Baseline Assessment – Democratic Republic of Congo

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

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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.

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Acronym List

ACHPR	African Commission on Human and Peoples' Rights
AIDS	Acquired immune deficiency syndrome
AMOCONGO	Avenir Meilleur pour les Orphelins au Congo
ART	Anti-retroviral treatment
ARV	Anti-retroviral medications
CAD	Club des Amis Damien
CCM	Country Coordinating Mechanism
CDF	Congolese Franc
CEICA	Centre d'Ecoute et Information Convivial pour les Adolescents
CIELS	Coalition Inter Entreprises de Lutte contre le VIH/Sida, la Tuberculose et le Paludisme
CNDH	Commission Nationale des Droits de l'Homme
CONERELA+	Réseau Congolais des Leaders Religieux Vivant Avec ou Personnellement Affectés par le VIH/SIDA
COMICO	Communauté Islamique en République Démocratique du Congo
CSO	Civil society organisations
DRC	Democratic Republic of Congo
EASHRI	East Africa Sexual Health and Rights Initiative
EHAIA	Ecumenical HIV and AIDS Initiative in Africa
FGD	Focus group discussion
FSW	Female sex workers
ICW	International Community of Women living with HIV
HCW	Health care worker
HEARD	Health Economics and AIDS Research Division
HIV	Human immunodeficiency virus
HTS	HIV testing services
GIPA	Greater involvement of People Living with HIV
IBBS	Integrated Biological and Behavioural Surveillance
KII	Key informant interview
LEA	Legal Environmental Assessment
LGBT	Lesbian, gay, bisexual, transgender
LINAC	Ligue Nationale Anti-tuberculeux et Anti-lépreuse du Congo
LINKAGES	Linkages across the Continuum of HIV Services for Key Populations Affected by HIV
MOJ	Ministère de la Justice
MOT	Modes of transmission

MPSMRM	Ministère du Plan et Suivi de la Mise en œuvre de la Révolution de la Modernité
MSF	Médecins sans frontières
MSM	Gay men and other men who have sex with men
MSP	Ministère de la Santé Publique
MSW	Male sex workers
NGO	Non-governmental organisation
ONUSIDA	Programme commun des Nations Unies sur le VIH/sida
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PNAS	Programme national de la sante de l'adolescent
PNMLS	Programme National Multisectoriel de Lutte contre le Sida
PNLS	Programme National de Lutte contre le Sida
PNLT	Programme Nationale de Lutte contre la Tuberculose
PNUD	Programme des Nations Unies pour le Developpement
PSSP	Progrès Santé Sans Prix
PvVIH	Personnes vivant avec le VIH
RACOJ	Réseau des Associations Congolaises des Jeunes contre le Sida
RENADEF	Réseau National des Organisations Non-Gouvernementales pour le Développement de la Femme
RDC	République Démocratique du Congo
RNOAC	Reseau national des oganisations des assises communautaires
SANRU	Santé Rurale
SGBV	Sexual and gender-based violence
SJS	Si Jeunesse Savait
TB	Tuberculosis
UCOP+	Union Congolaise des Organisation des PvVIH
UHAI	Unjinsia Haki Afya Imani
UKZN	University of KwaZulu Natal
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNIFEM	United Nations Development Fund for Women
US	United States
US$	United States dollar

USAID	The United States Agency for International Development
WHO	World Health Organization

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I. Executive Summary

Introduction

This report documents the results of a baseline assessment carried out in the Democratic Republic of Congo (DRC) 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 DRC, with 19 other countries, for intensive support to scale up programmes to reduce barriers to services. This baseline assessment for DRC, 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 DRC;
- Describe existing programmes to reduce such barriers;
- Indicate what a comprehensive approachto 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.

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[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 DRC. This effort will be followed up by similar assessments at mid- (2019) and end-points (2022) of the Global Fund's strategy in order to capture the impact of the scale up of programmes to remove barriers in DRC and in the other countries included in the intensive support initiative.

Methodology

The assessment was conducted between September and October 2017. It included a desk review, key informant interviews, focus group discussions and a preliminary results validation meeting convened during the final week of data collection. The assessment team did not collect data in conflict-affected areas for reasons of security and accessibility. As a result, this important feature of the context for HIV and TB services in DRC was not included in the assessment findings.

The populations included in the assessment are shown in the table below:

Key populations HIV	**Vulnerable populations HIV**	**Key populations TB**
▪ People living with HIV (PLHIV) ▪ Men who have sex with-men (MSM) ▪ Transgender women ▪ Male and female sex workers ▪ People who inject drugs (PWID) ▪ Prison inmates	▪ Adolescents and young people (particularly adolescent girls and young women); ▪ Women	▪ People living with TB ▪ PLHIV ▪ Prison inmates and prison workers ▪ Health care workers

These populations were selected on the basis of Global Fund criteria; the populations that the DRC defines as key and vulnerable populations within its national strategic frameworks for the multi-sectoral HIV and TB responses; and the guidance of the DRC Country Coordinating Mechanism (CCM). While internally displaced people and refugees in conflict zones are affected by human rights barriers to HIV and TB services, it was not possible during this assessment to gather sufficient data on them.

Summary of baseline assessment findings - HIV

At the time of the assessment, there was a significant gap in current, comprehensive data on the burden of HIV for most of the key and vulnerable populations included in the assessment (the exception is adolescent girls and young women). There was an equally important gap in data on access and uptake of HIV services. However, these gaps may be addressed by upcoming efforts to estimate sizes of key populations as well as to implement an IBBS.

Data that were available at the time of the assessment suggested a significantly higher burden of HIV amongst these key and vulnerable populations as well as lower access and uptake of HIV services, this later trend occurring in a broader context of low uptake and coverage of core HIV services country-wide. For people living with HIV, while their legal and human rights are recognised in law and policy, the assessment nevertheless found that they still face significant barriers to derive benefit from these provisions, mainly due to challenges regarding low levels of enforcement, legal literacy and access to justice. Prevailing socio-cultural norms attribute negative moral connotations to HIV disease meaning that people living with HIV continue to face stigma and discrimination in their personal and social environments, a consequence of which is self-stigma and the limitation this puts on an individual's motivation to seek out and remain in HIV services.

Women and girls, in particular, adolescent girls and young women, face both legal and socio-cultural barriers to HIV services, including a law that sets the age of legal capacity at 18 years, including for independent access to HIV and other sexual and reproductive health services. As a result, those who are sexually active face significant levels of stigma, and sometime refusals, on the part of health care workers (HCWs) when seeking needed services. Where parental consent is required, many will avoid going to health facilities rather than share confidential information about their sexual health needs with their parents. Within families and communities, high levels of stigma and shame surround survivors of sexual and gender-based violence (SGBV), especially those that are HIV-positive, which negatively affects service uptake as well as retention in care for those in need of anti-retroviral treatment (ART).

The situation is much more ambiguous and difficult for men who have sex with men and sex workers. Although these groups are not criminalised in the country, laws or policies to protect them from discrimination and violence either do not exist or are not implemented properly. Socio-cultural attitudes, practices and beliefs impose a heavy burden of stigma and discrimination on these groups within families and communities and affects their motivation to use health services, for fear of exposure and the further negative abuse this would engender. These things also influence the attitudes and practices of health care workers, including within those HIV services that are not provided in the very limited number of locations by key-population-focussed entities. Drug use is criminalised in DRC fuelling discrimination and abuse against people who inject drugs, particularly on the part of health care workers and the police, and limiting what HIV interventions can be implemented, particularly in relation to harm reduction. Conditions in the country's prisons are below the level at which basic necessities of food, shelter and hygiene can be assured meaning that, even when HIV services are available, inmates either cannot access them for lack of privacy or confidentiality, or cannot benefit from them because of malnutrition and other challenges.

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

While there are many human rights and gender-related barriers to HIV services for people living with HIV and other key and vulnerable populations in DRC, there are a number of efforts underway to address them. There are either recently completed or current interventions under each main programme area which, in all cases, key informants felt were contributing towards positive change. Human rights and gender issues were also becoming more and more integrated within broader HIV programming, particularly when comparing the current and new HIV strategic plans, and in comparing the current and new Global Fund programmes. However, it was also evident that most activities to remove human rights-related barriers to services were small in scale and being supported by small amounts of funding. In addition, many projects had not run long enough to be able to determine their effectiveness even at current levels of scale and scope that remain very local and not countrywide.

PA 1: Stigma and discrimination reduction

Current activities include the following:

- Conducting qualitative assessments of HIV-related stigma and discrimination (as a follow-up to the 2012 *PLHIV Stigma Index Survey*), as well as similar assessments for key populations, and for adolescents and young people;
- Convening community dialogues with key populations and local authorities, as part of the implementation of Global Fund and PEPFAR-supported interventions, in order to introduce programmes and to gain support of key local authorities, including the police;
- Conducting public campaigns and events, primarily focussed around World AIDS Day;

- Supporting involvement of people living with HIV in events and processes at provincial and local levels, largely through UCOP+;
- Supporting workplace stigma reduction programmes as a pilot initiative in one province.

A comprehensive approach to stigma and discrimination reduction should include the following actions:

- Implement again the *PLHIV Stigma Index* survey to inform advocacy and to guide programme development, implementation and evaluation. Current data is from 2011 and needs to be updated.
- Analyse data from the planned IBBS survey to provide any further information regarding which key populations (and their locale) might be experiencing stigma, discrimination and other human rights violations. Unfortunately the protocol did not include issues relating to stigma and discrimination or other human rights-related barriers to services.
- Based on the findings of the *Stigma Index* and IBBS surveys, develop coordinated, country-wide, multi-year action plans to reduce stigma and discrimination against people living with HIV and other key and vulnerable populations.
- Support key-population-led networks working in communities to reduce stigma and discrimination and to build personal and collective resilience to resist the negative impacts of stigma, discrimination and violence experienced by their members.
- Support the work of people who are openly living with HIV in communities to reduce stigma and discrimination. Many UCOP+ members already do this work but with limited or no support for their efforts, especially those working outside of urban settings.
- Scale up interventions in communities to engage local leadership, including cultural and religious leaders, in stigma and discrimination reduction. Current efforts that surround Global Fund and PEPFAR-supported *centres conviviaux* should be expanded.
- Scale up comprehensive sexual and reproductive health programmes for key populations that include psycho-social and other support to address the negative consequences of stigma, discrimination and violence. The *centres conviviaux* address this need but are currently limited in number.

PA 2: Training of health workers on human rights and medical ethics

Current activities include the following:

- Inclusion of health care workers in workshops on HIV and human rights convened by the Ministère de la Justice (MOJ);
- Training for health care workers attached to *Centres conviviaux* on issues for people living with HIV and other key and vulnerable populations;
- Monitoring of the quality of HIV services, including challenges of stigma and discrimination against people living with HIV, through the *Observatoire de l'accès et de la qualité des services VIH/TB.*

A comprehensive approach to strengthening professionalism, human rights and ethics in the provision of services for people living with HIV and other key populations should include the following:

- Incorporate content on key populations, medical ethics and human rights in the context of HIV in pre-service and in-service training curricula for HIV, including issues relating to TB and roll out updated in-service training in key health care facilities experiencing low uptake and retention rates.
- Evaluate changes in knowledge, attitudes and practices of health care workers following training interventions.

- Monitor the experiences of key populations, including people living with HIV, using health care services and use the data for advocacy and for improving interventions to reduce stigma and discrimination. The work of the *Observatoire*, which is currently done in three provinces (Kinshasa, Nord-Kivu, Kasai Oriental), should be expanded to other provinces and issues for key populations should be included in the monitoring framework (currently they are not).
- Scale up activities to forge collaborative relationships between health care workers in facilities, and members of key population groups, including people living with HIV for patient/retention support, patients' rights knowledge and feedback on quality of care.

PA 3: Sensitization of law makers and law enforcement agents

Current efforts include:

- A revision to the HIV and human rights training manual to include new content addressing the needs and concerns of key populations.
- Ongoing trainings for magistrates, lawyers, police officers, prison officials and others using the training manual.
- Training and sensitisation of prison workers on the importance of HIV service provision, particularly HIV testing and stigma reduction to encourage prisoners and staff to be tested.

A comprehensive approach to equipping the law and justice sector to be more active and engaged on HIV-related human rights concerns should include the following:

- Update curricula and materials and develop and roll out a training and engagement plan for the police in order to reduce abuses against key populations and to increase police commitment to protecting them in communities.
- Measure the outcomes of the MOJ-led training and sensitisation activities, including changes in knowledges, attitudes and practices regarding key populations, including people living with HIV, and whether or not there is increase support for these groups to address human rights violations against them. Current efforts are focussed on expanding training; however, at the moment it is not clear whether the training reduces abuse and increases access to justice, especially for key populations.
- Support the provincial *Groupes Thématiques* to develop proactive monitoring and response mechanisms for legal and human rights violations against key populations, including people living with HIV, in their provinces.
- Develop tools, materials and strategies to introduce harm reduction approaches to the law and justice sector.
- Develop a multi-year strategy to engage senior policy makers and parliamentarians in a process with civil society advocates, including people living with HIV and other key and vulenrable populations to build a protective law and policy environment for key and vulnerable populations.

PA 4: Legal literacy ("know your rights")

Interventions to improve legal and human rights literacy amongst people living with HIV and other key and vulnerable populations are limited and currently include:

- Work by UCOP+ at national, provincial and local levels to improve knowledge and awareness amongst people living with HIV regarding the Law on the Rights of People living with HIV.
- Limited interventions in prisons to raise awareness regarding HIV-related legal and human rights for detainees, including rights to receive HIV and TB services.

A comprehensive approach to address these gaps and to strengthen legal literacy amongst people living with HIV and other key and vulnerable populations should include the following:

- Develop legal literacy tools for key and vulnerable populations. The tools should address legal rights against assault, police abuses, and other violations these groups experience for which legal protections currently exist. For women and adolescents girls they should include information regarding harmful traditional practices and gender-based violence.
- Expand the content of current interventions for key and vulnerable populations to include legal and human rights literacy through, among other things, training community health care workers as peer human rights educators who can use and disseminate the tools.

PA 5: HIV-related legal service

Current efforts include:

- A primary objective of the workshops led by the Ministry of Justice is to capacitate lawyers and magistrates to apply the Law on the Rights of People living with HIV and to assist those in need.
- UCOP+ operates a 'ligne verte' for people living with HIV to report legal problems (amongst other things) and to be referred for legal advice and support.
- For people who can afford it, lawyers who have been trained are available to take on cases. Some entities have recently been funded to provide services free-of-charge to key populations, including people living with HIV.
- Within the FHI360 *centre convivial* model, there is a plan to assist key populations to report violence and other abuses and to support them to initiate legal processes.

A comprehensive approach to strengthen the provision of HIV-related legal services should include the following:

- Recruit, train, supervise and remunerate peer paralegals among key and vulnerable populations to provide basic legal advice; assist in dispute resolution; help mobilize communities around HIV-related rights, laws and policies; and refer cases to lawyers where appropriate.
- Develop and train a roster of *pro bono* or low cost lawyers willing to work with marginalized populations and supervise paralegals to provide legal support to people living with HIV and other key and vulernable populations.
- Put in place a system to track and monitor human rights violations and legal cases seeking redress.
- Roll out the *'accompagnement juridique'* component of the *centres conviviaux* model.
- Expand the *ligne verte* at UCOP+ to be a service for all key populations, including people living with HIV, to obtain legal information and advice and to be referred to lawyers or *cliniques juridiques* for support.

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

Current efforts include:

- The national *Cellule VIH et droits humains* has been the mechanism for a collective effort to remove provisions of the Law on the Rights of People living with HIV which criminalize HIV transmission and for changing the age of consent for HIV services.
- One outcome of the training at provincial level was the establishment of *Groupes Thématique Droit et VIH* whose purpose is to ensure that the training leads to actions and that they monitor trends and improvements.

- UCOP+'s *observatoire* has a component of monitoring compliance (or lack of compliance) with legal provisions for free HIV services as well as for confidentiality and informed consent.

A comprehensive approach to improving the law and policy environment for HIV programmes should include the following:

- Build capacities of key and vulnerable-population-led organisations to play leadership roles in efforts to secure law and policy reform.
- Support key and vulnerable populations to (a) identify opportunities for reform in existing laws and policies, (b) to develop background papers, legal briefs and other materials to support such reform and (c) develop an action plan for moving forward to improve their legal and human rights protections in the context of HIV. The Legal Environment Assessment conducted in 2013 did not address this.
- Develop and implement engagement plans involving advocates and representatives of key and vulnerable populations with senior policy-makers and parliamentarians to support and champion proposals for law and policy reform.
- Using the NSP 2018-2022 as the starting point, map out and implement a process to put in place a supportive policy framework for the introduction of harm reduction programmes.
- Strengthen the capacity of the Commission Nationale des Droits de l'Homme to be a monitoring body for the protection of human rights for people living with HIV and other key and vulnerable populations.

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

Current efforts to address human rights and gender-related barriers for women in the context of HIV are a sub-set of more comprehensive, country-wide interventions addressing issues of gender equality, women's empowerment, and the prevention of sexual and gender-based violence. The HIV-specific efforts include:

- In addition to participating in UCOP+, women living with HIV undertake their own activities for mutual support and empowerment through their own networks and other implementers.
- There were renewed efforts during the development of the PSN 2018-2021 to re-inforce gender as a crosscutting component. At the time the assessment was being done, a new gender assessment was underway using the revised UNAIDS/WHO tool.
- DRC is piloting a Francophone version of the SASA! Intervention model that has a component of engagement of communities to identify and confront harmful gender norms that perpetuate sexual and gender-based violence and limit access to HIV and other services.
- A pilot project is underway in two provinces to empower adolescent girls and young women with knowledge regarding HIV, human rights and sexual and gender-based violence.
- There are major efforts across the country to respond to sexual and gender-based violence through upstream prevention and comprehensive, integrated service provision that includes HIV testing, PEP, referral for PMTCT or HIV treatment, and access to justice through Cliniques juridiques focussed on responding to such violence.
- The FHI360 model for the *Centres conviviaux* includes an integrated component to address sexual and gender-based violence amongst key populations.

