Baseline Assessment – Benin

Scaling up Programs to Reduce Human Rights-Related Barriers to HIV and TB Services

2018
Geneva, Switzerland

The Global Fund

Disclaimer

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

Acknowledgment

With regard to the research and writing of this report, the Global Fund would like to acknowledge the work of the International Center for Research on Women, Johns Hopkins School of Public Health and Arc en Ciel, including authors Gnilane Turpin, Jae-Hee Honey, Carrie Lyons, Stefan Baral, and Anne Stangl, as well as the in-country team Anato Simplice.

Acronym List

ABDD	Association Béninoise de Droit du Développement
ACJSPH	Adorable Club des Jeunes Solidaires de Porto-Novo
ABPF	Association Béninoise pour la Promotion de la Famille
ABMS	Association Béninoise pour le Marketing Social et la Communication pour la Santé
AFJB	Association des Femmes Juristes du Bénin
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ASAJ-Bénin	Alliance pour la Solidarité et l'Aide à la Jeunesse du Bénin
ASV	Amis des Sans Voix
BORNES	Bénin Orientation Neutre Santé
BESYP	Bénin Synergies Plus Network
UNCAT	United Nations Convention against Torture
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CCPR	Covenant on Civil and Political Rights
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CERD	Convention on the Elimination of Racial Discrimination
CESCR	Covenant on Economic, Social and Cultural Rights
CeRADIS	Centre de Réflexions et d'Actions pour le Développement Intégré et la Solidarité
CFLS	Comité Frontalier de Lutte contre le Sida
CHLN	Canadian HIV/AIDS Legal Network
CIDA	Canadian International Development Agency
CIPEC	Centre d'Informations, de Prospectives et de Conseils
CISR	Commission de l'immigration et du statut de réfugié, Canada
CJAV	Centres Jeunes Amour & Vie
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CNLS	Comité National de Lutte contre le Sida
CSO	Civil Society Organization
DPAS	La Direction de l'Administration Pénitentiaire et de l'Assistance Social
DOJ	Department of Justice
EVAB	Espoir Vie Arc-en-ciel Bénin
FCFA	Franc de la Communauté Financière d'Afrique

FGD	Focus Group Discussion
FSW	Female Sex Worker
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
ICIS	Initiatives Conseil International Santé
IDLO	International Development Law Organization
IPV	Intimate Partner Violence
JHU	Johns Hopkins University
KP	Key Populations
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Queer
MOH	Ministry of Health
MSM	Men who Have Sex with Men
NGO	Non-governmental organization
OASH	Organisation d'Aide pour la Santé Humaine
OCAL	Organisation du Corridor Abidjan-Lagos
OFID	OPEC Fund for International Development
OHCHR	Office of the High Commissioner for Human Rights
OVC	Orphans and Vulnerable Children
PE	Peer Educator
PEPFAR	President's Emergency Plan for AIDS Relief
PIB	PLAN International Benin
PLHIV	People Living with HIV
PNLS	Programme National de Lutte contre le SIDA
PNPMT	Programme National de la Pharmacopée et de la Médicine Traditionnelle
PSLS	Programme Santé de Lutte contre le SIDA
PMA	Paquet Minimum d'Activités
PMTCT	Prevention of Mother-to-Child Transmission
PreP	Pre-exposure Prophylaxis
PSI	Population Services International
RAOFEM	Le Réseau des ONG et associations de femmes contre la féminisation du VIH/SIDA et les violences faites aux femmes au Bénin
ReBAP+	Le Réseau Béninois des associations de PVVIH
SIDA	Le syndrome d'immunodéficience acquise (AIDS)
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TB	Tuberculosis
TPB	Theory of Planned Behavior
UNAIDS	United Nations Programme on HIV/AIDS

UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USED	Union pour la Solidarité et l'Entraide au Développement
VCT	Voluntary HIV Counseling and Testing
WHO	World Health Organization

Table of Contents

Executive Summary

Introduction

This report documents the results of a baseline assessment carried out in Benin to support its efforts to scale-up programmes to reduce human rights and gender-related barriers to HIV and TB services. Since the adoption of its new *Strategy 2017-2022: Investing to End Epidemics,* the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programmes to remove such barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). Although the Global Fund will support all countries to scale up programmes to remove barriers to health services, it is providing intensive support in 20 countries in the context of its corporate Key Performance Indicator (KPI) 9: "*Reduce human rights barriers to services: # countries with comprehensive programs aimed at reducing human rights barriers to services in operation (Global Fund, 2016b)*." Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected Benin, with 19 other countries, for intensive support to scale up programmes to reduce barriers to services. This baseline assessment for Benin, focusing on HIV and TB, is a component of the package of intensive support the country will receive.

Governments, the Global Fund, technical partners and other experts have recognized the following programs areas as effective in removing human rights-related barriers to HIV and TB services and thus as critical enablers of the HIV and TB response: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB.[1] Additional program areas for TB include (a) ensuring confidentiality and privacy related to TB diagnosis and treatment, (b) mobilizing and empowering TB patient and community groups, (c) addressing overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and (d) making efforts to remove barriers to TB services in prisons.[2]

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* at the *right level of investment* to effectively remove human rights-related barriers and increase access to HIV, TB and malaria services.[3]

The objectives of the baseline assessment were to:

- Identify the key human rights-related barriers to HV and TB services in Benin;
- Describe existing programmes to reduce such barriers;
- Indicate what a comprehensive approach to existing barriers would comprise in terms of the types of programmes, their coverage and costs; and,
- Identify the opportunities to bring these to scale over the period of the Global Fund's 2017-2022 strategy.

---

[1] See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note,UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Technical Brief: *HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017) and Technical Brief: Tuberculosis, Gender and Human Rights, Global Fund to Fight AIDS, TB and Malaria (April 2017); see also *Political Declarations on HIV/AIDS* (2011, 2016)

[2] Technical Brief: Tuberculosis, Gender and Human Rights, Global Fund to Fight AIDS, TB and Malaria (April 2017)

[3] This definition of "comprehensiveness » for the purpose of GF Key Performance Indicator 9 was developed with the Global Fund Human Rights Monitoring and Evaluation Technical Working Group.

Overall, the results of the assessment are meant to provide a baseline of the situation as of 2017 in Benin.

Methodology

This baseline assessment comprised a literature review conducted in June 2017 of formal and informal literature on the HIV response in Benin followed by in-country research. The in-country research involved a total of 36 in-depth interviews with key informants, and 13 focus group discussions with a total of 104 representatives of key populations affected by HIV in Cotonou, Benin. A standard baseline assessment protocol, developed to be used across the twenty country baseline assessments and standard tools for the key informant interviews and focus groups discussions were used. An Inception Workshop was held with key stakeholders at the beginning of the data collection process to inform them of the assessment process and to consult with them on focus areas and key informants. This meeting was also used to fill any gaps in the literature review. Following finalization of this report, a multi-stakeholder meeting will be held to review the findings of the baseline assessment and agree on a 5-year plan to address the human rights-related barriers to HIV services in Benin.

Summary of baseline assessment findings

Key and vulnerable populations

This assessment includes key populations as defined by the Global Fund and the Comité National de Lutte Contre le SIDA Benin (CNLS), as well vulnerable populations that were determined through the fieldwork. As defined by the Global Fund, key populations include (a) men who have sex with men, (b) transgender people, (c) sex workers, (d) people who inject drugs and (e) people living with HIV. This assessment also incorporates the definition of key populations included in the Plan stratégique national de lutte contre le VIH/SIDA et les IST 2015-2017 released by the Comité National de Lutte Contre le SIDA Benin (CNLS), additionally comprising (f) clients of sex workers, including truck drivers truck drivers, (g) servers in bars and restaurants, (h) and prisoners (Sida 2011). Using data from the fieldwork, vulnerable populations were determined to include women, young people and people with disabilities.

Barriers to HIV services

The assessment identified the following as the most significant human rights-related barriers to HIV services:

a) Stigma and discrimination enacted in the community, by law enforcement agents, family members, and in health care settings;
b) Lack of enforcement of laws and policies designed to protect key and vulnerable populations;
c) Lack of access to legal services and a lack of knowledge of human rights and the protections of the law;

d) Gender-based discrimination and violence, particularly among female sex workers and women living with HIV, including married women who experience mistreatment and/or isolation from their spouses or spouses' extended family in response to disclosing their status; and
e) Experience of violence, rights violations, and abuse by the police towards female sex workers, exacerbated by a lack of police protection for those who are experiencing human rights violations.

The ways that these barriers impact on the key and vulnerable populations are described in detail in the findings section of the body of this report.

Programs to address barriers to HIV services – from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Benin to remove human rights-related barriers to HIV services and provides a summary of the elements of a comprehensive program, based on the seven program areas set out in the Global Fund HIV, Human Rights and Gender Equality Technical Brief[4].

The seven program areas include activities to:

PA 1: Reduce HIV-related stigma and discrimination

PA 2: Train health care workers on human rights and ethics related to HIV

PA 3: Sensitize lawmakers and law enforcement agents

PA 4: Provide legal literacy ("know your rights")

PA 5: Provide HIV-related legal services

PA 6: Monitor and reform laws, regulations and policies related to HIV

PA 7: Reduce discrimination against women and girls in the context of HIV

There is a network of motivated local organizations that are working to address human rights-related barriers to HIV services. Several government entities are also actively working in this domain, namely the CNLS (Comité National de Lutte contre le SIDA) and the PSLS (Programme Santé de Lutte contre le SIDA), along with the support of the Ministry of Health. However, the current programming landscape does not cover each program area fully and is largely focused in metropolitan, rather than rural, areas of the country. Part of the assessment process involved examining the outcomes and evidence for effectiveness of these interventions, in order to determine which ones would be appropriate to take to scale.

[4] Technical *Brief HIV, Human Rights and Gender Equality,* Global Fund to Fight AIDS, TB and Malaria (April 2017)

Summary of existing/recent programs and a description of a comprehensive response

Program Area 1: Programs to reduce stigma and discrimination
Several areas of programming currently exist in Benin to reduce stigma and discrimination in the context of HIV, including: (1) political advocacy efforts, (2) media campaigns aimed at influencing national policy and changing community norms around key and vulnerable populations, (3) key population-specific training and education efforts, and (4) targeted programming for key and vulnerable populations for whom access to HIV services is lower than for the rest of the population.

Based on the assessment findings, the following activities would build on various existing programming to provide a comprehensive response to stigma and discrimination:

- Support RéBAP+ to repeat the National Survey on Stigmatization and Discrimination of People Living with HIV in Benin (Stigma Index) on a 3-5 year basis to provide updated data for assessing the impact of programs to remove human rights-related barriers to HIV services in the country and to modify programming accordingly.
- Organize quarterly sessions organized with members of key populations to describe the impacts of stigma and discrimination and to popularize and disseminate the protective aspects of Law 2005-31 (described below in Section 4.2.3 Laws that Affect Key and Vulnerable Populations' Access and Use of Relevant Services).
- Organize and promote a list of groups that provide help for people living with HIV and key populations, partnerships between associations for people living with HIV and ones working with key populations, through information dissemination campaigns and collaboration with radio and community media
- Support the meaningful participation of people living with HIV and key populations in national stigma reduction strategies by (a) conducting trainings and/or discussions with key population association leadership about stigma and discrimination, (b) providing technical assistance stigma reduction and support services, and (c) supporting CNLS to advocate for their engagement.
- Support dissemination of stigma and discrimination-reduction messaging through public events and engagements led by key populations.
- Develop partnership between the CNLS, the Directorate for Occupational Health, and business leaders to develop and promote comprehensive anti-discrimination HIV policies to be deployed in the workplace in both the private and public sector.
- Develop partnerships with the media to improve the quality of HIV-related discourse in the press, radio and television and to increase public awareness of stigma faced by people living with HIV and key populations.
- Scale up training efforts through the Programme National de la Pharmacopée et de la Médicine Traditionnelle to include training on stigma and discrimination experienced by key and vulnerable populations and people living with HIV as related to HIV prevention, treatment, care and support. Collaborate with practitioners of traditional medicine through activities to disseminate messaging on stigma and discrimination reduction.

- Advocate for the inclusion of non-discrimination based on health and social status as part of institutional and workplace policies in employment and educational settings.

Program Area 2: Programs to train health care workers on human rights and ethics related to HIV

Programs to reduce human rights-related barriers in the healthcare setting have been limited to training of medical providers on ethics, human rights and confidentiality. These interventions should be expanded and refined as follows, alongside the implementation of additional activities:

- Incorporate stigma reduction, human rights, and medical ethics training in pre-service curricula as a require course for healthcare professionals, including medical, nursing, midwifery, and medical personnel schools and training programs. Training programs should address stigmatizing attitudes and discriminatory practices in health care settings and should provide health care providers with the knowledge, skills, and motivation necessary to ensure patients' rights to informed consent, confidentiality, non-stigmatizing treatment and non-discrimination. Training of staff members that provide services to people who have experienced sexual violence may include different strategies for intake and communication with cisgender and transgender women, men who have sex with men, and children. Adherence to existing medical ethics guidelines and policies should be assessed to frame training curricula. Additionally, it is recommended that incentives and motivations for improving adherence to medical ethics guidelines should be considered, such as facility or departmental certification for guideline adherence.
- Offer in-service trainings to staff working in HIV treatment services. These trainings would include modules on stigma and discrimination against key and vulnerable populations, better service delivery to PLHIV including key populations and creating a friendlier environment. During these trainings participants would develop a workplan with the aim of creating a more accessible and friendlier environment for the patients.
- Programs are also needed to facilitate communication between HIV service providers, programs and CBOs servicing key populations and police and to provide information on the vulnerability and heath care needs of PLHIV and key populations.
- Train prison personnel on the prevention, health care needs and human rights of detainees living with or at risk of HIV infection.
- Peer education and support programming may also be used to address the psychological impacts of negative experiences in seeking healthcare, the effects of which may include avoiding further engagement in health services. The provision of trained peer mediators may be useful to guide the experiences of those likely to experience stigma and discrimination in healthcare settings (KII32). Peer outreach programs, where target population members accompany their peers to medical appointments, have been found to be particularly effective in reducing fear of attending HIV services (Lowndes, Alary et al. 2007, Behanzin, Diabate et al. 2012, Behanzin, Diabate et al. 2013, Béhanzin 2016).
- Create awareness-raising sessions for healthcare professionals regarding the medical and ethical principles governing disclosure of a patient's sero-status as well as on the barriers faced by people living with HIV and key populations more broadly. These sessions could promote discussions between people living with HIV and their healthcare professionals

about their treatment options and the barriers they face to access and retention in HIV treatment services to increase understanding of PLHIV patient needs (UNAIDS 2016).
- Create awareness-raising sessions for healthcare professionals regarding the medical and ethical principles governing disclosure of a patient's sero-status, as well as on the barriers faced by people living with HIV and key populations more broadly.

Programs should be tailored to the specific needs of each population. For example, programs should include components that gather information about the different types of stigma and/or violence that women, female sex workers, men who have sex with men, transgender individuals and youth face when seeking and receiving healthcare.

Program Area 3: Programs to sensitize law makers and law enforcement agents
No widespread, systematic interventions aiming to sensitize law makers and law enforcement agents were found through this assessment. Current activities are limited to workshops and meetings with law makers and law enforcement agents that often fall under the umbrella of broader advocacy campaigns, rather than a focused strategy to reach and change attitudes and behaviors of law makers and law enforcement agents.

The following activities would sensitize law makers and law enforcement agents to the needs of key and vulnerable population comprehensively:

- Develop curriculum and institutionalize a training program for the police on the reduction of stigma, discrimination and violence against key populations and gender-based violence. The curriculum should incorporate information to increase knowledge of HIV transmission, disseminate information regarding stigma and discrimination experienced by key and vulnerable populations, the impact of HIV in cases of sexual violence, and sensitization to the negative consequences of illegal police activity on justice and on the HIV response. This curriculum should also include training around gender-based violence, intimate-partner violence, and gender discrimination more broadly. The training curriculum should also incorporate sessions explaining the importance of understanding and effectively implementing laws that protect key and vulnerable populations in Benin and sensitization training on providing supportive care for survivors of gender-based violence. The manual developed by OCAL, Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos, should be leveraged for this activity.
- Develop a process to review the practices of law enforcement agents and officers who work in prisons and to assess the effect of their behaviors on access to justice for people living with or vulnerable to HIV.
- Develop a workshop training curriculum for modules on the reduction of stigma, discrimination and violence against key and vulnerable populations, HIV-related human rights, and gender-based violence for law students. This training, once developed, should be integrated into existing coursework for law students throughout the country with the aim to build capacity within individual law schools to implement this program sustainably, through implementation of the workshop during their training. The manual developed by OCAL, Modules de formation et de sensibilisation sur les droits et les VBG

au profit des populations clés du corridor Abidjan-Lagos, should be leveraged for this activity and adapted specifically to Benin as needed.

- Develop training tools and job aides for key messages from the the manual developed by OCAL, Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos.
- Develop a training program that provides information and training for prison personnel on HIV prevention and treatment for themselves as well as on the health care needs and human rights of detainees living with or at risk of HIV infection, including reduction of violence, rape, needle sharing and stigma and discrimination.
- Convene a meeting to review the minimum package of activities developed by ICIS to support key and vulnerable populations that they suggested should be implemented in Benin to develop action plan and develop tools to support implementation of and adherence to minimum package of activities.

Program Area 4: Programs to provide legal literacy ("know your rights")
Current efforts to enhance legal literacy are limited to (1) trainings and (2) provision of booklets and other written material to a variety of populations.

The following activities would comprise comprehensive programming on legal literacy:

- Legal literacy and education on the rights of people living with HIV should be disseminated through a public awareness campaign, including information regarding human rights related to HIV services and the protective aspects of Law 2005-31.
- In concert with a public awareness generation campaign, legal literacy activities should be coordinated in schools, the workplace (including bars and restaurants), prisons, and social and healthcare domains may serve to support key and vulnerable populations' justice seeking beginning at earlier ages and serve to sensitize broader populations to their rights. Additionally, activities should be tailored for each key and vulnerable population, thus addressing their specific needs. Activities organized by networks of PLHIV and key populations could include monthly education and listening sessions for people living with HIV, men who have sex with men, female sex workers, people who inject drugs, women who work in bars and restaurants, prisoners, and youth on topic of human rights, including rights to privacy and confidentiality of HIV status, right to access HIV services, and freedom from discriminatory behaviors and unwarranted arrest. These sessions would be conducted either within the offices of the CBO organizing the session, or at a safe and confidential venue for PLHIV.
- Peer outreach is another strategy that can be used across program areas. Dissemination of legal literacy resources to key and hidden populations and, particularly, to those which are hidden, may be more effectively accomplished through peer-led outreach and telephone hotline approaches. Telephone hotline approaches, which have been successfully implemented through the CJAV centers and have been successful in many low-resource settings, could be implemented relatively cheaply and would eliminate barriers for those who are uncomfortable accessing services in public spaces due to the experience of stigma and discrimination.

Program Area 5: Programs to provide HIV-related legal services
Current programs to provide HIV-related legal services are limited to people living with HIV and women. They include: (1) legal advice and representation for people living with HIV, (2) legal information and referral for people living with HIV, and (3) legal information and referrals for women.

The following activities would comprise comprehensive programming:

- Establish partnerships between healthcare and legal clinics, health providers and lawyers. This "one-stop" approach can have many potential benefits, including convenience for target populations, strategy sharing around protecting individuals' rights from both sectors, coordination of providers, and consistent training on human rights barriers for staff involved in both types of services. Activities can include the development of partnerships between lawyers, legal clinics, medical clinics and hospitals as well as the assessment of the feasibility of positioning legal staff within healthcare settings for referrals for patients who report human rights violations or discrimination.
- Establish a network of paralegals and lawyers positioned in the country to provide free legal consultations to promote human rights among key and vulnerable populations, to assist key populations in reporting human rights violations to the network. Recruitment, training, and development of the development of legal crisis teams to assist swiftly in cases that require immediate attention. In providing legal advice, resolve disputes, help with advocacy and mobilization around rights, and assistance in arrests.
- Capacity-building sessions for lawyers and paralegals in the country on the application of Law 2005-31, including education on the protective elements on the law and sensitization to the elements of the law that have the potential to permit human rights violations of patient living with HIV. This capacity building sessions would be conducted for a group of lawyers and legal professions who agree to provide some level of support pro bono.

Program Area 6: Monitoring and reforming laws, regulations and policies relating to HIV
Current programming to monitor and reform laws, regulations and policies is limited to advocacy and lobbying for law reform.

The following activities would comprise comprehensive programming:

- Support advocacy from the networks of PLHIV and key populations for legal reform and the enforcement of laws, regulations and guidelines that prohibit discrimination and enable access to HIV prevention, treatment, care and support services.
- Coordinate with advocacy groups to encourage support of the legal reform process and to monitor the implementation of supportive policies and laws, including documentation of continued violations of existing laws and policies that affect access to HIV services.
- Support advocacy for the development and implementation of explicitly protective laws to protect the human rights and ability to access HIV services by LGBTQ populations, female sex workers, people living with HIV, prisoners, and youth. For example, although same-sex sexual acts between consenting adults over the age of 21 may not be explicitly

illegal in Benin, LGBTQ communities continue to face stigma, criminalization and widespread discrimination. There is no recognition of legal rights for same-sex couples, and no legal protections against discrimination based on sexual orientation (Canada: Immigration and Refugee Board of Canada 2015). Although article 36 of the Beninese Constitution contains a broad anti-discrimination provision, it does not include a specific prohibition against discrimination on the grounds of gender or sexual orientation (République du Bénin 1990, Article 36).

- Support advocacy for the removal or modification of laws that enable healthcare providers to disclose an individual's HIV status without notifying one's partner and without clear recourse if inappropriate disclosure or if reasons for disclosure are insufficient.

Program Area 7: Reducing discrimination against women in the context of HIV

Current programming to reduce discrimination against women in the context of HIV include: (1) strengthening of the legal and policy environment, (2) efforts to reform domestic relations, age-appropriate sexuality and life-skills education programming, and (3) programs to reduce harmful gender norms, including capacity development of civil society organizations working for women's rights and gender equality.

For a comprehensive response in this area, these interventions should be expanded and refined as follows, alongside the implementation of additional activities:

- Establish and support a coordination mechanism across sectors among a coalition of stakeholders involved in the prevention of gender-based violence and response efforts, bringing together government institutions and civil society to reduce gender-based discrimination and set priorities for reduction of gender-based violence.
- Develop training curricula for government officials, the healthcare sector, legal professionals, and law enforcement agents on GBV, human rights, and gender. Training sessions should discuss abuse, rejection, violence, and the need for legal defense of women and children victims, including partnerships with the Ministry for the Defense of Children in court.
- Support networks of women living with HIV to implement activities, like support groups or peer support, to reduce self-stigma related to HIV status. Exchange of testimony with other women who have successfully shared their HIV status with their partners and families could be an effective strategy to engage women living with HIV and their partners and families in these activities.
- Develop behavior change communication strategies to reach men and boys with information regarding gender norms, gender discrimination, gender-based violence, intimate-partner violence, and positive actions that men and boys can take in their communities to address these issues. These strategies will incorporate the messaging outlined above in the context of HIV prevention and access to care.

2016 investments and proposed comprehensive program costs

In 2016 a total of around $ 1,084,238 was invested in Benin to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
Embassy of the Netherlands	$ 13,225 USD
Global Fund	$ 894,618 USD
Plan International	$ 69,554 USD
Population Services International	$ 45,115 USD
Programme Santé de Lutte contre le SIDA (PSLS)	$ 7,171 USD
Total	$ 1,029,683 USD

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016
PA 1: Stigma and discrimination reduction for key populations	$ 213,332 USD
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$ 73,04 USD
PA 3: Sensitization of law-makers and law enforcement agents	$ 176,089 USD
PA 4: Legal literacy (“know your rights”)	$ 213,066 USD
PA 5: HIV-related legal services	$ 95,013 USD
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$ 24,280 USD
PA 7: Reducing discrimination against women in the context of HIV	$ 127,494 USD
Total	$ 849,348 USD

The costing for the 5-year comprehensive program is set out in the following table:

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations	$ 5,407,356 USD
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$ 370,664 USD
PA 3: Sensitization of law-makers and law enforcement agents	$ 76,829 USD
PA 4: Legal literacy ("know your rights")	$ 960,871 USD
PA 5: HIV-related legal services	$ 115,563 USD
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$ 125,579 USD
PA 7: Reducing discrimination against women in the context of HIV	$ 1,879,493 USD
Total	$ 9,862,507 USD

Details of yearly costs are set out in the main report below and detailed costing information is available in Annex 3.

1.6 Priorities for scaling up towards comprehensive programs to reduce barriers to HIV services

With funding from all sources for HIV and AIDS programming in Benin decreasing steadily since 2012, there is a need for a more effective and strategic approach to improving HIV outcomes through increased access to services. By addressing the human rights-related barriers to HIV services, existing services may be more effectively utilized through increased coverage. Therefore, we propose complementary programs to those focused directly on HIV services. Scaling up programs that aim to reduce barriers to HIV services is an efficient way to improve access and coverage of existing services. Priorities for scaling up interventions are outlined below.

