSA has, from time to time, implemented different social protection interventions, including cash transfers. The revised National Social Protection Strategy for Sierra Leone 2022-2026 identifies people with TB amongst individual living with disability or chronic illness, a category that is prioritized for social protection by NaCSA.

Recommendations

- Undertake an assessment of laws and policies affecting the national response to TB (this is a component of the TB Stigma Assessment Toolkit from Stop TB Partnership).
- Based on the findings of the assessment, develop a prioritised action plan for legal and policy reform.
- In the interim, develop a concept paper and advocacy plan for comprehensive legal protection against stigma and discrimination in the context of TB, similar to provision contained in the NAC Act of 2011.
- Amend the TB NSP to address human rights and gender-related barriers more explicitly in the context of TB, particularly stigma and discrimination reduction, legal literacy,

access to justice, and the elimination of TB-related gender discrimination, amongst other priorities.

(g) Reduce TB-related gender discrimination

TB program area	Score		
	Baseline	Mid-Term	Progress
Reduce TB-related gender discrimination	0.0	0.0	1.0

There has been very limited progress since the MTA to specifically address the gendered dimensions of TB in Sierra Leone, including TB-related gender discrimination. While data is disaggregated and there is an awareness of some of the gender-related differences in the burden of TB for the country, there are no specific actions to address or resolve gender-related inequities. Beyond insisting that everyone receives the same treatment, regardless of gender, there is no additional capacity amongst TB stakeholders to more comprehensively understand or address gender-related challenges.

The MTR for the TB NSP found that there was limited awareness regarding the concept of gender and its impacts on the effectiveness for TB prevention and control in the country. While there was some awareness amongst the participants in the progress assessment regarding cross-cutting issues related to gender and health - the reluctance of males to seek health care services; the limited socio-economic autonomy of women to access health care services when the need them - there was only limited grasp of the more comprehensive range of challenges related to gender that hinder the effectiveness and impact of TB prevention and control for the country. Additionally, no gender assessment of the TB response has been undertaken which would address the evidence gap and provide a basis on which to strengthen the technical capacity of TB stakeholders on this issue.

CISMAT in its community activities engages both women and men as TB survivors and champions. These individuals are able to share their unique experiences and perspectives with others and, to some extent, can confront the gender-related barriers that affected their own progress through the TB cascade. These include addressing shame and embarrassment amongst some men that they have succumbed to TB in the first place, and supporting women to navigate personal and family challenges that limit their ability to come forward for TB screening and diagnosis, and to subsequently undergo TB treatment, without experiencing exclusion and neglect from spouses and other family members.

Recommendations:

- The NLTCP jointly with CISMAT should undertake a TB gender assessment; the results should be used to inform a revision of the TB NSP so that it more comprehensively addresses the gendered dimensions of the TB epidemic in Sierra Leone.
- Legal literacy materials for TB, when they are developed, should include specific examples of the gendered nature of human rights challenges in the context of TB.

- General TB education and awareness materials and activities should include more specific and explicit content on TB and gender and encourage communities to identify and confront gender-related attitudes, beliefs and practices that limit the effectiveness of TB prevention and control.

(h) Supporting TB-related community mobilization and engagement

TB program area	Score		
	Baseline	Mid-Term	Progress
Supporting TB-related community mobilization and engagement	1.3	0.0	3.0

The MTR notes the strong commitment of the NLTCP and other stakeholders to community mobilization and engagement for TB. Some community level activities take place, largely led by CISMAT and its local CSO partners. Much of this work takes place in the absence of specific funding, however, nor is it routinely measured or documented. This is a change since the previous allocation period (2018-2020) when CISMAT received more direct support for community mobilization and engagement linked to its TB-focused CLM activities.

During the period covered by the progress assessment, CISMAT continued to play an active role in CLM as an SR under CRS with a primary focus on the TB components of the expanded CLM process. CISMAT, utilizing Global Fund resources, was continuing to support district coordinators in all 16 districts linked to CLM. CISMAT was also working to sustain support groups in each district despite the absence of funding. There was no longer routine monitoring of results of the work of the support groups, however, making it difficult to assess the scope and scale of their achievements in communities.

Finally, it was noted that discussions were underway to create a Stop TB Partnership platform in Sierra Leone to strengthen the coordination, advocacy, and engagement of communities on TB.

Recommendations:

- Stakeholders should expedite the dissemination and use of CLM data related to TB.
- Investment and support for the constituency of TB survivors should be scaled up. These individuals are critical players in communities for creating demand for TB services and for reducing stigma and discrimination.
- The creating of the Stop TB Partnership platform should be expedited.
- Using the platform, the NLTCP and CISMAT should collaborate to develop and roll out a national action plan for community mobilisation and engagement to end TB.

(i) Address the needs of people in prisons

TB program area	Score

	Baseline	Mid-Term	Progress
Address the needs of people in prisons	0.0	0.0	3.0

The assessment findings related to this program area were mixed. According to the medical leadership of the SLCS, it was attempting to provide TB services to all inmates under its care in all its facilities. However, it acknowledged that its ability to do so was limited by a number of factors, including overcrowding, the state of its physical facilities, the availability of qualified HCWs, and the continuous availability of commodities, including TB treatment. Access to TB diagnostics was also a challenge.