A comprehensive approach to strengthening the component of gender in the national HIV response should include the following:

- Support the human rights and law-related aspects of the results of the HIV/TB gender assessment.
- Sustain and scale-up programmes in communities that address harmful gender norms and prevent sexual and gender-based violence.
- Sustain and scale-up Cliniques juridiques for sexual and gender based violence and support legal advice and support for survivors of such violence.
- Train and deploy women living with HIV and young women as peer paralegals in communities to provide advice, legal knowledge and support, dispute resolution and referral to lawyers where necessary.
- Engage and train local cultural and religious leaders to sensitise communities on gender equality, prevention of sexual and gender-based violence and supporting women's and girls' access to HIV services, including PMTCT.
- Develop and implement gender sensitivity training for all stakeholders in the national HIV response.
- Support women living with HIV to take-up and remain in leadership positions within the national HIV response.

Interventions for adolescents and young people

There are a number of ways that stakeholders are trying to address HIV-related human rights priorities for adolescents and young people, including for adolescent girls and young women. The main examples are:

- A Global Fund-supported pilot project is underway in two provinces (Kinshasa and Mbuji-Mayi) to empower adolescent girls and young women with knowledge regarding HIV, human rights and sexual and gender-based violence. Interventions are delivered through schools, in communities and via health services.
- There are youth-friendly *centres conviviaux* (similar to those for key populations) as well as *Espaces Jeunes*, whose aim is to provide stigma-free and 'safe' environments in order to encourage more youth to use HIV and other health services.
- The *Programme national de la santé de l'adolescent* (PNAS) works with civil society partners to support a cadre of peer educators to improve knowledge about HIV and other sexual and reproductive health needs and link more young people to health services.
- CSOs have been engaged in advocacy for law and policy reform regarding age of consent as well as more accountability for youth-friendly services.
- The PNAS with partners has developed HIV prevention materials for young people from key populations that are meant to be used by CSOs and within youth-friendly spaces.
- CSOs and other non-governmental partners provide positive health and dignity interventions for older adolescents and young people living with HIV.

A comprehensive approach to addressing human rights and gender related barriers in the context of HIV for adolescents and young people, including those living with HIV, should include the following:

- Recruit (from among current outreach efforts/workers) peer human right educators and paralegals to provide human right and legal literacy and support to adolescents and young people living with HIV and other key and vulnerable adolescents and young people.
- Integrate human rights and legal literacy components including gender equality of adolescents and young people from key and vulnerable populations into youth-focussed programmes addressing HIV.
- Develop and implement a plan, including a monitoring framework, to shift HIV service provision, including the knowledge, attitudes and practices of HCWs, should the effort to

change the age of consent for HIV services succeed.

The PSN 2018-2022 makes a stronger, more explicit commitment to addressing human rights and gender in the context of the national HIV response. This includes more detailed strategies for improving the legal and socio-cultural context for HIV-related interventions for key populations. This in a sense provides a ‘blue print’ for developing more detailed plans and strategies that take into consideration the specific recommendations for building a comprehensive approach that are described in this report.

What a comprehensive program will cost – HIV

As a final component of the assessment for HIV, a prospective cost to implement the comprehensive approach was calculated. This is shown in **Table B**, below:

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations	USD 2,163,67
PA 2: Training for health care workers on human rights and medical ethics related to HIV	USD 2,539,726
PA 3: Sensitization of law-makers and law enforcement agents	USD 1,418,087
PA 4: Legal literacy (“know your rights”)	USD 466,583
PA 5: HIV-related legal services	USD 1,749,193
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 735,035
PA 7: Reducing discrimination against women in the context of HIV	USD 2,888,049
Other activities	USD 593,578
TOTAL	**USD $12,553,930**

Table B. Total Cost of 5-Year Program- refer to Annex A for more details

There was a challenge to collect comprehensive cost data for this component of the assessment meaning that estimates are, in some cases, broadly indicative. In addition, comprehensive programmes to address sexual and gender-based violence and to reduce HIV-related vulnerabilities for adolescent girls and young women were not costed due to insufficient data from current programmes. What is shown in this category are costs for programmes to improve access to HIV services for adolescents and young people more generally. The findings from the assessment on the level of current investment indicated that approximately US$1.7 million was available in 2016 for human rights and gender-related interventions, with programmes addressing sexual gender-based violence and adolescent girls and young women accounting for 85% or more of this amount.

Summary of baseline assessment findings - TB

The assessment identified that, while the TB epidemic is extensive in DRC, data are generally not available to show its differential impacts on the different key and vulnerable populations identified under the TB PSN and included within this assessment. Designated TB services are not available in all parts of the country and serious health system weaknesses limit the quality and availability of these services where they are provided. The human rights and gender-related dimensions of the TB epidemic are mostly undocumented and not well understood by most TB stakeholders, including the PNLT. The assessment did, however, identify some important barriers, particularly TB stigma in communities, including self-stigma, largely related to lack of knowledge about TB and TB treatment and negative associations with the illness. Fear of stigma, and internalised negative beliefs about TB, mean that individuals affected by the disease will delay seeking diagnosis or treatment until it is in an advanced stage. User-fees for TB screening (TB treatment itself is free) in health facilities also operate as a deterrent.

Although the country has infection control and workplace health and safety standards, implementation and compliance with them are poor. This places health care workers, in particular, at elevated risk of TB exposure. Although key informants were of the view that TB was a major concern in the mining sector, there are no data on TB for this sector and, consequently, no ability to know the extent of human rights barriers that may arise for mineworkers needing TB services. Finally, as already noted in the findings for HIV, there are major challenges in prisons for providing HIV and TB services. The large number of prisoners in temporary detention, either awaiting trial or sentencing, has a compounding effect on TB risk. Poor physical conditions in prisons, particularly malnutrition and severe overcrowding, limit the effectiveness of the TB services that are provided.

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

The assessment found that, while there is growing multi-sectoral engagement within the national TB response, there are almost no specific, human rights or gender-focused interventions in the context of TB in DRC. Those efforts that do exist include the following:

- All of the civil society key informants spoke about their efforts to integrate some human rights components as unfunded 'add-ons' into their community-level work, particularly the component of stigma reduction through improving community knowledge and awareness regarding TB.
- A component of UCOP+'s *observatoire* is monitoring access to TB screening for people living with HIV, including availability of the service and fees charged.
- At the time the assessment was carried out, a TB/HIV gender assessment was underway. The findings of the assessment, when available, will be an important source of guidance on how to strengthen the gender component of both the HIV and TB responses.
- Finally, a number of international and local partners are working with the Ministry of Justice to support TB programmes in prisons with activities that are largely focused on TB screening. This work has a component of improving knowledge and awareness about TB that also helps to reduce TB-related stigma. However, this work does not directly address human rights.

A comprehensive approach to addressing human rights and gender-related barriers to TB services should include the following:

PA 1: Reducing stigma and discrimination

- Measure TB-related stigma and discrimination in in communities. The PNLT with its technical partners should conduct a KAP study and develop an action plan to address the results.
- Measure TB-related stigma and discrimination in different sectors. Additional, focussed KAP studies should be done in the health, mining, and law and justice sectors (police, prisons, the military).
- Implement community level activities to reduce TB stigma and discrimination. Through the civil society platform, there is a structure in place to coordinate this work. What is lacking is adequate funding.

- Based on the results of the KAP studies, implement workplace programmes on TB awareness and stigma reduction. This work should have an initial focus on the mining sector (which the PNLT has identified as a priority), the health sector, the police and prisons.
- Measure TB-related stigma for people living with HIV and other key and vulnerable populations. Ensure that the next PLHIV Stigma Index Survey and studies on stigma, discrimination and violence amongst key populations include questions on TB-related stigma and discrimination.
- Integrate content on TB-related stigma and discrimination into efforts to reduce HIV-related stigma and discrimination. This should be done where feasible, especially in programmes working directly with people living with HIV and other key populations who are also at high risk for TB.

PA 2: Training of health care providers on human rights and medical ethics related to TB

- Include content regarding TB and human rights in TB training for health care workers. Where TB is addressed, in either pre-service or in-service training, content on the human rights and medical ethics of TB patients and the role and rights (to a safe working environment) of health care workers should be included and receive sufficient time and emphasis.
- Strengthen TB-specific workplace policies and practices for health care workers. While the PNLT moves to gather data on the situation of health care workers and TB, it should, at the same time, work with the MSP to strengthen protective policies and practices for health care workers and protect them from discrimination in the workplace.
- Monitor the availability of personal protective equipment and compliance with other infection control standards for TB in health facilities. This could be done as a collaborative venture of the TB civil society platform with the PNLT.

PA 3: Sensitization of law-makers, judicial officials and law enforcement agents

- Include TB-related human rights issues in HIV training for police, lawyers and magistrates. The HIV and human rights training manual can be expanded to include a section on TB and training based on the manual expanded accordingly.

PA 4: Legal Literacy (Knowing your TB-related rights)

- Develop and distribute TB-focussed rights/responsibilities literacy materials in communities. This should be an activity for the members of the civil society platform and should involve recruiting and training human right peer educators from TB community health outreach workers. Distribution of materials can be integrated with the community-level stigma reduction activities noted above.
- Integrate TB topics within legal literacy materials and activities for HIV. As legal literacy activities are strengthened and expanded for HIV, topics addressing TB can also be included.

PA 5: TB-related legal services

- Include TB-related issues in training for lawyers providing legal services for people living with HIV and other key and vulnerable populations. The training can be based on the revised HIV and human rights training manual noted above.

- Ensure that community level *Clinique juridiques* can also provide advice and support for claims regarding TB. This can occur as part of the training lawyers working in the clinics established for HIV and sexual and gender-based violence.
- Train and deploy peer paralegals in communities to provide information on TB-related legal and human rights, to do mediation, and to link to legal services. These paralegals can be part of the cadre of peer educators working in communities to reduce stigma and discrimination. They can also be attached to and supervised by *Cliniques juridiques* as outreach workers.
- Monitor and issue reports on TB-related human rights trends, and on access to justice. This should be a function of the civil society platform.

PA 6: Monitoring and reforming laws, regulations and policies relating to TB services

- Undertake a TB-specific legal and policy assessment and address results. As already noted, the 2013 LEA did not address TB. This gap should be closed.

PA 7: Reducing gender-related barriers to TB services

- Support the implementation of the human rights related aspects of the findings of the TB/HIV gender assessment. As the findings will become available after this assessment, they should be supported to address specific gender and human rights related barriers in the context of TB.

PA 8: Ensuring confidentiality and privacy

- Undertake an assessment on confidentiality and privacy across the national TB response. The assessment should incorporate the activities of CSOs and others, for example, that support the national TB response, as well as what takes place in health facilities.
- Based on the results of the assessment, develop a plan to strengthen confidentiality and privacy of health information across the national TB response. In addition to actions to strengthen practices in health facilities, guidelines and tools should also be developed/strengthened for CSOs and other partners working on the PNLT.

PA 9: Mobilizing and empowering patient and community groups

- Support the civil society platform to mobilise networks of people living with/affected by TB in communities for mutual empowerment and support as well as for legal literacy and mobilisation around human rights concerns regarding stigma, discrimination and lack of confidentiality related to TB. This should be a component of the programme of work for CSOs in communities

PA 10: Programmes in prisons and other closed settings

- Equip national TB-focussed CSOs to monitor the quality of services in prisons and to advocate for the human and health rights of prisoners in the context of TB. More CSOs should become involved in supporting the PNLT and the MOJ to address the human rights related aspects of TB in prisons.
- Support the Ministry of Justice and civil society to advocate for different policies and practices to reduce pre-trial detention and to sensitise judicial officers at all levels to the effects of pre-trial detention on the increased risk of TB. The Ministère de la Santé Publique (with PNLT) and the Ministry of Justice should collaborate on a programme of

sensitisation of judicial officers on the public health impacts of over-reliance on pre-trial sentencing and engage them in the project of reform (see below).

- Support the Ministère de la Santé Publique (with PNLT) and the Ministry of Justice to advocate for and put in place policies and procedures to treat prisoners with TB in adjacent health facilities. There has been some success with this through the Union project. Countrywide policies and procedures should be put in place to make this option routine when treating these individuals within prisons will jeopardise their own and others' health.
- Train prisoners and prison workers on their TB-related human rights and responsibilities. TB-focussed CSOs should be equipped to provide the training in collaboration with the PNLT and the MOJ.
- Undertake a multi-sectoral advocacy effort to improve general conditions in prisons. This would be a long-term effort using the current situation of TB as one of the main rationales for the urgent need to effect these changes.

Opportunities for scaling up interventions

Opportunities for scaling up human rights and gender-related interventions in the context of TB in DRC are limited, largely because core components of the TB programme remain unfunded, including much of what is directed towards community-level interventions.

Where there can be opportunities is through greater integration of human rights components in the TB interventions that are implemented. However, this will require a much stronger technical knowledge and commitment amongst all TB stakeholders, particularly the PNLT, to the human rights dimensions of the TB epidemic and the national TB response.

There are opportunities within the HIV response to further integrate human rights issues related to TB in the scale-up of human rights and gender-related interventions since a number of groups these efforts address are also risk populations for TB, particularly people living with HIV, people who inject drugs and prisoners. While there is already some momentum towards doing this, more effort will be needed to build the technical capacities of HIV-focussed stakeholders on TB human rights challenges for their focus populations and on efficient ways to include TB human rights concerns in their work as they seek to expand human rights programmes for HIV.

Needed investments to support the comprehensive approach

As a final component of the assessment for TB, a prospective cost to implement the comprehensive approach was calculated. This is shown in **Table C**, below.

The assessment found very little costing data for TB-related human rights interventions. As a result, costing data from the HIV component was used to calculate needed investments for the comprehensive approach. In 2016, only US$50,000 was identified in terms of current investments (community interventions for stigma reduction in two provinces and TB sensitisation in one prison). This was not surprising given that, as the assessment results demonstrate, issues of human rights or gender are not yet fully incorporated within the national TB response. The country has some distance to go, then, to mobilise sufficient resources to address this gap and to begin to implement the comprehensive approach to these issues that the assessment has outlined.

Table C: Costing of the comprehensive approach for TB

TB Human Rights Barriers Programme Area	**TOTAL**
PA 1: Stigma and discrimination reduction	**1,780,077**
PA 2: Training of health care workers on human rights and ethics	**156,469**
PA 3: Sensitisation of law-makers and law enforcement agents	**-**
PA 4: Legal literacy	**145,198**
PA 5: TB-related legal services	**431,396**
PA 6: Monitoring and reforming laws and policies	**379,731**
PA 7: Reducing discrimination against women in the context of TB	**157,912**
PA 8: Improving confidentiality and privacy	**157,912**
PA 9: Community mobilisation for people living with TB	**1,745,920**
PA 10: Improving TB services in prisons	**494,573**
Other activities	**350,789**
TOTAL	**5,799,976**

Table C. Total Cost of 5-Year Program- refer to Annex A for more details

II. Introduction

This report documents the results of a baseline assessment carried out in the Democratic Republic of Congo (DRC) 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). 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 (ibid.).*" The Global Fund has recognized that programmes to remove human rights and gender-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. These programs are described in the section below. 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 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).*" 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."* 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.[4]

Based on criteria that included needs, opportunities, capacities and partnerships in the country, the Global Fund selected DRC, with 19 other countries, for intensive support to scale up programmes to reduce barriers to services. This baseline assessment for DRC, focusing on HIV and TB, is a component of the package of intensive support the country will receive.

The objectives of the baseline assessment were to:

- Identify the key human rights and gender-related barriers to HV and TB services in DRC
- 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.

Overall, the results of the assessment are meant to provide a baseline of the situation as of 2017 in DRC. This effort will be followed up by similar assessments at mid- and end-points of the Global Fund's strategy in order to capture the impact of the scale up of programmes to remove barriers in DRC and in the other countries included in the intensive support initiative.

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[4] 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.

III. Methodology

The assessment was conducted between September and October 2017 according to the following methodology.

Conceptual framework

The conceptual framework that guided the baseline assessment was as follows:

- In DRC, as in other countries regionally and globally, there exist human rights and gender-related barriers to the full access to, uptake of and retention in HIV and TB services.
- These barriers are experienced by certain key and vulnerable populations who are more vulnerable to and affected by HIV and TB than other groups in the general population.
- There are human rights and gender-related programme areas comprising several interventions and activities that are effective in removing these barriers.
- If these interventions and activities are funded, implemented and taken to sufficient scale in the country, they will remove or at least significantly reduce these barriers.
- The removal of these barriers will increase access to, uptake of and retention in HIV and TB services and thereby accelerate country progress towards national, regional and global targets to significantly reduce or bring to an end the HIV and TB epidemics.
- These efforts to remove barriers will also protect and enhance Global Fund investments, strengthen health systems and strengthen community systems

The main categories of human rights and gender-related barriers to HIV and TB services that the assessment addressed were (Global Fund, 2017a, b; Timberlake, 2017):

- Stigma and discrimination, including within the provision of health care services
- Punitive laws, policies, and practices
- Gender inequality and gender-based violence
- Poverty and socio-economic inequality; and,
- Harmful working conditions and exploitation (mainly for TB).

Governments, UNAIDS, the Global Fund, and the Stop TB Partnership have identified the following main program areas to address and remove barriers (UNAIDS, 2012; Global Fund, 2017a,b; *Political Declarations on HIV/AIDS* (2011 and 2016)):

- Stigma and discrimination reduction
- Training for health care providers on human rights and medical ethics
- Sensitization of law-makers and law enforcement agents
- Legal literacy ("know your rights")
- HIV or TB-related legal services
- Monitoring and reforming laws, regulations and policies relating to HIV and TB; and,
- Reducing discrimination against women in the context of HIV and TB.

For TB, additional program areas include:

- Ensuring confidentiality and privacy related to TB diagnosis and treatment;

- Mobilizing and empowering TB patient and community groups;
- Addressing overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment; and,
- Making efforts to remove barriers to TB services in prisons.