- Update existing curricula and roll out trainings that address stigma and discrimination reduction, human rights and medical ethics, including issues related to the rights of women and sexual minorities, among law enforcement agents, and healthcare workers.
- Conduct outreach with key populations and Key populations led associations, and create a resource list of organizations that provide support services for key and vulnerable populations, including people living with HIV, in the context of accessing HIV services.
- Integrate HIV-related human rights into peer education programming for youth, as well as ensure human rights peer educators for female sex workers, men who have sex with men, people who inject drugs, and truck drivers. Expand efforts to reach transgender people, servers in bars and restaurants, and people with disabilities. Human rights peer educators or patient navigators are also urgently need to work with people living with HIV to support access to care and treatment.

- Develop and scale up networks of paralegals for each key and vulnerable population to support dispute resolution, access to justice and mobilization around rights, laws and policies. Adapting resources developed by OCAL and ABDD/IDLO into local languages is an urgent need, especially for rural regions of the country.
- As training activities for stigma and discrimination reduction, legal literacy, and legal assistance are scaled up, monitoring efforts should be implemented, including the PLHIV Stigma Index within the next three years. While the capacity of community-based organizations and public institutions is strong, there is a great need for comprehensive monitoring and evaluation to be built into existing and expanded programming.

1.7 Next Steps

The Global Fund will utilize this baseline assessment to assist the government, other stakeholders, technical partners and donors in Benin to develop a five-year, comprehensive program to remove human rights-related barriers to HIV services. Data from the baseline assessment has been used to inform the matching fund application of Benin and will inform its grant-making and implementation. Finally, the data will be used as a baseline for subsequent reviews at mid-term and end-term during the period of the Global Fund strategy to assess the impact of scaled up programs in reducing human rights-related barriers to services.

1. Baseline Assessment – reducing human rights-related barriers to HIV services in Benin

1.1 Introduction

This report comprises the baseline assessment conducted in Benin to support scaling up of programs to remove human rights-related barriers to HIV services. Since the adoption of its strategy, *Investing to End Epidemics,* 2017-2022, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human rights-related barriers in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria service";* and, to *"scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights and investing to reduce health inequities, including gender-related disparities*."[5] The Global Fund recognizes that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by the three diseases. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalize this Strategic Objective.

Though the Global Fund will support all recipient countries to scale up programs to remove barriers to health services, it is providing intensive support in 20 countries in the context of corporate Key Performance Indicator (KPI) 9 – «Reduce human rights barriers to services: # of countries with comprehensive programs aimed at reducing human rights barriers to services in operation". This KPI measures "the extent to which comprehensive programs are established to reduce human rights barriers to access with a focus on 15-20 priority countries".[6] Based on criteria that include needs, opportunities, capacities and partnerships in country, the Global Fund selected Benin as one of the countries for intensive support to scale up programs to reduce barriers to services. This baseline assessment, focusing on HIV, is the first component of the package of support the country will receive.

The objectives of this assessment in Benin are to: (a) establish a baseline of human rights-related barriers to HIV services and existing programs to remove them; (b) set out a costed,

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

[6] 2017-2022 Strategic Key Performance Indicator Framework, The Global Fund 35th Board Meeting, GF/B35/07a - Revision 1, April 2016

comprehensive program aimed at reducing these barriers; and (c) recommend next steps in putting this comprehensive program in place.

The programs areas recognized by UNAIDS, STOP TB and other technical partners as effective in removing human rights-related barriers to HIV services comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV.[7]

Programs to remove human rights-related barriers to services are *comprehensive* when the *right programs* are implemented *for the right people* in *the right combination* under each of the program areas set out above, at the *right level of investment* to remove human rights-related barriers and increase access to HIV, TB and malaria services.

The findings of this baseline assessment will be used by countries, the Global Fund, technical partners and other donors to develop a five-year plan by which to fund and implement a comprehensive set of these programs to remove human rights-related barriers to HIV services in Benin. Its data will also be used as the baseline against which will be measured the impact of the interventions put in place in subsequent reviews at mid-term and end-term during the current Global Fund Strategy period.

1.2 Methodology

Conceptual Framework

The conceptual framework for the baseline assessments is the following: (a) Depending on the country and local contexts, there exist human rights-related barriers to the full access to, uptake of and retention on HIV, TB and malaria services; (b) These human rights-related barriers are experienced by certain key and vulnerable populations who are most vulnerable to and affected by HIV, TB and malaria; (c) There are human rights-related program areas comprising several interventions and activities that are effective in removing these barriers; (d) If these interventions and activities are funded, implemented and taken to sufficient scale in country, they will remove, or at least significantly reduce, these barriers; (e) The removal of these barriers will increase access to, uptake of and retention in health services and thereby make the health services more effective in addressing the epidemics of HIV, TB and the malaria; and, (f) These programs to remove barriers also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems.

Under this conceptual framework, the assessment in Benin has identified:

[7] See *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses*, Guidance Note, UNAIDS/JC2339E (English original, May 2012); ISBN: 978-92-9173-962-2. See also Technical *Briefs HIV, Human Rights and Gender Equality* Global Fund to Fight AIDS, TB and Malaria (April 2017); *Tuberculosis, Gender and Human Rights* Global Fund to Fight AIDS, TB and Malaria (April 2017)

a) Human rights-related barriers to HIV services
b) Key and vulnerable populations most affected by these barriers
c) Existing programs to address these barriers; and
d) A comprehensive set of programs to address these barriers most effectively.

Human rights-related barriers to HIV services were grouped under the following general categories: stigma and discrimination; punitive laws, policies, and practices; gender inequality and gender-based violence; and, poverty and economic and social inequality.

Key populations have been defined as follows by the Global Fund:

a) Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the two diseases – due to a combination of biological, socioeconomic and structural factors;
b) Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and
c) The group faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and/or criminalization – which increase vulnerability and risk and reduces access to essential services.[8]

Vulnerable populations are people who do not fit into the definition of key populations, but nevertheless are more vulnerable to HIV and its impact.[9]

Based on these definitions and the data reviewed as well as the key populations defined in the Plan stratégique national de lutte contre le VIH/SIDA et les IST 2015-2017 released by the Comité National de Lutte Contre le SIDA Benin (CNLS), the following key and vulnerable populations are included in this assessment: (a) people living with HIV, (b) women, (c) young people, (d) men who have sex with men, (e) transgender people, (f) sex workers and their clients, (g) people who inject drugs, (h) people with disabilities, (i) servers in bars and restaurants, (j) prisoners, and (k) truck drivers (Sida 2011).

The design, outcomes and costs of existing programs to reduce human rights-related barriers for these populations were analyzed in terms of their scope and effectiveness, and based on this analysis, a comprehensive program to address human rights-related barriers at scale is described.

Steps in the assessment process:

[8] The Global Fund to Fight AIDS, Tuberculosis and Malaria. *Key Populations Action Plan 2014-17*. Geneva

[9] Greenall M, Kunii O, Thomson K, Bangert R and Nathan O (2017). Reaching vulnerable populations: lessons from the Global Fund to Fight AIDS, Tuberculosis and Malaria. *Bulletin of the World Health Organization* 2017;95:159-161.

a) *Desk review* - A search to assess human rights-related barriers to HIV services in Benin, key and vulnerable populations affected by these barriers and programs to address them was conducted using PubMed, Embase, and Web of Science to identify peer-reviewed literature. Twenty-one relevant articles were identified. The publications section of local NGOs and CBOs working in Benin in the HIV sector were also searched for relevant publications. In addition, searches were made in French, with a total of 106 publications found. Emails seeking additional information on programs were sent to several non-government organizations (NGOs) working on HIV in Benin to achieve a greater understanding of issues faced by their clients. Lastly, 5 phone and 10 in-person interviews were conducted with representatives of the government, local NGOs, national NGOs, and key population networks. A legal and policy review in the context of HIV was also conducted as a part of this assessment.
b) *Preparation for in-country data collection* - From the desk-review and initial consultations with stakeholders in Benin, a list of key informants and populations for focus group discussions was developed for the data to be collected in country. The data collection tools were written in English and translated into French. The data collection teams in country (all Beninese nationals) were trained on the content and background of the questions contained in the data collection tools. The Ministry of Health of Benin was contacted about the need for ethics approval. The research team was informed by the relevant government official that ethical approval was not required for this assessment. Johns Hopkins Institutional Review Board determined this assessment to be non-human subject research.
c) *In-country work* - An inception meeting introduced the project to national stakeholders, explained the objectives of the baseline assessment and the data collection procedures, and summarized the findings of the desk review. This was followed by key informant interviews and focus group discussions with members of key and vulnerable populations in the city of Cotonou. A total of 36 face-to-face interviews were carried out with 36 key informants; and 104 key population members participated in 17 focus groups.
d) *Data collection* - Data were collected on the following areas:
    - Human rights-related barriers to HIV services
    - Key and vulnerable populations most affected by these barriers
    - Programs and activities under the human rights program areas carried out presently or in the past that have been found through evaluation or through agreement by many key informants to be effective in reducing these barriers
    - Stated needs regarding comprehensive programs to address the most significant barriers for all groups most affected by these barriers
    - Funding of such programs (for 2016 financial year); and
    - Costing of effective[10] programs carried out presently or in the past.
e) *Data analysis* - The in-country data were analyzed to explore agreement with or divergence from the desk review findings and to add data on barriers and affected populations missing from the desk review. This information, together with data on funding in 2016, was used to develop the Baseline Data Summary. Data on effective projects and on stated needs were combined to suggest the comprehensive programs to reduce human rights barriers to HIV services in Benin.
f) *Finalization and next steps* –Upon finalization, this assessment was provided to the Global Fund Secretariat for use as background in preparation of an in-country multi-

[10] Effectiveness is determined either by evaluation or by broad agreement among key informants that a program is/was effective.

stakeholder meeting to consider best how to scale up programs to reduce human rights barriers to HIV services in Benin.

Costing Methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who were discovered to have financed any activities in the program areas for HIV were asked to supply details of the amount of funding provided and the program areas in which funding was provided; and, if possible, to state the type of activities and coverage of funded activities. This approach was largely successful in overall terms for HIV, in that most donors were able to state what program areas the funds were directed to, but did not provide details of the funded activities or their reach.

Second, specific implementers were approached and information was gathered on costs involved in carrying out specific interventions. This process followed the Retrospective Costing Guidelines (available from Global Fund on request). Individual costing sheets for services provided by each of the organizations were prepared.

Third, a prospective costing of the comprehensive program was carried out. The results of this process are provided in Annex X. For each type of intervention, an intervention-level cost was assembled.

The unit costs for activities included in the prospective costing of the 5-year comprehensive response were premised on the unit cost of the budgetary sheet of the main HIV country proposal submitted to GFATM (under allocation). This costing was based on the practicing rates of the Principal Recipients (i.e. the standard unit costs for activities like training, counselling etc.).

Limitations

The costing component of the baseline assessment was a rapid investment analysis, therefore it should not be viewed as a full-fledged resource need estimation. The retrospective costing has informed the estimation of intervention-level costs, hence the limited data collected through the baseline assessment inherently affected the prospective costing.

The baseline assessment encountered certain limitations in the costing component both as pertaining to HIV, TB and malaria programs aimed at removing human rights-related barriers:

- Certain key stakeholders were not able to take part in the data collection due to competing priorities. As a result, an important viewpoint on human rights barriers and on the effectiveness of current efforts to address them may be missing from the analysis. Stakeholders that could not participate also included a number of bilateral partners and, as a result, the description of current efforts to address and remove barriers may not include what these entities are currently funding or undertaking directly.

More specific limitations and challenges to the collection of financial data included:

- It appeared that a number or organizations felt that the information requested was too sensitive to share even though it was indicated in the invitation messages that the data would be consolidated and anonymized at the implementer level.
- Some organizations appeared to take the position that the benefit of completing the exercise was not worth the level of effort required, given other pressures on them.
- Most funders and intermediaries appeared to be unable to disaggregate their investments in combination prevention interventions to the level where funding for programmes addressing human rights barriers could be identified.
- Finally, as the analysis has noted there is a large gap in current and comprehensive quantitative data on a number of the human rights barriers identified by the assessment. As a result, there may be an over-reliance on individual or anecdotal accounts or perspectives which may not, in some cases, be an accurate reflection of an overall, country-wide trend.

2. Findings

2.1 Overview of epidemiological context and key and vulnerable populations

Overall, HIV incidence has been decreasing since approximately 1996 in Benin (UNAIDS/Spectrum 2016). The recent HIV incidence per 1000 adults aged 15-49 is 0.59 (0.37 - 0.94) (UNAIDS 2016). Approximately 3200 (1900 – 4900) adults aged 15 and over were newly infected with HIV in 2016 (UNAIDS 2016). New infections were greater among women in 2016 with approximately 1900 (1200 – 2900), compared to 1300 (<1000 – 2000) among men (UNAIDS 2016).

In Benin, the prevalence of HIV in the general population remained relatively stable from 2006 to 2016 with current prevalence estimates at 1.0% (0.7-1.4%) for adults aged 15-49 (UNAIDS 2016). An estimated 67,000 (47,000-94,000) people are living with HIV country-wide, and the highest prevalence estimates are among men and women in the country aged 30-34 (2.4%) (Ministère du Développement 2013, UNAIDS 2016). The Couffo region has the highest estimated prevalence at 2.8% for men and women aged 15-49, followed by the Mono region (2.5%) and the city of Cotonou (2.2%) (Ministère du Développement 2013).

The HIV epidemic in Benin is concentrated among the following key and vulnerable populations: men who have sex with men, transgender people, sex workers, people who inject drugs and people living with HIV. In addition to these key populations, the government of Benin in the Plan stratégique national de lutte contre le VIH/SIDA et les IST 2015-2017 released by the Comité National de Lutte Contre le SIDA Benin (CNLS) also includes clients of sex workers, servers in bars and restaurants, prisoners, and truck drivers (Sida 2011). Using data from the fieldwork, vulnerable populations were determined to include people with disabilities, women, and youth.

HIV prevalence estimates among key and vulnerable populations are disproportionately high compared to the broader population. Among men who have sex with men in Benin, the HIV prevalence is estimated to be 7.1%, with higher prevalence among men 25 years and older (UNAIDS 2016). The HIV prevalence among female sex workers is estimated to be 15.7% (ONUSIDA The Global Fund Ministère de la Sante 2015, UNAIDS 2016). Higher estimates have been observed in sex workers who are 25 years and older (19.1%) (UNAIDS 2016). The HIV prevalence among people who inject drugs is approximately 4.7%, with high prevalence among females who inject drugs (16.7% among females as compared to 4.3% among males) (UNAIDS 2016). The estimated HIV prevalence among incarcerated people is 1.4% (UNAIDS 2016). Women prisoners have significantly higher HIV prevalence estimates than male prisoners (4.9% compared to 0.7%, respectively) (UNAIDS 2016). Key populations for which less reliable or no data exist include transgender individuals, male sex workers, clients of sex workers including truck drivers, and servers in bars and restaurants.

There are approximately 6,300 (3,700-10,000) children between the ages of 0 to 14 who are living with HIV (UNAIDS 2016). The prevalence of HIV among young women is approximately 0.5% (0.2% – 0.9%) and among young men approximately 0.3(0.1% - 0.6%) (UNAIDS 2016). The HIV prevalence among women aged 15 to 49 is approximately 1.2(0.8 – 1.7)(UNAIDS 2016). Reliable data was not available for people with physical disabilities.

It was estimated that in 2015, 66.5% of men who have sex with men had had an HIV test within the last 12 months and knew their results (UNAIDS 2016). In 2015, it was estimated that 83.3% of female sex workers had an HIV test in the last 12 months and knew their results (UNAIDS 2016). Additionally, it was estimated that in 2016, 52.1% of people who inject drugs were aware of their HIV status (UNAIDS 2016).

Overall, treatment coverage has been increasing over the last decade, with the recent treatment coverage of 60% (43-83) adults living with HIV receiving ART. Among adult women living with HIV, ART coverage is 59% (42-82)(UNAIDS 2016).

The population size estimate among men who have sex with men is 5,845. However, this estimation may not be reliable, as estimating the size of a criminalized and somewhat hidden population presents challenges (UNAIDS 2016). Recent estimates that leveraged social media apps for the number of men who have sex with men across countries in the region are higher than official UNAIDS estimates.(Baral SD, Turner RM et al. 2018) The population size estimated for female sex workers in Benin is 14,926.(UNAIDS 2017) The population size estimate for incarcerated individuals is 6,847 (UNAIDS 2016)

2.2 Overview of the policy, political and social context relevant to human rights-related barriers to HIV services

The history and environment of laws and policies in Benin influences risks and vulnerabilities across key and vulnerable populations and is important in developing strategies to reduce human rights-related barriers to HIV services. The current government of Benin is organized by its 1990 constitution as a presidential democratic republic (République du Bénin 1990,

Preamble). Benin uses a combination of French colonial law and post-independence legislation, and incorporates international instruments into the legal system. Article 147 of the Constitution states that international treaties that Benin has ratified have authority exceeding that of national legislation, and have the force of law (République du Bénin 1990, Article 147). Benin has ratified the majority of the core international human rights treaties, including the ICESCR, CERD, CEDAW, CAT, ICCPR, CRC, and the CRPD (République du Bénin 1990, Article 8). The Constitution also contains a specific provision stating that the state is obligated to provides its citizens with equal access to health (République du Bénin 1990, Article 8). The penal code in force in Benin is an amended penal code from French West Africa.

The Constitution explicitly states a commitment to principles of democracy and human rights as defined by the Charter of the United Nations of 1945 and the Universal Declaration of Human Rights of 1948, the African Charter on Human Rights adopted in 1981 (République du Bénin 1990, Preamble). The ACHR is attached as an annex to the Constitution (République du Bénin 1990).

The Supreme Court and the High Court of Justice are the country's highest courts (Hauser Global Law School Program GlobaLex 2009). The Court of Appeal, district courts, village courts, and assize courts are subordinate courts (Immigration and Refugee Board of Canada 2016). The Constitutional Court allows private citizens to challenge the government (République du Bénin 1990, Article 147). The High Court of Justice is the only court which can judge the President, and is composed of members of the Constitutional Court, Parliament, and the President of the Supreme Court (République du Bénin 1990, Article 8).

Since a multi-party democratic system was reintroduced in 1990, Benin has peacefully organized six presidential elections, seven legislative elections, and three local elections (République du Bénin 1990, Article 8). The next legislative and presidential elections are planned for 2019 and 2021, respectively.

Protective laws (with challenges of enforcement)

The National Constitution of Benin indicates that the State has an absolute obligation to respect and protect its citizens, and to provide its citizens with equal access to health care (République du Bénin 1990, Article 8). It also provides that citizens are obliged to respect the rights of others without discrimination.(République du Bénin 1990, Article 36) The Constitution also ensures equality before the law irrespective of origin, race, sex, religion, political opinion or social position; that man and woman are equal in law; and that families, mothers, and children must be given special protection.(République du Bénin 1990, Article 26)

The National Law No. 2005-31 on the prevention, care and control of HIV/AIDS further guarantees civil, political and social rights without discrimination against people suffering from sexually transmitted infections or those living with HIV (République du Bénin 2006, Article 2). This law also requires that the State must provide medical monitoring of key populations (e.g. sex workers, men who have sex with men, and people who inject drugs) and must encourage voluntary HIV testing for these populations (République du Bénin 2006, Article 13). It provides

punishment for anyone that abandons a child or an incapable adult suffering from AIDS and that orphans of parents or legal guardians who have passed away because of AIDS will be provided medical assistance and psycho-social support (République du Bénin 1990, Article 7). While this law provides some protections for people living with HIV, and other key populations, as well as orphans, there are several problematic provisions, including a provision that may allow unauthorized disclosure of an individual's HIV status and an article that makes it a crime for any person who knows s/he has the "AIDS virus" to engage in unprotected sexual relations without disclosing her status to the sexual partner. These provisions are discussed in further detail in Section 3.3.6: Punitive laws, policies, and practices.

The 2009-2018 National Health Development Plan developed by the Ministry of Health also includes a priority area of "Combatting Disease," a sub-priority of which is combatting diseases of particular significance in the country including STIs, HIV/AIDS, malaria and tuberculosis (République du Bénin 2007). The 2015-2017 strategic plan of the Programme Santé de Lutte contre le SIDA (PSLS), previously referred to as PNLS, was developed by the Ministry of Health of Benin and the Comité National de Lutte contre le Sida (CNLS) and includes 4 strategic priorities: (1) prevention of HIV transmitted sexually or by blood; (2) prevention of mother to child transmission; (3) comprehensive care for PLHIV and orphans and vulnerable children; and (4) governance of the national response, monitoring and evaluation, and system strengthening (CNLS 2014).

With this strategic plan, CNLS has declared its overall strategic mission to be "zero new HIV infections – zero deaths due to AIDS – zero discrimination" (CNLS 2014). The plan specifies the conditions for success to achieve this mission, including: (1) maintenance of strong national coordination; (2) effective functioning of multi-sectorality; (3) involvement of high-level political authorities; (4) practice of results-based management and planning; (5) effective integration of HIV, AIDS, and STIs in development projects and programs, in the workplace, and in local development plans; (6) strengthening government involvement in all levels of the national response to STIs and HIV/AIDS; and (7) national coordination with technical and financial partners (CNLS 2014).

Law No 2003-04 relating to Sexual and Reproductive Health provides that the right to reproductive health is a universal right for all human beings, prohibiting discrimination based on age, sex, wealth, religion, ethnicity, marital status, health status, any other status, or the ability to pay. It also entitles a patient to receive full reproductive health treatment without discrimination based on sex, marital status, sanitary status or any other status, ethnic group, religion, age or the ability to pay. The law defines acts that violate the rights to sexual and reproductive health, punishable by the criminal code. These include all forms of sexual violence of which women and children are the victims, female genital mutilations and pedophilia, voluntary transmission of HIV, exploitation/forced prostitution of women and children, and forced marriages (République du Bénin 2003, Article 19).

Law No. 2011-26 on the Prevention and Repression of Violence Against Women prohibits traditional practices that are harmful to women, including restrictions on a woman's freedom of movement, pressure on a woman through her children, and rape – defined as all acts of vaginal,

anal, or oral penetration without informed and willing consent of the woman (Immigration and Refugee Board of Canada 2016). It also prohibits the abuse of power or willful negligence of an individual (including one's partner) with a view to dominate, subjugate, control, or assault a woman in a physical, verbal, psychological, proprietary, economic or sexual manner (Immigration and Refugee Board of Canada 2016).

The 1947 amendment to the Penal Code sets an age limit of 13 for sex with a child of either gender, but penalizes any act that is "indecent" or "against nature" if committed with a person of the same sex under 21 (République du Bénin 1947).

Challenges in enforcement and other gaps

Despite the many protective laws and policies that exist in Benin to support access to HIV services for key and vulnerable populations and reduce stigmatizing and discriminatory practices, many key informants expressed frustration with the level of enforcement of these laws (KII2 , KII38). While there seems to be political will to support these laws and policies, there is no systematic accountability for breaches of their provisions, including no systematic prosecution of those who violate the terms contained therein. According to several key informants, there are no penalties for those who disobey these laws (KII2). Furthermore, there is little respect paid to the human rights that are protected by law for key and vulnerable populations (KII34 , KII36). Another key informant noted that she has never seen anyone punished for having violated the rights of a person living with HIV or a man who engages in sex with men, despite the fact that there are legal policies in place to protect them (KII2). Though key informants suggested that the environment is more favorable and there is more government support now than there was five years ago to support key populations, the lack of enforcement or explicit operationalization of laws continues to be a problem (KII12). One key informant indicated that there is no formal apparatus through which individuals can report human rights violations (KII5).

The lack of enforcement of laws that protect human rights of key and vulnerable populations is compounded by discriminatory behaviors enacted by the police. Many key informants indicated that a lack of enforcement of the existing laws and regulations is one of the major obstacles to accessing HIV services among key and vulnerable populations. For example, one key informant indicated that when a person living with HIV reports a human rights violation to the police, the officer will cease to ask productive questions about the problem the moment that he or she finds out that the person is HIV positive (KII2).

While homosexuality is criminalized under Beninese law, key informants indicated that the law is not applied and that individuals engaging in same-sex sexual relations are not prosecuted. However, homosexuality continues to be incredibly stigmatized in society as well as in the media (USAID: Projet Dindji 2016).

While key informants suggested that the legal environment is favorable in theory, in practice, the support is not yet there (KII13). The tools that exist to apply the laws protecting human

rights are weak and the main issue appears to be the lack of education and awareness regarding laws protecting human rights (KII14 , KII18).