The SLCS is supported by the NLTCP, CISMAT and Prison Watch to provide TB services to inmates and staff. There were differing views between these partners on the success of SLCS to meet the TB-related and other health care needs of inmates and staff. Ostensibly, according to SLCS, all prisoners are screened for TB on entry and those with active TB are segregated and placed on TB treatment. Inmates are separated from others while they take treatment. Former inmates who participated in the assessment were aware of these efforts and noted that TB was a more common illness amongst prisoners than HIV. No disaggregated data were available to further illustrate the scope and quality of TB services provided within SLCS.

Four prisons were included as part of the expanded CLM process under GC6. CISMAT was responsible for coordinating data collection from both staff and inmates. There appear to be only limited, proactive efforts to empower inmates to prevent TB and along with other health challenges. As noted previously, the prison health policy was under review at the time of the assessment. No additional details were available, however, on the extent to which this would incorporate a rights-based approach to preventing and managing TB in closed settings. Given the expanding amount of drug use in Sierra Leone and the current response of law enforcement stakeholders, there is likely to be a very significant increase in TB related risks for inmates and staff. This underlines the urgency to have a focused and proactive response to address the gaps identified through this assessment.

Recommendations

- Ensure that the revision of the prison health policy creates the enabling conditions for rights-based provision of TB services to inmates and staff.
- Expedite the analysis and release of CLM data addressing the quality of TB services in prisons.
- Disaggregate and monitor data on the provision of TB services in SLCS.
- Design and roll out training materials for inmates and staff on rights-based responses to TB prevention and control in closed settings.

3.4. Cros-cutting Observations

Some important cross-cutting themes emerged from the findings of the assessment, including bottlenecks arising from grant implementation risk mitigation measures, lack of robust M&E frameworks to guide implementation and promote quality improvement, and challenges to balance scale, quality and equity.

Key informants expressed concern that timely implementation of programs to reduce barriers is being hampered by **extensive risk mitigation measures that are currently applied to the use of Global Fund resources in Sierra Leone**. These include no-cash restrictions for some implementers and the use of certain payment modalities (mobile money) that have resulted in tension between the PR and the SRs meant to be leading the implementation of human rights programs. These challenges are not new, however, and the assessment team was concerned by the limited amount of solution finding that had occurred which was contributing to the very low absorption rate and the limited if any implementation of these essential interventions. It was clear that not all flexibilities had been explored to resolve these challenges, either domestically within the means available to IHPAU, or between the Global Fund, the LFA and the Fiscal Agent. Nor did it appear that the CCM clearly apprised of the urgency of the situation (see below). The funds for human rights programs may represent a small overall proportion of Global Fund investments for the country, and therefore not be a first priority for ongoing oversight and intervention when bottlenecks arise. They are, nevertheless, important particularly given the daily risks and ongoing barriers faced by PLHIV and KPs that the assessment has outlined.

In planning for the review of the Human Rights Strategy, adequate budget allocation should be made to address the gap for **robust monitoring and evaluation frameworks** to track progress to reduce barriers. While CLM will address some of this gap, it will not speak directly to issues of program quality for human rights-related interventions, particularly at the outcome and impact levels. Adequate resources (technical and financial) should be included in the review process to develop a comprehensive M&E framework across all program areas for HIV and TB and to establish the required monitoring and oversight processes to routinely monitor progress. This can be linked to the new requirement to annually review the KPI E1 results. A comprehensive and robust M&E system will generate the data need to support any proposed changes in these values.

It was clear from the assessment that resources are limited for the HIV and TB programs, including for the components addressing human rights-related barriers (although even when resources were allocated, they were not spent). There is a heavy reliance on external resources, particularly from the Global Fund, with only limited, direct domestic investment in these areas. This has meant, historically, a constant stretching of the resources to continually increase the coverage of the programs to reach all affected individuals in communities. This includes human rights programs and other components of the

community-oriented delivery modalities for HIV and TB services. What was evident through0ut the assessment, particularly during the many encounters with members of the different community cadres (peer educators, peer navigators, or expert clients, among others), is that there is **a growing tension between scale, program quality and equity**. Members of community cadres constantly raised concerns regarding the low amounts of compensation they received for their work, and the absence of other benefits, amounts often considered inadequate to perform their roles effectively without compromising their safety and security, as well as their health and well-being. Program and project staff that worked directly with these cadres raised similar concerns leading some to consider seeking employment elsewhere despite their clear dedication to supporting PLHIV and KPs in communities to be able to access and to be maintained in essential HIV and TB services. Such challenges are not easy to resolve in an environment where resources are as constrained as they are in Sierra Leone. The continued effort to increase the scale and reach of HIV and TB programs, including the limited current components that aim to reduce barriers, is taking a toll on the commitment and general effectiveness of the essential community cadres, without whom, many of the programs could not operate or would do so only in a very limited manner. Moving forward, a better balance must be achieved to provide a more enabling minimum package of support to these cadres and the staff that support them while funding innovative ways (digital applications, for example) to reach more individuals with essential interventions to reduce barriers.