Activities under these program areas should be, where possible, integrated into HIV or TB prevention and treatment programmes, or be adapted as focused interventions to support prevention and treatment.

Scope of the assessment

- The DRC currently faces a growing number of social and political challenges that have human rights and gender-related dimensions, one of which is the growing internal conflict and the effect this is having on internal displacements and the alarming rates of sexual and gender-based violence (SGBV) perpetrated against women and men in conflict zones. The situation also has an influence on the burden of HIV and TB disease in the country in terms of increasing the vulnerability of individuals and communities to these two diseases and of limiting their access to needed services. Mapping the complexity of this situation was beyond the scope of a single baseline assessment. In order to provide guidance to the assessment team, the DRC Country Coordination Mechanism (CCM) set up a small Reference Group in July 2017 and, in collaboration with the Global Fund, determined that this assessment should focus on specific population groups and on identifying the human rights and gender-related barriers they face to access to HIV and TB services. The group advised that the assessment should not address the wider issues of vulnerability to HIV or TB disease given the complexity of these issues for the country at the current time. Thus, the assessment team did not collect data in conflict-affected areas for reasons of security and accessibility. As a result, this important feature of the context for HIV and TB services in DRC was not included in the assessment findings.

Key and vulnerable populations included in the assessment

The specific populations that are the focus of the assessment were identified by taking into account the following criteria:

- Global Fund and Stop TB Partnership criteria for identifying key and vulnerable populations for HIV and TB (Global Fund, 2013; Global Fund, 2017b);
- Those populations the DRC has identified within its national strategic documents, in particular the *Plan stratégique national de lutte contre le VIH et le Sida 2018-2022* (HIV PSN), and the *Plan stratégique nationale de lutte contre la tuberculose 2018-2020* (TB PSN) (Programme national multisectoriel de lutte contre le Sida (PNMLS), 2017b; Programme national de lutte contre la tuberculose (PNLT), 2017);[5] and,
- The guidance of the Reference Group noted above.

Table 1, below, shows the key and vulnerable populations for HIV and TB that the assessment addressed.

Table 1: Key and vulnerable populations for HIV and TB

Key populations HIV	Vulnerable populations HIV	Key populations TB
▪ People living with HIV (PLHIV)	▪ Adolescents and young people (particularly adolescent girls and young	▪ People living with TB ▪ People living with HIV ▪ Prison inmates and prison

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[5] The full list for HIV includes: Priority populations—people living with HIV, HIV/TB co-infected; Key populations—female sex workers, men who have sex with men, people who inject drugs, and people in uniform (inmates and prison workers are included in this group); Vulnerable groups—adolescents and young people 10-19 years, pregnant women, internally displaced people and refugees, orphans and vulnerable children (PNMLS, 2017b). For TB, the list includes people living with HIV, household contacts of TB patients, young children (<5 years), prison inmates and prison workers, miners and people in peri-mining communities, internally displaced people and refugees, health care workers (PNLT, 2017).

▪ Men-having-sex-with-men (MSM) ▪ Transgender women ▪ Male and female sex workers ▪ People who inject drugs (PWID) ▪ Prison inmates	women)	workers ▪ Health care workers

The populations included in the table are not the only population groups that are prioritised through the national HIV and TB responses or that experience significant human rights or gender-related barriers to services. They are, however, those groups whose situation was most feasible to study within the timeframe and resources available to conduct the baseline assessment.

Data collection and analysis

Data collection and analysis involved the following main steps:

Desk review

A comprehensive desk review was conducted of sources in English and French describing the context for HIV and TB in DRC; sub-populations and groups most affected by the two diseases; human rights and gender-related barriers to HIV and TB services for these groups; and the country's efforts to address and remove these barriers. Sources included in the review were peer-reviewed publications, national documents (plans, policies, strategies and progress reports), and reports and other items produced by the different stakeholders involved in efforts to address and remove barriers.

Development of fieldwork priorities and the fieldwork plan

Based on the results of the desk review, specific priorities for in-country data collection were defined. The fieldwork plan included key informant interviews (KIIs), round-table discussions, and focus group discussions (FGDs) with a full range of multi-sectoral partners, including representatives of key and vulnerable population groups. It also included data collection in four locations in addition to Kinshasa, which were Goma, Kisangani, Lubumbashi and Matadi.

In-country data collection

Data collection took place between 20 September and 13 October 2017. It was conducted primarily in French with translation provided for local languages when needed (Lingala and Swahili). Support to launch the data collection process was provided through the Secretariat of the DRC Country Coordinating Mechanism (CCM). Additional support was provided by PNMLS, particularly for the missions to provinces, as well as by the Union Congolaise des Organisations des PvVIH (UCOP+), the national network of PLHIV associations in DRC, and Progrès Santé Sans Prix (PSSP), one of the main non-governmental stakeholders providing HIV and other health services to key populations.

Overall, 60 entities and more than 200 key informants participated in the assessment. This included 12 national and provincial government entities, 6 international non-governmental organisations (NGOs), 34 national and local civil society organisations (CSOs), and 6 UN agencies and technical partners. In addition, in all five cities where data collection took place, focus group discussions were convened with representatives from key or vulnerable populations, including people living with HIV; people living with TB; gay men and other men who have sex with men; male and female sex workers; male and female people who inject drugs; transgender men and women; and older adolescents and young people, including those living with HIV.

As a final step for the in-country component, during the last week of data collection, high-level, preliminary results were shared in a workshop convened by the DRC CCM. This was an opportunity to assess the comprehensiveness of data collection and to have further dialogue with stakeholders on opportunities for strengthening and improving their collective efforts to address human rights and gender-related barriers.

Data analysis involved mainly thematic analysis of documents and interview notes according to the key themes and concepts set out in the conceptual framework.

A consultancy team, led by a lead researcher from the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal (UKZN), conducted the assessment. Overall ethics clearance was provided by UKZN. During the fieldwork-planning phase, the DRC CCM advised that this type of assessment, with its specific scope, did not require country-level ethics clearance.

Costing methodology

Three sets of costing processes were undertaken for this assessment:

First, all donors and funders who have financed any activities in the program areas for HIV, TB or malaria were asked to supply details of the amount of funding provided and the program areas for which funding was provided; and, if possible, to state the type of activities and reach or 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. For TB and malaria, no cost data was possible to obtain given the limited existing programs that were identified, as well as the limited number of interviews conducted in the frame of this rapid assessment.

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. For each type of intervention, an intervention-level cost was assembled.

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 and TB 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.

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process. Further costing considerations are described in detail in Annex 6.

Links with other processes

At the time the assessment took place, important related processes were either underway or recently completed. These included:

- The launch of the *Évaluation des sexospécificités pour les ripostes au VIH et à la tuberculose*;
- An UHAI-ESARHI-led situational assessment of key populations (completed in 2016 and released in 2017), which included a component on human rights and gender-related barriers to access and uptake of HIV and TB services (UHAI-ESARHI, 2017);
- A mapping and population size estimation study of men who have sex with men, sex workers, and people who inject drugs, to be followed by an integrated bio-behavioural surveillance (IBBS) survey (supported by Global Fund). At the time of the assessment, the mapping and size estimations had been completed for Kinshasa but were still underway in other parts of the country. The IBBS survey had not yet begun.
- A USAID-funded gender analysis of the HIV response (completed in 2016) (Harris Sapp and Boketa, 2016);
- A Global Fund-supported country case study on gender and the HIV response that was part of the larger multi-country thematic review under the Technical Evaluation Reference Group. Preliminary results were shared for the desk review, including documents and interview lists, as well as an early draft of the country report.
- The completion of the All In Phase II analysis on HIV trends for adolescents and young people (10-24 years), including a component on access to HIV services (PNMLS, 2017c);
- The evaluations of the 2014-2017 PSN HIV and the 2014-2018 PSN TB, which, for HIV, included information on achievements and challenges related to the human rights and gender components of the plan;
- The finalisation of the new 2018-2021 PSN HIV and the 2018-2020 PSN TB, which, for HIV, contains a number of elements on key populations, gender and human rights;
- The finalisation of the Global Fund catalytic funding request for programmes to reduce human rights-related barriers to HIV services (completed in August 2017).

The assessment took account of all of these activities and, to the extent their results were available, included them in the analysis.

In the sections that follow, the assessment findings are presented in two main sections. HIV is first, followed by TB.

IV. Baseline Findings: HIV

The findings for HIV are presented below in the following sequence: an overview of the HIV epidemic in DRC, with specific attention to the key and vulnerable populations included in the assessment; information on trends in access and uptake of HIV services to illustrate the extent of current gaps; an overview of the general context for the HIV response with a particular focus on the components addressing human rights and gender; an analysis of human rights-related barriers to HIV services; an analysis of current efforts to address such barriers, including gaps, challenges, and a description of the components for a comprehensive approach; and, finally, an analysis of opportunities for scaling up current efforts over a five-year period.

At the time of the assessment, there was a significant gap in current, comprehensive data on the burden of HIV for most of the key and vulnerable populations included in the assessment (the exception is adolescent girls and young women). There was an equally important gap in data on access and uptake of HIV services. However, these gaps may be addressed by upcoming efforts to estimate sizes of key populations as well as to implement an IBBS.

Data that was available suggested a significantly higher burden of HIV amongst these groups as well as lower access and uptake of HIV services, this later trend occurring in a broader context of low uptake and coverage of core HIV services countrywide. For people living with HIV, while their legal and human rights are recognised in law and policy, the assessment nevertheless found that they still face significant barriers to derive benefit from these provisions, mainly due to challenges with lack of enforcement, legal literacy and access to justice. Prevailing socio-cultural norms continue to attribute negative moral connotations to HIV disease meaning that people living with HIV continue to face stigma and discrimination in their personal and social environment, one consequence of which is self-stigma. These limit an individual's motivation to seek out and remain in HIV services.

Adolescents girls and young women face both legal and socio-cultural barriers to HIV services, including a law that sets the age of legal capacity at 18 years, including for independent access to HIV and other sexual and reproductive health services. As a result, those who are sexually active face significant levels of stigma, and sometime refusals, on the part of health care workers when seeking needed services. Where parental consent is required, many will avoid going to health facilities rather than share confidential information about their sexual health needs with their parents. Within families and communities, high levels of stigma and shame surround survivors of sexual and gender-based violence, especially those that are HIV-positive, which negatively affects service uptake as well as retention in care for those in need of anti-retroviral treatment (ART).

The situation is much more ambiguous and difficult for men who have sex with men and sex workers. Although these groups are not criminalised in the country, laws or policies to protect them from discrimination and violence either do not exist or are not enforced for their benefit. Negative socio-cultural attitudes and beliefs regarding homosexuality, drug use and sex work impose a heavy burden on members of key populations of stigma and discrimination within families and communities affecting their motivation to use health services, for fear of exposure and the further negative abuse this would engender. These things also influence the attitudes and practices of health care workers, including within general HIV services (i.e. those not provided in the very limited number of locations by key-population-focussed entities).

Drug use is criminalised in DRC fuelling discrimination and abuse against people who inject drugs, particularly on the part of health care workers and the police, and limiting what HIV interventions can be implemented, particularly in relation to harm reduction. Conditions in the country's prisons are below the level at which basic necessities of food, shelter and hygiene can be assured meaning that, even when HIV services are available, inmates either cannot access them for lack of privacy or confidentiality, or cannot benefit from them because of malnutrition and other challenges.

Despite this complex array of human rights and gender-related challenges to the access, uptake and retention in HIV services, there is a growing momentum to address them as illustrated by the range of current interventions across all human rights-related programme areas. Many of these activities have only recently been started, and more time is needed before their effectiveness can be measured. These efforts nevertheless provide the starting point for a comprehensive approach leading to further progress in addressing and removing human rights-related barriers to services. The PSN 2018-2022, with its clear focus on human rights and gender concerns, provides the blueprint for this work.

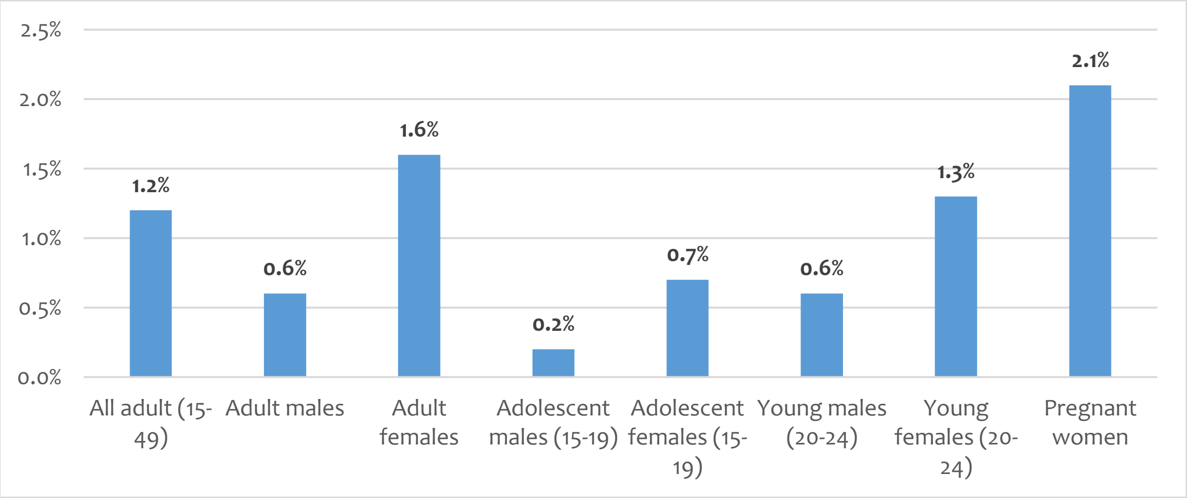
The sections that follow describe all of these trends and issues in more detail starting with a description of the current burden of HIV disease amongst the different populations included in the assessment.

Overview of epidemiological context and key and vulnerable populations

In 2016, amongst a population of 84 million, there were an estimated 14,940 new HIV infections across DRC - 8,344 or 55% amongst adult women and 3,338 or 22% amongst children (ONUSIDA, 2016). Overall, 72% of new infections occurred amongst individuals aged 24 years or younger (the same proportion of the overall population is in this age group). In the same year, there were an estimated 20,854 AIDS-related deaths - 10,215 or 49% amongst adult women and 2,700 or 8,7% amongst children. As a general trend, the numbers of new HIV infections and AIDS-related deaths continues to decline in DRC, with reductions of 32% and 52%, respectively, over the 2010-2016 period (PNMLS, 2017b). In 2016, there were 381,187 people living with HIV in the country - 224,673 or 59% of which were female, and 42,145 or 11% were children (ONUSIDA, 2016).

Detailed HIV prevalence data comes from 2013 (Ministère du plan et suivi de la mise en œuvre de la révolution de la modernité (MPSMRM) et al., 2014). **Figure 1**, below, shows the important variations by age group and sex.

Figure 1: HIV prevalence by age and sex

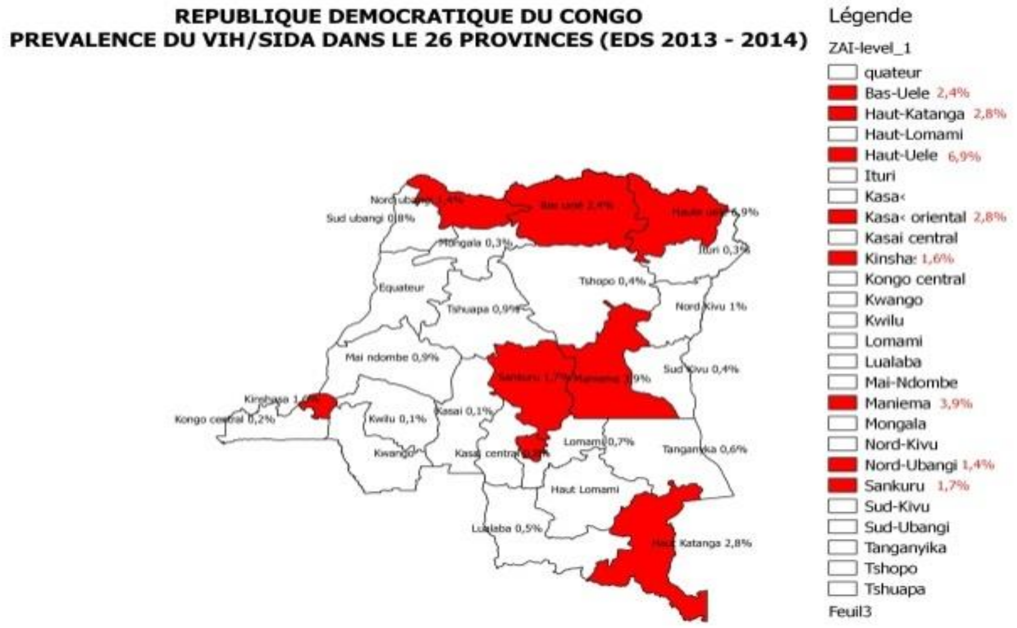


Source: MPSMRM et al., 2014

In 2013, adult HIV prevalence was estimated at 1.2% - 0.6% for males and 1.6% for females, illustrating the highly gendered nature of the HIV epidemic in the country. Similar disparities occurred for adolescents and young people. HIV prevalence was 0.2% for adolescent males (15-19 years), while it was 0.7% for adolescent females. For young males (20-24), it was 0.6% compared to 1.3% for young females. The sub-group of pregnant women had a higher HIV prevalence at 2.1% - a situation that is similar in other countries in the region as the risk for HIV infection is elevated amongst women having children.