One key informant indicated that the steps the Government has taken with the Global Fund has shown their commitment to fighting challenges related to HIV among key and vulnerable populations and another stated that the engagement of the State and political leadership is a hope for the country (KII4 , KII37). However, one key informant noted that this effort has not been sufficient to eliminate stigma and discrimination-related barriers experienced by members of these populations, specifically people who inject drugs, sex workers and men who have sex with men.(KII4)

Political and funding support for the HIV response

Below is a brief description of the primary government mechanisms in Benin that support the HIV response:

Programme Santé de Lutte contre le SIDA (PSLS)

- The 2015-2017 strategic plan refocuses efforts on high-impact interventions. One focus area includes comprehensive care for people living with HIV and children who have lost parents or guardians due to AIDS. Previous PSLS have included objectives regarding prevention of HIV in sex workers and the expansion of interventions for vulnerable groups.(Ministere de la Santé 2017)

National Health Development Plan 2009-2018

- Plan created by the Ministry of Health with five priority areas. The “Combatting Disease” area includes a sub-priority of combating priority diseases, STI/HIV/AIDS, malaria, and tuberculosis.(République du Bénin 2007)
- Creates special health programs in prisons as part of increasing partnership between the Ministry of Health and other ministries.(Ministry of Planning and Development 2016, Présidence de la République du Bénin 2016)

Programme d’Actions du Gouvernement

- Includes strengthening of basic social services and social protections, such as the provision of infrastructure and facilities to support health in all localities, access to water and electricity, the recruitment of doctors to facilitate access to care, and a commitment to protect the poorest and most vulnerable members of the population.(Ministry of Planning and Development 2016)

2.3 Human rights-related barriers to access, uptake and retention in HIV services

The major human rights-related barriers identified through the literature review and in-country data collection include:

a) Stigma and discrimination enacted in the community, by law enforcement agents, family members, and in health care settings;

b) Lack of enforcement of laws and policies designed to protect key and vulnerable populations, as well as illegal police practices including violence and abuse by the police towards female sex workers and people living with HIV, exacerbated by a lack of police protection for those who are experiencing human rights violations at the hands of others in the community.
c) Vague policies that impede strict maintenance of confidentiality of HIV status by healthcare providers (people living with HIV)
d) Lack of access to legal services and a lack of knowledge of the protections of the law;
e) Gender-based discrimination and violence, particularly among female sex workers and women living with HIV, extending to married women who experience mistreatment and/or isolation from their spouses or spouses' extended family in response to disclosing their status; and

Stigma and Discrimination

In Benin, stigmatization and discrimination were identified as the main obstacles to access, utilization, and retention in HIV services, nationally (KII1 , KII2 , KII3 , KII6 , KII11 , KII14 , KII23 , KII25 , KII34 , KII35 , KII36 , KII37). Stigma and discrimination in Benin are attributable to key and vulnerable population status as well as HIV status, and manifest at the structural, community, family, and individual levels. However, there is a need to better understand the mechanisms of HIV-related stigma, key and vulnerable population-related stigma, as well as the intersection of these stigmas in potentiating HIV risk in Benin.

HIV-related stigma and discrimination

Stigma and discrimination were cited most frequently as barriers to accessing HIV services among key and vulnerable populations. Stigma and discrimination are manifested in a variety of forms in Benin and affect key and vulnerable populations in myriad ways. These include but are not limited to: verbal harassment and emotional abuse; shunning and isolation of individuals and families; gossip and social exclusion; mistreatment; poor quality care or denial of services in healthcare settings; and physical assault. These are common barriers to HIV services that are influenced by stigma and discrimination attributable to HIV serostatus or membership of a key population or characteristics such as sexual orientation or gender identity.

Through stakeholder interviews and focus group discussions, HIV-related stigma was found to persist among families of people living with HIV in Benin (KII1 , KII17 , KII18 , KII23 , KII24 , KII28 , KII8 2017). A driver of this family-based stigma is fear of community shaming due to having a family member living with HIV, which can lead to isolation of individuals living with HIV and, in turn, decrease attendance and uptake of HIV treatment. In addition to stigma facilitated by community norms, judgment and stigmatization from family members can both exacerbate self-stigma and affect one's ability and desire to seek HIV treatment and care services. According to one key informant, HIV is often considered by the community as a shameful disease, which can lead to systematic rejection from the community, forced separation from one's family, and the abandonment of one's spouse or children (KII11). A key informant

indicated that all it takes is for people to know that you are living with HIV and immediately you are rejected by the community (KII37).

In focus group discussions, many women living with HIV cited judgment about their sero-status from their husbands and their husbands' extended families in particular as having a profoundly negative effect on their quality of life and ability to access treatment and care services (FGD3). A key informant indicated that even when laws supposedly protect women living with HIV from stigma and discrimination, this does not usually extend to their husbands, and women often continue to experience abuse at home due to their serologic status (FGD1 , FGD4 , FGD5 , KII10). Due to fear of stigmatization and abandonment, many women living with HIV will therefore hide their HIV status from their spouses, sexual partners, and/or immediate family. Being unable to disclose her status makes it difficult for a woman to keep appointments at the health center, may make it impossible for her to seek financial resources from her spouse or family, and ultimately compromises her ability to adhere to treatment services (FGD3). In the cases that a woman reveals her HIV status to her husband, she may face stigmatization, mistreatment, and exclusion from her husband's family and may face the possibility of her husband abandoning her and her children (FGD3). This can exacerbate existing financial burdens, especially if a woman is left as the sole provider for her children.

A barrier cited during interviews and focus group discussions was discrimination in the workplace. For people living with HIV, this can manifest in several ways. Several individuals indicated that people living with HIV can get fired from their jobs if their bosses find out that they are living with HIV (FGD2). Others mentioned that accessing services can be difficult when they fear that their job will be in jeopardy if they request time off to access care or else are late to work due to having gone to the health center (KII34).

While the men in the focus group convened for men living with HIV did not express having experienced stigma from their spouses to the degree that women did, several men indicated that they experienced stigma and discrimination from their bosses or at their places of work (FGD2). Several men indicated that they know people living with HIV who have lost their jobs when their bosses found out their HIV status (FGD2). Losing one's job in this way can make it difficult to find other work. One man indicated that others are reluctant to interact and collaborate with people living with HIV for fear of infection (FGD2).

Additionally, "self-stigma" – or the individual psychological impacts of enacted stigma such as feelings of blame or shame for one's group identification or serostatus - can lead to isolation and/or lack of seeking services in the community (KII12). For many individuals living with HIV, there is a negative psychological perception related to HIV, and it can be very difficult for them to accept and cope with their HIV status (KII11 , KII12). Additionally, individuals in focus group discussions noted examples of anticipated stigma among female sex workers and people who inject drugs, indicating that some people are hesitant to get tested for HIV due to fear that the results will be positive and that they will have to live with the knowledge and resulting treatment (FGD1 , FGD2 , FGD4 , FGD5).

The fieldwork highlighted the effects of stigma and discrimination on the ability of key and vulnerable populations to access HIV services. Cited examples included lack of service provision due to stigmatizing beliefs about a population (female sex workers, men who have sex with men, people living with HIV, people who inject drugs), financial struggles due to education and employment discrimination (people living with HIV, people who inject drugs, and men who have sex with men), and individuals' fear of seeking services in hostile environments (people who inject drugs, men who have sex with men, people living with HIV). Barriers may also include forced secrecy and invisibility for safety, blocked communication pathways to sharing critical health information with key and vulnerable populations, failure to seek or receive recourse for human rights violations, and mistreatment and abuse across community settings.

Stigma and discrimination based on social or legal status or sexual orientation and gender identity

Stakeholders and key informants identified a high importance placed on perceptions of the community as a cause of barriers to HIV services in Benin. Stakeholders noted that within many communities in Benin, there are negative perceptions of and attitudes toward key and vulnerable populations, specifically female sex workers, male sex workers, men who have sex with men, transgender individuals, and people who inject drugs.

Despite the existence of mixed interpretations of laws about LGBTQ community members in Benin, which some believe are protective, participants in focus groups expressed that there are strong negative perceptions of LGBTQ individuals and many view LGBTQ individuals and communities as "not natural," or abnormal (KII5 , Rodenbough 2014). This attitude drives and perpetuates stigma in Benin.

One key informant indicated that transgender individuals are viewed as abnormal and therefore experience discrimination in the country.(KII5) However, there is lack of data available on transgender experiences in Benin and there is no targeted programming for them in the country. This may be due to the stigmatization of transgender and gender variant individuals in Benin, which prevents them from being recognized or living openly within society. This may also contribute to the lack of visibility of transgender individuals and the lack of services designed to support them.

Stakeholders named current cultural values, traditions, and mores as significant causes of stigma among key and vulnerable populations in the country, many noting that this stigma manifests most strongly among men who have sex with men (FGD4 , FGD5 , FGD6 , KII3 , KII5 , KII6 , KII19 , KII20 , KII25 , KII35). One of the men in the focus group for men who have sex with men cited factors related to religion, explaining that some men think of themselves as devils due to their sexual behaviors, which may be a barrier to accessing health services and other forms of HIV prevention and care (FGD4 , KII5 , Rodenbough 2014).

Key informants and participants of focus groups indicated that self-stigma caused by or related to community norms is a major barrier to accessing medical care among key and vulnerable populations. For example, one participant in a focus group organized for people living with disabilities noted that many of his peers do not believe they have rights to access services due to their handicaps (FGD8 , KII12). The participant noted that the self-perceptions of people living

with disabilities needs to be changed in order to provide effective education on their right to frequent health centers and to receive care (FGD1 , FGD2 , FGD8).

One key informant indicated that the female sex workers themselves feel shame about their work in addition to stigma from the community (KII30 , Rodenbough 2014). She said that they do not feel comfortable becoming visible to speak out against human rights violations for fear of revealing the fact that they are sex workers (KII30). While there are many organizations in Benin that seek to amplify the voices of marginalized populations, many key informants indicated that it is important that members of key and vulnerable populations be involved in decision-making processes directly (KII4 , KII23 , KII24 , KII29). This can be difficult when self-stigma and stigma from the community prevents individuals from revealing their experiences as a member of a key or vulnerable population in order to represent their needs.

Many of the participants in the focus groups convened with waitresses in bars and restaurants expressed that their places of work make accessing healthcare services extremely difficult (FGD9). One server in a bar indicated that there are certain places that if you leave to access health services, you are fired from your job (FGD9). Several explained that often permission is not accorded to leave work to access care, and in some cases, if you do not return to work quickly enough, your pay is docked (FGD9). This concern may apply to other professions, but was noted as a particular concern among waitresses, many working very long hours for very little pay (FGD9). For example, one of the waitresses indicated that she works 6 days a week from 7 am until 2 or 3 in the morning and receives 25,000CFA/month (approximately $46 per month), meaning she would have little to no time to access care in her free time (FGD9).

People who inject drugs experience stigma related the societal perceptions about consuming drugs. Struggling against community norms that perceive them as delinquents or criminals, accessing HIV prevention services and retention in HIV care is an ongoing issue in this population (FGD8 , KII4). A key informant familiar with the experience of people who consume drugs in Benin indicated that the community never considers the healthcare needs of people who consume drugs due to perceptions that people who inject drugs are already a social burden and do not deserve prevention and treatment services (FGD8 , KII4).

Truck drivers also experience elevated levels of stigmatization that prevent them from accessing HIV services. One participant in a focus group explained that several drivers had once been filmed saying that truck drivers were the ones who brought AIDS to Benin and explained that the fear of this sort of stigmatization makes drivers less inclined to engage in HIV services (FGD12). The drivers indicated that they had not often been tested for HIV and were reticent to do so (FGD12). They suggested creating health services that were more accessible near the port, where they generally pass the time when they arrive in a city (FGD12).

Truck drivers indicated that there are outreach services that exist in Benin to provide them with information about HIV as well as testing services (FGD12). However, several individuals indicated that though truck drivers are generally aware that these services exist, they do not like when people come to speak with them about AIDS and will not attend testing or educational events (FGD12). The drivers indicated that they had not often been tested for HIV and were

reticent to do so (FGD12). They suggested creating health services that were more accessible near the port, where they generally pass the time when they arrive in a city (FGD12).

Stigma and discrimination in the workplace due to social status and/or sexual orientation or gender identity status was cited as a challenge for many key populations. A key informant indicated that many individuals lose their jobs due to their sexual orientation or sexual behaviors (FGD2).

Despite evidence pointing to the prevalence of stigma and discrimination based on social or legal status or sexual orientation and gender, systematic monitoring of such occurrences has not been organized on a grand scale. One key informant indicated that there is little interest in evaluating the level of stigma and stigmatization experienced in the country (KII36).

Intersections with poverty

Many of the key and vulnerable individuals interviewed in focus group discussions and as key informants highlighted a confluence of living in poverty and being a part of a key or vulnerable population (FGD1 , FGD2 , FGD3 , FGD8). This confluence was described as a barrier to accessing HIV prevention, treatment and care services and a major obstacle to addressing healthcare needs. In focus group discussions with people living with HIV and men who have sex with men, participants indicated that stigma and discrimination related to their HIV status or sexual orientation often compromises their job security, which may exacerbate existing financial burdens (FGD2 , FGD3 , FGD4 , FGD5 , FGD12). The experience of stigma and discrimination in the workplace and hiring processes can be a direct cause of unemployment, underemployment and poverty among key and vulnerable populations.

Fears are compounded by the precarious financial situation of many stigmatized populations in Benin, such as people living with HIV, men who have sex with men, and people who inject drugs. Lack of financial means was cited in nearly all focus group discussions and interviews with key informants as a major barrier to accessing HIV services for key and vulnerable populations. For people living with HIV and key populations who wish to get tested, this may disinhibit them from accessing services for fear of putting their jobs in danger or of losing any portion of the small salary that they receive to survive.

Stigma and Discrimination in the Health Care Setting

Stigma and discrimination in the healthcare setting affects patient engagement in and satisfaction with healthcare services, which can then affect service attendance and retention (Morin, Godin et al. 2008). Stigma, discrimination, and mistreatment by healthcare providers were cited by participants in the majority of focus group convened with key and vulnerable populations and were discussed in the majority of key informant interviews (KII10). Stigma and discrimination in healthcare settings in Benin can range from intentionally poor quality of treatment to inappropriate disclosure of a patients' HIV status to mistreatment due to group membership such as that of female sex workers (FGD1 , FGD2 , FGD3 , FGD4 , FGD5 , FGD6 , FGD7 , FGD8 , KII2 , KII3 , KII4 , KII5 , KII7 , KII8 , KII23 , KII24 , KII28 , KII29 , KII30). A key informant explained that healthcare providers sometimes refuse to provide services to individuals because of their sexual orientation and others refuse to provide care for people living

with HIV for fear of HIV infection (FGD2 , KII24). Current issues that exacerbate this problem include lack of training for healthcare workers on human rights and medical ethics, resource limitations, and limited accountability mechanisms.

Female sex workers indicated that one of their main barriers to accessing HIV services is stigmatization by health care workers and unfriendly treatment at health centers (FGD1 , FGD2). Several women mentioned that discrimination and negative treatment by nurses are obstacles to receiving treatment and that a fear of negative treatment by service providers often discourages female sex workers from accessing care (FGD1 , FGD2). Several women described how the treatment that they receive at the health center at Kowegbo and the Saint Potin and Mon Lapin clinics is particularly negative (FGD1). A representative of a local organization indicated that, when female sex workers try to access health services, they are not received in the same manner as people with other conditions, but that this situation is changing as centers open in the country that cater specifically to female sex workers (FGD2 , KII29). Women who work in bars indicated that they do not receive HIV services or outreach, and many indicated very little knowledge of the existing landscape of available HIV services (FGD9).

Nearly all the participants in the focus groups convened for men who have sex with men discussed fear of going to health centers as a primary barrier to accessing HIV services (FGD4 , FGD5 , Morin, Godin et al. 2008). One man explained that it is very difficult to disclose that you are living with HIV at a health center due to fear of judgment for being a man who has sex with men (FGD4). Several men discussed fear of being tested due to stigmatization and discrimination at health centers and indicted that they worry people will find out that they have sex with other men when they see them at the center (FGD4). Many men stated that service providers need to be educated about how to treat men who have sex with men; otherwise, men who have sex with men will continue to avoid HIV testing and treatment services (FGD5). One key informant indicated that this obstacle has improved slightly with centers that now specifically cater to LGBTQ populations (KII5).

In focus group discussions and individual interviews, people who inject drugs and key informants stated that people who use drugs are often judged by their appearances at health centers and that they do not receive the same care and treatment as others or else are disregarded altogether (FGD6 , FGD7). Many people who inject drugs said that they have experienced stigma and discrimination that has deterred them from accessing HIV prevention services and treatment. During focus groups convened for men who have sex with men and people who inject drugs, many participants mentioned that they are afraid of going to the health center in case they run into someone they know. They explained that they worry that the person will know why they are accessing health services, and this will expose the fact that they have sex with men or inject drugs.

In focus group discussions, many of the women living with HIV and several men living with HIV indicated that stigmatization, discrimination, and mistreatment from health care providers, as well as the fear that they will disclose one's status, have been main obstacles to receiving ARV treatment in the past (FGD1 , FGD2 , FGD3). Many of them indicated that they are currently

happy with the treatment that they receive at centers that specialize in the care of people living with HIV such as RACINES and Arc-en-Ciel in the city of Cotonou (FGD2 , FGD3).

People living with disabilities, not specifically defined by the CNLS as a key population, provided important information for further work to understand the HIV risk factors this group faces in relation to stigma and discrimination. The field discussions revealed that members of key and vulnerable populations are often discouraged by the poor welcome that they receive at health centers. In the focus group discussion for people with disabilities, participants mentioned that health service providers do not understand the rights of people living with disabilities (FGD8) Many participants mentioned that discrimination, prejudice and rejection of people living with disabilities are the main obstacles to accessing HIV services, and one participant mentioned that he/she would not go to any health center for fear of discrimination due to his/her physical handicaps (FGD4 , FGD5 , FGD8). That being said, participants mentioned that the situation is better than it was five years ago and that now sometimes providers are happy to receive them (FGD8).

Youth are often vulnerable to HIV risk due to a cultural taboo against talking about reproductive health and HIV. This stigma can result in a lack of communication that prevents young people from learning about or being able to access information about HIV testing and prevention services. A key informant estimated that about two-thirds of young people have received adequate information about HIV and STI prevention (KII24).

Gender-based discrimination

Gender-based discrimination was cited as a major barrier to accessing HIV services, particularly among female sex workers, women living with HIV, and women who work in restaurants and bars. Additionally, many key informants mentioned during individual interviews that gender-based discrimination and vulnerabilities are profound obstacles to equitable HIV prevention and care services. One key informant indicated her perception that gender-based discrimination is experienced much more frequently in the north of Benin, outside of major cities (KII16). Despite protections under the law, perpetrators of gender-based violence are not often prosecuted. A key informant indicated that the majority of time, there are no consequences when a woman experiences gender-based violence (KII37).

Intimate partner violence is a significant problem in Benin. According to a study referencing the Ministry of the Family and National Solidarity on Violence Against Women in Benin (Ministère de la Famille et de la Solidarité Nationale sur la Violence envers les Femmes au Bénin), a 2009 survey of 4,649 women and girls showed that 68.6% of respondents 15 years of age and older reported having suffered some form of gender-based violence at least once in their life (Immigration and Refugee Board of Canada 2016). A spouse or partner was the perpetrator of the violence in 69.5% of reported cases (Immigration and Refugee Board of Canada 2016).

Gender-based violence and discrimination are also prevalent among women who work in bars (FGD9). Several women expressed in a focus group that they experience high levels of violence in their places of work and that clients often try to force sex on them (FGD9). A promoter of a

bar indicated that, even when servers in bars report cases in which they are victims of sexual violence, police officers are willing to turn a blind eye to their case if the perpetrator pays them a bit of money (KII34). Despite being exposed to elevated risks, some of which overlap with those experienced by female sex workers, there is no targeted HIV programming for women working in bars and restaurants in Benin (FGD9 , KII34). A representative of an organization that works with multiple bars and restaurants said that conditions vary among women working and operating in different sectors, but programming does not often reflect this reality (KII34). He highlighted that women working as cooks, waitresses, and dancers are not adequately represented in terms of HIV programming (KII34).

Violence is highly prevalent among female sex workers. One study observed a high prevalence of all forms -- physical, sexual, and psychological abuse among a group of this population -- with estimates of 33.5%, 17.2%, and 13.5%, respectively (Tounkara, Diabate et al. 2014). A combination of physical, sexual and psychological violence was associated with increased HIV risk, which may be attributable in part to the association between acts of sexual violence and instances of condom breakage (Tounkara, Diabate et al. 2014). Additionally, a history of abuse was highlighted as a factor that may compromise condom negotiation (Tounkara, Diabate et al. 2014). Finally, both physical and sexual violence were invoked in the development of anticipated stigma and in hesitance to disclose HIV status. In focus group discussions and key informant interviews, gender-based violence was cited by multiple individuals as a common occurrence in the country among both female sex workers and women more broadly and was cited as an important barrier to accessing HIV services (FGD1 , FGD6 , FGD8 , KII7 , KII10 , KII15 , KII21 , KII26 , KII30). Several women noted that when they are victims of sexual violence, there is no one available to help them, including the NGOs who propose to support them and the managers of the brothels where they work (FGD1).

Punitive laws, policies and practices

Key areas of law and policy barriers were highlighted in previous sections and include a lack of laws and policies protecting the confidentiality of healthcare information and protecting from stigmatizing and discriminatory treatment. Benin's Penal Code of 1996 criminalized same-sex behaviors. However, this law has been amended and same-sex behaviors are no longer illegal in Benin (Amnesty International 2013, ILGA 2017). The penal code does still provide for unequal ages of consent for different-sex and same-sex sexual activities (ILGA 2017).

Criminalization of the consumption of drugs and a lack of protection for people who consume drugs are two principal legal obstacles to accessing HIV services among people who inject drugs. Laws that criminalize drug use can create an environment in which individuals are afraid to disclose their behaviors and become increasingly hidden and difficult to access HIV prevention and treatment services (KII4). The fact that people who consume drugs are often perceived as delinquents who do not contribute to society makes it difficult to vote a law into existence that protects the rights of people who inject drugs to access HIV prevention, treatment and care services (KII4).

The Beninese Constitution prohibits discrimination based on age, sex, wealth, religion, ethnicity, marital status, and discrimination towards people living with sexually transmitted infections or HIV (République du Bénin 1990, Article 26, République du Bénin 2003, Article 2). However, there are no specific provisions or laws in Benin that prohibit discrimination on the grounds of sexual orientation or gender identity. This lack of protection under the law permits the stigmatization, discrimination, and marginalization of those engaging in same-sex relations and other members of LGBTQ communities that impedes access, uptake and retention in HIV services.

Furthermore, a 1947 amendment to the Penal Code sets an age limit of 13 for sex with a child of either sex, but penalizes any act that is "indecent" or "against nature" if committed with a person of the same sex under 21 (Canadian HIV/AIDS Legal Network 2007, ILGA 2017). This language stigmatizes same-sex relations, aggravating negative perceptions of people engaged in same-sex relations while providing no clear legal protections against stigma and discrimination.

Problematic testing policies and practices

Policies that impede maintenance of confidentiality of HIV status create barriers for people living with HIV to seek and be retained in healthcare services (KII37). Article 4 of Law No 2005-31 protects patients from disclosure of health information by health care professionals. However, it also requires people living with HIV to disclose their seropositive status to their partners, an overly broad requirement which may leave gaps in protections for people living with HIV against discrimination and possible prosecution, regardless of their risk of transmission (Canadian HIV/AIDS Legal Network 2007).However, there were no instances noted in which people living with HIV were prosecuted for failure to disclose their status.

Another provision, Article 6 of Law No. 2005-31 allows a healthcare professional to breach a patient's confidentiality to protect certain parties from transmission, which leaves gaps in accountability for health care providers who make inappropriate and harmful disclosures (République du Bénin 2006, Article 6). In addition, healthcare professionals in Benin are not required to notify a person living with HIV before disclosing their status to a partner (Canadian HIV/AIDS Legal Network 2007). While problematic testing policies and practices were not highlighted as a major concern during the course of the fieldwork, several individuals in a focus group convened with women who work in bars and restaurants did note that fears about lack of confidentiality of HIV results were an obstacle to accessing HIV testing services, citing a mistrust in health professionals (FGD9).

Illegal police practices

Police harassment and abuse are experienced widely by sex workers in Benin and create significant barriers to accessing healthcare for HIV prevention and treatment. Focus groups highlighted this issue as many female sex workers indicated having experienced abuse from agents of the police and several mentioned officers extorting money from them or raping them (FGD1). According to a survey of 1180 female sex workers in Benin, almost 10% reported that

the last instance of sexual or physical violence they had experienced was perpetrated by an agent of the police (ONUSIDA The Global Fund Ministère de la Sante 2015).

In addition to increasing negative perceptions towards certain key populations, mistreatment from law enforcement officers can affect an individual's ability to seek recourse for human rights violations. One key informant indicated that when a person living with HIV reports a human rights violation to a police officer, often the officer will seize on the fact that they are seropositive and will henceforth cease to deal with the problem that the person is facing, making access to justice difficult in these situations. A representative of another NGO indicated that police continue to target sex workers and people who inject drugs and trivialize and ignore complaints that they lodge, including when a woman reports having been a victim of domestic abuse (KII10). One key informant who works with female sex workers explained that it is not acceptable for a female sex worker to seek legal recourse when she has been the victim of an act of violence or human rights violation (KII29). Despite provisions under Beninese law that protect key and vulnerable populations, if the means to report and penalize human rights violations do not exist, the provisions do not serve their purpose.

Lack of legal literacy ("know your rights")

One major obstacle to accessing HIV services in Benin is lack of information and knowledge about human and legal rights among key and vulnerable populations (KII12). Key informants revealed in interviews that the people who disseminate information about legal rights to members of key populations are often representatives of local NGOs who are not experts in this domain, demonstrating a lack of investment in providing high-quality information to key populations (KII7 , KII24). Even when individuals are aware of their rights under the law, often the judicial system is such that following a case through to a verdict is very difficult (KII37). For this reason, many times victims of human rights violations become tired of moving through the system and eventually abandon their case (KII37). One key informant highlighted that individuals living in rural regions of Benin are less likely to be aware of their rights (KII35 , KII37)

Legal services

There are also very few lawyers who specialize in the representation of key and vulnerable populations and the specific human rights violations that they face (KII24). Even in cases where individuals wish to report human rights violations, this lack of adequate and informed representation creates an environment in which legal assistance and recourse is difficult or impossible to attain. Key informants across the board highlighted the lack of service provision available in rural regions as compared to those available in major cities and.