Recommendations

- The CCM should urgently convene key stakeholders to resolve bottlenecks to timely fund disbursement and programme implementation for human rights investments. Engage the Global Fund, LFA and Fiscal Agent in this dialogue.
- NAS should lead the design and roll-out a comprehensive M&E framework to track progress of programmes to reduce barriers at output, outcome and impact levels and to promote continuous quality assurance; link the framework to the revised National Human Rights Strategy.
- The CCM should convene the PRs, SRs and other implementers to review compensation scales and to create comprehensive national guidelines for minimum packages of compensation and other investments in community cadres and programme staff.

3. Emerging Evidence of Impact

For the numerous reasons outlined in the analysis, only limited information was available with which to assess evidence of impact for programs to reduce barriers to services in Sierra Leone. As noted previously, while there has been gains in the access and uptake of HIV and TB services, if only incremental in some cases, it was not possible to clearly attribute these, even in a tentative manner, to investments in programs to reduce barriers because of limited implementation. This is not to suggest that there has been no progress at all, only

that one of the objectives of the progress assessment could not be fully addressed. The assessment has noted that the awareness of the importance of identifying and removing human rights barriers has continued to grow in Sierra Leone since the MTA, along with some of the technical skills needed to identify and understand the barriers, particularly in the context of HIV. Through the engagements with stakeholders and the discussions with program beneficiaries, in the absence of other forms of data or evidence, it was clear that some progress was being made at the outcome level (increased access to services) with some signs of momentum in terms of impacts (improved quality of life) but with limited links to BDB investments (given the low level of spending) and more likely as a result of Global Fund support for HIV programming more broadly This progress is far short of what may have been achieved during the sixth year that BDB support has been available to Sierra Leone had their been more implementation of programs over this time.

The theory of change underpinning the BDB initiative, and guiding efforts to realize outcomes and impact for national HIV and TB responses, has four components. The assessment found that there is at least some momentum all of these components in Sierra Leone but not yet at the level to be certain the durable change is occurring particularly in the daily lives of people living with or affected by HIV and TB, and for KPs. This is summarized below (**Table 4**).

Table 4: BDB theory of change and emerging evidence of impact

Component	Emerging evidence of impact
Reducing stigma, discrimination, violence and other threats towards people living with HIV, TB, and key populations to increase safety and security, and to improve the willingness and ability of individuals to access and remain in HIV and TB services.	While there is anecdotal evidence that some forms of stigma, discrimination and violence are reducing (in some health care settings, for example), these gains are limited, particularly for KPs and children and adolescents. Given the dynamics of the HIV and TB epidemics in Sierra Leone, the limited progress to reduce stigma, discrimination and violence may, in turn, sustain gaps for access and retention in services for the most affected or most at risk individuals in communities.
Empowering knowledgeable and engaged individuals in communities to know their rights and responsibilities, and providing pathways for effective redress, so that there this is demand for and uptake of quality services.	Levels of legal literacy are improving in Sierra Leone, although the knowledge gained is not always positive since, for some, legal literacy can mean the realization that there is an absence of protective laws and policies, or limited to no redress mechanisms. The balance between literacy and effective redress has not yet been achieved in Sierra Leone with individuals knowing that their rights have been compromised but seeing few if any effective pathways for redress. As a result, the ultimate aim of having empowered and enabled individuals in communities with ownership for their health and well-being, and demanding for quality services is not yet fully achieved.
Creating and sustaining enabling environments law and policy reform and through positive changes in institutional behaviors	The NAC Act of 2011 directly addresses stigma and discrimination against PLHIV but mechanisms through which to benefit from these provisions are not yet easily available to all PLHIV who need them. There has been little

towards people living with HIV, TB and KPs.	to no progress to determine how the provisions may be utilized by KPs given the absence of other protective laws to work in their favor. Sierra Leone has not gone the route of other countries in the region to decriminalize or further restrict individuals from KP groups. While the HRCSL is a promising institution, it has yet to deliver substantive gains for people living with HIV, TB and KPs in communities. The institution has a substantive agenda of human rights challenges to address for all citizens in Sierra Leone and is limited, largely operationally, in its flexibility to prioritize or specifically focus on specific populations or communities.
Building and sustaining the leadership and capacity of communities to monitor progress and to organize and advocate for improved services.	Although a plan is in place and moving forward to position a stronger, renewed CARKAP as the leader and coordinator of the community response, in all its diversity, progress has been slow. Significant technical and financial investment are needed to complete the renewal plan. There are strong leaders and advocates in the country but there is a significant weakness for coordination and coherence. The limited progress on CLM is a clear example of this.

As a final point of reflection, it is clear that there are a number of key ingredients present in Sierra Leone to achieve more progress. However, these are not yet effectively coordinated or leveraged for their mutual synergies to achieve more substantive and durable change.