HIV prevalence also varies by location. Figure 2, below, shows the distribution of HIV prevalence by province:

Figure 2: Distribution of HIV prevalence by province



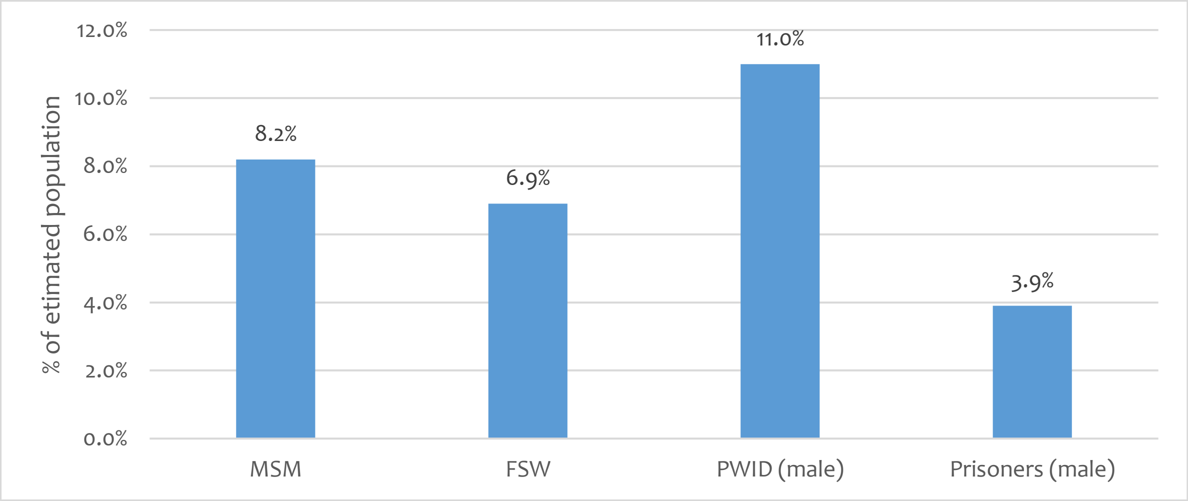
RDC, PNLS decembre 2016

Source: MPSMRM et al. 2014

Provinces with the highest prevalence are indicated in red and include Haut-Uele (6.9%), Maniema (3.9%), Haute Katanga and Kasa-Oriental (both at 2,8%), and Bas-Uele (2.4%). Work is on-going at country level to understand these differences in order to more strategically target HIV investments and interventions in these areas.

HIV prevalence and incidence data for key populations is neither current nor comprehensive. **Figure 3**, below, summarizes information from studies, national documents and programme reports that were available at the time of the assessment to give a very general indication of prevalence rates.

Figure 3: HIV prevalence by key population group



Sources[6]

HIV prevalence data comes from different time periods and has been estimated using different methods. As a result, both the rates themselves and comparisons between groups are indicative only**.** Overall, what these data indicate is that HIV prevalence is significantly higher in these population groups compared to the general population. There are no current population size estimations for these groups although, as noted above, a study to address this gap was underway at the time of the writing of the assessment. Preliminary results for Kinshasa showed an estimated 55,000 sex workers, 30,000 men who have sex with men and 3,500 people who inject drugs - figures that may seem low for an urban population of 9,5 million (DRC CCM, 2017).

Current trends in access and uptake of HIV services

DRC currently has challenges for coverage and uptake across the continuum of HIV services. Programme data for 2015 suggest that approximately 50% of people living in DRC are aware of their status (PNMLS 2016c). According to the same source, 32.8% of the estimated number of adult people living with HIV in DRC were on ART in that year (ibid.). Coverage was 24.6% for children. It was highest for adult women at 38.6% who are largely initiated on ART through the prevention-of-mother-to-child transmission (PMTCT) programme (ibid.). It should be noted, however, that of all people living with HIV enrolled in HIV care by 2015, 71% were on ART according to national guidelines in place at the time (using 2013 WHO eligibility criteria). For people living with HIV on ART, only 7% had access to viral load testing in that year. With regard to retention in care, data from health facilities using the Three Interlinked Electronic Registers (TIER) system (14% of all facilities in the country) showed that, in 2014, rates were 86% at 12 months, 80% at 24 months and 79% at 60 months (ibid.).

At the time of the assessment, there were no current countrywide data on access to and uptake of HIV services for key populations. The PNLS has recently defined a minimum package of interventions for men who have sex with men, female sex workers and people who inject drugs which includes (PNLS, 2017a):

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[6] Sources: PNMLS (2016) for MSM, FSW, PWID and prisoners. A note is given in the text that FSW data is from PNLS (2012a).

- Pre-exposure prophylaxis (PreP)
- Syndromic management of sexually transmitted infections
- HIV Testing Services (HTS) in fixed and mobile settings
- Distribution of condoms and lubricants
- HIV treatment, care and support
- Family planning, and
- Care and support for survivors of sexual violence, including provision of post-exposure prophylaxis (PEP).

It is notable that no harm reduction interventions for people who inject drugs are included. At the time of the assessment, the package had not been rolled-out other than through 7 *Centres conviviaux* (5 in Kinshasa and 2 in Lubumbashi) supported through the Global Fund and the United States President's Emergency Plan for AIDS Relief (PEPFAR).[7] Data from 2015 showed that 13,410 female sex workers and men who have sex with men were tested and received their results in these centres, of which 730 or 5.4% were HIV-positive (PNLS 2016b). Of 447 female sex workers and 85 men who have sex with men newly enrolled in HIV care, 76% and 88%, respectively, were started on ART. Seven percent were subsequently lost-to-follow-up.

With regard to people who inject drugs, data from a Global Fund-supported programme implemented by PSSP showed that, in 2015, of approximately 190 service users, 61% had been tested for HIV and received their results, and 11.7% were HIV-positive (PNMLS 2016c). No data were available regarding uptake of ART for this group.

PSSP data also showed that of 38 transgender tested for HIV (18 transgender men and 20 transgender women), three were HIV-positive, all of them transgender women. Again, no data were given on access to other HIV services (ibid.).

Programme data for 2015 from the Ministère de la Justice (MOJ) showed that of 2,972 inmates tested for HIV, of whom 115 or 3.9% were HIV-positive (PNMLS 2016c).[8] No additional data were given on access to ART or other services.

Gaps in the data available at the time of the assessment make it impossible to determine a countrywide trend for access and uptake of HIV services for key population groups although most participants in the assessment were of the view that it was very low. Without countrywide population size estimates, however, the true extent of gaps in service access cannot be known. Once these estimates are available (expected in 2018), understanding of the nature and extent of current barriers for these groups will improve, and there will be an ability to measure progress should such barriers be reduced or removed.

Overview of country context for HIV-related human rights

The findings under this section describe the country context for DRC for work on HIV-related human rights concerns. They address law, policy and strategy issues as well as more general considerations regarding the political and socio-cultural context for HIV and key and vulnerable populations. While key and vulnerable population groups and their human rights and gender-related concerns are recognised in a number of policy documents for HIV, the

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[7] *Centres conviviaux* are drop-in centres, operated by key-population-focused NGOs/CSOs, that are linked to/co-located with health facilities that can provide HIV and other sexual and reproductive health services (the facilities serve the general population as well). Different types of psycho-social support activities are also available, including peer support. Income generation projects and legal support are also planned to be part of the model starting in 2018.

[8] There were an estimated 20,000 detainees in 120 facilities country-wide in 2015. 73% were pre-trial/on remand detainees. See: http://www.prisonstudies.org/country/democratic-republic-congo

broader legal and socio-cultural context remains complex and difficult for these groups, and this continues to impede the growing number of efforts to improve access and uptake of HIV services for them.

Legal Framework for HIV-related Human Rights

The legal framework supporting HIV-related human rights in DRC has both strengths and weaknessess. While the importance of human rights in the context of HIV has been recognized in DRC since at least 2008, under the *Loi n° 08/011 du 14 juillet 2008 portant protection des droits des personnes vivant avec le VIH/SIDA et des personnes affectées* (the *Law to Protect the Rights of People Living with and Affected by HIV)*, there is not yet a comprehensive legislative framework supporting all human rights or gender-related elements, with the gaps being the largest for key populations other than people living with HIV.

The United Nations Development Programme (UNDP) supported a Legal Environmental Assessment (LEA) in DRC in 2012 (Programme des Nations Unies pour le Developpement (PNUD), 2013). It outlined how the *Constitution* of DRC frames the context for HIV-related priorities regarding human rights and gender. The *Constitution* defines civil, political, social, economic and cultural rights for all citizens (République Démocratique du Congo (RDC), 2011). It includes special provisions regarding gender equality, gender-based violence and the protection of children. Amongst its many items, it also provides for the right to health and food security (Article 47). However, given the lack of reliable and effective mechanisms in the DRC for law enforcement and access to justice, individuals are very limited in the means by which to claim these rights and hold relevant 'duty bearers' accountable in the context of HIV or otherwise. This is discussed in more detail below.

The LEA noted the importance of the *Law to Protect the Rights of People Living with and Affected by HIV* that sets out a comprehensive range of rights and entitlements for people living with HIV and those around them (RDC, 2009). These include provisions addressing stigma and discrimination, including in healthcare settings; confidentiality and privacy; informed consent; and positive obligations on the part of the State to provide HIV testing and treatment free-of-charge, and to ensure HIV service delivery in certain settings, particularly prisons. The law also states (Article 2) that its protections apply to vulnerable groups at high risk for HIV infection. These vulnerable groups include: "*la femme, les jeunes, les professionnels de sexe, les toxicomanes, les homosexuels*." The list does not include transgender. While this recognition in law of key populations in the context of HIV is important, the law contains no more specific provisions for these groups and, as a result, has had limited to no effect in addressing human rights or gender-related issues for them. It has, nevertheless, provided impetus for the inclusion of these groups in policies and programmes, as described in the next section. The law also includes some highly problematic provisions regarding disclosure of HIV status and criminalisation of HIV transmission. These issues are discussed further under **Section 4.4.4**, below.

HIV-related Policies, Strategies and Guidelines

At the time the assessment was conducted, the country was in the final stages of endorsing the PSN 2018-2021. This is the main policy instrument for the national HIV response. Amongst its guiding principles are respect for human rights and gender (*"le respect des droits humains et du genre"*), as well as alignment with regional and international commitments, including the 2016 *Political Declaration on HIV and AIDS*, the Sustainable Development Goals, the UNAIDS 90-90-90 fast-track strategy, and the 'test and start' approach for HIV treatment (PNMLS, 2017b).

The focus of the PSN on human rights and gender is elaborated under Impact 5, which states, "*L'impact des violations des droits humains liés au VIH (la stigmatisation et de la discrimination, droit à la santé, à l'égalité de genre, à la sécurité physique) sur les Personnes*

Vivant avec le VIH et PA [personnes affectées], sur les populations clés et les femmes ainsi que sur les jeunes et adolescents est réduit de 90% d'ici 2021 (PNMLS, 2017b)." The specific strategies that will achieve this impact are discussed in **Section 4.6**, below.

All of these elements of the PSN represent a significant increase in attention and engagement on the human rights and gender-related dimensions across the national HIV response. They very much reflect the progress made during the previous PSN (2014-2017) to introduce these elements as critical enablers for achieving stronger results and impacts. However, as the results of the external review demonstrated, and a number of key informants affirmed, there was a significant gap between what was elaborated in the PSN and what was funded and implemented (PNMLS, 2017b).

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

The national HIV response in DRC is led by the PNMLS that was established by Presidential decree in 2004. A *Conseil national mutli-sectoriel de lutte contre le VIH/SIDA* governs the PNMLS with the President of DRC as the chairperson. The PNMLS has provincial entities with a similar governance structure. Within the national office, there is a focal person for HIV and human rights that liaises with the public and civil society sectors, including key population constituencies. However, political engagement on HIV - as measured by domestic financial contributions - is minimal. The HIV programme in DRC is largely funded from non-government sources. In 2014, the latest year for which comprehensive data are available, on a total direct programme expenditure of US$222 million, 44% was funded from private sources (mostly out-of-pocket expenses from PLHIV households) (PNMLS, 2015). Of the remaining 56%, 24% was funded from (central) government sources and the remainder from external sources, primarily the Global Fund and PEPFAR. Other external contributors included UN agencies (such as UNDP, UNFPA and UNIFEM) and other bilateral partners (such as Belgium, Canada, France, Germany and Sweden).

The social context for the HIV response is challenging. More than 60% of the 84 million inhabitants of DRC lives in rural areas; 46% are under the age of 15; and 73% are under the age of 25 (UNDP, 2016). Seventy-seven percent of the population lives on less than US$2 per day, and 85% on less than US$3 per day (ibid.). Most health services in DRC require user-fees and, although HIV treatment is free of charge, other related services are not (PNMLS, 2017b). There are a number of health system challenges at all levels, which include weakness in supply chain management (that have caused stock-outs of ART and other commodities such as HIV test kits or post-exposure prophylaxis (PEP)), under-staffed health facilities, and in some parts of the country, on-going conflict which has led to service interruptions, as well as the destruction of health infrastructure (PNMLS, 2017b; KII with PNMLS, Goma, October 2017). On-going conflict has also led to internal displacement of populations that can increase risk for HIV or TB infection and also can cause disruptions in treatment regimens (Ibid.).

Finally, it should be noted that the broader context for identifying and acting on human rights concerns is challenging in DRC. National and international entities have been highly critical both of the extent and breadth of general human rights issues that continue to arise, as well as the insufficient efforts on the part of the government and others to address and resolve them (African Commission on Human and People's Rights (ACHPR) 2017; Amnesty International, 2017; United States Department of State, 2016). This includes a current state of fear and intimidation, which includes threats of physical violence (including death) against human rights defenders and civil society entities active on human rights issues (ACHPR, 2017). A draft bill has been tabled by the Ministry of Justice to change this situation, but its contents have been criticised as not aligning with United Nations standards for the protection of human rights defenders.[9]

These factors contribute to challenges to identify and remove or reduce human rights or gender-related barriers to HIV services for the populations that are the focus of this assessment. The following section describes the nature of the human rights-related barriers to HIV services.

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

Overview

The findings in this section consolidate information derived from the desk review as well as from the fieldwork. They describe human rights-related barriers to HIV services related to stigma and discrimination in health care settings and communities; punitive laws, policies and practices affecting key populations; low levels of legal literacy and lack of access to justice; gender-based discrimination and inequality, including harmful gender norms and practices, and all forms of gender-based violence, including those that affect access to services for adolescents and young people; and, finally, barriers arising from poverty.

Stigma and discrimination

The findings in this section draw on quantitative data as well as the observations of the assessment participants. With regarding to stigma and discrimination against people living with HIV, the *PLHIV Stigma Index* survey data are from 2012 (UCOP+ and others, 2012). At that time, they showed high levels of HIV-related stigma and discrimination across a number of domains.[10] For example, between 20% and 25% of participants had faced some form of exclusion from family, or from social or cultural activities. Moreover, 45% had experienced HIV-related insults or verbal harassment at least once in the past 12 months. More than half (52%) of participants experienced self-stigma in the form of shame regarding their HIV positive sero-status. Fear of HIV and lack of knowledge about how HIV is transmitted were the most frequently cited reasons why people living with HIV felt stigmatised by others.

With regard to housing and employment, more than 50% of respondents were forced to change residence or were denied housing, of which 38% indicated it was because they were living with HIV. One-third had lost employment or their main source of revenue, of which 40% indicated it was because they were living with HIV. With regard to health services, 6% had been denied services because of their sero-status, including dental services, within the previous 12 months.

Overall, 23% of participants had experienced at least one human rights violation and of these, only 22% had attempted to find some form of redress. This finding is alarming given that most of these violations comprised violations of the provisions of the *Law to Protect the Rights of People Living with and Affected by HIV* (this is discussed further in **Section 4.4.5**, below).

It is important to note that, with regard to the broader socio-cultural context for HIV in DRC, in 2013 it was found that only 21.8% of adults (15-64) had comprehensive knowledge of HIV (29% of males, 19.2% of females) (MPSMRM et al. 2014). Amongst adolescents and young people (aged 15-24 years), the figures were 25% and 18.6%, respectively. With regard to accepting attitudes towards people living with HIV, overall, only 4.2% of the study population

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[9] See, for example, https://www.ishr.ch/news/democratic-republic-congo-draft-law-human-rights-defenders-harmful-says-un-human-rights

[10] Of the study sample, less than 5% were from key populations with female sex workers being the largest group of participants at 43 out of a total of 1,411. As a result, no specific findings were made that distinguished the experiences of people living with HIV who were also members of key populations.

demonstrated accepting attitudes on the standardized four-point scale. On the individual measures, the scores were more promising with 71.5% accepting to care for a sick parent in the home; 46% agreeing to buy vegetables or fruit from an HIV-positive vendor; and, 49% agreeing that an asymptomatic HIV-positive teacher should be able to work. However, 26% of the sample felt that it was not necessary to keep the HIV status of a PLHIV family member confidential.

Participants in the baseline assessment, including members of PLHIV networks and support groups, some of whom were aware of the *Stigma Index* survey results, spoke about ongoing challenges regarding stigma and discrimination in their personal and social environments and, to a lesser degree, in the provision of public services, such as housing and employment. They noted how HIV-related stigma and discrimination continued to negatively affect the quality of life of people living with HIV, and their motivation to participate in HIV programmes, particularly outside of main urban centres where PLHIV networks, including UCOP+, are more active.

Some of the more compelling examples that were given involved situations within families, particularly for women living with HIV, where they experienced rejection and blame for bringing HIV into the family. In some cases, this triggered verbal and physical abuse. Other examples included having an individual's HIV status disclosed to other family members without consent or to members of the community as a way of punishing or shaming these women (KIIs with Foundation Femmes Plus, Si Jeunesse Savait, International Community of Women living with HIV (ICW) DRC, September 2017).

Key informants working with children and adolescents living with HIV gave examples where children were rejected by parents or extended families, particularly after one or both of the parents had died of HIV (FGD with caregivers, Heal Africa, Goma, October 2017). Fear of HIV, lack of knowledge about how HIV is transmitted, and moral shame were the most frequently cited reasons why all groups of people living with HIV felt stigmatised by others. In rural areas, where access to PLHIV networks or support groups is very limited, key informants described how a general atmosphere of stigmatizing beliefs about HIV caused people living with HIV to feel very isolated. This negatively affected their self-esteem and their motivation to use HIV services, including for retention on HIV treatment (FGD with members of local PLHIV networks, Kisangani, Goma, October 2017).