One key informant who works for a local NGO indicated that there is a major lack of information regarding the availability of legal services and regarding legal services in general among incaracerated populations (KII36). A representative of the government agency "La Direction de l'Administration Pénitentiares et de la Protection des Droits Humains" also stated that there is a

major obstacle to accessing legal information among individuals who are in prison (KII11). Part of the issue can be attributed to a lack of education among legal actors, many of whom do not understand the intricacies of the law and the protections afforded under laws related to HIV (KII11).

2.4 Programs to address barriers to HIV services

Overview

In terms of general HIV and AIDS programming, the majority of funding in the country comes from the Global Fund, with additional financial support from UNAIDS, UNICEF, USAID, the governments of the Netherlands, France, Canada, and Benin and other bilateral or multilateral organizations who contribute on a smaller scale (KII23 , KII24 , KII25 , KII30 , UNAIDS 2016). According to a UNAIDS report in 2016, 55% of funding for HIV programming comes from the Global Fund, 25% comes from the State of Benin, and 20% comes from other international funders (UNAIDS 2016). Funding for HIV programming in Benin has been steadily decreasing since 2012. A UNAIDS report demonstrated that funding from all sources for HIV and AIDS programming in Benin in 2015 was 40% less than the available funding from all sources in 2012 (UNAIDS 2016).

In terms of programming to address human rights-related barriers to the access, uptake and retention in HIV services, key informants indicated that the Global Fund is the only organization that continues to provide funding for these activities in Benin (KII5 , KII10 , KII12 , KII13 , KII25 , KII29). Key informants indicated that many technical and financial partners who used to provide support for human rights and health-related initiatives in Benin have disengaged from the fight against HIV, as they no longer consider it to be a priority in the country (KII8 , KII13 , KII24).

Limited funding for human rights and HIV-related programming was cited by key informants as a major constraint to overcoming human rights-related barriers to access, uptake, and retention in HIV services in Benin (KII1 , KII8 , KII17 , KII18 , KII23 , KII24 , KII28).

In this context, there have been several programs and implementers that have focused on improving access to HIV prevention, care, and treatment among key and vulnerable populations, either through specific programming that seeks to reduce human rights-related barriers to HIV services, or through broader programs that include elements that seek to reduce these barriers. This text below describes existing or recent programs in Benin that aim to reduce human rights-related barriers to HIV services as well as the comprehensive program that, if put in place at scale, would effectively remove these barriers to service access. It is organized by the under the seven program areas set out in the Global Fund Technical Brief. (The Global Fund 2017)

Program Area 1: Stigma and discrimination reduction

The table below provides an overview of current programmatic efforts on stigma and discrimination reduction as well as recommendations for scaling up these activities to a comprehensive response. Many of the activities described address stigma and discrimination indirectly but efforts to reduce stigma and discrimination could be made more explicit and scaled up. The content of the table is further elaborated upon in the text following the table.

Stigma and discrimination reduction for people living with HIV and other key and vulnerable populations				
Program	**Description**		**Limitations**	
Measurement of HIV-related stigma experienced by key and vulnerable populations	Formal analyses conducted to assess the HIV-related stigma experienced by key and vulnerable populations, including PLHIV, in Beninese society and in the media		There is an opportunity for analyses of stigma and discrimination experienced by key and vulnerable populations to be operationalized to inform sensitization trainings, though it is unclear if these reports have been used for such purposes in the past.	
Implementer	***Population targeted***	***Activities***	***Timeframe***	***Recommended scale-up***
RéBAP+ with support from UNAIDS & OCAL	PLHIV	National study published describing the level of stigma and discrimination experienced by PLHIV in Benin	2015	Efforts should be made to support maintenance of projects such as the three reports mentioned in this table, which analyze stigmatizing representations of FSW, MSM, and PLHIV in the media. This process should be scaled up to include analyses of stigmatizing representations of other key and vulnerable populations in the media. It is important that any formal analysis be tied directly to action items. Results should be used to inform sensitization training for members of the media to promote the human rights of key and vulnerable populations in the context of HIV services.
OCAL/Projet Dindji	FSW; MSM	A report published by Project Dindji analyzing the manifestation of stigmatizing language against FSW & HSH in the media in Benin, including stigmatizing language and expressions in published news articles in print and on the Internet and on radio and television	May 2016	
CNLS	KPs; PLHIV	A National Plan to Fight HIV-related Stigma and Discrimination released by CNLS for 2017-2020, the aim of which is to promote and protect the rights of PLHIV and key populations for zero discrimination by the year 2020. The report gives an overview of the experience of HIV-related stigma and discrimination by KPs and provides recommendations for reducing barriers to HIV services.	November 2016	
Program	**Description**		**Limitations**	
Peer education	Peer education and outreach that trains key populations to provide services such as counseling around HIV risk reduction strategies,		Level of integration of human rights-related information relayed within each peer education program is unclear and difficult to assess; little data	

	how to access HIV testing services or treatment for PLHIV, and/or information about HIV-related human rights to their peers.			on the level and quality of training received by peer educators; effectiveness of outreach provided by individuals peer educators may vary and may be difficult to assess; retention of KP peer educators may pose problems, especially among MSM, FSW, PWID and other marginalized populations	
Implementer	***Population***	***Activities***	***# Trained # Reached***	***Timeframe***	***Recommended scale-up***
ABMS/PSI – Centres Jeunes Amour & Vie	Youth; PLHIV	Opened ~20 youth centers, covering the regions of Dassa, Savè, Parakou, Djougou, Natitingou, Porto-Novo, Dango, Abomey-Calavi, and Cotonou. Youth centers encourage conversations between parents and youth about sexual health that can serve to reduce the HIV/STI-related stigma that may prevent communication about prevention strategies.	450 new peer educators trained 180 group leaders trained 20 youth centers 11,000 youth reached in 2014 13,206 youth reached in 2015	May 2012 – 2018	Several organizations have had success in engaging youth using peer education programming, for youth in general and specifically to reach young women and girls. The CJAV program has had extremely high satisfaction rates among youth, has been shown to be effective at removing barriers to HIV services and should be provided with support to maintain services The Dutch government financed the implementation of the CJAV centers by ABMS/PSI from May 2012 until June 2015 and continued to provide technical assistance from 2015-2018, though the level of support is unclear. Programing for FSW, MSM, and PLHIV has also been successful in the country and should be scaled up. Lessons learned from the large-scale Project SIDA (which was implemented in Benin from 1992-2008) could be applied to the development of
Plan International Bénin	Youth	Young girls who works as mobile vendors are trained to be peer health educators, organizing educational sessions within the community	438 youth trained at peer educators 210,877 youth reached	2013 – present	
	Truck Drivers; MSM; PWID; PLHIV	Training of peer educators to increase the access of key populations to HIV prevention, care, and treatment services at the community level	32 peer educators trained 1,863 people reached by peer educators	January 2016 – December 2017	

OCAL/BESYP	FSW; PLHIV; MSM	Community-based intervention to train peer educators	15 MSM PEs trained in 2016 1431MSM reached in May-Dec 2016 Number of PLHIV & FSW reached unknown	January 2016 – December 2018	peer education programming, as data have shown that the program was effective at reducing human rights-related barriers to HIV services among FSW. Currently, there is peer education program for youth, FSW, MSM, PWID, and some for prisoners, truck drivers and PLHIV. Peer education programs should be scaled up to reach more FSW, MSM, PWID, truck drivers and prisoners. Programming should be created to train peer educators to reach transgender people, servers in bars and restaurants, and people with disabilities. Peer educators or patient navigators should also be trained to work specifically with PLHIV to support access to care and treatment.
Project Dindji/BESYP	FSW; MSM	Community-based intervention to train peer educators	60 PEs trained from Jun-Sep 2016 600 MSM reached from Jun-Sep 2016 Number of FSW reached unknown	March 2015 – March 2018	
PNLS	FSW; Prisoners	PNLS worked with 19 NGOs in 2015 to offer tailored outreach efforts to FSW and prisoners in Cotonou, Abomey-Calavi, Parakou, Sèmè-kpodji, Porto-novo & surroundings	25,562 FSW reached in 2015 8,248 Prisoners reached in 2015	2014 – 2015 (timeframe is unclear, data are only available for these dates)	

Program	**Description**			**Limitations**	
Community outreach/mobilisation	Community outreach efforts designed to sensitize community members to issues faced by PLHIV and other key and vulnerable populations and to reduce the stigma experienced by these populations			Outreach aiming to disseminate information about Law 2005-31 must determine very carefully how to deliver the protective provisions of the law, while keeping in mind the problematic aspects of the law regarding human rights.	
Implementer	***Population targeted***	***Activities***	***# Reached***	***Timeframe***	***Recommended scale-up***

ABPF/BESYP	Mayors of Cotonou, Porto-Novo, Parakou, Abomey-Calavi	Political advocacy efforts to encourage inclusion of key populations in national action plans, including workshops organized with mayors of 4 cities to encourage integration of key populations in HIV programming in the community	4 mayors reached with advocacy efforts	2016	BESYP and ABMS/PSI are both well-positioned to continue community mobilization efforts and should be supported in the continuation of this work. BESYP was cited in focus group discussions and key informant interviews as an active advocate for the reduction of the human rights-related barriers to HIV services experienced by key and vulnerable populations, and has strong ties to many other community organizations in Benin. BESYP works with many organizations that support MSM and LGBTQ rights, though they have not traditionally worked to reach transgender individuals directly (beyond any individuals who have been reached incidentally through MSM outreach work). Transgender individuals experience high levels of stigma in Benin and many do not freely express their gender identity, making this population increasingly difficult to access. Though there is no HIV prevalence data available for trans individuals, given the high prevalence in many similar contexts, it important that outreach efforts be designed to include this population.
BESYP	Members of MSM Associations in Benin MSM; PLHIV	Development of an advocacy guide for member organizations to advocate for inclusion of KPs in national action plans Celebration of commemorative days, including the Day of Homophobia, AfricaGay Day against AIDS, and World AIDS Day, with the aim to reduce stigma and discrimination experienced by MSM and PLHIV	14-member organizations reached with advocacy materials 504 individuals touched by activities of three commemorative days in 2016	2016	
ABMS/PSI – Centres Jeunes Amour & Vie	Youth	« La Ligne Verte 7344 » is an interactive service accessible by mobile phone through which individuals can reach counselors who provide advice and referrals, which may be effective at linking individuals to prevention and care services that fear accessing HIV services due to stigma	Tele-counselors responded to concerns of 16,312 callers	2016	
CeRADIS	Stakeholders including CSOs, State	“Fast Track” workshops organized to plan ways to increase access to testing and	Unknown	2015	

	representatives; key populations	other prevention services for key and vulnerable populations, placing a focus on community mobilization			
Program	**Description**			**Limitations**	
Media and advertising campaign	Media campaigns designed to influence national policy and influence community norms around HIV-related stigma and discrimination experienced by PLHIV and other key and vulnerable populations			Difficult to evaluate the effect of mass media and advertising campaigns in concert with other broader stigma and discrimination reduction efforts; Campaigns aiming to disseminate information about Law 2005-31 must determine very carefully how to deliver the protective provisions of the law, while keeping in mind that problematic aspects of the law regarding human rights	
Implementer	***Population targeted***	***Activities***	***# Reached***	***Timeframe***	***Recommended scale-up***
CeRADIS	Key and vulnerable populations	Conduct media campaigns to influence national policy and influence community norms around key and vulnerable populations Includes publishing articles in newspapers and magazines	Unknown	Ongoing	An evaluation of language used by the media that stigmatizes key populations highlighted the problematic way in which journalists often broach issues related to key and vulnerable populations. Media sensitization campaigns such as Project Dindji's programming should be scaled up. The campaign should include comprehensive training on stigma and discrimination faced by key populations (specifically MSM, sex workers, PWID, transgender people, and PLHIV) and how to present these groups in more positive light in the media. The training should also include general education about sexual orientation and gender identity.
Project DINDJI	FSW; MSM	Targeted media campaign to promote environment that is favorable to the promotion of human rights among KPs Targets journalists, directors of radio and TV channels, regulatory agents, key populations and the general population to educate the public about the problems that female sex workers and men who have sex with men face in	Unknown	September 2015 – March 2018	

		meeting HIV-related needs, reducing stigma and discrimination towards this population			Radio and TV programming such as the programming distributed by CJAV could serve as a model for radio and TV broadcasts that target stigma and discrimination through mass media.
Centres Jeunes Amour & Vie	Youth; PLHIV	Broadcast of TV programs and radio shows that reinforce the importance of communication about sexual health between parents and their children. Records radio programs in both French and in local languages. Maintains a Facebook page and a magazine with regular publications, which is another rarely tapped opportunity to reach youth with messages regarding reducing of HIV/STI-related stigma	200 radio broadcasts on 12 stations; 9 broadcasts of TV Program on Canal3 80,000+ fans on Facebook 60k copies printed, reaching approximately 1.7 million people	May 2012 – 2018	
PNLS	PLHIV; Women	Radio programming regarding human rights, specifically those concerning people living with HIV, gender-based violence, and health care services that are available.	Unknown	Present	

Program	**Description**			**Limitations**	
Engagement with religious and community leaders	Cultivating productive partnerships with religious and community leaders in Beninese society to develop strategies to reduce the HIV-related stigma and discrimination experienced PLHIV and other key and vulnerable populations			While several key informants indicated that religious and community leaders would be amenable to engaging in stigma and discrimination-reduction strategies, it is important to note that not all leaders may readily agree to engage in such efforts.	
Implementer	***Population targeted***	***Activities***	***# Reached***	***Timeframe***	***Recommended scale-up***
ABMS/PSI	Unknown	Involved religious leaders to promote health	Unknown	Unknown	The PNPMT has developed strong relationships with practitioners of

Centres Jeunes Amour & Vie		activities within places of worship, capitalizing on an important opportunity to engage religious leaders and organizations in reducing HIV-related stigma			traditional medicine and has developed a robust training guide to incorporate biomedical information regarding HIV prevention, care and treatment into their work. This program could be expanded to include more information about stigma and discrimination reduction, building on the existing programming. ABMS/PSI and CeRADIS have experience working with religious and community leaders and would be well positioned to continue to engage with these leaders in stigma and discrimination-reduction efforts. Trainings and workshops should be expanded to all regions of Benin, specifically in the north of the country.
Programme National de la Pharmacopée et de la Médicine Traditionnelle (PNPMT)	PLHIV; MSM	Training program for Practitioners of Traditional Medicine on best practices for prevention of HIV and care of PLHIV. Components of training were focused on the reduction of stigma among PLHIV, information about the effects of HIV on KPs, and the legal rights of PLHIV	47 Practitioners of Traditional Medicine trained from 2006-2009 4,747 Practitioners of Traditional Medicine reached with these trainings from 2007-2011	2006-2011	

Current Programs

There are several ongoing and recent programs in Benin that include components and activities aimed at reducing stigma and discrimination experienced by key and vulnerable populations in the context of HIV services.

Measurement of HIV-related stigma

There have been several formal analyses of the HIV-related stigma experienced by key and vulnerable populations in Benin as well as stigmatizing representations of key and vulnerable populations in the media. Having a baseline understanding of the stigma experienced by key and vulnerable populations as well as the social context and negative media representations is important for building a foundation upon which targeted stigma and discrimination reduction efforts can be undertaken.

In 2015, RéBAP+ published a comprehensive national study with support from UNAIDS & OCAL, describing the level of stigma and discrimination experienced by people living with HIV in Benin. Additionally, a National Plan to Fight HIV-related Stigma and Discrimination was released by CNLS for 2017-2020. The aim of which is to promote and protect the rights of people living with HIV and other key populations for zero discrimination by the year 2020. The report provides an overview of the experience of HIV-related stigma and discrimination by key populations and provides recommendations for reducing barriers to HIV services.

Focusing specifically on the media, Project Dindji, in collaboration with OCAL, published a report analyzing the treatment of female sex workers and men who have sex with men in the media in Benin. Their analysis focused on the use stigmatizing language and expressions in published news articles in print, on the Internet, on radio, and on television. The report is comprehensive, though it is unclear whether the data contained within has been used to develop programming in any systematic way.

Limitations/Challenges
Assessment of stigma and discrimination in Benin has been limited to people living with HIV broadly and to the treatment of men who have sex with men and female sex workers in the media. The PLHIV Stigma Index has not been conducted in Benin and is recommended. An update version of the PLHIV Stigma Index is currently being piloted in sub-Saharan Africa and will include metrics for key populations and intersectional stigma. This updated version is recommended if available at the time of the assessment. Research utilization of existing data is limited. There is an opportunity for analyses of stigma and discrimination experienced by key and vulnerable populations to be operationalized to inform sensitization trainings, though it is unclear if these reports have been used for such purposes in the past.

Peer education, support, and outreach

Peer education and support has been shown to be an effective way to reach marginalized people such as key populations, who may be hard to engage with outreach strategies that are effective with the general population. Activities have been organized for several population groups,

including youth, men who have sex with men, people who inject drugs, truck drivers, and for female sex workers in a program that was discontinued. Peer education generally consists of training members of key populations to engage their peers with services such as counseling around HIV risk reduction strategies, how to access HIV testing services or treatment for people living with HIV. Additionally, programs often provide materials to clients such as condoms and lubricants, and may serve as a vital link to other health services such as HIV testing, treatment, and care for people living with HIV. A key informant indicated that the approach of engaging people living with HIV as peer mediators has been very successful, but that the program merits further evaluation (KII26). Among these many activities and objectives, peer education and support activities have also been utilized in Benin to reduce stigma and discrimination experienced by key and vulnerable populations and to provide information about HIV-related human rights. These elements could be further enhanced and supported in peer education/outreach efforts and could also include training peer educators to provide legal and human rights literacy as well as paralegal support.

One critical limitation of many peer education programs surveyed for purposes of this report is a focus on provision of information about HIV and the distribution of condoms and lubricant, without paying sufficient attention to other human rights-related barriers to HIV services such as self-stigma, systematic human rights violations and psychobiological distress as a result of experiences with stigma and discrimination. Currently, the level of integration of human rights-related information relayed within each peer education program is unclear and is often difficult to assess.

Several organizations have had success in engaging youth using peer education programming, including interventions for youth in general and those specifically aiming to reach young women and girls. ABMS/PSI and Plan International-Bénin currently run the stigma and discrimination reduction programming for youth. Lessons from these organizations could be used and adopted for designing peer education programming for other, or intersecting populations.

L'Association Béninoise pour le Marketing Social et la Communication pour la Santé (ABMS), which is an affiliate of Population Services International (PSI), created approximately 20 youth centers in Benin called Centres Jeunes Amour & Vie (Love and Life Youth Centers), which use a peer education approach to address HIV-related stigma among youth. These youth centers, which have been in operation since 2012 in the regions of Dassa, Savè, Parakou, Djougou, Natitingou, Porto-Novo, Dango, Abomey-Calavi, and Cotonou have involved the training of 400 peer educators (youth themselves as well as their parents) and 180 womens' and men's group leaders trained to facilitate dialogues between young people and their parents (UNAIDS 2016). The centers provide "youth friendly atmospheres", including internet access and games where youth can receive sexual and reproductive health services, and also offer "Open Door Days," when parents are invited to visit to increase the visibility of the centers (ABMS 2016, ABMS 2018). Services offered at the center include HIV testing and counseling, STI care, cervical cancer screening, family planning, counseling for gender-based violence, and prenuptial counseling, and the program also organizes home visits to families and out-of-school youth and extracurricular school programs that promote communication as a means for behavior change. In 2015, the average age of clients at the Centres Jeunes Amour & Vie (CJAV) was 16.9 years,

many whom were male (60.2%) (UNAIDS 2016). Programs in these youth centers encourage conversations between parents and youth about sexual health that can serve to reduce the HIV/STI-related stigma that may prevent communication about prevention strategies (UNAIDS 2016). The centers have been shown to be effective at removing barriers to HIV services. ABMS' annual report of 2016 showed that 97% of youth were satisfied with the benefits they received at the centers (ABMS 2016). Plan International Bénin (PIB) also currently coordinates peer education programming for youth, including a program that has trained more than 400 young females who works as mobile vendors to be peer educators in their communities. These peer educators have organized educational sessions to reach more than 210,000 youth in the country.

Programming for female sex workers, men who have sex with men, and people living with HIV have also been implemented in the country, though programs have not been as well-documented as the programming for youth and comprehensive evaluations were not available at the time this report was written.

In addition to programming for youth, ABMS also coordinated with Plan International-Bénin (with the support of the Global Fund) to develop programming for key and vulnerable populations, including men who have sex with men, people who inject drugs, and truck drivers, with the goal of increasing the access of key population groups to HIV prevention, care, and treatment services at the community level (ABMS 2016). Peer educators from each of these population groups were trained to conduct sensitization sessions with their peers. Forty-eight men who have sex with men, 38 people who inject drugs, and 75 truck drivers were trained as peer educators and were able to reach 2,897 MSM, 1,695 PWID, and 13,500 truck drivers, respectively (ABMS 2016).

The BESYP Network has supported peer education efforts for key populations with several organizations. In collaboration with BESYP, OCAL implemented a community-based peer education intervention for female sex workers, men who have sex with men, and people living with HIV, which was scheduled to run from January 2016 through December 2018. OCAL is an organization that works along the corridor from Abidjan, Cote d'Ivoire to Lagos, Nigeria with key populations, including female sex workers, men who have sex with men and truck drivers as well as people living with HIV (KII22). The program trained 15 men who have sex with men as peer educators, who reached 1,413 of their peers. There are no data available on how many female sex workers and people living with HIV were trained as peer educators and how many were reached through this program. Project Dindji, with support from BESYP, also implemented a community-based intervention for female sex workers and men who have sex with men, which successfully trained 60 peer educators and reached 600 men who have sex with men. There is no data available on how many female sex workers were reached with this program.

Multiple key informants indicated that OCAL has taken a solid leadership role in the fight against HIV and that their work has been very effective. One key informant indicated that the reason that OCAL has been successful is that they have sufficient funding to support their work, unlike many other organizations for which a lack of funding is a primary barrier to providing services (KII36).

Though it is not currently operational, Project SIDA was a large-scale project implemented in Benin from 1992-2008 that was shown to be effective in reducing human rights-related barriers to HIV services among female sex workers by engaging women in peer education programs. From 2014 to 2015, the Programme Santé de Lutte contre le SIDA (PSLS), which was referred to as the Programme National de Lutte contre le SIDA (PNLS) at the time of implementation, also organized peer education programming for female sex workers, and notably, for prisoners, who are not currently being reached with peer education.

Limitations
Part of this difficulty can be attributed to a lack of data on the level and quality of training received by peer educators, including the contents and comprehensiveness of the trainings themselves, the frequency that peer educators receive training, whether there is a systemic quality assessment process, and which elements of the training that peer educators are receiving are operationalized in sessions conducted with their peers. It also may be difficult to assess the effectiveness and quality of outreach provided by individual peer educators. Members of key populations may have mixed feelings about peer education, and some groups and individuals may be more likely than others to be willing to interact with peer educators. Others, especially marginalized populations such as men who have sex with men, female sex workers, and people who inject drugs, may fear interacting with peer educators for lack of trust or fear of their confidence being breached. Perceptions from focus group participants were mixed, though some cited hesitancy to engage with peer educators due to fears related to confidentiality.(FGD4) For similar reasons related to confidentiality, retention of peer educators who are members of stigmatized key populations may pose a problem. Peer education programs may also have limited reach due to the preference for some key populations to remain underground to avoid the experience of stigma and discrimination.

Among female sex workers, data demonstrated that community mobilization through strategies such as peer-outreach programs could effectively reduce stigma-related barriers to engaging in HIV-related services (Behanzin, Diabate et al. 2013). This model has been used in outreach programs for youth, as well (UNAIDS 2016). However, other key and vulnerable populations have not been engaged in programs using this approach. Additionally, although family-initiated stigma toward women living with HIV was mentioned in field discussions, few programs appeared to address family stigma that leads partners or spouses to avoid HIV testing and services for fear of repercussions from one's immediate or one's partner/spouse's family members (FGD3 2017). Project SIDA, which was implemented in Benin in from 1992 to 2006, included services for clients and partners of female sex workers.(Lowndes, Alary et al. 2007, Behanzin, Diabate et al. 2013) However, couples-based services have not been widely indicated in the general population, missing a significant opportunity to increase access to and uptake of prevention and treatment services by working with couples to reduce stigma experienced in sero-discordant couples.

Community mobilization, outreach, and advocacy

Community outreach, mobilization, and advocacy efforts have been conducted in Benin. These activities are designed to sensitize community members and other stakeholders to issues faced by people living with HIV and other key and vulnerable populations, and to advocate for

programming, policies and legal provisions that reduce the experience of stigma and discrimination in these populations.