4. National Ownership and Enabling Environment

Since 2021, the *Sierra Leone Human Rights Strategy for HIV and TB* has been in place and there have been some efforts to disseminate it and to build awareness and commitment to its implementation. The *Community Charter*, which addresses all three diseases, has further reinforced the commitment amongst community actors to reduce and remove human rights barriers. At the time of the assessment, a Human Rights Technical Working Group was in place but not able to meet on a routine basis due to lack of resources. This gap is meant to be addressed through reprogramming with a proposal to support the HRCSL to convene a human rights steering committee to monitor and quality assure the implementation of the Strategy. Given this gap, there has been no comprehensive review of the progress of implementation of the Strategy (other than what this progress assessment will contribute). Addressing these gaps - having a steering committee in place and committing to reviewing and revising the Strategy - are programmatic conditions for the human rights matching funds for GC7. Country stakeholders will therefore be further encouraged to address this gap for coordination and coherence of their collective effort to reduce or remove human rights barriers.

This absence of a formal coordinating body has not limited the commitment of stakeholders to take action to remove barriers, as the results of the assessment have laid out. Despite the strong frustration that Global Fund resources designated to support programs to reduce barriers remained mostly not disbursed during 2021-2023, stakeholders were finding other ways to move forward. The main champions of this at the national level are NAS, UNAIDS and UNDP, with important contributions from other bilateral and multi-lateral partners, including UNICEF, UNFPA, WHO and USAID. CARKAP and its members were also making efforts within limited means to maintain an emphasis on human rights-related priorities.

None of this can justify, however, the non-disbursement of funds, particularly given the enormous needs amongst beneficiaries for more protection and support of their human and legal rights. While there were many reasons given by IHPAU, for example, for the extensive delays, in the end it did not appear that this aspect of the grant was prioritized. The CCM itself appeared unaware of the extent of the delays and the real risk that, given the limited time remaining for grant implementation, much of the US$3 million would not be utilized. The situation, if not addressed, will raise the question of why Sierra Leone should continue to be prioritized for inclusion in the Breaking Down Barriers initiative.

This missed opportunity becomes more compelling considering the country context for programs to reduce barriers and the existence of highly motivated community-led CSOs that are well placed to implement effective programs. While Sierra Leone continues to have cross-cutting challenges for the rule of law, the administration, and the effective protection and promotion of human rights for all, to date it has not succumbed to trends emerging in the region for additional criminalization and exclusion of sexually and gender diverse populations, for example, or for a harsh 'law and order' responses to the spiraling challenges of poverty and drug use. Global Fund investments are meant to catalyze and assist national stakeholders to seize such opportunities and to make durable progress. For this reason, stakeholders must redouble their efforts to find solutions for the effective and responsive management of these investments in Sierra Leone. Too much remains at stake for the national HIV and TB responses, and the beneficiaries that depend on them, for these resources not to be fully utilized.

Recommendations

- Increase the capacity (technical and operational) of NAS to lead and support coordinated efforts to remove barriers to HIV and TB services.
- Accelerate the provision of support to the HRCSL to coordinate and monitor the implementation of the Human Rights Strategy.
- Convene annual accountability meetings to monitoring progress to implement the Strategy.
- Prepare for an evaluation and renewal of the Strategy in 2024.
- The CCM should clearly define criteria for the effective management of investments to reduce human rights-related barriers and select PRs appropriately.

- The CCM should define performance indicators and a monitoring process for the ongoing oversight of Global Fund investments to reduce barriers. There is insufficient oversight at the current time resulting in insufficient engagement of the CCM to resolve the ongoing bottlenecks.

Annex 1: Abbreviations and Acronyms

AIDS	Acquired immuno-deficiency syndrome
ART	Anti-retroviral therapy
AWOD	Alliance for Women Development
BDB	Breaking Down Barriers
CARKAP	Consortium for the Rights of Key Affected People
CISMAT	Civil Society Movement Against Tuberculosis
CCM	Country Coordinating Mechanism
CDO	Complaint Desk Officer
CLM	Community-led monitoring
CRS	Catholic Relief Services
CSO	Civil society organization
DHS	Demographic and health survey
DIC	Drop-In Centre
DOTS	Directly observed therapy short-course
DRIM	Disability Rights Movement Sierra Leone
DSD	Differentiated service delivery
FGM	Female genital mutilation
FSU	Family Support Unit
GBV	Gender-based violence
GC7	Grant Cycle Seven
HCW	Health care worker

HRCSL	Human Rights Commission Sierra Leone
HIV	Human Immunodeficiency Virus
IBBS	Integrated bio-behavioural surveillance
IHPAU	Integrated Health Project Administration Unit
KP	Key population
KPI	Key performance indicator
LFA	Local Funding Agent
MOHS	Ministry of Health and Sanitation
MSM	Men who have sex with men
MTA	Mid-term assessment
MTR	Mid-term review
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NaCSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NETHIPS	Network of HIV Positives in Sierra Leone
NFM	New Funding Model
NGO	Non-governmental Organization
NLTCP	National Leprosy and Tuberculosis Control Programme
NSP	National Strategic Plan
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PrEP	Pre-exposure prophylaxis
PWUID	People who use or inject drugs
RODA	Rofutha Development Association
SGBV	Sexual and gender-based violence
SL	Sierra Leone
SLCS	Sierra Leone Correctional Service
SLP	Sierra Leone Police
SLYDCL	Social Linkages for Youth Development And Child Link
SWAASL	Society for Women and AIDs in Africa Sierra Leone
TB	Tuberculosis
WICM	Women in Crisis Movement
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
US$	United States Dollar
WFP	World Food Programme