For other key populations, especially gay men and other men who have sex with men, transgender women, sex workers and people who inject drugs, the burden of stigma, discrimination and verbal and physical harassment and abuse continues to be significant, according to key informants as well as recent assessments. For men who have sex with men, transgender and the broader LGBT constituency, strongly negative socio-cultural attitudes and beliefs about homosexuality drive stigma and exclusion of them in families and communities. It also drives stigma and discrimination in other spheres, such as employment, education and housing. For example, in 2016, in a study amongst a small convenience sample of 200 LGBT participants in Kinshasa, it was found that 82% had been the subject of malicious gossip about their sexual orientation at least once in the past 12 months; 64% had experienced verbal harassment; 59% had experienced negative attitudes and behaviours towards them in their households; and, 29% had experienced physical harassment (CONORELA+, 2016). Approximately one-fifth of all respondents had been forced to move, lost employment, or been refused health services in the past 12 months as a result of their sexual orientation. It was not surprising, then, to also see in the study results that 75% had constant fears of these different forms of stigma and discrimination recurring in their lives and that levels of self-stigma were high, with 75% of participants having experienced feelings of shame at some point in the previous year. These trends have, for the most part, been amplified in larger, countrywide qualitative studies, including one completed in 2017 (Si Jeunesse Savait, 2014; UHAI-ESARHI, 2017).

These experiences were also confirmed by fieldwork participants. Not all experiences were negative, however. A small number of key informants (mostly from Kinshasa) working with gay men and other men who have sex with men spoke about how things were changing in DRC and, at least in their social spheres, and how family members and local communities were becoming more tolerant. While stigma and discrimination was still a reality for their network members, in their experience, it was diminishing and individuals were becoming more confident and resilient to these negative experiences when they arose (FGD with MSM networks supported by AMOCONGO, Kinshasa, October 2017).

With regard to male and female sex workers, there are no current quantitative data. For female sex workers, questions (one each) on physical violence and rape were included in the 2012 IBBS. In each case, approximately one-third of respondents had experienced these things at least once in the recent past (PNLS, 2014). More recent descriptive information has been captured (Kiernan, Mishori, Masoda, 2016; UHAI-ESARHI, 2017). What these findings show, and what the fieldwork participants largely confirmed, is that, similar to men who have sex with men and transgender people, strong socio-cultural attitudes and beliefs characterising sex work and sex workers as 'sinful' or 'an abomination' fuel stigma and discrimination against them in families and communities. They also fuel verbal and physical harassment, abuse and violence from clients, the police and some family and community members (FGD with sex worker peer educators for PSSP and AMOCONGO, September-October 2017).

For adolescents and young people, HIV-related stigma and discrimination was linked to a broader trend of secrecy and shame regarding sexuality and sexual activity, particularly for those under 18 years of age (Roundtable with member organisations of Réseau des Associations Congolaises des Jeunes contre le Sida (RACOJ) in Kinshasa, Matadi, Goma, September-October 2017; Arenas and Loock, 2016). One of the effects of this was low overall knowledge and understanding about HIV and other sexual and reproductive health risks. Key informant observations echoed, for example, what was found in the 2014 DHS whereby, amongst the 15-24-year age group, only 25% of males and 18.6% females showed comprehensive knowledge regarding HIV (MPSMRM et al. 2014).

HIV-related stigma and discrimination affects other populations, including people who inject drugs and prisoners. Findings for people who inject drugs come from focus group discussions with peer educators. All confirmed that people who inject drugs remain heavily stigmatised, including by their families, and as result, remain in their closed networks, far away from the limited number of interventions designed to reach them (FGDs with PWID peer educators, Kinshasa, Goma, Matadi, Lubumbashi, September-October 2017). Deplorable conditions in prisons mean that there is no opportunity for confidentiality in the general prison population for people living with HIV on treatment, for example, leading to stigma and discrimination against them, and also contributing to the reluctance of prisoners to use HIV services (PNUD, 2013; Round-table with prison administration and prisoner representative, Goma, October 2017).

Stigma and discrimination in health services

Stigma and discrimination in health services, including denial of services, lack of professionalism and breach of confidentiality, continue to be reported by people living with HIV and other key population groups. The *PLHIV Stigma Index* found that, in 2012, amongst the human rights violations captured by the study, respondents most frequently cited having been forced to undergo a medical procedure, including being tested for HIV, with as many as 50% of rural respondents having experienced this (UCOP+ et al., 2014). When considering trends such as these, however, key informants noted that, since the study was done, such things were declining. For people living with HIV, according to key informants, the challenges arose where health care workers had not been trained on the minimum package for HIV services, or in facilities outside of urban areas, particularly where there were low number of people living with HIV. With regard to health care workers, PLHIV networks and other key informants drew attention to the high rates of turnover as one reason for the periodic lack of

HIV-competent service providers in a particular health facility (KII with UCOP+, ICW DRC, and PNLS, September-October 2017).

For men who have sex with men, female sex workers and transgender the challenges are more severe. Both qualitative and quantitative data from published sources describe instances of stigma and discrimination within health care settings, including instances where individuals are coerced to undergo medical procedures, including HIV testing, and where there have been serious breaches of confidentiality and privacy. However, the countrywide frequency of such things is difficult to determine. In the Kinshasa-based study noted in the previous section, in addition to the finding that one-fifth of LGBT respondents had been denied health services, of the 50% that indicated they had experienced a human rights violation, half of this group stated that being forced to undergo a medical procedure without consent, including HIV or STI screening, was the type of violation they had encountered (CONORELA+, 2016). A number of descriptions of similar experiences were also contained in the 2017 situational assessment (UHAI-ESARHI, 2017).

Assessment participants largely confirmed these findings. There are a small number of facilities in DRC that provide key-population-friendly services, but outside of these, key informants described how there are still many instances of lack of professionalism, including exposure and ridicule, as well as breach of confidentiality, when health care workers discover that an individual is either a man who has sex with men or transgender, for example. As a result, individuals either do not disclose important information about themselves that affects their health, or do not use health services until it is absolutely essential, mostly out of fear that they will experience these ill treatment, verbal abuse or lack of confidentiality (KIIs and FGD with peer educators working with sex workers, MSM, transgender and PWID; CONORELA+, 2016; UHAI-ESARHI, 2017). Transgender and people who inject drugs were said to use health services the least, or not at all, for these reasons (ibid.).

Key informants working with adolescents and young people explained that challenges for adolescents are related to age of consent for services and socio-cultural assumptions regarding when they should be sexually active. Young people below the age of 18 years need to involve parents or guardians to access health services and, because of this, need to disclose why they need services. As a result, there is no confidentiality, and they can be exposed to judgemental attitudes on the part of both parents and service providers. In addition, many either experience, or fear, negative attitudes and behaviours from health care workers, including moral judgement as well as breach of confidentiality, particularly if they are living with HIV (Arenas and Loock, 2016; Valles et al. 2016; Carlor et al. 2015). Further challenges for adolescents and young people, especially adolescent girls and young women, in health care settings are described in **Section 4.4.6**, below.

Punitive laws, policies and practices

There were a number of significant findings regarding punitive laws, policies and practices, as well as access to legal redress. These affected all groups included in the assessment. Concerns related to laws, policies and practices are described below; concerns related to access to justice are describe in the next section.

With regard to people living with HIV, key informants noted that the criminalisation of HIV transmission, in the *Loi n° 08/011 du 14 juillet 2008,* and in laws addressing sexual and gender based violence and the rights of children, adds to an overall trend of stigma and discrimination against people living with HIV and may act as a deterrent to HIV testing and the use of other HIV services (KIIs with UCOP+, MOJ and UNDP; PNUD, 2013; RDC, 2009).[11] The *Law to*

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[11] These other provisions are: Paragraph 9, Section 174 i, of the *Loi no 06/019 du 20 juillet 2006 modi ant et complétant le Décret du 06 août 1959 portant Code de Procédure pénale congolais*, which states, *"Sera puni d'une peine de servitude pénale à perpétuité* [life imprisonment] *et d'une amende de deux cent mille francs congolais constants, quiconque aura délibérément contaminé une personne d'une infection sexuellement transmissible incurable* [there is no direct mention of HIV]*"*; and, Section 4,

Protect the Rights of People Living with and Affected by HIV further stipulates that an individual is required to disclose his or her HIV status, as soon as it becomes known, to spouses or partners in advance of further sexual contact (in order to avoid the potential for criminal prosecution for 'deliberate transmission of HIV (Article 45),' amongst other reasons) and that, where an individual does not do so, a physician may share this information without consent for reasons of 'medical necessity', a term that is not defined. Some key informants were of the view that these provisions may fuel individuals' reluctance to know their HIV status.

Not all key informants agreed with this, however. Although a very small number of cases were mentioned by some key informants of women being accused of infecting their husbands as part of divorce proceedings, for example, there have been no formal prosecutions or convictions for transmission of HIV since 2009.[12] These same informants were also well aware of the limitations of criminalisation, particularly the near impossibility of establishing, with any certainty, when an individual was infected with HIV and how this occurred (KII with lawyers and magistrates participating in a 'Lessons Learnt' workshop about the UNDP/MINJUSTICE training [described in **Section 4.5.4**, below], September 2017).

There are more important gaps for key populations. While, for example, there is no direct criminalisation of same sex-relationships, non-conforming gender identity, or sex work, there are also no protective laws; and, partly due to the broader negative and punitive socio-cultural environment, laws that protect all citizens from things like physical violence or police abuse can be flouted.[13] According to key informants, this is the reason for acts of violence and abuse perpetrated against them by police and security services, or by other individuals and groups in the community, all of which are against the law, but for which there is relative impunity (KIIs and FDGs with MSM, transgender and sex worker peers in Kinshasa, Goma, Matadi, Kinsangani, Lubumbashi; CONERELA+ 2017; Si Jeunesse Savait (SJS) 2014; SJS and Sexual Rights Initiative 2014; UHAI-EASHRI, 2017).[14]

For male and female sex workers, police abuse can take the form of taking money from clients (particularly when an individual has refused to pay and the police has become involved); destroying condoms; arbitrary arrest in order to extort bribes; and physical and sexual violence. Section 175 of the *Code pénal*, which sets out offences against public order, is sometimes used by the police as the basis to arrest and detain men who have sex with men, transgender people and sex workers, but actual cases are rarely registered and, instead, are settled through financial transactions (FDGs with MSM and sex worker peer educators Goma, Kinshasa, Kisangani, Lumbumbashi, Goma; PNUD, 2013; UHAI EASHRI, 2017). While there are laws against such abusive practices by the police and others, those who are subjected to these things will not open formal cases for fear of additional abuse and humiliation, loss of privacy, or for fear of retribution (ibid.).

Key informants described the link between such negative experiences (or fear of such things) and participation in HIV programmes. Particularly for men who have sex with men and transgender people, the additional fear of having the particulars of sexual identity or sexual practice inadvertently or deliberately shared with others kept individuals away from HIV and other health services. There was also a fear that health care workers themselves would share the same biases as the police, for example, or other members of communities (FDGs with MSM and sex worker peer educators Goma, Kinshasa, Kisangani, Lumbumbashi, Goma).

Article 177, of the *Loi n° 09/001 du 10 janvier 2009 portant Protection de L'enfant*, which states, *"Quiconque contamine délibérément un enfant d'une infection sexuellement transmissible incurable, notamment le VIH/SIDA, est puni d'une servitude pénale à perpétuité et d'une amende de cinq cents mille à un million de francs congolais."* (both: RDC, 2009).

[12] The case, involving the rape of a young girl by her father, is described in PNUD (2014).

[13] There are, however, provisions in the the *Loi no 06/019 du 20 juillet 2006* against forcing an individual into prostitution, living off the proceeds of someone forced in prostitution, and sex trafficking.

[14] There are no quantitative data on the frequency of such violence or abuse. All of the sources cited give qualitative accounts, albeit very compelling, of such experiences.

Laws criminalising drug use come from different time periods (1903 and 1957, for example) (PNUD, 2013). Marijuana, amphetamines and heroin are included in a larger list of prohibited substances. Although a *Programme national de lutte contre les toxicomanies et les substances toxiques* exists within the Ministère de la Santé Publique (MSP), its mandate and programmes do not address any other aspects of harm reduction except for detoxification and rehabilitation. Key informants working with people who inject drugs described how the legal context fuels police harassment and abuse. According to them, people who inject drugs are often arrested solely for the purposes of extortion rather than to launch criminal cases (FGD with PWID peer educators, Kinshasa). The legal context ensured that people who inject drugs remain clandestine, and do not access HIV and other services, nor are easily reachable by such programmes, largely due to a deep distrust of those outside their networks.

With regard to adolescents and young people, the *Code de la famille* defines "children" as anyone under the age of 18 years (RDC, 2016). While the law contains a number of important protective provisions for children's welfare, one of its effects is that adolescents under the age of 18 years cannot independently give consent to health services, including for HIV testing or for access to condoms or other sexual or reproductive health commodities offered through public health facilities. All key informants working with this population raised the significance of this challenge both for the provision of HIV interventions and for broader efforts to promote sexual and reproductive health. Health care workers insist on parental involvement, and this requires adolescents needing services to disclose the fact that they are sexually active to their parents when they are otherwise not willing to do so. For adolescents who acquire HIV, the situation is more serious, and non-governmental partners working with these individuals must find creative means to support access to services when parental disclosure is neither desired nor possible (KIIs with RACOJ and Heal Africa, September-October, 2017).

For prisoners and other detainees, the assessment found that the efforts of the Ministère de la Justice (MOJ), with support from partners, to provide HIV services, in line with legal provisions requiring the provision of health services to prisoners, were significantly limited in their effectiveness by an overall trend of not complying with laws stipulating minimum standards for prison conditions as well as for basic conditions for survival of inmates (Amnesty International 2017;PNUD, 2013; United States Department of State 2016). In addition, there continues to be on-going abuse of judicial procedure through the overuse of pre-trial detention to illegally incarcerate individuals for extended periods. As a result, prison facilities face serious overcrowding. Furthermore, much of the inmate population is transient (PNMLS, 2017b).

Low levels of legal literacy and lack of access to justice

Legal literacy amongst people living with HIV and other key and vulnerable populations in DRC is considered to be low. For example, although the statute protecting their legal and human rights has been in place for almost a decade, few people living with HIV know about its provisions, and few consider it a means to address the different types of legal and human rights violations they experience (FGDs with PLHIV members of UCOP+ networks, September-October 2017). Key informants who noted these things reflected the earlier findings of the *PLHIV Stigma Index* that, in 2012, revealed that even though 80% of respondents had heard of the national law protecting their rights, only 45% had either read or discussed it (UCOP+ et al., 2014).[15] Few, if any, people living with HIV seek legal redress

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[15] It should be noted that the primary mode of participant recruitment of the *PLHIV Stigma Index* survey was through UCOP+ and other PLHIV networks (UCOP+ et al, 2014). PLHIV who participate in UCOP+ activities will, for example, have many opportunities to know about and become familiar with this law which is why proportion of participants having read or discussed it is significant. A broader, more representative survey of the diversity of PLHIV in DRC might indicate a much lower, general awareness of or actual familiarity with (having read or discussed it) this law.

because of lack of funds to hire lawyers and pay necessary fees to open dockets and pursue cases through the legal system.

Knowledge of legal and human rights was considered to be similarly low amongst other key populations, one reason being the absence of specific laws in the domestic context that address sexual orientation or gender identity and expression, for example. Although there has been recent work by UNDP with LGBT groups to raise awareness about international norms and standards regarding sexual orientation and gender identity and expression, complementing similar, on-going efforts of key population-led groups in DRC, some key informants noted how practical avenues for benefiting from this work were non-existent in the country. Although knowledge about laws prohibiting physical and sexual violence as well as police abuses was considered to be more relevant, engaging legal support to take cases forward was rare, both for financial reasons but also out of a desire to resolve issues quickly and to limit public exposure in families or communities (Key informants; PNUD, 2013; UHAI EASHRI, 2017).

The assessment identified other barriers, mostly arising from latent or explicit stigma and discrimination against key population groups on the part of legal service providers. For example, amongst key informants who were lawyers, and who had participated in sensitivity trainings regarding the Law on the Rights of People living with HIV and issues for key populations, there was a stated reluctance to take on cases that involved men who have sex with men or sex workers, for example. This reluctance clearly arose as a result of individual religious beliefs or moral convictions. On the other hand, key population-led networks and CSOs were not aware of lawyers or magistrates in their locales that had received such training and were firm in their view that legal service providers were not interested in the legal problems they faced, even if they had the financial resources to launch cases.[16]

As a final observation, the Commission Nationale des Droits de l'Homme (CNDH) was created in 2013 and its inaugural group of Commissioners appointed in 2015. However, key informants from a number of stakeholders did not view it as an entity that could assist with HIV-related human rights violations and noted its lack of visible engagement regarding key population concerns. The CNDH has an HIV and human rights focal point, but these same key informants observed that technical and financial support for this individual is limited, a challenge that is crosscutting for the CNDH generally. Overall, for most Congolese, access to justice for legal redress, both in the context of HIV and otherwise, remains next to impossible, due largely to severe levels of poverty but also to lack of confidence in a system perceived to be ineffective and highly corrupt (PNUD, 2013).

Harmful cultural norms and practices based on gender

The findings from key informant interviews and the desk review support the fact that there are many elements of the legal, social and cultural context that increase women and girls' vulnerability to HIV infection, as well as inhibit their access to HIV services. For example, socio-cultural beliefs about the lower status of women and girls in DRC appear to result in females having less access to education or employment (Harris Sapp and Boketa, 2016; Davis, Fabbri, Alphonse, 2014). Deeply entrenched and frequently severe poverty further compounds the precariousness of the position of women. Key informants noted that severe poverty was a catalyst for women and men to begin selling sex, even in early adolescence, and that this is often a primary source of income by which to support children. Transactional sex was also said to be a primary mode of survival for adolescent girls living on the streets (Valles et al. 2016).