The Bénin Synergies Plus Network (BESYP) is a network of non-governmental organizations that support men who have sex with men in Benin, which serves as a bridge between men who have sex with men and the services available to them (KII5). The network is composed of more than 14 LGBTQ member organizations that work in the service of providing training, education, advocacy, resource mobilization, support services and the promotion and defense of the rights of men who have sex with men, key populations and people living with HIV more broadly (KII5 , Plateforme ELSA: Centre de ressources francophones sur le VIH/sida en Afrique (n.d.)). Founding member organisations include Adorable Club des Jeunes Solidaires de Porto-Novo (ACJSPH), Alliance pour la Solidarité et l'Aide à la Jeunesse du Bénin (ASAJ-Bénin), Amis des Sans Voix (ASV), Espoir Vie Arc-en-Ciel Bénin (EVAB), MADNICE, et Union pour la Solidarité et l'Entraide au Développement (USED) (BESYP 2016).

BESYP also engages in advocacy efforts on a political level to encourage the representation of key populations in action plans and to increase the protection of LGBTQ populations (KII5). Several men mentioned that the BESYP network is extremely useful in their community, by supporting men who have sex with men directly and providing solidarity among the disparate organizations who work with and for men who have sex with men in the country.(FGD5) BESYP also serves as an umbrella organization and a liaison between financial backers and men who have sex with men associations, facilitating the funding of education and programming on the ground for reducing stigma and discrimination reduction and other human rights-related barriers to accessing HIV prevention and treatment services (FGD5).

In 2016, BESYP developed an advocacy guide for member organizations to advocate for inclusion of key populations in national action plans. BESYP has also coordinated community mobilization and outreach through celebration of commemorative days, including Day of Homophobia, AfricaGay Day against AIDS, and World AIDS Day, with the aim to reduce stigma and discrimination experienced by men who have sex with men and people living with HIV.

With the support of BESYP, the Association Béninoise pour la Promotion de la Famille (ABPF) has organized and engaged in political advocacy efforts to encourage inclusion of key populations in national action plans. They have also organized workshops with city mayors to encourage integration of key populations in HIV programming in the community. In 2016, the mayors of Cotonou, Porto-Novo, Parakou, Abomey-Calavi were engaged in political advocacy efforts.

ABMS/PSI, described above, also organized community mobilization and political advocacy efforts. Strong involvement of health officials in programming resulted in appropriate provision of medicines and qualified health personnel at the youth centers, as well as routine monitoring of the centers to ensure they reach compliance standards. They have also introduced the « ligne verte 7344 », which is an interactive service accessible by mobile phone through which individuals can access health information and counseling (ABMS 2017). This novel approach allows people to access information about HIV and HIV services without having to enter health

services in person, which may subject them to stigmatizing treatment from health providers and their peers (ABMS 2017). Approximately 42% of youth between the ages of 10-17 and 58% of individuals 18-24 were aware of the number. Among clients of CJAV surveyed, most were likely to have heard about #7344 through TV (53.2%), advertising posters (50.7%), the Magazine Amour & Vie (49.3%) or through the radio campaign (32.1%) (ABMS 2017).

Centre de Réflexions et d'Actions pour le Développement Intégré et la Solidarité (CeRADIS) is an organization that works on health and education broadly, with programs addressing HIV and AIDS (KII7). CeRADIS invests in political advocacy efforts and the evaluation of existing programs, strategies, the political climate and the national response to HIV (KII7). CeRADIS has created workshops among multiple key actors in the response to HIV, including national bodies, civil society organizations, partners and representations of key populations to develop an accelerated strategy ("Fast Track") to respond to HIV among key and vulnerable populations in Benin (UNAIDS 2016). The main objective of these workshops was to develop a plan to increase access to testing and other prevention services among key and vulnerable populations, placing a particular focus on community mobilization (UNAIDS 2016). CeRADIS is working towards the goal of "Zero Discrimination" and this workshop sought to revise the existing laws regarding HIV and to document and promote best practices (UNAIDS 2016). While no formal evaluation has been conducted of the programming provided by CeRADIS, the organization was cited as an important actor in the realm of advocacy for key and vulnerable populations among many of the key informants interviewed (KII1 , KII3 , KII24 , KII28). Individuals in focus group discussions also cited CeRADIS as an important resource for information regarding HIV and AIDS (FGD9). Therefore,

Limitations

One weakness of the activities realized by BESYP is that they have had issues with their testing program because individuals fear of being identified as men who have sex with men and stigmatized as a result (KII5). This concern highlights the need for a clear communication and implementation of anonymous and confidential testing .Outreach aiming to disseminate information about Law 2005-31 must determine very carefully how to deliver the protective provisions of the law, keeping in mind the problematic aspects of the law regarding human rights.

Media and advertising campaignse

Media campaigns have also been used in Benin as a strategy designed to influence national policy and community norms around HIV-related stigma and discrimination experienced by PLHIV and other key and vulnerable populations.

Project DINDJI is a USAID initiative designed to offer HIV services to key populations along the corridor from Abidjan to Lagos in West Africa, focusing specifically on female sex workers and men who have sex with men (USAID: Projet Dindji 2016). Phase 1 of the project was launched in September 2015 and is scheduled to continue until March of 2018 (USAID: Projet Dindji 2016). The program aims to provide high-quality health services to key populations, to encourage HIV

prevention methods and to promote "a socio-cultural and judicial environment" that is favorable to the promotion of human rights among key populations through a targeted media campaign (USAID: Projet Dindji 2016). The media campaign component targets journalists, directors of radio and TV channels, regulatory agents, key populations and the general population to educate the public about the problems that female sex workers and men who have sex with men face in meeting HIV-related needs, reducing stigma and discrimination towards this population (USAID: Projet Dindji 2016). In a focus group discussion with men who have sex with men in Benin, it was expressed that the DINDJI project provides useful information for men who have sex with men in Cotonou (FGD5). Though the project was not designed to extend into the north of the country, focus groups expressed some dismay that the program is only available in the south and that it is therefore difficult for men in the north to access its services (FGD5).

CeRADIS, described above, was noted to be a strong advocate for the reduction of stigma and discrimination experienced by key and vulnerable populations in the media. The organization engages in a comprehensive media campaign to influence national policy and community norms around key and vulnerable populations (KII7).

PSLS was also cited in stakeholder interviews to release media campaigns to support people living with HIV and survivors of gender-based violence. PSLS releases radio programming regarding human rights, specifically those concerning people living with HIV, gender-based violence, and health care services that are available.

A strength of the Centres Jeunes Amour & Vie Centers (described above) is their capacity to reach their target population in novel ways. The program maintains a Facebook page, produces two television programs reinforcing the importance of communication about sexual health between parents and their children, and publishes a youth-friendly magazine, which printed 60,000 copies of 6 editions in 2016 (ABMS 2016, UNAIDS 2016). ABMS also released 200 radio broadcasts targeting youth, in both French and in local languages (ABMS 2016). Using these communication channels is a rarely tapped opportunity to reach youth with messages regarding reducing of HIV/STI-related stigma (UNAIDS 2016).

Limitations/Challenges
Though it does not diminish the need for such efforts, it may be difficult to evaluate the direct impact of mass media and advertising campaigns on knowledge, attitudes and behaviors, especially when they are working in concert with other broader stigma and discrimination reduction efforts. As mentioned above, campaigns aiming to disseminate information about Law 2005-31 must determine very carefully how to deliver the protective provisions of the law, while keeping in mind the problematic aspects of the law regarding human rights.

Engagement with religious and community leaders

Due to their privileged position in Beninese society, cultivation of productive partnerships with religious and community leaders in Beninese society can be extremely effective in the

development of strategies to reduce the HIV-related stigma and discrimination experienced by people living with HIV and other key and vulnerable populations.

Practitioners of traditional medicine are often consulted as a primary form of prevention, treatment and care among key and vulnerable populations, on their own or in concert with allopathic medicine practitioners (FGD1 , FGD2 , FGD7).

The government of Benin has shown a commitment to collaborating with practitioners of traditional medicine in their fight against HIV as early as the 1990s (CNLS 2015). Through the Programme National de la Pharmacopée et de la Médicine Traditionelle (PNPMT), the Ministry of Health introduced a strategic plan in 2006 to integrate the services offered by practitioners of traditional medicine into the national health system and to reinforce collaboration between practitioners of traditional medicine and practitioners of allopathic medicine (Programme National de la Pharmacopée et de la Médicine Traditionelles 2009). This plan included a comprehensive training strategy to support sensitized and effective treatment of people living with HIV by practitioners of traditional medicine (Programme National de la Pharmacopée et de la Médicine Traditionelles 2009). Through this program, the Ministry of Health deployed 47 trainers to train more than 3147 practitioners of traditional medicine on best practices for the care of people with HIV between 2006 and 2009 (Programme National de la Pharmacopée et de la Médicine Traditionelles 2009). Components of this training were focused on addressing human right-related barriers to HIV services and the reduction of stigma among people living with HIV (Programme National de la Pharmacopée et de la Médecine Traditionnelles 2012). The training manual also included information regarding the key populations who are most affected by HIV in Benin and the legal rights of people living with HIV (Programme National de la Pharmacopée et de la Médecine Traditionnelles 2012).

While the human rights elements of this program are not currently robust, practitioners of traditional medicine are an important resource in Beninese society and are well positioned to provide credible and effective HIV education and information that de-stigmatizes key populations and reduces HIV-related stigma. Given their privileged position in Beninese society and the trust that their patients grant them, working in partnership with practitioners of traditional medicine on stigma and discrimination reduction strategies carries significant potential to mitigate stigma and discrimination faced by people living with HIV, and other key and vulnerable populations in Benin and to reduce human rights-related barriers to accessing effective HIV prevention, care and treatment programming.

The ABMS/PSI Centres Jeunes Amour et Vie (CJAV Centers), while primarily targeting youth, also involved coordination with religious leaders to promote health activities within places of worship, capitalizing on an important opportunity to engage religious leaders and organizations in reducing HIV-related stigma (UNAIDS 2016).

Limitations/Challenges

Several key informants indicated that religious and community leaders would be amenable to engaging in stigma and discrimination-reduction strategies, however, it is important to note that not all leaders may readily agree to engage in such efforts. Collaboration between HIV medical service providers, practitioners of traditional medicine, religious leaders, and community

leaders could provide a significant opportunity to access populations that might otherwise be missed, for purposes of service provision and dissemination of messaging about HIV stigma-reduction.

Moving to more comprehensive programming

There is significant opportunity to expand existing programs and to develop new programming to reduce stigma and discrimination towards key and vulnerable populations. Engagement with key and vulnerable populations in the evaluation and development of such programming is an important strategy to address the specific stigma-related barriers experienced by key and vulnerable populations in Benin. While there are many organizations in Benin that seek to amplify the voices of marginalized populations, many key informants indicated that it is important that members of key and vulnerable populations be involved in decision-making processes directly (KII4 , KII23 , KII24 , KII29). Future programming should incorporate the guidance of key and vulnerable populations into planning and implementing HIV programming within the health sector, educational institutions, and the media and in the development of other advocacy strategies. The participation of leaders and members of key and vulnerable populations through capacity-building and community mobilization will provide valuable insight into the ways that programming can be most effective in their communities.
No programs or activities advocating for policies requiring employers to maintain non-discriminatory atmospheres in the workplace appear to exist in Benin and there appears to be no formal mechanism that provides oversight for employers that violate HIV-related human rights in the workplace. No activities that support non-discrimination as part of institutional workplace policies in employment and educational settings were discovered in the fieldwork or in the documents reviewed through this assessment, even though participants in focus group discussions and key informants mentioned a need for such policies in Benin to combat stigma and discrimination in the workplace. Key informants indicated that no programs exist to support individuals across key and vulnerable populations who have lost their jobs due to stigma and discrimination caused by their sexual orientation or serologic status (KII5). One of the men living with HIV reiterated in a focus group that a program to help individuals living with HIV to rejoin the work force after having experienced discrimination due to their HIV status would be useful (FGD2). Additionally, key informants indicated that no programs exist to support individuals across key and vulnerable populations who have lost their jobs due to stigma and discrimination caused by their sexual orientation or serologic status (KII5). One of the men living with HIV reiterated in a focus group that a program to help individuals living with HIV to rejoin the work force after having experienced discrimination due to their HIV status would be useful (FGD2).

The following recommendations are made to move towards comprehensive programming to reduce stigma and discrimination:

- Provide support to RéBAP+ to repeat the National Survey on Stigmatization and Discrimination of People Living with HIV in Benin (Stigma Index) on a 3-5 year basis to provide updated data for assessing the impact of programs to remove human rights

barriers to HIV services in the country and modify recommendations for programming accordingly. The most recent report was published in April of 2016 using 2015 data.

- Organize quarterly sessions by outreach workers at CBOs servicing KP, to describe the impacts of stigma and discrimination and to popularize and disseminate the protective aspects of Law 2005-31 (described above in Section 4.2.3 Laws that Affect Key and Vulnerable Populations' Access and Use of Relevant Services).
- Organize and promote in collaboration with CBOs servicing KP a list of groups that provide help for people living with HIV and key populations, partnerships between associations for people living with HIV and ones working with key populations, through information dissemination campaigns and collaboration with radio and community media. This approach could foster participation of people living with HIV and key populations in associations that support them and increase uptake in non-stigmatizing health services.
- Support the meaningful participation of people living with HIV and key populations in national stigma reduction strategies by (a) conducting trainings and/or discussions with key population association leadership about stigma and discrimination, (b) providing technical assistance stigma reduction and support services, and (c) supporting CNLS to advocate for their engagement.
- Support dissemination of stigma and discrimination-reduction messaging through public events and engagements led by key populations.
- Develop partnership between the CNLS, the Directorate for Occupational Health, and business leaders to develop and promote comprehensive anti-discrimination HIV policies to be deployed in the workplace in both the private and public sector.
- Develop partnerships with the media to improve the quality of HIV-related discourse in the press, radio and television and to increase public awareness of stigma faced by people living with HIV and key populations.
- Scale-up training efforts through the Programme National de la Pharmacopée et de la Médicine Traditionelle to include training on stigma and discrimination experienced by key and vulnerable populations and people living with HIV as related to HIV prevention, treatment, care and support. Collaborate with practitioners of traditional medicine through activities to disseminate messaging on stigma and discrimination reduction.
- Advocate for the inclusion of non-discrimination as part of institutional and workplace policies in employment and educational settings. Workplace discrimination is a key area of programming need.

Program Area 2: Training of health care providers on human rights and medical ethics related to HIV

The table below provides an overview of current programmatic efforts to train health care workers on human rights and medical ethics related to HIV, as well as recommendations for scaling up these activities. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table.

Training for health care workers on human rights and medical ethics related to HIV					
Program	**Description**			**Limitations**	
Healthcare worker training	Training of health care workers on the human rights and medical ethics as related to HIV; development of manuals and training guides to be used with healthcare professionals; adaptation of health care services to reduce the human rights-related barriers to HIV services experienced by key and vulnerable populations			While a standardized guide and training process would streamline the process, in-service trainings need to be adapted to the healthcare workers and specific settings where they are implemented. Additionally, it will be important to determine who at each facility is best positioned to deliver the training and to whom staff will be most receptive.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timefra me**	**Recommended scale-up**
OCAL: Project Dindji	Healthcare providers	Developed a manual to train health workers to offer services adapted to KPs, specifically focusing on how to offer sensitive and non-stigmatizing care to KPs, specifically MSM	Unknown	Unknown	Project Dindji developed a training manual to educate health workers on how to offer services adapted to key populations, specifically focusing on MSM. This manual, while serving as a good foundation, should be expanded to include other key and vulnerable populations who experience stigma and discrimination in healthcare settings, including sex workers, transgender people, PWID and PLHIV. In addition to stigma and discrimination reduction, the training should also be expanded to include gender-based violence, and other human rights that are relevant to PLHIV and other key and vulnerable populations. Stigma and discrimination in healthcare settings continue to be major barriers to HIV services among key and vulnerable populations and previous efforts to sensitize healthcare workers have not been successful. Integrating this guidance into pre-service training for healthcare workers could be an effective way to ensure coverage among all healthcare workers. As noted in the fieldwork, RACINES has been effective at training their workforce to provide non-stigmatizing care, which has reduced barriers to services among the PLHIV who access their services.
RACINES	Healthcare providers	Sensitization training for healthcare professionals regarding human rights and medical ethics	Unknown	Unknown	

Current Programs

Although many of the programs identified through the assessment mentioned the training of health care providers to improve service delivery, few highlighted training of health care providers on human rights and ethics. Although the experience of stigma in the healthcare setting was cited as one of the primary human rights-related barriers to HIV services throughout the fieldwork, very few programming efforts have addressed this area with any real force or reach. Several key informants indicated in individual interviews that efforts to train health care providers on human rights and medical ethics as related to HIV have not been successful for the most part and have called for increased programming in this area.

Health care worker training

Project DINDJI, which is implemented by OCAL and financed by USAID (described in the previous section), has developed a manual to train health workers to offer services adapted to key populations, specifically focusing on men who have sex with men (Projet Dindji 2015). However, the extent to which this manual has been used to train healthcare providers is unclear and there have been no formal evaluations of the program (if it has been implemented in Benin). The manual, which is organized into twelve modules, is designed for health providers and is oriented towards educating providers on how to offer sensitive and non-stigmatizing care to men who have sex with men and other key populations (Projet Dindji 2015).

The training highlights the impact individuals' perceptions can have others' abilities to access prevention and care services, provides tools for participants on how to recognize stigma and discrimination, describes human rights as related to men who have sex with men and access to HIV services, and instructs participants on how to reduce stigma and discrimination in the healthcare context (Projet Dindji 2015). It also gives an overview of the epidemiology of HIV and STIs in Benin and provides an orientation to the differences between sexual behavior, sexual orientation, gender identity, and gender expression (Projet Dindji 2015). The training also includes an overview STI and HIV symptom-identification, modes of HIV transmission, and a module defining the importance of monitoring and evaluation (Projet Dindji 2015). While this manual provides an excellent foundation to develop training curricula for healthcare staff, the lack of documentation of the program's effectiveness and reach will require further analysis in the initial stages of scaling up this program.

Project SIDA, which was implemented from 1992 and discontinued in 2008, was a program that aimed to design clinics that were "user-friendly" for female sex workers (Ahoyo, Alary et al. 2007, Alary, Lowndes et al. 2013, Semini, Batona et al. 2013, Batona, Gagnon et al. 2015, Dugas, Bedard et al. 2015). Programming included healthcare worker training on human rights and stigma faced by female sex workers. While these user-friendly clinics were shown to be effective in evaluations of Project SIDA, the clinics are no longer operational in the country, and participants in focus group discussions did not indicate that the clinics were effective in reducing the global level of stigmatization towards female sex workers.

Organizations such as RACINES have been effective in providing training for healthcare workers that reduces the human rights-related barriers to service for people living with HIV and other key populations, mainly female sex workers. RACINES is a Beninese NGO created in 1999 that serves HIV-positive women and their partners. The organization provides comprehensive support services for people living with HIV in Benin and is an example of the ways in which sufficient sensitization training for health service providers can improve retention in healthcare services among people living with HIV (RACINES 2015). The program operates throughout Benin with programming in the areas of education and health, with a focus on HIV. Many of the women in the focus group convened for women living with HIV mentioned the positive treatment at RACINES and welcoming atmosphere and indicated that they were able to receive services there regularly without judgment (FGD3). Several men living with HIV indicated that they had received similar treatment from RACINES and at Arc-en-ciel, a treatment center for individuals living with HIV, but that other centers and public hospitals mistreated them (FGD2). While participants did mention that these organizations have been effective at creating welcoming atmospheres for clients as a means to reduce barriers to service, neither seems to have a formal stigma and discrimination reduction training for healthcare workers and there have been no formal evaluations of the services offered by either group.

A key informant indicated that programs to educate healthcare providers with regards to barriers to accessing HIV services have been effective within the country and that they have seen a real change in the quality of care provided in hospitals in response to these efforts. However, this sentiment was not reflected by participants in focus group discussions, other than those who receive care through RACINES and Arc-en-ciel (KII36). Many participants indicated that they are currently happy with the treatment that they receive at centers that specialize in the care of people living with HIV such as RACINES and Arc-en-Ciel (FGD2 , FGD3).

Limitations/Challenges

Other than the guide developed by Project Dindji, there have been no comprehensive and sustained initiatives to train healthcare providers on stigma and discrimination reduction strategies and other approaches to reduce human rights-related barriers to HIV services. The guide developed by Project Dindji is a useful foundation, but training that is not adapted to individual contexts may not be effective in other contexts. Having a standardized guide and training process would streamline the process, but without an adaptable programming structure, the training may not be equally effective across healthcare settings. Additionally, it will be important to determine who at each facility is best positioned to deliver the training and to whom staff will be most receptive. Additionally, if all actors in the health system do not receive the training, the programming may not be as effective.

Additionally, while there have been several models of trainings for individual health care providers, no systematic training of health care administrators or health care regulators has been implemented in the country.

Comprehensive programming

Programs that seek to reduce human rights barriers in the healthcare setting should focus on reducing barriers to healthcare access (stigma reduction in the community), increase training of medical providers on ethics, human rights and confidentiality, and the reduction of stigma, discrimination and violence that occur during medical service provision.

- Incorporate stigma reduction, human rights, and medical ethics training in pre-service curricula as a require course for healthcare professionals, including medical, nursing, midwifery, and medical personnel schools and training programs. Training programs should address stigmatizing attitudes and discriminatory practices in health care settings and should provide health care providers with the knowledge, skills, and motivation necessary to ensure patients' rights to informed consent, confidentiality, non-stigmatizing treatment and non-discrimination. Training of staff members that provide services to people who have experienced sexual violence may include different strategies for intake and communication with cisgender and transgender women, men who have sex with men, and children. Adherence to existing medical ethics guidelines and policies should be assessed to frame training curricula. Additionally, it is recommended that incentives and motivations for improving adherence to medical ethics guidelines should be considered, such as facility or departmental certification for guideline adherence.
- Offer in-service trainings to staff working in HIV treatment services. These trainings would include modules on stigma and discrimination against key and vulnerable populations, better service delivery to PLHIV including key populations and creating a friendlier environment. During these trainings participants would develop a workplan with the aim of creating a more accessible and friendlier environment for the patients.
- Programs are also needed to facilitate communication between HIV service providers, programs and CBOs servicing key populations and police and to provide information on the vulnerability and heath care needs of PLHIV and key populations.
- Train prison personnel on the prevention, health care needs and human rights of detainees living with or at risk of HIV infection.
- Peer education and support programming may also be used to address the psychological impacts of negative experiences in seeking healthcare, the effects of which may include avoiding further engagement in health services. The provision of trained peer mediators may be useful to guide the experiences of those likely to experience stigma and discrimination in healthcare settings (KII32). Peer outreach programs, where target population members accompany their peers to medical appointments, have been found to be particularly effective in reducing fear of attending HIV services (Lowndes, Alary et al. 2007, Behanzin, Diabate et al. 2012, Behanzin, Diabate et al. 2013, Béhanzin 2016).
- Create awareness-raising sessions for healthcare professionals regarding the medical and ethical principles governing disclosure of a patient's sero-status as well as on the barriers faced by people living with HIV and key populations more broadly. These sessions could promote discussions between people living with HIV and their healthcare professionals about their treatment options and the barriers they face to access and retention in HIV treatment services to increase understanding of PLHIV patient needs (UNAIDS 2016).

Programs should be tailored to the specific needs of each population. For example, programs should include components that gather information about the different types of stigma and/or violence that women, female sex workers, men who have sex with men, transgender individuals, people with disabilities and youth face when seeking and receiving healthcare.

Program Area 3: Sensitization of law-makers and law enforcement agents

The table below provides an overview of current programmatic efforts to sensitize law makers and law enforcement agents, in addition to recommendations for scale-up. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table.

Sensitization of law makers and law enforcement agents					
Program	**Description**		**Limitations**		
Sensitization of law makers and law enforcement	Programming that seeks to inform and sensitize people who make laws and those who enforce them (including parliamentarians, judges, police officers, lawyers, traditional and religious leaders) about the important role of the law in the response to HIV and how to protect those affected by HIV against discrimination and violence and to support access to HIV prevention, treatment, care, and support.		Analysis of such programs and recommendations have been developed, however, there has been no operationalization of these reports or analyses. There has been no (visible) commitment by these stakeholders to take the lessons learned through such trainings and apply them to national policy and results of such efforts can be difficult to measure. Furthermore, the absence of a legal or regulatory framework for sex work in Benin renders such efforts difficult.		
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
CNLS	Judges, lawyers, law enforcement agents	Organization of training sessions to educate judge, lawyers, and law enforcement agents about the content of HIV law and protections contained therein.	Unknown	Unknown	The Minimum package of activities developed by ICIS can be used as a foundation to develop specific and targeted training activities for law makers and law enforcement agents, though it would be useful for such activities to be scaled up and systematized to increase coverage. It would be useful to expand the contents of the manuals, which focus on legal rights, to include stigma and discrimination reduction, sexual orientation and gender identity training, and education around gender-based violence. Training for law enforcement agents should include information regarding stigma and discrimination of key and vulnerable populations, gender-based violence, including abusive police activities as well as sexual orientation and gender identity education. Additionally, these sessions should cover general information on HIV
Initiatives Conseil International Santé	PLHIV; strategic actors intervening in organizations working with PLHIV; healthcare providers; judicial staff; police officers	In 2009 and 2016, ICIS developed reports outlining the minimum package of activities that should be offered for KPs in Benin. ICIS organized dissemination workshops for stakeholders, including judges, lawyers, law clerks and the police, with the aim to increase their familiarity with the link between HIV and human rights, the role of the justice system, laws in reducing stigma and discrimination & HIV-related legal services	80 participants reached at the workshops convened in 2010; Unknown how many workshops were convened in response to 2016 report	2009-2016	
OCAL	journalists, judges, lawyers, and other legal professionals and law enforcement agents	Manual designed to inform KPs and key actors such as journalists, judges, lawyers, other legal professionals, and law enforcement agents about legal issues related to HIV, GBV, and the protection of human rights of key populations.	Unknown	Unknown	

					transmission, prophylaxis for HIV infection, and HIV care and treatment. This training could be systematically integrated into training that police receive before beginning their service and rolled out during in-service sessions.