Annex 2: Scorecard Methodology

Scores for the progress assessment are calculated according to the following definitions:

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 3: Summary of Recommendations

The assessment offers recommendations for continuing to scale up and strengthen comprehensive programs to reduce human rights-related barriers to HIV and TB services. These are summarized below:

Program Area	Recommendations
HIV	
Eliminate stigma and discrimination in all settings	▪ Develop a comprehensive action plan to eliminate stigma in all settings in line with the 10-10-10 commitments. Link the action plan to the Human Rights Strategy. ▪ Accelerate the roll-out of tools and materials to reduce HIV-related stigma in DICs and other settings for KPs; ▪ Routinely monitor progress to reduce/eliminate HIV and TB stigma, discrimination, and violence (routinely analyse and share CLM data on these topics). ▪ Undertake rapid assessments to measure HIV-related stigma and discrimination in education, workplace and humanitarian settings. Use the results to scale up relevant interventions. ▪ Fully integrate the needs and concerns of people with disabilities living with or at risk for HIV into comprehensive interventions to reduce HIV-related stigma and discrimination. ▪ Undertake tailored stigma and discrimination reduction interventions of children and adolescents living with HIV or at high risk for HIV acquisition.
Ensure non-discriminatory	▪ NACP should pilot and roll-out a 'facility-wide' stigma and discrimination reduction intervention, prioritising high volume ART sites and those accessed by KPs.

provision of health care	▪ Scale up and sustain efforts to promote the Patients Charter and to monitor the provision of health services considering its provisions. ▪ Create opportunities for KPs to raise quality of service complaints and to have them addressed. ▪ Review and revise training materials for all cadres of HCWs to ensure specific and robust content on human rights and medical ethics (including scaling-up the components on sexual and gender diversity developed by Jhpiego). ▪ Accelerate efforts to modify pre-service training materials and curricula to include content on human rights and medical ethics and the elimination of all forms of stigma and discrimination in health care settings. ▪ Address and resolve the concerns of people with disabilities for unimpeded access to comprehensive HIV and TB services. ▪ Sustain and scale up current efforts to support children and adolescents living with HIV at access and be retained in HIV services.
Ensure rights-based law enforcement practices	▪ Design and institutionalise a training programme for SLP adapted from best-practice models (Ghana, for example). This programme should include a version of the training curriculum for deployed officers. The programme should be inclusive of representatives from PLHIV and KP communities. ▪ Using results from CLM and other sources, there should be routine accountability sessions with SLP leadership to monitor institutional behaviour changes as the training is rolled out. ▪ NAS should engage the leadership of the FSU arm of SLP to undertake internal advocacy and sensitisation so that this service can be available to all KPs who experience sexual violence. ▪ Use the evolving engagement with the Judiciary to create a platform for all law and justice stakeholders to strengthen efforts to reduce or remove barriers.
Improve legal literacy ("know your rights")	▪ Accelerate the implementation of the plan to train and deploy community paralegals. ▪ Accelerate the implementation of the plan to strengthen the role of CDOs to be more active in promoting legal literacy and facilitating access to justice. ▪ Including within the CLM tools indicators to monitor levels of legal and human rights literacy. ▪ Continue to integrate components on legal and human rights literacy within core HIV interventions for PLHIV and KPs.
Improve access to justice (HIV-related legal services)	▪ Accelerate the engagement of a qualified legal services provider. ▪ Accelerate the engagement of the HRCSL to more proactively promote and protect the human rights PLHIV and KPs in communities. ▪ Monitor the engagement with the Judiciary to ensure it produces tangible results. ▪ Deploy a monitoring/case management system. Benefit from the experience of other BDB countries in the region that have already put something in place.
Improve laws, regulations and	▪ Sustain the engagement with the Judiciary and monitor and report on outcomes for law and policy change.

policies related to HIV and HIV/TB	▪ Develop and roll-out an advocacy plan for law reform, prioritising 'public nuisance statutes', drug laws that impede harm reduction, and criminal provisions regarding sexual and gender diversity, and sex work. ▪ Consider commissioning the HRCSL to undertake a special report on HIV, TB, and human rights to inform the development of the advocacy plan.
Reducing HIV-related gender discrimination	▪ CLM data on gender-based violence for KPs and PLHIV should be validated and shared. This data should be routinely monitored to track trends in violence and redress mechanisms, particularly once paralegals are deployed and the legal services provider is engaged. ▪ Conduct high-level engagements with SLP to address the lack of trust of KPs to use their protection services for those experiencing GBV.
Support community mobilization and engagement	▪ Urgently resolve the challenges preventing the dissemination and utilisation of CLM data. ▪ Accelerate the strengthening and renewal of CARKAP. ▪ Ensure that, by the beginning of the GC7 allocation period, the ownership and leadership for CLM is clarified and that CLM itself is situated within a technically competent and responsive host organisation with full ownership and accountability on the part of communities. ▪ Put in place clearer and more proactive systems and platforms to routinely analyse and use CLM data to reduce human rights-relate barriers and to promote quality improvements for HIV and TB services. ▪ Develop a time-bound action plan to build the capacity of sex workers to from their own sex-worker-led CSOs and to play an ownership role in the delivery of HIV and TB programmes for their peers in communities.
TB	
Eliminate TB-related stigma and discrimination	▪ Prioritise the roll-out of the TB stigma assessment before the end of the current allocation period. ▪ Based on the findings of the assessment, design a multi-year action plan to reduce TB-related stigma in all settings and include components within the programme for GC7. ▪ Ensure that data on TB-related stigma is included in CLM processes and that such data is routine analysed and utilised to guide stigma reduction efforts. ▪ In future periods, explore emerging methodologies for undertaking integrated HIV and TB stigma assessments.
Ensure people centered and rights-based TB services at health facilities	▪ Expedite the roll-out of the TB stigma assessment, including the module for HCW. ▪ Based on the results, design and implement an action plan to reduce TB-related stigma in the context of health care and to strengthen other components of the human-rights-based provision of TB services, including confidentiality and privacy. ▪ Revise all training materials for TB to include content on the human-rights-based provision of TB services for all cadres and for all components of TB care.