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[16] There is no established practice of 'pro bono' work amongst lawyers in DRC. While there are a number of entities funded by Global Fund and others to provide legal services, largely in the context of SGBV, many key informants from key population constituencies felt that these services were not for them even if they or their clients had experienced SGBV themselves.

Sexual and gender-based violence is endemic in the country, with most girls and women having experienced some form of such violence. Country data from 2013, for example, showed that 75% of female respondents continued to believe that their husbands could use violence against them for such reasons as burning food (MPSMRM et al. 2014). Conversely, 59.5% of male respondents shared the same view. These factors likely contribute to the finding that 51% of female respondents had experienced physical violence since adolescence (15 years) and 27% in the past twelve months; 27% had ever experienced sexual violence, 17% in the past 12 months (ibid.). When asked to comment on these findings, most key informants stated that the situation had not substantively changed since these data were collected (Roundtable with members of RENDAF, September 2017).

The high prevalence of sexual and gender-based violence, both countrywide, but particularly in conflict zones, remains both a national and an international priority and concern (Comité des droits de l'enfant, 2017; United Nations Security Council, 2017). Such violence is perpetrated against men as well as women, and against children (Sonke Gender Justice Network and Promundo, 2013; Malemo et al., 2011; Comité des droits de l'enfant, 2017). While the government is seized with the seriousness of the problem, progress to stop it is slow (Comité des droits de l'enfant, 2017; United Nations Security Council, 2017). The recent prosecution of military leaders for perpetrating sexual and gender-based violence was said by a number of key informants to signal a change in government leadership and commitment to address these criminal acts (KIIs with UNAIDS and other UN partners, Kinshasa and Goma, October 2017).

There are major efforts across DRC to prevent sexual and gender-based violence and to support survivors. However, trends in the socio-cultural environment limit the effectiveness of these efforts, including uptake of services and seeking legal redress. A socio-cultural stigma is attached to women who have been raped resulting in their being shunned by their families and communities, some even being considered to be 'contaminated with HIV' as a result of the rape (Key informants; Kelly et al., 2011). For men who are survivors of sexual violence, stigma and shame are more severe to the extent that they do not access services at all (Sonke Gender Justice Network and Promundo, 2013).

Charges for services also affect survivors of sexual violence since police dockets must be opened first before a woman can access PEP at a health facility.[17] Some key informants described how the time needed to find funds and to reach a health facility meant that some women arrived only after the 72-hour window for effective administration of PEP had expired. The PNLS and others have reported that stock-outs of PEP have also limited access to services (PNLS, 2016b; Médecins sans frontières (MSF), 2015; Barthes, 2017).

For most women, as well as men, the deep cultural stigma regarding HIV means that an HIV-positive diagnosis is viewed as a catastrophe, the result being that HIV testing is to be avoided, or one's status to be hidden for as long as possible (the low uptake of HIV testing in DRC was described in **Section 4.2**, above). While community and family level discrimination are feared by men and women whose HIV-positive status becomes known, either willingly or unwillingly, the assessment noted that the consequences are more acute for women who face the possible loss of their children, their marriage, their home or their livelihood (KIIs with Foundation Femmes Plus, ICW DRC and women PLHIV members of UCOP+).

Finally, prevailing gender norms also affect key populations, particularly LGBT. (CONERELA+ 2016; UHAI EASHRI 2017; SJS 2014). A number of key informants working with these populations spoke about alarming examples of verbal and physical harassment, frequently from family and community members, stemming from the fact that LGBT individuals did not 'conform' to prevailing socio-cultural or religious norms. This particularly

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[17] There was disagreement about this amongst key informants with police indicating there was no charge to open a docket but women's groups saying that there was. One explanation given by a police key informant was that at individual police stations there may be lack of compliance to the policy that such services are free-of-charge.

affected transgender women as well as gay men and other men who have sex with men deemed to be too 'feminine' or too open about their sexual orientation and/or gender identities (FGD with MSM and transgender peer educators, Kinshasa, Lubumbashi, Kisangani, Goma, Matadi, September-October 2017).

Poverty-related barriers

While the assessment found that stigma and discrimination, punitive laws and policies, and harmful gender norms worked as substantive barriers to HIV services, it also found that poverty was an important concern. As already noted, poverty is endemic and severe across the DRC, including for people living with HIV and other key and vulnerable populations affected by HIV (UNDP, 2016). All key informants addressed this issue, reinforcing what, for example, the *PLHIV Stigma Index* survey found which was that one third of respondents lived in households with monthly incomes of US$165 or less (the average household size was 7) (UCOP+ et al., 2014). In addition, 85% lived in households where the income was less than US$1 per person per day and where at least one member had insufficient food for at least five days out of the previous 30 days at the time the study was conducted. Food insecurity is known to be a main contributor to poor adherence on ART for people living with HIV in DRC (Musumari et al., 2013).

Key informants noted that although certain aspects of HIV treatment should be provided free-of-charge (HIV testing and ARVs, for example), not all health facilities abided by this rule (Harris Sapp and Boketa, 2016; PNUD, 2013; UCOP+, 2017). In addition, other aspects of HIV care have service charges, particularly laboratory investigations and treatment for opportunistic infections. Furthermore, a number of key informants noted how HIV-related stigma caused individuals to go to health facilities numerous times for HIV-related illnesses before they finally accepted to be tested, meaning that they incurred numerous costs before this step, and that for some they did not reach this far and were not tested until they were hospitalised for advanced HIV disease.

Key populations have additional vulnerabilities related to poverty. Key informants reinforced for the most part the findings of the recent situational assessment (UHAI EASHRI 2017). The study described how its LGBT respondents were largely poor, with some working in the informal sector and fewer still with formal employment.[18] It stated that some were driven to the informal sector due to workplace discrimination. Others were simply denied opportunities within their families for professional education or for funds to start business activities. Such stigma-driven poverty affected an individual's ability to access HIV services, because of lack of funds for transport or service fees, and an individual's motivation to regard their health as important.

Programs to address and remove human rights-related barriers to HIV services – from existing programs to comprehensive programs

Overview

While the human rights-related barriers to HIV services for people living with HIV and other key and vulnerable populations in DRC are many, there are a number of efforts underway to address them. As noted previously, while human rights and gender-related aspects of HIV in DRC have been recognised for some time, specific efforts to address them are relatively new and have been mainly gaining scope and momentum since 2014.

The sections that follow examine in more detail interventions under each of the programme areas described above, as well as broader approaches that integrate human rights or gender-related components. For DRC there are either recently completed or current interventions

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[18] There were no comparisons made to the general population which, as noted above, also has high rates of poverty and unemployment. However, as explained, the argument of the study was that these things arose because of discrimination and not necessarily other factors.

under each programme area which, in all cases, key informants felt were contributing towards positive change. Human rights and gender issues were also becoming more and more integrated within broader HIV programming, particularly when comparing the current and new PSN, and in comparing the current and new Global Fund programmes. However, what was also evident was that most projects and activities were still small in scale and being implemented using equally small amounts of funding. In addition, many projects had not run long enough to be able to determine their effectiveness even at current levels of scale and scope that remain largely local and not countrywide.

It was also clear that knowledge and understanding of the full extent of human rights and gender issues in the context of HIV was still evolving across many stakeholders. While issues for people living with HIV, such as discrimination on the basis of HIV status, were well understood, other areas were not. For example, a number of key informants felt that extending HIV services to key populations addressed their HIV-related human rights issues and that there was no need to go further and to deal with challenges in the broader socio-cultural context (which some felt could not be changed). The view expressed by these key informants was that there was no discrimination in the provision of HIV services and that it was up to key population communities to now come forward to utilize them and then to report any difficulties they encountered. There was a very limited understanding of how negative factors in the external programme environment affected HIV-related health seeking behaviour, and how this limited uptake of HIV testing or other services.

Among key population constituencies themselves, knowledge and understanding of human rights and gender concepts are still evolving. This is due in part to the fact that the situation of LGBT constituencies or sex workers is complex from a legal perspective. While, as has been noted, there are no criminal laws, there are also no protective laws or policies upon which to advance specific human rights claims. For example, there are no laws that prohibit discrimination on the basis of sexual orientation or gender identity. For the protective laws that do exist, e.g. laws against police abuses, there remain a number of challenges to overcome before key populations can benefit from the rights and protections such laws are meant to afford. Even though members of key populations can in theory claim the basic rights and entitlements of all citizens in DRC, most key informants from key population groups felt they could not do so. For them, such actions risked provoking negative reactions and losing the safe personal or communal spaces that individuals and networks have managed to create for themselves through privacy and discretion. As one key informant stated, “It is better not to poke the dragon.”

It is important, then, to take these considerations into account when assessing the extent of current efforts, as well as when proposing what a comprehensive approach to addressing human rights or gender-related barriers to HIV services in DRC should entail. In the discussion that follows, which is organized according to the human rights programme areas described above, examples of current interventions are described, gaps and challenges within these efforts are identified, and the components of a comprehensive approach set out. In addition, **Annex A** lists specific activities under each programme area in order to provide further detail on what this comprehensive approach should include.

PA 1: Stigma and discrimination reduction for key populations

Examples of current approaches used by stakeholders to address stigma and discrimination are described in **Table 2**, below.

Table 2: Interventions to reduce stigma and discrimination

Main activity	Description	Coverage	Implementers
Stigma research & measurement	UNDP supported rapid assessments in two provinces in 2016 on HIV stigma and discrimination. CONORELA+ undertook an assessment of key populations that included a component of qualitative measurement of stigma, discrimination and violence. A plan is under consideration to repeat the *PLHIV Stigma Index*. UNDP is developing a stigma index tool for key populations.	UNDP: Nord-Kivu, Sud-Kivu. CONORELA+: Kinshasa.	UCOP+; CONORELA+; UNDP
Community dialogues with key populations and local authorities	Community level stakeholders have been brought together as part of the Global Fund programme to do sensitization about key-population-specific activities. These meetings have been opportunities to raise problems that key populations experience and, in response, to secure commitments to allowing programmes and services to operate without interference. For example, work has been done with local police in advance of outreach activities, including nighttime mobile testing campaigns, in order to gain their support and a pledge not to interfere.	Primarily Kinshasa, Goma, Bukavu, Lubumbashi and Matadi.	Cordaid, SANRU, PSSP, FHI360.
Public campaigns and events.	Stakeholders, led by PNMLS at national and provincial levels, use World AIDS Day as an opportunity to combat stigma and discrimination reduction against PLHIV.	National/provincial.	PNMLS at national and provincial levels.
PLHIV involvement and support.	UCOP+'s provincial chapters implement local level stigma and discrimination reduction activities that generally involve being active as openly-disclosed PLHIV in local processes. UCOP+ also supports community networks or support groups of PLHIV that are opportunities for individuals to share experiences of stigma and discrimination and to collectively discuss how to resolve them. These groups also provide an opportunity for PLHIV, particularly those newly diagnosed, to address self-stigma.	Country-wide	UCOP+
Legal protections	The importance of the *Law to Protect the Rights of People Living with and Affected by HIV* as a tool for reducing stigma and discrimination against PLHIV is discussed in **Section 4.5.7**, below.	Country-wide	PNMLS
Policy development	A number of key informants spoke about how the inclusion of key populations in national documents, particularly the PSN, has helped to bring issues for MSM, transgender, and male and female sex workers 'out of the shadows' and that this has contributed to reducing stigma and discrimination, at least amongst key stakeholders across the national HIV response.	National	
Engaging	CONORELA+, COMICO and EHAIA work to	Country-wide	COMICO,

opinion leaders (religious leaders, journalists, local politicians) in stigma reduction	improve knowledge and awareness about HIV amongst religious leaders and to strengthen their role in reducing HIV-related stigma.		CONORELA+ EHAIA
Workplace stigma reduction programmes.	CIELS has implemented a pilot project to train 100 peer educators to promote workplace HIV awareness, stigma reduction and to mobilize for HIV testing.	Pilot project in Congo Central	CIELS

In addition to what is in the table, there are interventions that integrate stigma reduction components. A number of stakeholders implement HIV testing campaigns, for example, and as a part of the community mobilization component speak to HIV-related stigma in terms of correcting misperceptions about HIV and HIV transmission, and in terms of allaying individual fears of testing and the potential for an HIV-positive result.

Santé Rurale (SANRU), one of the Global Fund's Principal Recipients in DRC, operates a national *ligne verte* to provide information about HIV as a way to address negative perceptions and misunderstandings, amongst other purposes. Statistics for the month of August detail the volume and nature of calls that have continuously increased since the service was launched (SANRU, 2017). More than 90% of callers were male who mainly asked about basic information on HIV and HIV transmission. In the categorisation of topics addressed by the individuals answering the calls, there are no specific categories regarding stigma, discrimination or human rights, however.

The Réseau National des Organisations des Assises Communautaires (RNOAC) supports community level ART distribution in selected sites in the country to make medication more accessible for clinically stable people living with HIV. The model involves community distribution points (PODI) for ARVs managed by people living with HIV on treatment. In addition to facilitating easier access to ART for some people living with HIV, the peer-to-peer model also contributes to stigma reduction (Vogt et al., 2017).

Within key population interventions, the components of stigma reduction largely focus on individual issues. Peer outreach workers, for example, speak to clients about self-stigma and, as one way of addressing it, promote the fact that friendly services exist that recognize their specific issues and needs. Through the *Centres conviviaux*, clients also have opportunities to raise issues of stigma, discrimination and violence against them and to receive both clinical and psychosocial support (the aspect of '*accompagnement juridique*' is discussed in **Section 4.5.6**, below). And, as an additional component, FHI360 has begun rolling out a programme of micro-credit for income generation activities amongst MSM. The programme has an objective of building self-esteem and autonomy, including resilience to stigma and discrimination.

Finally, a very important component of how key population groups develop personal and collective resilience to the harsh socio-cultural environment is through networks. The assessment encountered representatives from such networks in all places where data collection occurred. These networks, for the most part, do not receive any form of external funding but rather raise funds from their members or do small-scale fundraising activities. A main reason they exist is to provide mutual support and assistance, both in terms of building personal and collective strength to maintain positive attitudes and outlooks, and to provide assistance, including financial assistance, when one of their members is directly affected by stigma, discrimination or violence.

Across these collective efforts, however, there are some important gaps:

- There are no current, countrywide data on the extent of HIV-related stigma and discrimination. This affects the ability of all stakeholders to understand the effectiveness of past or current efforts to address it as well as to continue to plan for and implement new interventions.
- Similarly, there are no current, countrywide data on stigma and discrimination against key populations. Existing qualitative assessments contain compelling accounts of individual experiences; however, more quantitative data are needed to help 'make the case' for the extent of stigma, discrimination and violence against key population groups, and to inform the content, scale and scope of needed interventions to reduce and prevent such things.
- There is no comprehensive, countrywide plan for addressing HIV-related stigma and discrimination. While some relevant actions are contained in the NSP 2018-2022 these are not yet linked to a multi-year operational plan that includes, amongst other things, roles and responsibilities for different stakeholders as well as details on how this work will be rolled out, funded, coordinated and monitored.
- This lack of an overall framework was evident during the assessment where it was observed that stigma reduction interventions are activity focused (occurring around World AIDS Day, for example, and not at other times), of short duration, and of limited scale. There are few, if any, follow-up mechanisms to track whether knowledge, attitudes or practices positively shift once the interventions are finished.
- The ability of UCOP+ members working in local communities to continue to combat stigma and discrimination is continuing to diminish due to lack of funding. In the fieldwork locations outside, these individuals spoke about their declining motivation and their growing frustration, both arising from the tension between their personal commitment to their work as openly disclosed people living with HIV in communities and that fact that there was very limited or no financial support for the efforts they were making.
- Assessment participants from key population constituencies stated how most interventions only address HIV-related stigma and discrimination and not other issues for key populations. As one LGBT representative commented, "The community has been reduced to sexual activity, particularly HIV. We have other needs and other dreams and for now there is no solution; it's always in HIV." Other key informants noted how programme components for self-esteem, personal development, and psychosocial support to build resilience against stigma and discrimination have been minimized in favour of pushing for targets for HIV testing, diagnosis and referral for HIV care and treatment.
- The limited scale and reach of key populations programmes countrywide similarly limits efforts to address stigma and discrimination against them.
- Very few interventions address specific issues for transgender.
- Almost no interventions directly address stigma and discrimination against people who inject drugs.

A comprehensive approach to reducing stigma and discrimination over a five-year period should include the following:

- Measure current levels of stigma and discrimination to inform advocacy and to guide programme development, implementation and evaluation. UCOP+ and its partners should repeat the *PLHIV Stigma Index* survey in order to establish a baseline for the comprehensive approach. The data collection tools and participant recruitment methodology should be revised to ensure that people who are also members of key populations are adequately represented in the survey sample and that their experiences of stigma and discrimination are fully captured by the survey. A commitment should be made now to repeat the survey in years 4 or 5 of the comprehensive plan in order to measure progress on these issues.