Current Programs

No widespread, systematic interventions aiming to sensitize law-makers and law enforcement agents were found through this assessment. Several entities have organized series of workshops and meetings with law-makers and law enforcement agents, but there has been no clear strategy or evaluation to elucidate how these activities translate into a more hospitable policy environment for key and vulnerable populations in the context of access to HIV services. The activities to sensitize decision-makers that do currently exist in the country often fall under the umbrella of broader advocacy campaigns, rather than any focused and targeted strategy to reach law-makers and law enforcement agents.

The Comité National de Lutte contre le Sida (CNLS) is one association that has taken on the task of sensitizing law-makers and law enforcement agents. CNLS is a multi-sectoral organization that functions under the President of the Republic and has been working since 2002 to coordinate the national response to HIV (Dia, Seck et al. 2012). Many key informants indicated that CNLS has demonstrated a strong leadership role in the response to HIV in the country. During the period of 2012-2015, CNLS introduced a new national strategy to combat AIDS in the country, working in connection with the Programme *Santé de lutte contre le Sida* (PSLS) in the Ministry of Health with financial support of a number of international development partners (Dia, Seck et al. 2012). The strategy commits to "prioritizing the promotion of human rights and the fight against HIV-related discrimination and stigmatization"(KII21 , CNLS 2014). Activities performed by CNLS include the organization of training sessions to educate judges, lawyers, and law enforcement agents about the content of HIV laws and the protections contained therein (CNLS 2014). CNLS has also convened meetings with members of the public and private sector, civil society organizations, and journalists to educate them about the protections of the law (CNLS 2014). In evaluations of this programming, there is no explicit discussion of the problematic elements of the law that have been presented above, which would be need to be systematically addressed in any further programming targeting these stakeholders.

In pursuit of sensitizing stakeholders across Benin (including law-makers and law enforcement agents) on these issues, the Initiatives Conseil International Santé (ICIS) published a strategy to reduce human rights-related barriers to HIV services among key and vulnerable populations that was developed in concert with workshops with key stakeholders in the country. They developed a minimum package of activities to support key and vulnerable populations that they suggested should be implemented in Benin (Santé 2016). The report developed by ICIS is aligned with three human rights-aligned principles: (1) *engagement* – mobilization of all necessary human, financial and material resources to obtain significant results in the fight against HIV and STIs among key populations; (2) *universality* – the framework should allow all individuals in Benin access to all essential interventions, regardless of sex, ethnicity, religion, place of residence, or sexual behavior; and (3) *globality* – the framework will be part of the overall effort of prevention and care that comprises not only transmission risk factors within key populations, but also economic and social issues that affect the dynamic of the epidemic among key populations (Santé 2016). The activity analyzed current activities offered to key populations, created a minimum package of activities for each key population, and proposed strategies for the implementation of these activities, the actors that should be implicated, and the methods for

monitoring activities. (Santé 2016). A corresponding workshop for key stakeholders, held in March 2016, brought stakeholders together and included sensitization elements (KII5).

The strengths of this organizing process include commitment by facilitators to promote "conditions for success" for each intervention area (Santé 2016). This includes cultivating political will, developing of standards and intervention guidelines for each key population, and developing the capacity of CSOs, CBOs, and associations to promote human rights in the context of HIV, and the application of and respect for medical ethics (Santé 2016).

The Organisation du Corridor Abidjan-Lagos (OCAL) developed a manual called the *Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos,* which was designed for members of key populations and key actors such as journalists, judges, lawyers, and other legal professionals and law enforcement agents (Organisation du Corridor Abidjan-Lagos (OCAL) (n.d.)). The manual's primary objective is to use five modules to sensitize target participants to human rights and gender-based violence. The manual provides information to sensitize decision-makers to human rights issues faced by key populations. The training manual guides the facilitation of five training modules: (1) epidemiological situation of HIV in West Africa; (2) multi-sectorality and fight against gender-based violence; (3) human rights; (4) gender-based violence; and (5) protecting human rights (international and regional mechanisms and monitoring rights violations) (Organisation du Corridor Abidjan-Lagos (OCAL) (n.d.)). It was developed as a follow-up to other activities carried out in hospital facilities and border posts between Abidjan and Lagos and in response to the Global Fund's focus on HIV interventions that incorporate the defense of human rights.(Organisation du Corridor Abidjan-Lagos (OCAL) (n.d.)).

In addition to efforts by CNLS, ICIS, and OCAL, a key informant indicated that UNAIDS has provided training of different actors within the legal realm, including law enforcement agents regarding the intersection of HIV with stigma and discrimination in the law (KII24). He also indicated that the actors who were trained received these activities with great interest, but there remains a lot of work to be done in the area of sensitization training of law-makers and law enforcement agents (KII24). No formal documentation of these trainings could be found and no further information was available regarding the scope of the trainings, how many people were trained, and whether the trainings were deemed to have been successful.

A representation of the government indicated that some initiatives do exist to protect people living with HIV (KII12). These initiatives include the provision of security agents for events and protests organized by LGBTQ persons or other key populations and a team of security agents that may be deployed as needed for their protection. A key informant said that the city of Cotonou provides these services whenever they are requested and that their office provides agents to attend sexual health education events that explain to people that they have the same rights as everyone else. However, little data from the review described these programs in more detail and it is unclear how much coverage these programs have provided to key and vulnerable populations.

Limitations/Challenges

The assessment of the workshops organized by ICIS notes constraints such as weak involvement of community actors and media, lack of support for awareness-raising campaigns around stigma and discrimination, and the absence of a legal or regulatory framework for sex work in Benin. Additionally, while the organizing process engaged stakeholders on many levels, unfortunately there have been no documented efforts to operationalize the suggestions contained in the report. The first step is to engage lawmakers and law enforcement agents in a collaborative process, but there has been no (visible) commitment by these stakeholders to take the lessons learned through such trainings and apply them to national policy. These sensitization strategies may, nevertheless, be effective at sensitizing those in attendance, even though there has been no formal evaluation of the results, which are difficult to measure.

One of the major limitations of several of the projects undertaken in Benin around human rights-related barriers to HIV services has been a lack of documentation of the results of programming and whether activities have been effective in reaching the target populations.

Comprehensive programming
The data demonstrate remarkable opportunity to address the following areas of need for programs that sensitize law-makers and law enforcement agents to the needs of key and vulnerable population, including:

- Institutionalize a training program for the police on the reduction of stigma, discrimination and violence against key populations. The curricula should incorporate information to increase knowledge of HIV transmission, disseminate information regarding stigma and discrimination experienced by key and vulnerable populations, the impact of HIV in cases of sexual violence, and sensitization to the negative consequences of illegal police activity on justice and on the HIV response. This curriculum should also include training around gender-based violence, intimate-partner violence, and gender discrimination more broadly. The training curriculum should also incorporate sessions explaining the importance of understanding the effectively implementing laws that protect key and vulnerable populations in Benin. The manual developed by OCAL, Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos, should be leveraged for this activity.
- Develop a process to review the practices of law enforcement agents and officers who work in prisons and to assess the effect of their behaviors on access to justice for people living with or vulnerable to HIV.
- Develop a training curriculum on the reduction of stigma, discrimination and violence against key and vulnerable populations, HIV-related human rights, and gender-based violence to be implemented for law students to reach legal professionals through required instruction in law schools. This training, once developed, should be rolled out with the aim to build capacity within individual law schools to implement this program sustainably. The manual developed by OCAL, Modules de formation et de sensibilisation

sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos, should be leveraged for this activity and adapted specifically to Benin as needed.

- Develop training tools and job aides for key messages from the the manual developed by OCAL, Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos.
- Develop a training program that provides information and training for prison personnel on the prevention, health care needs and human rights of detainees living with or at risk of HIV infection, including comprehensive stigma and discrimination reduction training.
- Convene a meeting to review the minimum package of activities developed by ICIS to support key and vulnerable populations that they suggested should be implemented in Benin to develop action plan and develop tools to support implementation of and adherence to minimum package of activities.

Program Area 4: Legal literacy ("know your rights")

The table below provides an overview of current programmatic efforts in the area of HIV-related legal literacy as well as recommendations for scaling up these activities. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table.

Legal Literacy					
Program	**Description**			**Limitations**	
Development of Informational Material and References	Development of training manuals or other materials intended to be used to disseminate knowledge of human and legal rights among people living with HIV and other key and vulnerable populations			Informational materials have been developed, but the number of training sessions conducted and number of people reached was not available at the time of this assessment. Stakeholders referenced a critical need for more texts and resources in local languages. Many educational materials are available only in French, which is not well understood by all members of the populations being served. When texts are translated into local languages, the translations are not always exact or easy to follow.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
OCAL	MSM; FSW; PWID; Other key stakeholders	Manual designed to inform KPs and key actors such as journalists, judges, lawyers, other legal professionals, and law enforcement agents about legal issues related to HIV, GBV, and the protection of human rights of key populations.	Unknown	Unknown	While materials have been developed, the quantity and effectiveness of training sessions has not been documented. Existing materials should be adapted to include trans women. Additionally, materials should be developed in local languages to maximize the reach of programming. Materials with illustrations could be piloted to determine effectiveness with individuals with limited literacy.
ABDD/IDLO	Unknown	Development of a booklet titled "Human Rights protections in the law related to HIV and AIDS in Benin," which uses illustrations to communicate legal information related to HIV/AIDS	Unknown	2009-2011	
Program	**Description**			**Limitations**	
Community mobilization and education	Awareness raising campaigns and activities that provide information about rights and laws related to HIV			Information regarding legal literacy efforts is limited and the reach of existing programming is unclear. There is a noted lack of awareness-raising campaigns providing	

				information about HIV-related rights & laws through the media. A lack of peer outreach efforts to educate KPs about their legal rights.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
Ministry of Justice	Women and girls; People with disabilities	Engages in activities to disseminate information about laws related to human rights as related to HIV	Unknown	Unknown	The fieldwork highlighted the fact that some work to promote legal literacy has been undertaken, but that no systematic approach or programming has been introduced in the country. Legal assistance programming should be expanded to provide to provide services for all key and vulnerable populations in the country. Legal literacy programming could also be integrated with legal assistance programming described in PA 5 below. Initiatives have been introduced to train paralegals to provide legal services to several groups of key and vulnerable populations, which could be expanded to include other key populations and to include community education efforts around HIV-related human rights.
RACINES	PLHIV	Provides information to women living with HIV about their rights under the law	Unknown	Unknown	

Current Programs

Information regarding legal literacy efforts in Benin is limited and the reach of existing programming is unclear. The fieldwork highlighted the fact that some work to promote legal literacy has been undertaken, but that no systematic approach or programming has been introduced in the country. Manuals for several information and training sessions to increase knowledge of legal rights among people living with HIV and other key and vulnerable populations have been published, but data regarding the number of sessions conducted and number of people reached was not available at the time of this assessment.

Materials and References

Described in the previous section, OCAL created a manual whose purpose was to sensitize relevant stakeholders about human rights as related to gender-based violence and HIV. While the manual does provide information that can be used to sensitize decision-makers to human rights issues faced by key populations, its primary goal is to inform target groups (key populations and key actors) about HIV, gender-based violence, and human rights more broadly (Organisation du Corridor Abidjan-Lagos (OCAL) (n.d.)). There is no data available about how many people have been reached with this training manual and the effectiveness of the training on increasing HIV-related legal literacy among key and vulnerable populations.

Another resource was developed in 2016 by the International Development Law Organization (IDLO_ and the *Association Béninoise de Droit du Développement (ABDD),* with the support of UNAIDS and OFID (International Development Law Organization 2011). The booklet "Human rights protections in the law related to HIV and AIDS in Benin" acts as a law guide for a broad audience in Benin's communities, and primarily uses illustrations to communicate HIV-related legal information (International Development Law Organization 2011). The existence of this resource provides strong opportunity for legal literacy programs to be developed around its contents, however, there was no data available for how many people have been reached using the booklet at the time of this assessment.

Community mobilization and education

The Ministry of Justice also engages in activities to disseminate information about laws related to human rights, in particular those related to the rights of women and girls and people living with disabilities in general (KII14). According to a key informant, programming includes working with groups of women to address issues specific to women such as gender-based violence or repression experienced by women (KII14). The programming efforts of the Ministry of Justice do not seem to engage with or disseminate information regarding human rights protections for populations other than women and girls and people living with disabilities (KII14 , KII33). Similar to other HIV-related legal literacy efforts, no data was available regarding the specific contents of the activities organized by the Ministry of Justice, nor was data regarding how many people have been reached with these efforts.

Limitations/Challenges

Aside from the training manuals, booklets and components of the pilot project cited in the Legal Services section of this report, the assessment did not find a significant body of programs that provide legal literacy resources and education related to human rights barriers to HIV services.

There was a noted lack of awareness-raising campaigns that provide information about rights and laws related to HIV through the media, and a lack of peer outreach efforts that seek to educate key and vulnerable populations about their legal rights.

In individual interviews, stakeholders and key informants confirmed these concerns, mentioning the lack of legal assistance available to key and vulnerable populations in the country. One key informant indicated that programs in the country have not succeeded in educating people about their legal rights, explaining that legal rights in the domain of HIV still are not well known or respected (KII24). Many key informants highlighted the essential need for vulgarization of Law 2005-31 concerning the prevention, care and control of HIV/AIDS, as many citizens of Benin are not aware of its existence and enforcement of the law remains weak (KII1 , KII7 , KII24 , KII25 , KII26 , International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009).

Stakeholders referenced a critical need for more texts and resources in local languages. Many educational materials are available only in French, which is not well understood by all members of the populations being served. When texts are translated into local languages, the translations are not always exact or easy to follow. The need for materials translated into local languages, although highlighted in the category of legal literacy, extends to other program areas.

Comprehensive programming

- Legal literacy and education on the rights of people living with HIV should be disseminated through a public awareness campaign, including information regarding human rights related to HIV services and the protective aspects of Law 2005-31.
- In concert with a public awareness generation campaign, legal literacy activities should be coordinated in schools, the workplace (including bars and restaurants), prisons, and social and healthcare domains may serve to support key and vulnerable populations' justice seeking beginning at earlier ages and serve to sensitize broader populations to their rights. Additionally, activities should be tailored for each key and vulnerable population, thus addressing their specific needs. Activities organized by networks of PLHIV and key populations could include monthly education and listening sessions for people living with HIV, men who have sex with men, female sex workers, people who inject drugs, women who work in bars and restaurants, prisoners, and youth on topic of human rights, including rights to privacy and confidentiality of HIV status, right to access HIV services, and freedom from discriminatory behaviors and unwarranted arrest. These sessions would be conducted either within the offices of the CBO organizing the session, or at a safe and confidential venue for PLHIV.
- Peer outreach is another strategy that can be used across program areas. Dissemination of legal literacy resources to key and hidden populations and, particularly, to those which are hidden, may be more effectively accomplished through peer-led outreach and telephone hotline approaches. Telephone hotline approaches, which have been successfully implemented through the CJAV centers and have been successful in many low-resource settings, could be implemented relatively cheaply and would eliminate

barriers for those who are uncomfortable accessing services in public spaces due to the experience of stigma and discrimination.

Program Area 5: HIV-related legal services

The table below provides an overview of current programmatic efforts to provide HIV-related legal services as well as recommendations for scaling up these activities. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table.

HIV-related legal services					
Program	**Description**			**Limitations**	
Legal advice, information, representation, and referrals	These programs include activities that facilitate access to justice and redress for people living with HIV and women in cases of HIV-related discrimination (in employment, education, housing, or social services), dispute resolution, property grabbing, child custody or other legal matters related to HIV, such as breaches of privacy and confidentiality and illegal action by the police. Activities include provision of information and advice regarding legal rights, as well as representation and referrals.			Major barriers to implementation of such programs include: fear of stigma or familial/social marginalization, lack of literacy to digest written informational materials; financial costs; a dearth of paralegals and lawyers; and a lack of scaled programming for victims of GBV, youth, KPs experiencing discrimination, or other forms of injustice. Major obstacles to legal service effectiveness in human rights cases include lack of documentation of instances of discrimination against PLHIV & other KPs and the absence of a formal mechanism for individuals to report experiences of stigma or discrimination.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
ABDD	PLHIV; Government Officials	Training government officials; organizing round-tables and workshops to disseminate information regarding human rights-related barriers to HIV services	Unknown	Unknown	Several organizations have developed mechanisms to provide legal services to key and vulnerable populations in the context of HIV services. ABDD, with the support of IDLO and OHCHR, has in the past offered programing to PLHIV and other KPs for legal assistance in the case of the experience of human rights violations in relation to accessing HIV services. This service should be scaled up to increase the range of key and vulnerable populations who are
ABDD (with support of IDLO and OHCHR)	PLHIV	Legal consultations, legal advice and legal assistance provided to PLHIV and other key and vulnerable populations with the aim of reducing HIV-related stigma and discrimination and other human rights-related barriers to HIV services	In 2015: 58 legal consultations 2,653 provision of advice & legal information	2009-2015	

			60 legal assistance provided		included in programming. One valuable strategy included the training of paralegals on HIV-related human rights issues to provide legal support to key populations, which may extend the reach of programming farther than if only lawyers and judges were trained on these issues. Following the model of the program from 2010, services could include workshops to train legal professionals on the link between HIV and human rights and the role of justice and the law in reducing discrimination and stigmatization. Comprehensive monitoring and evaluation need to be built into programming planning efforts
ABDD & AFJB	PLHIV; People with disabilities; Family members of PLHIV; OVC	Pilot project carried out to provide legal services to PLHIV, people with disabilities, families of PLHIV and OVC. Program staff met clients at their regular healthcare facilities, increasing confidentiality and decreasing stigma faced by participants. Organized capacity-building workshops with PLHIV, healthcare providers, legal professionals, law enforcement agents, and other stakeholders involved with the project	At mid-term evaluation: 96 legal information sessions for PLHIV 67 legal consultations 127 files opened: 79 carried to term; 47 settled using alternative means	2010-2012	
ABDD/IDLO	PLHIV; Legal stakeholders	Train-the-trainer workshops on the promotion of legal services, organized to increase knowledge of the link between HIV and human rights, the role of justice and law in reducing discrimination and stigmatization, and availability of HIV-related legal services.	2 train-the-trainer workshops 80 participants	2010	
RACINES	PLHIV	Organize workshops with lawyers, members of civil society, and the mayor's office to encourage them to respect the human rights of PLHIV and other KPs.	Unknown	Unknown	

Current Programs

According to UNAIDS, HIV-related legal services include the provision of legal information and referrals, legal advice and representation, engaging religious or traditional leaders with a view to resolving disputes and changing harmful traditional norms, and strategic litigation (UNAIDS 2012). There have been several initiatives to provide legal services to women and people living with HIV, however, legal services that address human rights-related barriers to HIV services need to be expanded to reach other key and vulnerable populations in Benin.

Legal advice and representation for people living with HIV

There have been several initiatives to provide legal services for people living with HIV in Benin. Since 2009, ABDD has engaged in the fight against HIV and the protection of vulnerable individuals through various activities such as the training of government officials, round-tables, workshops, and the defense of victims of stigma and discrimination.(CNLS 2016) The activities of ABDD include following and reforming national laws and policies, evaluating stigma and discrimination in communities and institutions, and providing programming to familiarize individuals with their rights.(KII7) Working in concert with the PSLS, ABDD also provides legal aid at treatment centers to people living with HIV who have been victims of violence, stigma or discrimination due to the fact that they are living with HIV.(CNLS 2016) A report outlining the national strategy to fight HIV-related stigma and discrimination in Benin for 2017-2020 indicates that the level of legal assistance provided in the current national response is insufficient.(CNLS 2016) A stakeholder in an initial phone interview indicated that this program is currently only available for people living with HIV. However, a representative of ABDD attested that AFJB currently helps them with activities that cater to other key populations, suggesting that the program could be extended to include other groups.(KII2) PSLS also provides resources to ABDD to defray legal costs in the case of a court case concerning a person living with HIV.(KII26)

Legal information and referrals for people living with HIV

A pilot project was carried out in a partnership between the ABDD and AFJB at three sites in Cotonou to provide legal services to people living with HIV, people with disabilities, close family members of people living with HIV, and orphans and vulnerable children.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) The project was designed to address lack of widespread knowledge of and enforcement of national laws on HIV prevention and care, high levels of stigma and discrimination among people living with HIV, and difficulties in seeking legal recourse following cases of discrimination.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) The program, *Promotion des services juridiques au profit des PVVIH et d'autres personnes vulnérables au Bénin* was implemented by ABDD in partnership with the Association des Femmes Juristes du Bénin (AFJB) and funded by the OPEC Fund for International Development (OFID) with technical assistance from International Development Law Organization (IDLO).(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) The program was first implemented in July 2010 in Cotonou and was carried out for two years.(International Development Law Organization (IDLO) & Association Béninoise de Droit

du Développement (ABDD) 2009) The project held workshops and information sessions with people living with HIV and key stakeholders, such as physicians, lawyers, and members of law enforcement, to make them aware of the national law for HIV/AIDS care and control, increase knowledge about the link between HIV and human rights, and provide legal support for people living with HIV.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) According to a midterm program evaluation, the program reported significant improvements in participants' legal knowledge, regarding both PLHIV program beneficiaries and the legal staff involved.(International Development Law Organization 2011) In 2015, the program provided 58 formal legal consultations, provided legal assistance in 60 cases, and provided legal advice and information in more than 2,500 instances.

This program carried a key strength of accessibility to its beneficiaries. For example, program staff met clients at their regular healthcare facilities, which enabled clients to receive treatment, social services, and legal assistance in the same location. A midterm report from the program notes that this increased confidentiality and minimized stigma faced by participants.(International Development Law Organization 2011) The report also highlighted the importance of raising awareness of the national laws among key actors other than people living with HIV and vulnerable populations, such as doctors, lawyers and journalists, who were unfamiliar with or who simply "ignored" the law before. This strengthened the capacity of legal services to effectively seek justice for clients.(International Development Law Organization 2011)

Another workshop led by the ABDD as part of IDLO's "HIV and Health Law program," served to strengthen the effectiveness of legal service outcomes for people living with HIV and other vulnerable populations.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) This included two train-the-trainer workshops on the promotion of legal services.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2009) The workshops were held in 2010 and consisted of the following objectives: increasing knowledge of the link between HIV and human rights, the role of justice and law in reducing discrimination and stigmatization, and HIV-related legal services.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2010) Eighty participants attended the workshop, including people living with HIV and legal service stakeholders.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2010) A post-workshop evaluation from participants showed that the workshop largely accomplished its objective to "strengthen the capacity of participants to know and better protect the rights of people who are HIV/AIDS-affected, the measures to be taken to preserve these rights and to better manage associated legal issues."(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2010) These objectives were intended to lead to better management of HIV/AIDS.(International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) 2010)

Legal information and referrals for women

When asked about services or programs in Benin that support the human rights of women living with HIV, responses from stakeholders were mixed. For example, the majority of the women in the focus group convened for women living with HIV indicated that there are no representatives or organizations in positions of power who fight for their rights, and several indicated that no formal programs or services exist to defend or protect the rights of women living with HIV.(FGD3) However, two women in the same focus group indicated that the organization RACINES advocates for the rights of women living with HIV on a small scale and that they provide the women with information about what their rights are under the law.(FGD3) In addition to providing information to women at the center, RACINES has convened workshops with lawyers, members of civil society, and the mayor's office in order to encourage them to respect the human rights of people living with HIV and to take into account the needs of key populations.(KII28) Though participants in focus groups were in consensus about the value of services provided by RACINES, no data on these activities were made available at the time of this assessment.

Limitations/Challenges

Several challenges noted by the program implemented by ABDD can help inform future legal service planning efforts. These include an issue of the "sociological and cultural environment" in Benin that does not favor or promote prosecution or legal recourse. Women, in particular, face barriers to taking legal action against a spouse or family members due to risk of familial or social marginalization. Illiteracy also prevented some participants from understanding invitations sent by ABDD for workshops. Individuals do not have easy access to the legal system. Clients also faced financial barriers of additional costs in the process of hiring a lawyer, obtaining legal files and for submitting a case. Due to the geographic limitation of the project to three sites, it was noted that clients who use the ABDD services at any of these three sites could disseminate information about the project in their communities, but the project was not widely discussed due to fear of stigma. Other major obstacles to legal service effectiveness in human rights cases include lack of documentation of instances of discrimination against people living with HIV and key populations as well as the absence of a formal mechanism of assistance for individuals who are exposed to stigma or discrimination.(CNLS 2014)

Few services were found that were tailored to key populations such as female sex workers and men who have sex with men who often need help pursuing legal action for discrimination in work, healthcare, and community settings and as a result of police abuse. Furthermore, there are very few lawyers in the country who specialize in the legal needs of key populations and have the training to represent them when they are confronted with problems.(KII24) A program that provides security support to these populations in the city of Cotonou was mentioned in individual interviews but not found in the literature.(KII12) No scaled programs were found for victims of gender-based violence. Similarly, no systematized services were found for people living with HIV whose sero-status is inappropriately disclosed by a healthcare provider. Nor were services found specifically for youth who are victims of sexual violence or key population discrimination.