	▪ Integrate content on TB into programmes to reduce HIV-related stigma and discrimination in health care settings (use one, integrated, facilitated-wide approach to address all forms of stigma and discrimination). ▪ Expedite the release of CLM data related to TB-related stigma in health care settings.
Ensure rights-based law enforcement practices for TB	▪ Ensure that content on rights-based responses to TB are included in the proposed training for the SLP. ▪ Expedite planned high-level engagement with law and justice stakeholders and use this as an opportunity to address the importance of rights-based to both HIV and TB. ▪ Support SLP to undertake an assessment of TB and TB-related risks, including the risk of stigma and discrimination, amongst its ranks. ▪ Use the results of the assessment to update health policies and practices to ensure enabling and supportive environments for reducing TB-related risks in all settings for this population.
Improve TB-related legal literacy	▪ Modify the plan for enhanced legal literacy interventions and the engagement of paralegals to more explicitly include components related to TB. ▪ Ensure that TB survivors and TB champions are equitably represented in legal literacy training and implementation activities. ▪ Ensure that some paralegals are allocated to CISMAT to promote legal literacy and improve access to justice in the context of TB. ▪ Design and roll-out legal literacy tools and materials that fully integrate HIV and TB topics.
Improve access to justice in the context of TB.	▪ Ensure that some paralegals are allocated to CISMAT to promote legal literacy and improve access to justice in the context of TB. ▪ Design and roll-out training materials on TB-specific legal and human rights challenges and use these to equip paralegals and the legal services provide ▪ Ensure that the legal services provider, when appointed, can address TB-related challenges.
Improve laws, regulations and policies related to TB	▪ Undertake an assessment of laws and policies affecting the national response to TB (this is a component of the TB Stigma Assessment Toolkit from Stop TB Partnership). ▪ Based on the findings of the assessment, develop a prioritised action plan for legal and policy reform. ▪ In the interim, develop a concept paper and advocacy plan for comprehensive legal protection against stigma and discrimination in the context of TB, similar to provisions for HIV contained in the NAC Act of 2011. ▪ Amend the TB NSP to address human rights and gender-related barriers more explicitly in the context of TB, particularly stigma and discrimination reduction, legal literacy, access to justice, and elimination of TB-related gender discrimination, amongst other priorities.
Reduce TB-related gender discrimination	▪ NLTCP jointly with CISMAT should undertake a TB gender assessment; the results should be used to inform a revision of the TB NSP so that it more comprehensively addresses the gendered dimensions of the TB epidemic in Sierra Leone.

	▪ Legal literacy materials for TB, when they are developed, should include specific examples of the gendered nature of human rights challenges in the context of TB. ▪ General TB education and awareness materials and activities should include more specific and explicit content on TB and gender, and encourage communities to identify and confront gender-related attitudes, beliefs and practices that limit the effectiveness of TB prevention and control.
Support community mobilization and advocacy	▪ Stakeholders should expedite the dissemination and use of CLM data related to TB. ▪ Investment and support for the constituency of TB survivors should be scaled up. These individuals are critical players in communities for creating demand for TB services and for reducing stigma and discrimination. ▪ The creating of the Stop TB Partnership platform should be expedited. ▪ Using the platform, the NLTCP and CISMAT should collaborate to develop and role out a national action plan for community mobilisation and engagement to end TB.
Address needs of people in prisons and other closed settings	▪ Ensure that the revision of the prison health policy creates the enabling conditions for rights-based provision of TB services to inmates and staff. ▪ Expedite the analysis and release of CLM data addressing the quality of TB services in prisons. ▪ Disaggregate and monitor data on the provision of TB services in SLCS. ▪ Design and roll out training materials for inmates and staff on rights-based responses to TB prevention and control in closed settings.
Other recommendations	
Cross-cutting	▪ The CCM should urgently convene key stakeholders to resolve bottlenecks to timely funds disbursement and programme implementation for human rights-related investments. Engage the Global Fund, LFA and Fiscal Agent in this dialogue. ▪ NAS should lead the design and roll-out a comprehensive M&E framework to track progress of programmes to reduce barriers at output, outcome and impact levels and to promote continuous quality assurance; link the framework to the revised National Human Rights Strategy. ▪ The CCM should convene the PRs, SRs and other implementers to review compensation scales and to create comprehensive national guidelines for minimum packages of compensation and other investments in community cadres and programme staff.
National Ownership	▪ Increase the capacity (technical and operational) of NAS to lead and support coordinated efforts to remove barriers to HIV and TB services. ▪ Accelerate the provision of support to the HRCSL to coordinate and monitor the implementation of the Human Rights Strategy. ▪ Convene annual accountability meetings to monitoring progress to implement the Strategy. ▪ Prepare for an evaluation and renewal of the Strategy in 2024.