- Through the planned IBBS survey, measure stigma, discrimination and other human rights violations against key populations. The PEPFAR partners and national stakeholders planning to conduct the IBBS survey for key populations should confirm that the methodology, including the data collection tools, contain questions on stigma and discrimination and other human rights barriers to HIV services. A commitment should be made now to repeat the survey in years 4 or 5 of the comprehensive plan in order to measure progress on these issues.
- Based on the findings of the PLHIV Stigma Index and IBBS surveys, develop coordinated, country-wide, multi-year action plans to reduce stigma and discrimination against PLHIV and other key and vulnerable populations. PNMLS should lead this effort and the plan should include a monitoring framework that, in addition to the Stigma Index and IBBS surveys, provides for other types of routine measurement of the effectiveness of the interventions the plan contains. The plan should also detail how the countrywide effort will be coordinated.
- Support the work of key-population-led networks in communities to reduce stigma and discrimination and to build personal and collective resilience to resist the negative impacts of stigma amongst their members. The role that these networks play should be recognised, expanded, and supported with both technical and financial resources. Existing key-population-led or key-population-focussed organisations (such as SJS, PSSP or AMOCONGO) should be equipped to support this work. The support provided should recognise and respect what local communities want to achieve with their networks, in terms of personal and collective empowerment, for example, and not be exclusively focussed on expansion of HIV interventions until this is a locally-defined priority (these networks should not be used only as opportunities to achieve targets for HIV-specific outreach programme or HIV testing). In a first phase of expansion, particularl attention should be paid to areas of the country where these networks do not yet exist (and where there is a local opportunity and collective will to establish them) or where they are most fragile.
- Support the work of people living with HIV who are open about their HIV status in communities to reduce stigma and discrimination. UCOP+ and the PNMLS should collaborate to strengthen, scale up and sustain the critical role that openly disclosed people living with HIV play in communities in terms of stigma and discrimination reduction, including challenges of internalised stigma.
- Scale up interventions in communities to engage local leadership, including cultural and religious leaders, in stigma and discrimination reduction. To strengthen this work, common tools and approaches should be developed and their use linked to funding support. In addition, mechanisms should be put in place to measure change. Finally, it is important that this work include reducing stigma and discrimination against key populations as, for the most part, it currently only addresses issues for people living with HIV.
- Scale up comprehensive sexual and reproductive health programmes for key populations that include psychosocial and other support to address the negative consequences of stigma, discrimination and violence. One model has already been developed through the PEPFAR and Global Fund-supported grantees implementing the *centres conviviaux*. These should be expanded to reach more provinces and districts in the country (informed by the results of the IBBS survey). Other models should be explored for settings where these *centres* would not be feasible or not appropriate (smaller, non-urban settings, for example).
- Provide technical and operational support to key population constituencies to develop strong and visible national networks. While there are a growing number of LGBT CSOs in the country, they are not yet organized within one strong and visible national network. For other constituencies, such sex workers or people who inject drugs, there are no prominent

key-population-led CSOs or networks. This gap should be addressed.

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

Examples of current approaches to build the capacities of health care workers (HCWs) to provide non-discriminatory, supportive and stigma-free services are described in **Table 3**, below.

Table 3: Interventions to train health care workers on human rights and medical ethics

Main activity	Description	Coverage	Implementers
Communications with HCWs about laws and policies on human rights and HIV.	Some HCWs are included in training sessions led by the MOJ on HIV and human rights, which include the relevant provisions of the *Law to Protect the Rights of People Living with and Affected by HIV* covering HIV service delivery.	Kinshasa, Bunia, Mbuji-mayi, Matadi	UNDP, UCOP+, MOJ
Dialogue sessions with key populations.	Key population representatives are sometimes included in the training sessions noted above. There are also specific sessions, organised through PSSP or FHI360, for example, that bring HCWs and key population representatives together.	Kinshasa, Bunia, Mbuji-mayi, Matadi	UNDP, UCOP+, MOJ, FHI360, PSSP
Training of health care providers for HIV services.	Training of HCWs for HIV-related service provision is the responsibility of the PNLS. The training curriculum is largely structured around the delivery of the minimum package of HIV services. It contains components regarding the *Law to Protect the Rights of People Living with and Affected by HIV* and addresses stigma and discrimination reduction. The training does not, however, address the needs of key populations in any comprehensive manner.	National	PNLS
Training of health care providers for key population services.	Through the *Centres conviviaux*, training is provided to HCWs on key population needs and the importance of stigma-free service provision. More recently, in FHI360-supported centres, training is being rolled-out to proactively address physical and sexual violence for these populations.	Kinshasa, Lubumbashi	FHI360, PSSP, SJS
Policy development	As noted previously, in the new PNLS HIV services guidelines, a minimum package of services for key populations is included. At the time of the assessment, implementation had not begun (financing to support this was expected under the next grant from Global Fund).	Not yet implemented.	PNLS
Monitoring of quality of services.	The *Observatoire de l'accès et de la qualité des services VIH/TB* covers over 60 health zones across three provinces. In the latest report, from June 2017, it was stated that the issues of charges for HIV services and stock-outs were continuing to	Kinshasa, Nord-Kivu, Mbuji-Mayi	UCOP+

	compromise the quality of care for PLHIV (UCOP+, 2017).		

Key informants also noted that pre-service training for health care workers (nurses, physicians, etc.) includes content on medical ethics. However, they were not aware that it included any specific content on human rights. There are some additional gaps and challenges within current efforts to equip health care workers to provide discrimination and stigma-free services:

- Health care workers not involved in the direct provision of HIV services, e.g. laboratory technicians and pharmacists, are not trained or sensitised on stigma and discrimination.
- Pre-service training curricula do not include the provisions of the *Law to Protect the Rights of People Living with and Affected by HIV* that apply to health care workers and health care settings.
- Aside from the health facilities covered by the *Observatoire*, there are no mechanisms to monitor trends in HIV-related stigma and discrimination amongst health care workers.
- There is no content in pre-service training that addresses the health needs of key populations.
- There is no countrywide mechanism for monitoring the effectiveness of in-service training on key population health needs (outside of what is done in the context of the *centres conviviaux* and the health facilities these are linked to these).

A comprehensive approach to address these gaps and to strengthen professionalism and ethics in the provision of services for PLHIV and other key populations should include the following:

- Update the curriculum and train health care workers on human rights and medical ethics in the context of HIV and TB. PNLS should lead this effort with the collaboration and involvement of from UCOP+ and key population CSOs. Such training should be first rolled out where there are particular issues with uptake and retention of prevention and treatment.
- Measure changes in knowledge, attitudes and practices of health care workers following training interventions. PNLS should conduct routine KAP studies to measure the effectiveness of its training programmes in reducing stigma and discrimination.
- Monitor the experiences of people living with HIV and other key and vulnerable populations using health care services and use the data for advocacy and for improving interventions to reduce stigma and discrimination. This could be achieved by expanding the *observatoire* to cover more health facilities and by ensuring that it also measures instances of stigma and discrimination against key and vulnerable populations.
- Scale up activities the forge collaborative relationships between health care workers in facilities, people living with HIV and members of other key and vulnerable population groups. A component of the *observatoire* is collaborative problem-solving based on the data it collects. As this intervention is expanded to cover more facilities, this component of the model should be strengthened.

PA 3: Sensitization of law-makers and law enforcement agents

Current efforts to build the capacity of the law and justice sectors on their role in promoting and protecting HIV-related human rights are described in **Table 4**, below.

Table 4: Interventions to sensitise law-makers and law enforcement agents

Main activity	Description	Coverage	Implementers
Development of training	The PNMLS has released a revised version of the HIV and human rights training	Not yet rolled-out.	PNMLS, MOJ

materials.	manual. A major component of the revision is new content addressing the needs and concerns of key populations.		
Training and sensitisation of law and justice sector stakeholders.	The office of the National Focal Point on HIV and Human Rights conducts trainings for magistrates, lawyers, police officers, prison officials and others using the training manual. Workshops are generally for 3 days and involve 50 participants. PLHIV also participate and share testimonials during the sessions.	Kinshasa, Bunia, Mbuji-mayi, Matadi	UNDP, MOJ, PNMLS, UCOP+
Sensitisation of local police and judicial officers.	In addition to the training, sensitisation sessions are conducted by implementers in locations where there are *centres conviviaux* or where outreach activities take place. There is no standard format or content for the sessions. The main objective is to gain the support of local police for the provision of HIV services to key populations without harassment or interference on their part.	Kinshasa, Lubumbashi	PSSP, FHI360
Sensitisation of prison workers.	Partners working with the penitentiary service undertake training and sensitisation of prison workers on the importance of HIV service provision, particularly HIV testing and stigma reduction to encourage prisoners and staff to be tested. There is no specific content on legal rights for prisoners.	Kinshasa, Mbuji-mayi,	PSSP, the Union, others
Engagement of parliamentarians	Through the national *Cellule* (see below), parliamentarians are engaged on HIV issues as the need arises. Two examples given were the interventions in 2013/2014 to prevent a proposed bill criminalising homosexuality being tabled in the national assembly; and, current work to mobilise parliamentarians to support changes to the *Law to Protect the Rights of People Living with and Affected by HIV*, and changes to the age of consent for HIV and other health services.	National	UNAIDS, UNFPA, MOJ, UCOP+ and others.

The current National Focal Point on HIV and Human Rights was appointed in 2012 by the Minister of the Ministry of Justice and Human Rights (there is now a separate Ministry of Human Rights). She is also President of the Court of Appeal so has considerable standing and respect for her role. The MOJ contributes some support for this role but the office is mostly reliant on external support from UNDP, particularly for its training and sensitisation work with lawyers and the judiciary. To guide its work, the Office convenes a national *Cellule Droit et VIH* which is a multi-sectoral group working on human rights issues. While the Office has been largely focussed on issues for people living with HIV, particularly for women living with HIV, it is now beginning to take up more issues for other key populations. There is need to better engage the National Focal Point and the Cellule Droit and VIH.

The training workshops led by the Office of the National Focal point that are focused on the *Law to Protect the Rights of People Living with and Affected by HIV* (and now the revised manual) have been the primary modality for working with stakeholders for building knowledge and skills regarding HIV-related human rights and for sensitising them on the particularly challenges faced by people living with HIV in communities. One outcome of the training at provincial levels has been the establishment of *Groupes Thématiques Droit et VIH* whose purpose is meant to ensure that the training leads to actions and that they monitor trends and improvements within their jurisdictions. These groups mirror the national *Cellule*. At the provincial level, convening the *Groupes Thématique* falls within the Human Rights Division of the local department of the MOJ. Their effectiveness relies on local leadership and commitment as there is no specific funding to support these activities following the training.

Within these efforts, some gaps remain:

- Key informants who were representatives of people who live with HIV and other key populations were concerned that the training does not lead to more engagement with constituencies and the identification and follow-up of legal cases or other challenges related to stigma, discrimination and human rights.
- The *Groupes Thématique* are not yet effective mechanisms of engagement between those who have undergone the training and key population constituencies.
- The training programme has not been evaluated, particularly using a longitudinal approach to track how the law and justice sector is more able and willing to take up HIV-related human rights concerns for people living with HIV and key populations as a result of the intervention.
- There are no specific interventions for the police, including no nationally co-ordinated plan, regarding issues for key populations that go beyond what is done with individual police officers or policing units in the limited number of locations where key population programming is underway.
- There are no mechanisms to consistently track police abuses against key populations in order to generate data for advocacy and for the development of effective interventions.
- There are no interventions in either the law or justice sectors that specifically address issues for people who inject drugs. The focus at the moment is on people living with HIV, LGBT people and sex workers.
- There are no interventions that engage parliamentarians on issues for key populations. Some key informants described this as strategic in order to avoid another attempt to table an anti-homosexuality bill, for example.

Comprehensive programming: Sensitization of law-makers and law enforcement agents

A comprehensive approach to equipping the law and justice sector to be more active and engaged on HIV-related human rights concerns should include the following:

- Measure the outcomes of the MOJ-led training and sensitisation activities, including changes in knowledges, attitudes and practices regarding people living with HIV and other key populations, and increases in support for these groups to address human rights violations against them. As already noted, there are signs that the MOJ's efforts are not as effective as they should be. Measuring the outcomes of this activity would clarify what these weaknesses are and how to resolve them. The national *Cellule* should be responsible for leading the monitoring process.
- Support the provincial *Groupes Thématiques* to develop proactive monitoring and response mechanisms for legal and human rights violations against people living with HIV and other key populations. This includes technical and operational support. There should be more emphasis placed on outreach and engagement with local PLHIV and key population networks and constituencies.
- Measure police abuses and other human rights violations against key populations. The

measurement process should include both quantitative and qualitative approaches. The *ligne vert* operated by UCOP+ could be expanded to play the role of a reporting mechanism.

- Develop a training and engagement plan, with curricula and materials, for the police and the military in order to reduce abuses against key populations and to increase their commitment to protecting them in communities. While including members of the police force or the military in broader training on HIV and human rights is still valuable, specific interventions for the police and the military are necessary given the frequency with which key populations groups report abusive behaviour. Work underway with the police and the military to equip them to protect (and not perpetuate) sexual and gender-based violence against women and girls could inform the development of the intervention plan, including training and follow-up support strategies.
- Train prisons staff on HIV, TB and human rights for detainees. This should be led by the PNMLS and the MOJ with participation from CSOs working with prisons and prisoners.
- Develop tools, materials and strategies to introduce harm reduction approaches to the law and justice sector. This work should begin with the development of a co-ordinated, multi-year plan given that, based on current realities, the barriers are substantial and will take some time to address and resolve.
- Develop a multi-year strategy to engage senior policy makers and parliamentarians in a process to build a protective law and policy environment for key populations. While this work must be appropriately staged to avoid unintended negative reactions or outcomes, it nevertheless needs to occur. The public health approach remains the entry point for raising greater awareness and commitment to continuing to improve the law and policy environment for these groups.
- Scale up efforts in communities to create collaborative relationships and joint activities between local key population networks and constituencies, the police, and local political, cultural and religious leaders. The success of PSSP, SJS, FHI360 and its partners, and others in creating 'safe spaces' for key population programmes should be built on and expanded.

PA 4: Legal literacy ("know your rights")

Interventions to improve legal and human rights literacy amongst people living with HIV and other key populations are limited in DRC. **Table 5**, below, describes current efforts.

Table 5: Interventions to promote legal literacy

Main activity	**Description**	**Coverage**	**Implementers**
Empowering PLHIV to know their rights.	UCOP+ supports its members to build knowledge and awareness amongst PLHIV regarding the provisions of the *Law to Protect the Rights of People Living with and Affected by HIV.*	Country-wide	PNMLS, MOJ
Interventions in prisons	Some implementers have conducted limited interventions in prisons to raise awareness regarding legal and human rights for detainees, including legal rights to receive HIV and TB services.	Kinshasa, Mbuji-mayi, Goma	MONUSCO, the Union

Within interventions addressing key populations, legal and human rights literacy is not a routine component. Peer educators who participated in the assessment stated that they discussed these issues with clients on a case-by-case or individual basis, sharing their own knowledge, and using this as a way to improve self-esteem and resilience against negative experiences in households and communities. But human rights literacy was not a core component of the outreach package they provided.

Where topics for key populations were included within broader HIV-related rights literacy interventions it was largely from the perspective of improving social tolerance through greater understanding and awareness. The content was not specific to the particular human or legal rights that are infringed for key populations, such as their rights and entitlement as citizens to health services and other public benefits, as well as to those constitutional protections that are infringed through police abuses, for example.

Comprehensive programming: Legal Literacy

A comprehensive approach to address these gaps and to strengthen legal literacy amongst people living with HIV and other key populations should include the following:

- Develop user-friendly legal literacy information tools for key populations. These should be specific to key populations groups, such as gay men and other men who have sex with men, transgender, sex workers, and people who inject drugs. Key population constituencies should lead this process, requesting technical support when needed, so that the information tools are user-friendly to their members, including illiterate ones and are relevant to their lived realities and their needs and aspirations for the realisation of their legal and human rights within the specific context of DRC. These tools should also include patients' rights information.
- Integrate human rights/legal/patients' rights information and outreach into existing prevention and treatment community outreach to key populations. The contents of outreach encounters, for example, will vary from individual to individual. Nevertheless, all individuals reached with these efforts should know that such information exists and is available to them. In addition, these tools should be available within *centres conviviaux* and opportunities, such as information sessions, provided for service users to learn more about the legal and human rights they possess. A cadre of community outreach workers should also be trained as peer human rights educators and be a resource in each local outreach effort.
- Support and scale up the work of key population networks to empower their members with knowledge about their legal and human rights. The primary purpose of this is to strengthen individual and collective self-esteem and resilience to the negative consequences of the harsh and punitive socio-cultural context for key populations in DRC.
- Measure changes in knowledge regarding legal and human rights amongst key populations. Such efforts should include tracking changes in basic knowledge as well as tracking changes in how individuals and constituencies use this knowledge to achieve positive change in their personal and community settings.
- Evaluate the effectiveness of legal/human/patients' rights literacy programmes for people living with HIV. This could be done as part of a new *PLHIV Stigma Index* survey and the results used to adjust both the content of such programmes as well as their delivery modalities. Specific attention should be paid to the link between promoting knowledge and awareness of the *Law to Protect the Rights of People Living with and Affected by HIV* and how PLHIV use this knowledge to address the legal and human rights challenges they encounter in communities and in health care settings.

PA 5: HIV-related legal services

Efforts to provide HIV-related legal services and to improve access to justice are described in **Table 6**, below:

Table 6: HIV-related legal services and access to justice

Main activity	**Description**	**Coverage**	**Implementers**
Training of lawyers and magistrates.	A primary objective of the MOJ's workshops is to capacitate lawyers and magistrates to apply the *Law to Protect the Rights of People Living with and Affected by HIV* and to assist those in need.	Kinshasa, Bunia, Mbuji-mayi, Matadi	PNMLS, MOJ
Legal information and referrals	UCOP+ operates a 'ligne verte' for PLHIV to report legal problems (amongst other things) and to be referred for legal advice and support.	Country-wide	UCOP+
Legal services and representation	For individuals that can afford it, lawyers that have been trained are available to take on cases. Some entities have recently been funded as *cliniques juridiques* to provide services free-of-charge to PLHIV and key populations. Also the National Focal Point for HIV and Human Rights is compiling a list of lawyers willing to work on a *pro bono* basis.	Kinshasa, Bunia, Mbuji-mayi, Matadi	MOJ, Cordaid, legal services NGOs and individual lawyers.
'Accompagnement juridique'	Within the FHI360 *centre convivial* model, there is a plan to assist key populations to report violence and other abuses and to support them to initiate legal processes. At the time of the assessment, this component had not yet been implemented.	Not yet implemented but will initially roll-out in Kinshasa and Lubumbashi.	FHI360, PSSP

Offering HIV-related legal services and improving access to justice for those with cases to take forward is still relatively new in DRC. Training of lawyers and magistrates on the *Law to Protect the Rights of People Living with and Affected by HIV* has the objective of encouraging more people living with HIV to come forward with cases to supportive lawyers and magistrates capable of assisting. However, as noted previously, people living with HIV who have cases to pursue must have their own financial resources o engage lawyers and to cover the costs of taking cases forward. Provision of *pro bono* legal services is not a common practice in DRC. Also, as previously noted, although the training includes content regarding key populations, there is still a reluctance on the part of those trained to address key population concerns.