Similar to the other programs mentioned in this section, little data on program activities and results demonstrates that comprehensive monitoring and evaluation needs to be built into

programming planning efforts in order to continue to be aware of and to respond to existing gaps in programming.

Comprehensive programming
There has been no systematic programming initiative to provide legal services to people who experience HIV-related human rights violations and legal barriers to HIV services. This leaves a significant need for programs and resources for people to seek recourse and enforcement of their rights, including rights to health information and privacy. Lessons from services that have been piloted can be used to inform the development of comprehensive programming scaled up to provide services for key and vulnerable populations in the country.

- Expand the above-referenced program implemented by the ABDD and AFJB to female sex workers, men who have sex with men, transgender individuals, and victims of gender-based and sexual violence. When scaling legal services, financial barriers of participants should be accounted for. These include transportation costs as well as the cost of the services themselves. Another common theme that should be integrated in service development is the need for anonymity and confidentiality in receiving services. For example, women who pursue legal recourse for intimate-partner violence should have ways of accessing and maintaining participation in legal services that does not increase their risk of further violence through the discovery of their involvement in these services. The same issue applies to the other key and vulnerable populations discussed in terms of the risks that they face due to stigma and discrimination (e.g. among men who have sex with men, transgender individuals, people who inject drugs,female sex workers, and individuals with disabilities).
- Establish partnerships between healthcare and legal clinics, health providers and lawyers. This “one-stop” approach can have many potential benefits, including convenience for target populations, strategy sharing around protecting individuals’ rights from both sectors, coordination of providers, and consistent training on human rights barriers for staff involved in both types of services. Activities can include the development of partnerships between lawyers, legal clinics, medical clinics and hospitals as well as the assessment of the feasibility of positioning legal staff within healthcare settings for referrals for patients who report human rights violations or discrimination.
- Establish a network of paralegals and lawyers positioned in the country to provide free legal consultations to promote human rights among key and vulnerable populations, to assist key populations in reporting human rights violations to the network. Recruitment, training, and development of the development of legal crisis teams to assist swiftly in cases that require immediate attention. In providing legal advice, resolve disputes, help with advocacy and mobilization around rights, and assistance in arrests.
- Capacity-building sessions for lawyers and paralegals in the country on the application of Law 2005-31, including education on the protective elements on the law and sensitization to the elements of the law that have the potential to permit human rights violations of patient living with HIV. This capacity building sessions would be conducted for a group of lawyers and legal professions who agree to provide some level of support pro bono.

Program Area 6: Monitoring and reforming laws, regulations and policies relating to HIV

The table below provides an overview of current programmatic efforts to monitor and reform laws, regulations, and policies relating to HIV as well as recommendations for scaling up these activities. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table.

Monitoring and reforming laws, regulations and policies relating to HIV					
Program	**Description**			**Limitations**	
Advocacy and lobbying for law reform	Advocacy and lobbying efforts to monitor and reform laws, regulations, and policies so they support access to HIV and health services, including revision of existing laws, regulations, and policies and development of new policies to support and protect PLHIV and key populations			No programs were found that systematically monitor law and policy changes that affect the human rights of key and vulnerable populations or the barriers they face to services in Benin. Data collection and documentation of human rights barriers and violations are essential to advocating reform. Stakeholders and key informants emphasized the need for legal reform as it pertains to same-sex sexual relations, criminalization of the activities of PWID, and the rights of PLHIV.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
CNLS	Unknown	Advocacy for legal reform; Revision of legal code of Benin to provide protections of PLHIV	Unknown	2002-present	Coordination between PSLS, CNLS and local advocacy groups to encourage support of the legal reform process and to monitor the implementation of supportive policies and laws, including documentation of continued violations of existing laws and policies that affect access to HIV services should be undertaken. While there are some protective provisions of Law 2005-31, the problematic provisions regarding a provider's rights to breach confidentiality of HIV test results in certain circumstances complicates wide dissemination of the law without sensitivity to which parts of the law are shared and how. PSLS has claimed that they are involved with advocacy efforts to reform this law, which should be supported.
PSLS	Unknown	Advocacy regarding revision of Law 2005-31 regarding the prevention, support, and control of HIV/AIDS in the Republic of Benin	Unknown	Unknown	

Current Programs

In Benin, monitoring and reforming laws, regulations and policies related to human rights barriers to HIV services was highlighted as a goal important to stakeholders. However, few such programs exist to comprehensively address these issues.

Advocacy and lobbying for law reform

The Comité National de Lutte contre le Sida (CNLS) is one association that has taken on the task of developing monitoring and law reform activities. CNLS advocated for the reform of several laws in the time period before 2010, revising the legal code of Benin to provide protections of persons living with HIV (CNLS 2014). Their activities have included reforms that emphasize the right to health of people living with HIV, the development of provisions that HIV testing be voluntary and that test results be confidential (with some problematic caveats), and a mandate for the basic right to health and non-discrimination of people living with HIV (République du Bénin 2006).

The Programme Santé de Lutte contre le SIDA (PSLS), which was previously referred to as the Programme National de Lutte contre le SIDA (PNLS), has also been instructive in the development of laws concerning the prevention, care and control of HIV and AIDS, cited by one key informant as a solid leader in the fight against human rights-related barriers to HIV services (KII11). In April of 2006, Law 2005-31 regarding the prevention, support and control of HIV/AIDS in the Republic of Benin was voted into law, providing certain protections for key and vulnerable populations, including people living with HIV (République du Bénin 2006). Law 2005-31 is described in more detail in Section 4.2.3 above. According to a representative of PSLS and an interview with a key informant in 2017, PSLS is involved in engaged in taking positive steps towards protecting the rights of people living with HIV and is involved in ongoing discussions on how to improve the provisions of the law (KII26 , CeRADIS ONG 2013). According to a representative of PSLS, revisions to the law include efforts to discourage stigmatization of people living with HIV (CeRADIS ONG 2013).

Limitations/Challenges

No programs were found that systematically monitor law and policy changes that affect the human rights of key and vulnerable populations or the barriers they face to services in Benin, highlighting the need for the development of a consistent process to monitor laws, regulations and policies that affect these populations and their access to HIV services.

Surveillance of human rights violations experienced in the context of access to HIV services remains a significant area of need across populations in Benin. Data collection and documentation of human rights barriers and violations are essential to advocating reform. Programs are needed to provide surveillance of human rights violations across key and vulnerable populations, to document delays in legal procedures that impede justice for populations facing discrimination and stigma, and to monitor the regional and local conditions that affect the magnitude of education, employment and housing discrimination faced by key and vulnerable populations. Stakeholders and key informants emphasized the need for legal reform as it pertains to same-sex sexual relations, criminalization of the activities of people who

inject drugs, and the rights of people living with HIV (KII4 , KII7 , KII23 , KII26 , CeRADIS ONG 2013).

There is also a lack of programming that develops legal provisions to protect key populations and there has been no comprehensive assessment of the legal and policy barriers to HIV services and the degree to which the legal environment impedes or supports health service uptake, use, and retention.

One area with the potential for legal reform is through modification of the Penal Code of Benin. The legality of same-sex relations in Benin is contentious, with some sources indicating that sexual acts with individuals of the same sex are penalized and others indicating that they are legal (Amnesty International 2013, Rodenbough 2014, ILGA 2017). The only law in effect regarding same-sex relations is from 1947, which sets an unequal age of consent for heterosexual and homosexual sexual relations ((République du Bénin 1947). While focus groups participants and stakeholders provided no evidence to suggest that same-sex sexual relations have been criminalized in Benin in recent history, the lack of clarity on the law has the potential to create a stigmatizing environment for people engaging in same-sex relations, regardless of whether there is the potential for criminal action against them. Therefore, the law should be clarified and updated to remove all negative references to same-sex sexual relations.

Comprehensive programming

- Support advocacy from the networks of PLHIV and key populations for legal reform and the enforcement of laws, regulations and guidelines that prohibit discrimination and enable access to HIV prevention, treatment, care and support services.
- Coordinate with advocacy groups to encourage support of the legal reform process and to monitor the implementation of supportive policies and laws, including documentation of continued violations of existing laws and policies that affect access to HIV services.
- Support advocacy for the development and implementation of explicitly protective laws to protect the human rights and ability to access HIV services by LGBTQ populations, female sex workers, people living with HIV, prisoners, and youth. For example, although same-sex sexual acts between consenting adults over the age of 21 may not be explicitly illegal in Benin, LGBTQ communities continue to face stigma, criminalization and widespread discrimination. There is no recognition of legal rights for same-sex couples, and no legal protections against discrimination based on sexual orientation (Canada: Immigration and Refugee Board of Canada 2015). Although article 36 of the Beninese Constitution contains a broad anti-discrimination provision, it does not include a specific prohibition against discrimination on the grounds of gender or sexual orientation (République du Bénin 1990, Article 36).
- Support advocacy for the removal or modification of laws that enable healthcare providers to disclose an individual's HIV status without notifying one's partner and without clear recourse if inappropriate disclosure or if reasons for disclosure are insufficient.

PA 7: Reducing discrimination against women in the context of HIV

The table below provides an overview of current programmatic efforts reduce discrimination against women in the context of HIV as well as recommendations for scaling up these activities. The content of the table, the existing program descriptions, and recommendations for a comprehensive approach are included in the narrative below the table

Reducing discrimination against women in the context of HIV					
Program	**Description**			**Limitations**	
Strengthening the Legal and Policy Environment	Strengthening the legal and policy environment through reform of the legal environment and enforcement of laws that protect women and girls from gender inequality and violence; Provision of legal literacy training and legal support services to women and girls in support of human			There is a need to bolster the evaluation capacity of programs for women to better understand women's experience of abuse and violence in healthcare settings, particularly during pregnancy and while giving birth to integrate components that address these issues as appropriate. Challenges identified in this program included unequal coverage of the intended project area, where smaller, more rural communities were left out of awareness campaigns; resistance to formal case reporting and punitive approach of project in some communities, who saw incarceration of community men as "disruptive to family structure and order;" mistrust of police was a barrier to formally reporting cases of GBV; awareness messaging omitted men and boys.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
CNLS	Law enforcement agents; Judges; Social workers	Education and training of law enforcement agents, judges and social workers on methods to provide psychosocial support to victims of GBV Training for paralegals and legal assistants about the rights of victims of GBV	14 support centers created 600 Legal consultations offered to victims of GBV	Unknown	WILDAF Bénin, who was responsible for implementing the EMPOWER II program, is well-positioned to support the development of continued programming efforts for women and girls. The second phase of the EMPOWER program, which reached 700,000 people, ended in August of 2017. There is no concrete information available about whether financing has been secured for a second phase of the project. The project was shown to have a far reach
CAREInternational (EMPOWER I) WILDAF Bénin (EMPOWER II)	Community members; Law enforcement; Government officials; Victims of GBV; Women	EMPOWER I: Supported women and girls in 56 communes through mass media campaign; Community mobilization activities; Sensitization actions to raise awareness of GBV and women's rights-related issues and laws; Advocacy trainings and the	EMPOWER I: 5,000 community members trained in community mobilization techniques 700,000 people reached	2013-2017	

		promotion of GBV legislation among members of the judicial system; Referrals to legal and care/support services EMPOWER II: Opened three integrated support centers for victims of GBV in Cotonou, Goho, and Parakou	EMPOWER II: No formal evaluation		and to be effective in raising awareness of GBV and women's rights-related issues and laws.
Program	**Description**			**Limitations**	
Efforts to reform domestic relations	Efforts to reform domestic relations and domestic violence laws and law enforcement where they fail to sufficiently protect women or create barriers to HIV prevention, treatment, care and support			Without comprehensive evaluations of their activities, it is unclear how effective or how much coverage these programs provide.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
RACINES	PLHIV; Women	Program developed to strengthen participation of spouses in care of women living with HIV	151 women living with HIV and 135 spouses	Unknown	There is insufficient programming that addresses the fact that women may have unstable living situations and may be forced to move frequently due to gender-based discrimination and violence; discrimination in inheritance, property-holding, marriage, divorce and custody; lack of equal access to educational and economic opportunity; and lack of support to caregivers in HIV-affected households.
Program	**Description**			**Limitations**	
Age-appropriate sexuality and life-skills education programming	Programming for young girls that is age appropriate, including life-skills training and sexuality education that seek to reduce gender inequality and gender-based discrimination			Other than these standalone programs for young girls, programming designed for women does not adequately address the needs of young girls.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**

Centres Jeunes Amour et Vie	Young girls	Youth activities, including discussions around gender stereotypes, activities advocating for women and girls' rights, the end of violence against girls and women, and an increase in girls' and women's leadership in the fight against HIV/AIDS	Unknown	May 2012 – 2018	The CJAV centers and Kpote Kiosque program organized by CeRADIS should also be scaled up and efforts to engage young girls in sexual health education and linkage to care for girls living with HIV should be maintained.
CeRADIS – Vulnerable Girls	Young girls	The program creates spaces that welcome young people and provide sexual health education and linkage to health services. The Vulnerable Girls offshoot was developed when the implementers of the program determined that boys were using the services of the program more frequently that young girls.	2012-2015: 100 peer educators trained; 169 counseling sessions; 5,000 youth reached 2014: 138 educational group sessions held	Unknown	
Program	**Description**			**Limitations**	
Programs to reduce harmful gender norms	Programs that seek to reduce harmful gender norms and traditional practices that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women's rights and gender equality.			Programs designed for women in the country have not differentiated the needs of transgender women from cisgender women, nor have programs been designed to adequately address the needs of immigrant women. Immigration is a critical consideration for intervention scale-up at Benin's borders and in cities with significant populations of immigrants. Additionally, current programs do not appear to sufficiently address men and boys in activities aimed at reducing harmful gender norms and gender-based violence.	
Implementer	**Population targeted**	**Activities**	**# Reached**	**Timeframe**	**Recommended scale-up**
RAOFEM	Women; FSW; PWID	Training FSWs to take on leadership roles in the formation of a FSW network; Advocating for FSW rights among law enforcement agents, advocating	Unknown	Unknown	Formal evaluations of the programming organized by RAOFEM were not available, but the RAOFEM network was also frequently cited in the

		for the destigmatization of people who consume drugs			fieldwork as a powerful advocate for women and girls and as an organization that supports women and girls in the context of HIV-related human rights among FSW and women living with HIV. Due to their experience working with women and girls in Benin, it would be useful to engage in RAOFEM in any activities supporting them.

Current Programs

Programming in Benin that address the reduction of discrimination against women in the context of HIV are organized into three main program areas, including strengthening of the legal and policy environment, efforts to reform domestic relations, age-appropriate sexuality and life-skills education programming, and programs to reduce harmful gender norms, including capacity development of civil society organizations working for women's rights and gender equality.

Strengthening the legal and policy environment to ensure that laws protect women and girls from gender inequality and violence

Under the national strategy of CNLS, several activities have been undertaken to provide support for victims of gender-based violence (GBV) (CNLS 2014). Programming has included education and training of law enforcement agents, judges and social workers on methods to provide psychosocial support to victims of gender-based violence and specialized support in 14 centers where legal consultations were offered to more than 600 victims of GBV (CNLS 2014). The national strategy also provided training for paralegals and legal assistants about the rights of victims of GBV (CNLS 2014). A report also cites a weak response to gender-based inequalities and violence as an ongoing challenge for the national response (CNLS 2014).

Another program, the EMPOWER Project, was implemented by CARE and sponsored by USAID from 2007 to 2012. This program served to reduce discrimination against women. The project served women and girls in 56 communes throughout the country. Program activities included a range of components including mass media campaigns and community mobilization and sensitization activities to raise awareness of GBV and women's rights-related issues and laws. (CAREInternational 2013) Additionally, the program provided referrals to legal and care and support services (Arnoff 2013). It also provided "support to the legal system through advocacy trainings and the promotion of GBV legislation among members of the judicial system and forces of law," including for police and local and national government authorities as well as care and support "to survivors of GBV through local referral mechanisms of existing government services and local NGOs"(Arnoff 2013). The program also developed "reintegration support" for survivors and perpetrators by training community leaders in counseling (Arnoff 2013). According to an evaluation of the program and EMPOWER documents, the program reached over 700,000 people nation-wide with nearly 5,000 community volunteers trained in community mobilization techniques (Arnoff 2013, CAREInternational 2013). This included the facilitation of over 2,000 behavior change and communication workshops" (CAREInternational 2013).

An evaluation by Arnoff et al. concluded that several aspects of this program were effective (Arnoff 2013). These included: project messages on women's rights and GBV were deemed effective with powerful impactful awareness campaigns; GBV case reporting processes improved and may have a secondary effect of reducing cases of violence in communities; "DOJ actors were instrumental in drafting, promoting, and passing Benin's first GBV-specific law" in 2011 – the project "lobbied lawmakers and conducted media campaigns," bringing together a coalition of

civil society members, justice system employees, and government officials to build momentum (Arnoff 2013). Additional strengths included the harmonization of intervention approaches from US bilateral actors (DOJ, Department of State, USAID); strong national and local collaboration working in tandem with local referral system engaged community members and organizations and encouraged cooperation across sectors at the local level (Arnoff 2013).

Challenges identified in this program included unequal coverage of the intended project area, where smaller, more rural communities were left out of awareness campaigns; resistance to formal case reporting and punitive approach of project in some communities, who saw incarceration of community men as "disruptive to family structure and order;" mistrust of police was a barrier to formally reporting cases of GBV; awareness messaging omitted men and boys. Additionally, it was noted that lack of funds prevented the program from assisting survivors in seeking medical care and necessary medical documents as well as lack of integrated survivor support, which could have included key financial support and housing for survivors, many of whom have been rejected by their families as a result of formally holding "perpetrators legally accountable for their actions".

EMPOWER II, the second iteration of this project, was led by WILDAF-Benin and supported financially by USAID from June 2013 until August of 2017 (AZANMASSO 2017). WILDAF is an international network of NGOs working for the promotion and defense of human rights, with a specific focus on women's rights and gender-based violence (WILDAF BENIN 2017). The EMPOWER II Project continued with education and advocacy campaigns, capacity building, and support for survivors of gender-based violence. The program opened three integrated support centers for survivors of GBV in Benin, one in Cotonou, one in Goho, and a third in Parakou (Ahossi 2017). WILDAF-Benin had previewed opening three centers, but were not able to complete this work, indicating that they would hope that a third phase of the project could complete this work. There have been no formal evaluations of the effectiveness of EMPOWER II as compared to the original EMPOWER project.

Limitations/Challenges
There is a need to bolster the evaluation capacity of programs for women to better understand women's experience of abuse and violence in healthcare settings, particularly during pregnancy and while giving birth to integrate components that address these issues as appropriate.

Efforts to reform domestic relations

Efforts to reform domestic relations and domestic violence laws and enforcement of domestic violence laws have the ability to reduce the barriers that intimate partner violence can create to HIV prevention, treatment, care and support services for women.

One initiative designed by RACINES was developed to strengthen the participation of spouses in the overall care of women affected by HIV at the organization's AIDS center (RACINES 2015). The project promotes access to testing for spouses of women living with HIV, accompanying spouses when they share the status with their partner, and mobilizing spouses to join the treatment program at the ADIS center with their family members. In the first year (2014-2015),

151 women and 135 spouses of women living with HIV participated in the program (RACINES 2015). The majority of participants and staff had a favorable view of the program at the midterm evaluation and saw an appreciable difference in their spouse's attitude and involvement in terms of financial support, moral support, accompaniment to the center, and assistance in taking medicines. However, some spouses have refused to get tested or to share their status with their wives (RACINES 2015).

Systematic efforts have not been made to address domestic relations and domestic violence through policy reform in Benin. Additionally, no systematic training of law enforcement agents to recognize domestic violence and provide support to women to remove the barriers that such abuse can create to HIV prevention, treatment, care and support have been implemented in the country.

Limitations/Challenges
Existing programs focus on community-level programs that address rights to sexual and reproductive decision-making and gender-based violence. However, it is unclear how effective or how much coverage these programs provide without coordinated, structural approaches to this issue such as provision of comprehensive resources that assist women with sustainable options to leave, protection upon leaving, and social and emotional support around community attitudes toward decisions that women may make to remove themselves from abuse and violence.

There is insufficient programming that addresses the fact that women may have unstable living situations and may be forced to move frequently due to gender-based discrimination and violence; discrimination in inheritance, property-holding, marriage, divorce and custody; lack of equal access to educational and economic opportunity; and lack of support to caregivers in HIV-affected households.

Age-appropriate sexuality and life-skills education programming

A component of the Centres Jeunes Amour & Vie (referenced previously in the stigma reduction program section) consisted of extracurricular activities for youth, including discussions about gender stereotypes that aim to transform attitudes. Additional groups in this project were held on the promotion of rights in schools and villages. Youth clubs were formed for youth to advocate respect for women and girls' rights, to create advocacy networks of youth, to promote local authorities' investment in women and girls' rights and education, to advocate an end to violence against girls and women, and to increase respect for girls' and women's leadership in the fights against AIDS.

The NGO CeRADIS also seeks to reduce gender-driven HIV service barriers among women and girls. The Kpote kiosk project promotes sexual and reproductive rights of young people. Its offshoot, Vulnerable Girls' is a project whose objective is to strengthen the capacity of girls to realize their rights sexual and reproductive health through educational sessions. The program creates spaces that welcome young people and provide sexual health education and linkage to health services. The Vulnerable Girls offshoot was developed when the implementers of the

program determined that boys were using the services of the program more frequently that young girls. In 2014, 138 educational group sessions were held (CeRADIS ONG 2013). From 2012 to 2015, 100 peer educators were trained through the program, 169 peer counseling sessions were held, and 5,000 youth were reached with information about human rights related to sexual and reproductive health and HIV.

Limitations/Challenges
The programs that have been designed for women do not sufficiently address the disparate needs of young girls or older women.

Programs to reduce harmful gender norms, including capacity-development of civil society organizations working for women's rights and gender equality

Le Réseau des ONG et associations de femmes contre la féminisation du VIH/SIDA et les violences faites aux femmes au Bénin [The Network of NGOs and associations of women against the feminization of HIV/AIDS and violence against women in Benin] (RAOFEM) is a network of NGOs and associations in Benin that focuses on supporting the national HIV response as it pertains to issues that affect women and girls. RAOFEM represents and provides support for female sex workers, people who inject drugs and people living with HIV. RAOFEM works to reinforce the capacities of member associations for the equitable access to reproductive services, elimination of gender-based violence and discrimination against key populations and people living with disabilities. Their activities include training female sex workers to take on leadership roles in the formation of a network for female sex workers, advocating for the rights of female sex workers among law enforcement agents, advocating for the destigmatization of people who consume drugs as well as direct distribution of health products (KII30). At the time of this assessment, there was no documentation available about the specific programming that is organized by RAOFEM or results of the activities organized by the organization.

Limitations/Challenges
Programs designed for women in the country have not differentiated the needs of transgender women from cisgender women (women whose gender identity matches with the sex that they were assigned at birth). This is an important distinction to make in terms of programming considerations, as transgender women often experience heightened levels of stigmatization and gender-based violence. The health concerns that transgender women experience are also categorically different than those experienced by cisgender women and it is important that health care providers are sensitized to these health issues in order to provide knowledgeable and non-stigmatizing care regardless of gender identity or sexual orientation.

Immigrant women were also rarely mentioned in program documents and data suggested that multilingual resources are needed for programs to appropriately serve women who speak languages other than French. This is a critical consideration for intervention scale-up at Benin's borders and in cities with significant populations of immigrants.

Additionally, current programs do not appear to sufficiently address the ways in which men and boys engage in community norms that make women and girls, as well as men and boys, vulnerable to HIV infection (RACINES 2015).

Comprehensive programming

Although programs for women living with HIV are present in Benin, interventions addressing discrimination faced by the broader population of women rarely addressed the varied needs of women of by age, location, and economic circumstance. The data from this report demonstrate that the magnitude of gender-based discrimination is greater than the capacity of existing programming to address this issue.

- Facilitate coordination of a coalition of stakeholders involved in gender-based violence prevention and response efforts across sectors, and bring together government institutions and civil society to reduce gender-based discrimination. Bring together actors from the government, community, health, and education sectors to set priorities for gender-based violence reduction.
- As community mobilization and advocacy efforts will increase demand for services, governments and donors will need to ensure a proportionate focus on building support services for survivors of gender-based violence to ensure that the system can meet this increased demand.
- Development of multi-sectoral reference guide and training curricula for government officials, the healthcare sector, legal professionals, and law enforcement agents on GBV, human rights, and gender. Training sessions should discuss abuse, rejection, violence, and the need for legal defense of women and children victims, including partnerships with the Ministry for the Defense of Children in court.
- Sensitization training for health care staff in particular is imperative to reduce stigma-related fear of accessing HIV prevention, treatment and care services for women. The HIV-related stigma is often experienced differently for women living with HIV than men living with HIV. This stigma may manifest in the home as mistreatment, abuse, or abandonment by their partners and/or families or else a fear to disclose their HIV status that leads to difficulties being retained in HIV treatment services. This should include an emphasis on patient rights for women, particularly as in the context of antenatal care. This should be combined with CBO monitoring of health care provision for women. At the health facility, it may manifest as refusal to provide services, mistreatment, breach of confidentiality, gossiping which constitutes violations of the patient's rights.
- Support networks of women living with HIV can be used to reduce self-stigma related to HIV status. Exchange of testimony with other women who have successfully shared their HIV status with their partners and families could be an effective strategy to engage women living with HIV and their partners and families in these activities.
- Tailor specific services for female sex workers and women who work in bars and restaurants based on schedules and area of work
- Behavior change communication strategies should be developed and disseminated to reach men and boys with information regarding gender norms, gender discrimination, gender-based violence, intimate-partner violence, and positive actions that men and boys can take in their communities to address these issues.