	▪ The CCM should clearly define criteria for the effective management of investments to reduce human rights-related barriers and select PRs appropriately. ▪ The CCM should define performance indicators and monitoring process for the ongoing oversight of Global Fund investments to reduce barriers. There is insufficient oversight at the current time resulting in insufficient engagement of the CCM to resolve current bottlenecks.

Annex 4: Key informants and site visits

Organization	Location	Participants	
		Name	**Title/Position**
IHPAU	Freetown	Alpha U. Jalloh	Team Lead
		David Muana	Deputy Team Lead
		Edward Koroma	Grants Manager
		Ansu Kamanda	Grant Officer
		Peter Bailey	GMO
		Amara Lebbie	Senior Technical Advisor-NAS
		James Sawyerr	Senior Accountant
		Mohamed Bah	Procurement Officer
		Kemoh Mansaray	KP Adviser
CRS	Freetown	Mohamed Yankson	MEAL Manager
		Alfred Nyuma	Manager G. Fund
		Sulaiman Moseray	MEAL Officer
		Solomon Kelfalla	MEAL Officer
		Regena J. Kain	Program Manager
NAS	Freetown	Kemoh Mansaray	KP Adviser
		Amara Lebbie	Senior Technical Advisor
		James L. Kamara	Deputy Director General
		Abdul Rahman Sesay	Director General
NACP	Freetown	Dr. Gerald M. Young	Programme Manager
		Aminata Sheriff	Ag. HTS Coordinator

		Dr. Eshatu Tabor	Technical Officer
Human Rights Commission Sierra Leone	Freetown	Joseph Kamara	Executive Secretary
		Mohamed Kuyateh	Director
		Paul Jesse Moriba	Director of Finance and Administration
CARKAP	Freetown	Harry B. Alpha	Program Manager
		Nellie Grey	Focal Point Person
		Maie Banjamin	Chair, Steering Committee
		Mohamed Sheriff	Member
AWOD		Nellie Grey	Executive Director
NETHIPS	Graftor, Freetown	Wilhemina Bah	Advocacy National Coordinator
		Mariama Conteh	Nurse/Counsellor
		Isata Bah	Admin Officer
		Marvel Spaine	National Coordinator-VOW
		Emmanuel Banga	Office Assistant
		Kabai Sannoh	Finance Officer
		Mohamed B. Kallon	M&E Officer
		Edward Tural	CDO
		Joe Samuel Harding	Project Officer
		Obai Bangura	Office Assistant
		Alfred Kemoh	Finance Officer
ART Clinic, Connaught Hospital	Freetown	Dr. Sulaiman Lakoh	Infectious Disease Physician
		Dr. Darlinda Jiba	Internal Medicine Registrar
		Mabinty Mansaray	Nurse
ART Clinic, Lumley Hospital		Winifred Bah	Matron
		Ann Mambu	Nurse
		Margaret seisy	Nurse Counsellor
		Kumba B. Mbawa	Nurse Counsellor
HAPPY Kids and Adolescents	Freetown	Betty Dawo	Counsellor
		Maseray Swarray	Head of Programs
		Sia Ceciia Sesay	Finance /Admin Officer
		Abertina Campbell	Programme Officer
		Samuel Kamara	M&E Officer
Sierra Leone Correctional Service		Ibrahim Lamin	Regional Health Officer
		Ramatu Conteh	Nurse HIV Data Clerk
		Abu Bakarr Kamara	Lab. Technician
		Dr. Tamba Lebbie	Medical Superintendent
Dignity Association	Freetown	Hudson Tucker	National Coordinator
CISMAT	Freetown	Alimamy J. Koroma	Admin/Finance Manager
		Dizy Saquee	Partnership/Advocacy Officer
		Emerica Jal-Koroma	Admin Officer
		nsaray Samura	Program Manager

		Paul B. Bangura	Director
Prison Watch	Freetown	Karim Mansaray	Chief Detention Monitor
		Eleanor G.M Kanu	Admin & HR Officer
		Berthan Lamin Bangura	Program Officer
		Mohamed Jalloh	Program Manager
		Mambu S. Feika	Director
SWAASL	Freetown	Princess Komba	ART Nurse
		Tenneh Tamba	GF Nurse Counsellor
		Princess Collier	Nurse Counsellor
		Marie Benjamin	Executive Director
Women In Crisis Movement	Freetown	Juliana Koneh	Executive Director
		Hawa Kpomassi	Office Assistant
		David Vandi	M&E Officer
		Alimatu Conteh	HIV/AIDS Nurse Counsellor
		Abibatu Kargbo	HIV/AIDS Nurse Counsellor
		Hawanatu Koroma	Nurse Counsellor
		Lucy Bayoh	Nurse Counsellor
		Musu Gogra	ART Nurse
		Maunica Sesay	Peer Educator
		Hannah Kamara	Peer Educator
		Ahmed S. Bangura	Field Officer
		Kadiatu Ruth Jimissa	Peer Navigator
		Juliana Vandi	DIC Focal Person East
		Magnus T Beah	Board Member
		Ben Tucker	Board Member
		Tommy Tucker	Program Manager
		Joe Beah	Finance Assistance
		Samuel Kamara	Office Assistant
SLYDCL	Freetown	Sylvester George	Senior Field Officer
		Charles Coomber	HIV Counsellor
		Ibrahim Koker	Data Officer
		Joseph S. Bangura	DIC Focal Person
		Mustapha Kellah	NSEP Manager
		Emmanuel Rogers	Program Manager
CCM Debrief	Freetown	Amara Lebbie	Senior Technical Adviser
		Prince Kamara	Oversight Officer
		Emmanuel Lahai	Admin Finance Manager
		Augustus Kamara	Project Coordinator
		Lynton Tucker	Country Coordinator
HIV/AIDS Unit, Bo Government Hospital	Bo	Ibrahim Turay	HIV Nurse Counsellor
		Augustine Kamara	HIV Counsellor
		Patrick Ansumana	HIV Focal Peron 11
		Kadijatu C. Kargbo	HIV Focal Peron 1

		Paul Jay Musa	Lab Technician
		Seibatu Kemoh	CHO
SLYDCL	Bo	Eric S. A. Jones	HIV Counsellor
		Francis Samai	Finance/Admin Assistance
		Saffa Kemokai	Field Officer
		Philip S. Lukulay	Program Officer
		Amara A. Sannoh	Office Assistant
Human Rights Commission Sierra Leone	Bo	Bridget Kpendema	Senior Human Rights Officer
		James E. Bundu	Intern
		Glen Kangaju	AHRO
		Roselino Koroma	Volunteer
		John Abdulai	Office Assistant
		Mablu Yovuwa	Admin
		Ansu Osman	AHRO
		Ibrahim Tucker	Driver
NETHIPS	Bo	Sovula Aruna	M&E Assistant
		John B. Kamara	Advocacy Assistant
SLYDCL	Bo	Sheriff Kargbo	M&E Officer
		Victor Luseni	Coordinator
		Momoh Pabai	M&E Assistant
		Mohamed Barrie	Office Assistant
Round Table meeting with KP Organizations	Freetown	Hudson Tucket	Dignity Association
		Paul Bangura	CISMAT
		Mohamed Samura	CISMAT
		Wilhemina Bah	NETHIPS
		Nellie Grey	AWOD
		Mariae Banjamin	SWAASL
		Mohamed Sheriff	CARKAP
		Harry B. Alpha	CARKAP
		Juliana Konteh	Women In Crisis Movement
		Berthan Lamin Bangura	Prison Watch
		Emmanuel Rogers	SLYDCL
		Tewoh Kallon	SWAASL
		Isata Hull	Dignity Association
		Fatmata Mansaray	AWOD
		Ahmed S. Bangura	Women In Crisis Movement
		Edward Aruna Turay	NETHIPS
Meeting with Recipients of care (ROC), NETHIPS	Freetown	Jeneba Kamara	PRO
		Cecilia T Conteh	Coordinator
		Hawa Kargbo	Member
		Ademla Rhodes	Coordinator
		Mary Ahmed	Secretary
		Musu Kombo	Coordinator
		Ferreh Dumbuya	Secretary

		Musu Jimmy	Coordinator
		Aminata Kamara	Member
		Fudia Kargbo	Peer Educator
		Lamin Turay	Peer Educator
		Joseph Sumanah	Coordinator
		Samba Koi	Secretary
NaCSA	Freetown	Ahmed A. Mansaray	Commissioner, National Youth Commission
		Dr. Iddriss Turay	Sr. Director, Social Protection
Sierra Leone Police Service	Freetown	Mr. William Fayia Sellu	Inspector General
		AIG Mohamed I. Jalloh	Director - Medical Services

Focus Group Discussions

Group Type	Location	Participants		
		M	F	Total
TG on ART	Freetown	0	8	8
TG		0	8	8
FSW	Bo	0	8	8
PWID/PUD	Bo	8	0	8
FSW	Waterloo	0	6	6
Ex-Prison Inmates	Freetown	4	2	6
TB Survivors	Freetown	2	2	4
Adolescents on ART	Freetown	3	3	6
MSM on ART	Freetown	6	0	6
MSM	Freetown	8	0	8
PWID/PUD	Freetown	3	2	5
FSW on ART	Freetown	0	6	6
FSW	Freetown	0	6	6
FSW	Freetown	0	6	6
PLHIVS	Bo	1	5	6
MSM	Bo	7	0	7
	Total	42	62	104