2.5 Investments to date and costs for a comprehensive program

1.5 2016 investments and proposed comprehensive program costs

In 2016 a total of around $ 1,084,238 was invested in Benin to reduce human rights-related barriers to HIV services. Major funders and allocated amounts for reduction of human rights barriers to HIV services in 2016 were as follows:

Funding source	2016 allocation
Embassy of the Netherlands	$ 13,225 USD
Global Fund	$ 894,618 USD
Plan International	$ 69,554 USD
Population Services International	$ 45,115 USD
Programme Santé de Lutte contre le SIDA (PSLS)	$ 7,171 USD
Total	$ 1,029,683 USD

Although several funders stated that they were unable to provide exact figures for the amounts allocated to each program area, the assessment team calculated the likely split between program areas by acquiring expenditure data from the funded organizations and matching these to activities under each program area. This gave the following split of funding across program areas to remove human rights-related barriers to services:

HIV Human Rights Barriers Program Area	2016
PA 1: Stigma and discrimination reduction for key populations	$ 213,332 USD
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$ 73,04 USD
PA 3: Sensitization of law-makers and law enforcement agents	$ 176,089 USD
PA 4: Legal literacy (“know your rights”)	$ 213,066 USD
PA 5: HIV-related legal services	$ 95,013 USD
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$ 24,280 USD
PA 7: Reducing discrimination against women in the context of HIV	$ 127,494 USD
Total	$ 849,348 USD

The costing for the 5-year comprehensive program is set out in the following table:

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations	$ 5,407,356 USD
PA 2: Training for health care workers on human rights and medical ethics related to HIV	$ 370,664 USD
PA 3: Sensitization of law-makers and law enforcement agents	$ 76,829 USD
PA 4: Legal literacy ("know your rights")	$ 960,871 USD
PA 5: HIV-related legal services	$ 115,563 USD
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	$ 125,579 USD
PA 7: Reducing discrimination against women in the context of HIV	$ 1,879,493 USD
Total	$ 9,862,507 USD

Details of yearly costs are set out in the main report below and detailed costing information is available in Annex 3.

Costing of a 5-year comprehensive HIV program

Estimated costs for the recommended interventions for the five-year comprehensive program set out are set out in the table below. Detailed intervention areas and costs are set out in Appendix 3.

HIV Human Rights Barriers Program Area (USD)	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction for key and vulnerable populations	1,203,417	996,869	1,193,960	996,869	1,006,326	**5,407,356**
PA 2: Training for health care workers on human rights and medical ethics related to HIV	184,992	0	184,992	0	0	**370,664**
PA 3: Sensitization of law-makers and	38,344	0	38,344	0	0	**76,829**

law enforcement agents						
PA 4: Legal literacy ("know your rights")	210,422	192,113	185,937	178,520	192,113	**960,871**
PA 5: HIV-related legal services	57,675	0	57,675	0	0	**115,563**
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	87,004	0	38,344	0	0	**125,579**
PA 7: Reducing discrimination against women in the context of HIV	414,027	354,190	365,751	354,190	387,884	**1,879,493**
Total	**2,157,537**	**1,543,172**	**2,026,659**	**1,729,228**	**1,785,971**	**9,862,507**

3. Limitations, Measurement Approach and Next Steps

Limitations

Given the rapid nature of this assessment, it is possible that some programs or interventions, particularly those that occur at the local level and those that have less of an online presence have been missed. Furthermore, because fieldwork tool place in the city of Cotonou, it is possible that programming in more remote or rural regions of the country have been missed. However, the inclusion of several stakeholder meetings, such as the inception meeting and multi-stakeholder meeting, as part of the assessment allowed for several opportunities for program implementers and funding agencies to share documentation about programs that were missing from the review.

Measurement approach

Qualitative Assessment

In order to understand how the comprehensive response is influencing human rights-related barriers to HIV services, it will be critical to conduct midline and endline qualitative assessments. Such assessments will provide more nuanced understanding of the various approaches being implemented and will help to understand the combined influence of the structural, community-level and individual-level interventions being proposed. Qualitative assessments could also shed light on new programs, such as systematic pre-service training for law enforcement officers and formalized engagement with practitioners of traditional medicine on the reduction of HIV-related stigma and discrimination that have not been previously implemented in Benin.

Quantitative Assessment
While it may not be possible to quantitatively evaluate all of the programs implemented as part of the comprehensive response, Benin should consider strategically evaluating some of the interventions. For example, it will be important to determine if the stigma and human rights pre-service training for healthcare workers leads to increased utilization of healthcare services for men who have sex with men, people who inject drugs, and people with disabilities. Likewise, it would be important to evaluate the influence of informational materials developed in local languages and adapted to provide information to individuals with limited literacy. In addition to evaluations of specific programs, the impact of the comprehensive response can be assessed with several outcome and impact level indicators, most of which are already being collected in Benin as part of the national monitoring system for HIV. The indicators, baseline values (where possible), data sources and proposed level of disaggregation are described in Annex 2. Data sources included: the 2016 PLHIV Stigma Index; indicators reported to UNAIDS as part of Global AIDS Monitoring (GAM) and Spectrum; the 2011-2012 Benin DHS; and the 2016 Behavioral Surveillance Survey. Outcome indicators are proposed for people living with HIV, key populations, the general population, healthcare workers, institutions and financing.

Measurement Limitations
It will not be possible to directly link the activities supported under the comprehensive response with key outcomes and impacts. However, comparison of baseline values with values collected at midline and endline, and examination of the findings of the repeated qualitative assessments, will provide a sense of how the addition or expansion of efforts to remove human rights-related barriers to HIV services has influenced Benin's progress towards reaching the 90-90-90 targets for HIV.

Next steps
This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights-related barriers to HIV services. Towards this end, the Global Fund arranged a multi-stakeholder meeting in country where a summary of the key points of this assessment was presented for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV services.

4. Setting priorities for scaling up interventions to reduce human rights-related barriers to HIV and services

With funding from all sources for HIV and AIDS programming in Benin decreasing steadily since 2012, there is a need for a more effective approach to improving HIV outcomes through increased access to services. By addressing the human rights-related barriers to HIV services, existing services may be more effectively utilized through increased coverage. Therefore, this assessment proposes programs that would be complementary to those directly involving HIV services. Scaling up programs that aim to reduce barriers to HIV services is an efficient way to improve access and coverage of existing services. Priorities for scaling up interventions are outlined below.

Given the nature of human rights-related barriers to HIV services in Benin, it is recommended that the early focus be on updating existing curricula that address stigma and discrimination reduction among parliamentarians, law enforcement agents, and healthcare workers. Existing training materials could be used as a solid foundation to develop comprehensive training curricula to be integrated into pre-service and in-service training for healthcare workers, law students, policymakers, judges, and the police force. In addition to stigma and discrimination reduction, it is also recommended that these resources be adapted to include training on human rights, sexual orientation and gender identity, human rights-related barriers faced by key populations, and medical ethics. As stigma and discrimination in the healthcare setting was cited as the most pressing barrier to HIV services, efforts should be made to implement training materials as soon as possible for in-service training before eventually scaling up programming within pre-service training for all healthcare staff and within medical schools.

In addition to developing and implementing training materials, expansion of peer education efforts to reach more key populations should be prioritized. It is recommended that these services be maintained for youth and scaled up for female sex workers, men who have sex with men, people who inject drugs, and truck drivers. It is recommended that peer education programming be expanded to train peer educators to reach transgender people, servers in bars and restaurants, and people with disabilities. Peer educators or patient navigators are also urgently need to work with people living with HIV to support access to care and treatment. Transgender women may already be reached by peer education outreach programming tailored for men who have sex with men, but it would be advised that strategies be developed to reach transgender individuals with targeted and sensitized peer education efforts.

Following the completion of these initial activities, legal literacy efforts and legal assistance programming should be scaled up and adapted to reach more key and vulnerable populations. Adapting resources developed by OCAL and ABDD/IDLO into local languages is an urgent need, especially for rural regions of the country. In concert with legal literacy efforts, it is recommended that legal assistance programming be scaled up to continue to reach people living with HIV and expanded to include other key populations. It is recommended that a network of paralegals be developed to provide services for key populations facing human rights violations who provide free consultation sessions for key and vulnerable populations, expanding on the program implemented by ABDD/AFBJ.

As training activities for stigma and discrimination reduction, legal literacy, and legal assistance are scaled up, monitoring efforts should be implemented, including the PLHIV Stigma Index within the next three years. While the capacity of community-based organizations and public institutions is strong, there is a great need for comprehensive monitoring and evaluation to be built into existing and expanded programming.

References

ABMS (2016). Rapport Annuel ABMS 2016.
ABMS (2017). Bénin (2016) : Enquête sur la qualité des services offerts dans les Centres Jeunes Amour et Vie Plus (CJAV) au Bénin. Cotonou, Bénin.
ABMS. (2018). "AMOUR & VIE." from http://www.abmsbj.org/index.php/projets-programmes-2/amour-vie-2.
Ahossi, R. (2017). Fin du Projet Empower Conduit par WILDAF/BENIN: Mme Huguette Bokpè Gnacadja Fait le Point Des Actions. La Presse du Jour.
Ahoyo, A. B., M. Alary, H. Meda, M. Ndour, G. Batona, R. Bitera, C. Adjoni, V. K. Medegan, A. C. Labbe and T. Adjimon (2007). "[Female sex workers in Benin, 2002. Behavioural survey and HIV and other STI screening]." Sante **17**(3): 143-151.
Alary, M., C. M. Lowndes, P. Van de Perre, L. Behanzin, G. Batona, F. A. Guedou, I. Konate, I. Traore, C. Asamoah-Adu, E. Akinocho and N. Nagot (2013). "Scale-up of combination prevention and antiretroviral therapy for female sex workers in West Africa: time for action." Aids **27**(9): 1369-1374.
Amnesty International (2013). Making Love a Crime: criminalization of same-sex conduct in sub-Saharan Africa.
Arnoff, E., Hill, L., Bloom, S.S., & Maman, S. (2013). Empowerment Initiative: Lessons Learned and Implications for Gender-Based Violence Programming in Sub-Saharan Africa, MEASURE Evaluation.
AZANMASSO, T. (2017). Projet Empower II : Wildaf-Bénin et l'Usaid font le bilan. Matin Libre.
Baral SD, Turner RM, Lyons CE, Howell S, Honermann JD, Garner A, Hess R, Diouf D, Ayala G, Sullivan P and Millet G (2018). "Leveraging Social Media to Better Estimate the Number of Gay and Bisexual Men and Other Men Who Have Sex With Men " JMIR.
Batona, G., M. P. Gagnon, D. A. Simonyan, F. A. Guedou and M. Alary (2015). "Understanding the intention to undergo regular HIV testing among female sex workers in Benin: a key issue for entry into HIV care." J Acquir Immune Defic Syndr **68 Suppl 2**: S206-212.
Behanzin, L., S. Diabate, I. Minani, M. C. Boily, A. C. Labbe, C. Ahoussinou, S. Anagonou, D. M. Zannou, C. M. Lowndes and M. Alary (2013). "Decline in the prevalence of HIV and sexually transmitted infections among female sex workers in Benin over 15 years of targeted interventions." J Acquir Immune Defic Syndr **63**(1): 126-134.
Behanzin, L., S. Diabate, I. Minani, C. M. Lowndes, M. C. Boily, A. C. Labbe, S. Anagonou, D. M. Zannou, A. Buve and M. Alary (2012). "Decline in HIV prevalence among young men in the general population of Cotonou, Benin, 1998-2008." PLoS One **7**(8): e43818.
Béhanzin, L. G., F. A.; Geraldo, N.; Mastétsé, E. G.; Sossa, J. C.; Zannou, M. D.; Alary, M. (2016). "Early antiretroviral therapy and pre-exposure prophylaxis for HIV prevention among female sex workers in Cotonou, Benin: A demonstration project."
BESYP (2016). BESYP: Rapport Annuel 2016.
Canada: Immigration and Refugee Board of Canada (2015). Bénin : information sur le traitement réservé aux minorités sexuelles par la société et les autorités, y compris sur les lois, la protection offerte par l'État et les services de soutien. Ottawa, CA.
Canadian HIV/AIDS Legal Network (2007). "A human rights analysis of the N'Djamena model legislation on AIDS and HIV-specific legislation in Benin, Guinea, Guinea-Bissau, Mali, Niger, Sierra Leone and Togo."
CAREInternational (2013). The EMPOWER Project: Fostering Alliances for Action Against Gender Based Violence in Benin: Lessons Learned.
CeRADIS ONG (2013). Plaidoyer du CeRADIS-ONG pour une meilleure efficacité des politiques et programmes de prise en charge du VIH au Bénin: la partition de la pressee béninoise.
CNLS (2014). Plan stratégique national de lutte contre le VIH/SIDA et les IST 2015-2017.

CNLS (2015). "Rapport de Suivi de la Declaration de Politique Sur le VIH Et Le SIDA au Benin 2015."
CNLS, R. (2016). "Plan National De Lutte Contre La Stigmatisation Et La Discrimination Liees Au Vih 2017-2020."
Dia, A. T., I. Seck, F. M'boussou, K. Yao, C. Itamar, S. K. Katz, W. Wong and D. Glandon (2012). Analyse de la Perennite de la Reponse Nationale au VIH et au SIDA du Benin Rapport Final. Bethesda, MD, Abt Associates Inc.
Dugas, M., E. Bedard, G. Batona, A. C. Kpatchavi, F. A. Guedou, E. Dube and M. Alary (2015). "Outreach strategies for the promotion of HIV testing and care: closing the gap between health services and female sex workers in Benin." J Acquir Immune Defic Syndr **68 Suppl 2**: S198-205.
FGD1 Focus Group Discussion with Female Sex Workers.
FGD2 Focus Group Discussion with Men living with HIV.
FGD3 Focus Group Discussion with Women living with HIV.
FGD4 Focus Group Discussion with Men who have Sex with Men (aged > 24 years old).
FGD5 Focus Group Discussion with Men who have sex with men (aged 18-24 years old).
FGD6 Focus Group Discussion with People with Inject Drugs (aged > 24 years old).
FGD7 Focus Group Discussion with People with Inject Drugs (aged 18-24 years old).
FGD8 Focus Group Discussion with People with Disabilities.
FGD9 Focus Group Discussion with women who work in bars and restaurants.
FGD12 Focus Group Discussion with truck drivers.
Hauser Global Law School Program GlobaLex. (2009). "Introduction to Benin Legal and Judicial System." from http://www.nyulawglobal.org/globalex/BENIN.htmls.
ILGA (2017). State-Sponsored Homophobia: A World Survey of Sexual Orientation Laws: Criminalisation, Protection and Recognition.
Immigration and Refugee Board of Canada (2016). "Benin: Domestic violence, including availability of state protection and support services (2009-2015)."
International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) (2009). Services juridiques aux personnes vivant avec le VIH et aux personnes vulnérables du Benin.
International Development Law Organization (IDLO) & Association Béninoise de Droit du Développement (ABDD) (2010). Rapport général de l'atelier de formation des formateurs sur l'approche VIH/SIDA, droits humains et services juridiques au profit des PVVIH et autres personnes vulnérables au Benin.
International Development Law Organization, A. B. d. D. d. D., Association des Femmes Juristes du Bénin (2011). Promotion des services juridiques liés au VIH au Bénin: Rapport de l'évaluation à mi-parcours de la première phase.
KII1 Interview with Representative from ARC-EN-CIEL Bénin. ARC-EN-CIEL Bénin.
KII2 Interview with Representative from ABDD. ABDD.
KII3 Interview with Representative from ABMS/PSI. ABMS/PSI.
KII4 Interview with Representative of BORNES.
KII5 Interview with Representative from BESYP. BESYP.
KII6 Interview with Representative from CARITAS. CARITAS.
KII7 Interview with Representative from CeRADIS ONG. CeRADIS ONG.
KII8 Interview with Representative from Coalition SIDA-BENIN. Coalition SIDA-BENIN.
KII8 (2017). Interview with Representative from Africa Consultants International (ACI). ACI. D. Sow.
KII10 Interview with Representative from CNCO. CNCO.
KII11 Interview with Representative of La Direction de l'Administration Pénitentiaires et de la Protection des Droits Humains. La Direction de l'Administration Pénitentiaires et de la Protection des Droits Humains.

KII12 Interview with representative from the City of Cotonou Service des études de la politique urbaine et des zones d'activités.
KII13 Interview with representative from the Ministry of Communication Ministry of Communication.
KII14 Interview with Representative from the Ministry of Justice Ministry of Justice.
KII15 Interview with Representative from the Ministry of Health Ministry of Health.
KII16 Interview with Representative from the Ministry of Security Ministry of Security
KII17 Interview with Representative from the Ministry of Security. Ministry of Security.
KII18 Interview with Representative from the Ministry of Security. Ministry of Security
KII19 Interview with Representative from "La Nation". "La Nation".
KII20 Interview with Representative from "Nouvelle Expression". "Nouvelle Expression".
KII21 Interview with Representative from OASH-ONG. OASH-ONG.
KII22 Interview with Representative from OCAL OCAL.
KII23 Interview with Representative from Plan Bénin International. Plan Bénin International.
KII24 Interview with Representative from ONUSIDA. ONUSIDA.
KII25 Interview with Representative from PSLS PSLS.
KII26 Interview with Representative from PSLS. PSLS.
KII28 Interview with Representative from ONG Racine. ONG Racine.
KII29 Interview with FSW Representative. Peer educator.
KII30 Interview with Representative from RAOFEM. RAOFEM.
KII32 Interview with Representative from ReBAP+. ReBAP+.
KII33 Interview with Representative from the Tribunal of Abomey-Calavi. Tribunal of Abomey-Calavi.
KII34 Interview with Representative from l'Association des entrepreneurs promoteurs des bars/restaurants de Cotonou.
KII35 Interview with Representative from L'Association Nationale des Transporteurs du Bénin.
KII36 Interview with Representative of ASSOPIL.
KII37 "Interview with Representative from FAJED-ONG."
KII38 Interview with Representative of Syndicat national des transporteurs du Bénin.
Lowndes, C. M., M. Alary, A. C. Labbe, C. Gnintoungbe, M. Belleau, L. Mukenge, H. Meda, M. Ndour, S. Anagonou and A. Gbaguidi (2007). "Interventions among male clients of female sex workers in Benin, West Africa: an essential component of targeted HIV preventive interventions." Sex Transm Infect **83**(7): 577-581.
Ministere de la Santé. (2017). "Les projets-programmes: PNLS - Programme National de Lutte contre le Sida." Retrieved 01/08/2017, from http://www.sante.gouv.bj/spip.php?article29.
Ministère du Développement, d. l. A. É. e. d. l. P. I. N. d. l. S. e. d. l. A. É. I. (2013). Enquête Démographique et de Santé (EDSB-IV) 2011-2012. Cotonou, Benin.
Ministry of Planning and Development (2016). Programme d'Actions du Gouvernement 2016-2021.
Morin, D., G. Godin, M. Alary, M. R. Sawadogo, M. Bernier, N. Khonde, F. Kintin, A. Kone, M. N'Dour, J. Pepin, S. Rached, F. Sobela, J. Soto, M. Sylla and C. Traore (2008). "Satisfaction with health services for STIs, HIV, AIDS among a high-risk population in West Africa." AIDS Care **20**(3): 388-394.
ONUSIDA The Global Fund Ministère de la Sante (2015). "Enquête de surveillance de deuxième génération relative aux IST, VIH et SIDA au Benin(ESDG-2015) Professionnelles de Sexe & Serveuses de Bar et Restaurants."
Organisation du Corridor Abidjan-Lagos (OCAL) ((n.d.)). Modules de formation et de sensibilisation sur les droits et les VBG au profit des populations clés du corridor Abidjan-Lagos (OCAL).

Plateforme ELSA: Centre de ressources francophones sur le VIH/sida en Afrique. ((n.d.)). "BESYP Bénin." Retrieved 03 August, 2017, from https://plateforme-elsa.org/structure/besyp/.
Présidence de la République du Bénin (2016). Programme d'Actions du Gouvernement 2016-2021 Synthese.
Programme National de la Pharmacopée et de la Médecine Traditionnelles (2012). Manuel de Formation: A l'usage du Practicien de la Médecine Traditionelle.
Programme National de la Pharmacopée et de la Médicine Traditionelles (2009). La Pharmacopée et la Médicine traditionelles au Bénin: Etat des lieux et perspectives.
Projet Dindji, U. (2015). Formation des Agents Socio-santaitres sur l'Offre de Services adaptés aux Populations Clés.
RACINES (2015). Evaluation à mi-parcours du projet « Mobilisation des conjoints des femmes séropositives suivies au centre ADIS de RACINES pour le dépistage et le renforcement de la prise en charge familiale du VIH.
République du Bénin (1947). Droit Penal Applicable en Afrique Occidentale Francaise, 1947 Amendment.
République du Bénin (1990). Constitution de la République du Bénin.
République du Bénin (1990, Article 7). Constitution de la République du Bénin, Article 7.
République du Bénin (1990, Article 8). Constitution de la République du Bénin, Article 8.
République du Bénin (1990, Article 26). Constitution de la République du Bénin, Article 26.
République du Bénin (1990, Article 36). Constitution de la République du Bénin, Article 36.
République du Bénin (1990, Article 147). Constitution de la République du Bénin, Article 147.
République du Bénin (1990, Preamble). Constitution de la République du Bénin, Preamble.
République du Bénin.
République du Bénin (2003, Article 2). Loi N° 2003-04 du 03 mars 2003 en matière de santé sexuelle et reproductive, Article 2.
République du Bénin (2003, Article 19). Loi N° 2003-04 du 03 mars 2003 en matière de santé sexuelle et reproductive, Article 19.
République du Bénin (2006). Loi n° 2005-31 du 10 avril 2006, Portant prévention, prise en charge et contrôle du VIH SIDA en République du Bénin. 2005-31. Bénin.
République du Bénin (2006, Article 2). Loi n° 2005-31 du 10 avril 2006 portant prévention, prise en charge et controle du VIH/SIDA en République du Bénin, Article 2.
République du Bénin (2006, Article 6). Loi n° 2005-31 du 10 avril 2006 portant prévention, prise en charge et controle du VIH/SIDA en République du Bénin, Article 6.
République du Bénin (2006, Article 13). Loi n° 2005-31 du 10 avril 2006 portant prévention, prise en charge et controle du VIH/SIDA en République du Bénin, Article 13.
République du Bénin, M. o. H., General Secretariat, Directorate of Planning and Forecasting (2007). National Health Development Plan (2009-2018).
Rodenbough, P. (2014). Being LGBT in West Africa, USAID.
Rodenbough, P. (2014). A Virtual Student Foreign Service Project and Independent Report Exploring Regional Sexual Orientation and Gender Identity Issues.
Santé, I. C. I. (2016). Paquet minimal d'activités au profit des populations cleés au Bénin. Ouidah, Benin.
Semini, I., G. Batona, C. Lafrance, L. Kessou, E. Gbedji, H. Anani and M. Alary (2013). "Implementing for results: program analysis of the HIV/STI interventions for sex workers in Benin." AIDS Care **25 Suppl 1**: S30-39.
Sida, C. N. d. L. C. l. (2011). "Plan stratégique national de lutte contre le VIH/SIDA et les IST 2011-2015."
The Global Fund (2017). HIV, Human Rights and Gender Equality: Technical Brief. Geneva, Switzerland.

Tounkara, F. K., S. Diabate, F. A. Guedou, C. Ahoussinou, F. Kintin, D. M. Zannou, A. Kpatchavi, E. Bedard, R. Bietra and M. Alary (2014). "Violence, condom breakage, and HIV infection among female sex workers in Benin, West Africa." Sex Transm Dis **41**(5): 312-318.
UNAIDS (2012). Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.
UNAIDS. (2016). "HIV and AIDS Estimates (2016)." from http://www.unaids.org/en/regionscountries/countries/benin.
UNAIDS. (2016). "Key Populations Atlas." from http://www.aidsinfoonline.org/kpatlas/#/home.
UNAIDS (2016). Rapport de Suivi de la Declaration de politique sur le VIH/SIDA au Bénin 2016 UNAIDS, Conseil National de Lutte contre le Sida, Ministere de la Sante Republique de Bénin.
UNAIDS (2017). UNAIDS DATA 2017.
UNAIDS/Spectrum. (2016). "HIV and AIDS Estimates (2016) - Spectrum." from http://www.unaids.org/en/regionscountries/countries/benin.
USAID: Projet Dindji, A. G. (2016). Analyse de la stigmatisation et de la discrimination des populations clé dans les médias au Benin et au Togo.
WILDAF BENIN. (2017). "PRESENTATION." Retrieved January 27, 2018, from http://www.wildafbenin.org/presentation/.