The Ministry of Justice keeps no countrywide register of legal cases brought by people living with HIV or other key populations. Although the office of the National Focal Point records and tracks cases that are brought to its attention, there is no formal tracking and monitoring system. UNDP has stated that, as a result of the training, since 2016, legal support has been provided in 45 cases involving sero-discordant couples, of which 11 have been settled or dismissed due to lack of evidence (KII with UNDP, September 2017). During key informant interviews, some examples were given of current cases include divorce, breach of confidentiality and disputes regarding inheritance. No legal cases involving key populations were identified.

A comprehensive approach to strengthen the provision of HIV-related legal services should include the following:

- Develop and maintain a roster of lawyers and magistrates that have been trained and make it available to people living with HIV and key and vulnerable population networks. A part of the training programme, participants should be asked for their consent to have contact details shared so that people living with HIV and key and vulnerable population networks know who has been trained in their respective locations and how to contact them.

- Develop and deploy peer paralegals who are living with HIV or are members of other key and vulnerable populations to provide basic legal advice, to assist with mediation, and to refer cases to lawyers where appropriate. This can be rolled-out initially through additional training support for a selection of existing peer educators working in community outreach key population programmes and of UCOP+ members already working in communities.
- Roll out the *'accompagnement juridique'* component of the *centres conviviaux* model. This can be done in a phased approach, aligned to the planned expansion of the number of *centres*. Following a pilot phase, an evaluation should be done to guide the expansion process.
- Expand the *ligne verte* at UCOP+ to be a service for both people living with HIV and key and vulnerable populations to obtain legal information and advice and to be referred to paralegals, lawyers or *cliniques juridiques* for support. Given that the equipment and processes for this type of service already exist, additional technical and operational support should be made available to expand its mandate and reach to include issues for key populations. Promotional materials should also be adapted to reflect this broader focus.
- Scale up free or low cost access to lawyers for people living with HIV and other key and vulnerable populations. Though access to peer paralegals in communities should take care of the bulk of need for legal advice and support, these paralegals should have lawyers supervising and supporting them and people should have access to legal representation when it is needed. Access to pro bono or low cost lawyers could be increased by (1) increasing the number of *cliniques juridiques* offering services; (2) supporting the work of the National Focal Point to gain the commitment of more lawyers country-wide to provide *pro-bono* or reduced cost legal services; and (3) placing and supporting a few lawyers dedicated to working with marginalized people in key NGOs, CBOs or networks.
- Put in place a system to track and monitor legal and human rights cases. The office of the National Focal Point should be equipped to support this mechanism. As part of the training, lawyers and magistrates should be requested to support the system. Provisions for confidentiality and security of this information must be included in the reporting and monitoring processes. Annual progress reports should be produced as awareness raising and advocacy tools.

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

At the national level, there are important efforts underway to change problematic legal provisions regarding criminalisation of HIV transmission and age of consent for HIV services. There are also some important actions for more government engagement on HIV in some provinces. **Table 7**, below, gives more details on these efforts.

Table 7: Advocacy for law and policy reform

Main activity	Description	Coverage	Implementers
National level advocacy and lobbying for law reform.	The *Cellule* has been the mechanism for a collective effort to remove provisions of the *Law to Protect the Rights of People Living with and Affected by HIV* criminalizing HIV transmission and for changing the age of consent for HIV services. These efforts started in 2014 and have been sustained despite a number of challenges encountered in parliamentary processes. The dossier is now ready to be tabled in parliament	National	PNMLS, MOJ, UCOP+, UNAIDS, others

	although a specific date has yet to be given, a situation made more difficult by the recent death of the dossier's long-time political sponsor.		
Provincial level advocacy	In Nord Kivu, there is active collaboration amongst stakeholders, facilitated through UNAIDS and PNMLS, to identify and take action on advocacy issues such as provincial government commitment to HIV programmes as well as to address stock-outs and other problems for HIV services.	Nord-Kivu	PNMLS, UCOP+, MSF, UNAIDS
Monitoring compliance with existing laws and policies.	UCOP+'s *observatoire* has a component of monitoring compliance (or lack of compliance) with legal provisions for free HIV services as well as for confidentiality and informed consent. It is also intended to expand the Observatoire to include malaria as well and HIV/TB with a focus on user fees and stock outs.	Kinshasa, Nord-Kivu, Mbuji-Mayi	UCOP+
Documentation of human rights abuses and legal redress	An externally-supported report was released mid-2017 documenting accounts from LGBT and sex workers of legal and human rights abuses (UHAI-EASHRI, 2017). In 2014, SJS produced a similar report.	Kinshasa, Lubumbashi, Goma, Kisangani, Kalemie and Bukavu	UHAI-EASHRI
Documentation and advocacy with international human rights bodies.	SJS, for example, has made submissions to the UPR for DRC on human rights and key populations.	National	SJS and others

The national-level *Cellule* functions as an important mechanism for dialogue and coordination around HIV-related human rights issues. UN partners, such as UNAIDS, also contribute support towards coordinating advocacy activities. However, while the collaborative effort to bring about changes to the *Law to Protect the Rights of People Living with and Affected by HIV* and to address the age of consent shows that there is collective capacity for monitoring and reforming laws and policies, there are some important gaps:

- Work to foster law and policy change does not currently include priorities for key populations.
- Representatives from key populations constituencies, particularly LGBT and sex workers, are not visible or vocal within the *Cellule* or within other fora where their priorities for law and policy change could be advanced. While there are members of the *Cellule* that speak to and for key population priorities, these voices are not yet represented directly.[19]

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[19] Key informants offered some explanations for this, including, until recently, the exclusion of key population representatives from opportunities where HIV-related advocacy issues and priorities were discussed or determined; lack of access to technical and financial resources to build networks that would strengthen their visibility and inclusion in these larger processes; and, the very high-risk socio-cultural and political environment surrounding open disclosure and advocacy that has been described elsewhere in this report. While these risks and challenges are substantive, there was, nevertheless, no indication of a collective effort across the different stakeholders in the national HIV response to find ways to mitigate these risks and to create opportunities for key populations to be directly represented and heard in these important spaces. As one of these senior level stakeholders stated, "We are not ready for that."

- There is no national level process that addresses the law or policy-related needs of people who inject drugs, despite their inclusion in the PSN as a key population and the proposals in it for expanded harm reduction interventions, including opioid substitution therapy. One aspect of this lack of attention is that, largely because interventions supporting people who inject drugs are new and very few in number, people who inject drugs, themselves, are in the very early stages of becoming a more visible constituency, even in the local areas where current programming is operating.
- As already noted, the CNDH does not play an active role regarding HIV-related human rights priorities including those involving key populations. While there is an HIV focal point, the CNDH's technical and operational capacities to be more present and proactive are limited. The National Focal Point in the MOJ takes on much of what could be their work.
- Limited financial resources has seriously constrained the ability of the PNMLS at provincial levels to play its convening role to monitor legal and human rights trends, amongst other functions, and to coordinate appropriate responses with local multi-sectoral stakeholders.

A comprehensive approach to improving the law and policy environment for HIV programmes should include the following:[20]

- Identify opportunities in existing laws and policies to improve legal and human rights protections for key populations and develop an action plan for moving forward. While the 2013 LEA recommended that this should be done it did not provide details on which laws and policies should be the starting points. This gap should be addressed and the opportunities categorised in terms of their short-, mid-, or long-term chances for success.
- Develop background papers, legal briefs and other materials to support efforts for law and policy reform for key populations. Some initial work was done by UNDP as previously noted to support the effort to prevent the anti-homosexuality bill from being introduced to the National Parliament. More forward-looking work needs to begin to build a more enabling and protective law and policy framework for key populations. At a minimum, law and policy should protect key populations from discrimination and violence.
- Develop and implement engagement plans with senior policy-makers and parliamentarians to support and champion proposals for law and policy reform. This work is already occurring as 'below the radar' activities. It should be expanded, and should begin to involve key population representatives directly, along with other national stakeholders.
- Using the NSP 2018-2022 as the starting point, map out and implement a process to put in place a supportive policy framework for the introduction of harm reduction programmes. The public health approach, as it is described in the NSP, should be the basis on which to engage other stakeholders to create a more enabling environment for the development and implementation of harm reduction interventions. Once these interventions are established and can generate evidence of their effective, longer-term efforts should commence for legal reform to further support the harm reduction approach.
- Strengthen the capacity of the CNDH to be a monitoring body for the protection of human rights for PLHIV and other key and vulnerable populations. This should be done in collaboration with the Office of the National Focal Point at the MOJ.

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

Current efforts to address human rights and gender-related barriers for women in the context of HIV services include those described in **Table 8**, below.

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[20] Actions for prisons and inmates are include under **Section 5.5.10**, below as they are the same for HIV and TB.

Table 8: Efforts to reduce discrimination against women in the context of HIV

Main activity	Description	Coverage	Implementers
Empowerment of women living with HIV.	In addition to participating in UCOP+, women living with HIV undertake their own activities for mutual support and empowerment through other implementers.	National	SJS, Fondation Femme Plus, ICW
Gender mainstreaming in HIV policies and strategies.	Based on the gender assessment of the national response carried out in 2013, an effort was made to significantly strengthen components related to gender in the 2014-2017 PSN. The external review of the PSN found, however, that a number of the recommended actions were not implemented. Based on these lessons, there were renewed efforts during the development of the PSN 2018-2021 to re-inforce gender as a crosscutting component. At the time the assessment was being done, a new gender assessment was underway using the revised UNAIDS/Stop TB Partnership tool.	National	PNMLS, Foundation Femme Plus, RENADEF
Community interventions to reduce harmful gender norms and practices.	DRC is piloting a Francophone version of the SASA! Intervention model that has a component of engagement of communities to identify and confront harmful gender norms that perpetuate SGBV and limit access to services.	Kinshasa, Nord-Kivu, Mbuji-Mayi	Cordaid
Responding to gender-based violence against women.	There are major efforts across the country to respond to SGBV through upstream prevention and comprehensive, integrated service provision that includes HIV testing, PEP, referral for PMTCT or HIV treatment, and access to justice through *Cliniques juridiques* focussed on responding to SGBV.	27 country-wide	Cordaid
Responding to gender-based violence against key populations.	The FHI360 model for the *Centre convivial* includes an integrated component to address SGBV amongst key population. This aspect of the service package includes pro-active screening for physical and sexual violence, comprehensive clinical and psychosocial care, as well as access to justice. At the time of the assessment, this component was just beginning to be implemented.	Kinshasa, Lubumbashi	FHI360

It should be noted that these activities are a sub-set of more comprehensive, country-wide interventions addressing issues of gender equality, women's empowerment, and the prevention of sexual and gender-based violence that have been mapped elsewhere (PEPFAR, 2016, for example).

While a number of key informants working on gender issues within the national HIV response expressed the view that the understanding of and commitment to gender priorities in the context of HIV was improving, with significant changes noticeable between the current and new PSN, and between the current and new Global Fund programmes, they also noted that there was still some distance to go before they would consider that issues of gender had been comprehensively understood and addressed (KIIs with RENADEF, Foundation Femme Plus, ICW DRC, September-October 2017).

The main outstanding gaps and challenges included the following:

- In a number of key informant interviews, it was evident that the gendered-dimensions of the HIV epidemic in DRC were not well understood, nor was gender itself an important consideration in designing a more effective national response (As one senior level [male] key informant stated, "The problem is with the women themselves.")
- While the PSN 2018-2022 contains many elements addressing gender, it was not clear how they will be coordinated, implemented or monitored.
- Women living with HIV continued to feel marginalised, particularly at leadership levels in current structures, including in UCOP+.
- Understanding of harmful beliefs and practices regarding gender as a driver of stigma, discrimination and violence against key populations was very limited, including amongst some key population groups or key population services providers themselves.

A comprehensive approach to strengthening the component of gender in the national HIV response should include the following:

- Address the results of the HIV/TB gender assessment. Once the findings are available, a comprehensive action plan and monitoring framework should be developed.
- Sustain and scale-up programmes in communities that address harmful gender norms and prevent sexual and gender-based violence. Once the pilot is evaluated, the adapted SASA! programme should be scaled up country-wide.
- Scale up the human rights aspects of comprehensive, countrywide services for survivors of sexual and gender-based violence. These services provide important entry points for women to reduce their risk of HIV infection (PEP, for example) as well as for HIV care and treatment, including PMTCT, should they need them. Human rights funding should support activities that ensure that survivors are informed of their rights and relevant laws, are referred to shelter and/or protection from further harms, and are provided access to legal support and services.
- Sustain and scale-up Cliniques juridiques for survivors of sexual and gender-based violence. These are essential for women to claim and defend their legal and human rights. Services that support HIV-related human and legal rights claims, in addition to those linked to SGBV, should also be available.
- Training and deploy women living with HIV as paralegals in communities. These individuals can extend the reach of existing legal services. The training should include advanced skills in mediation and conflict resolution. Appropriate arrangements need to be in place to ensure that these women are protected from harm related to both their status as people living with HIV and as women.
- Engage, train and support traditional and community leaders to provide community dispute resolution (including with regard to property-grabbing, custody and inheritance), reduce stigma and discrimination, and deal with harmful gender practices and violence. This work is already underway in DRC. It should be scaled up and sustained over a multi-year period.
- Fund gender-focussed CSOs in communities to scale up and sustain their work promoting women's equality and supporting access to HIV and other SRH services. This assessment has highlighted the current gap in this respect that should be addressed.
- Develop and implement gender sensitivity training for all stakeholders in the national HIV response. This should include all levels from the leadership level of the PNMLS to CSO working in communities, including those that are key-population-led or key-population-

focussed.

- Support women living with HIV to take-up and remain in leadership positions within the national HIV response. The current experiences of these women of marginalisation should be addressed and reversed.

PA 8: Interventions for adolescents and young people

There are a number of ways that stakeholders are trying to address HIV-related human rights priorities for adolescents and young people, including for adolescent girls and young women. The main approaches are:

- Empowering adolescent girls and young women with knowledge on HIV, human rights and sexual and gender-based violence. A Global Fund-supported pilot project is underway in two provinces (Kinshasa and Mbuji-Mayi) to empower adolescent girls and young women with knowledge regarding HIV, human rights and sexual and gender-based violence. Interventions are delivered through schools, in communities and via health services.
- Centre d'Ecoute et Information Convivial pour les Adolescents (CEICA)—There are six CEICA that are implemented through RACOJ in three regions (there were 36, formerly, until funding was reduced). They are meant to provide stigma-free services for adolescents, including opportunities for HIV testing, STI diagnosis and treatment, and referral for HIV treatment and other sexual and reproductive health interventions.
- Espaces Jeunnes—There are eleven that are implemented by RACOJ. These are youth-friendly recreational spaces that are attached to health facilities. They are meant to be 'safe-spaces' for adolescents and young people where, amongst other things, they can learn about HIV and other sexual and reproductive health needs and then have opportunities for HIV testing, for example, or to receive other services.
- Training and support for peer educators—The Programme national de la santé de l'adolescent (PNAS), in collaboration with RACOJ and other partners, implements training and support for peer educators to work with adolescents and young people regarding sexual and reproductive health. A component of this work is to address self-stigma and the reluctance of adolescents and young people to use services.
- Capacity strengthening for youth associations—RACOJ works with its members to implement organizational capacity strengthening to ensure that these entities can function as community-level platforms for raising awareness regarding the sexual and reproductive health needs of young people, including components regarding HIV. One of the intended effects of this work is addressing community and individual stigma and encouraging young people to be more resilient to challenge these barriers to health services in their family and community environments.
- Research and monitoring on barriers and enablers to access and uptake of services—Médecins du Monde recently completed study on socio-cultural determinants of sexual and reproductive health for adolescents and young people in Kinshasa and Nord-Kivu (Arenas and Loock, 2016). The results have provided an important body of evidence for understanding the complex individual and community-level barriers these groups face to obtain information, to understand and express their own sexual health needs, and to then seek out and receive needed services, including those related to HIV. As noted previously in this report, DRC participates in the All In Initiative which, amongst other components, supports data collection and analysis that informs advocacy, policy-making and programming for HIV, especially for adolescent girls and young women
- Advocacy for law and policy reform—RACOJ has been active in the national level effort to amend the *Law to Protect the Rights of People Living with and Affected by HIV* to allow adolescents as young as 13 years to independently access HIV services.

- Standards for adolescent-friendly services—These were developed by the PNAS and, in the guiding principles component, speak to the rights of adolescents and young people to stigma-free information and services regarding HIV and other sexual and reproductive health needs. With support from partners, PNAS has been training health care providers on the standards (no data on numbers of individuals trained or on the effectiveness of the training were available).
- HIV prevention materials for young key populations—At the time of the assessment, PNAS was working with other stakeholders to develop HIV prevention materials (*boites a images*) specifically focused on young people from key populations (MSM, FSW and PWID) and street-involved youth. The intention was that these would be used by RACOJ and others to, amongst other things, be more inclusive of young key populations in their youth-focussed HIV programming and, in doing so, begin to address stigma and reluctance within youth networks to involve peers from key populations.
- Supporting positive, health and dignity for adolescents and young people living with HIV. Heal Africa in Goma is one of a small number of other partners country-wide offering specific programmes for adolescents and young people living with HIV (Heal Africa also works with children living with HIV). In addition to care and treatment, the programme provides psychosocial support to equip these individuals to address stigma and discrimination in their home and community environments.

Despite these important efforts, some gaps and challenges remain:

- The coverage of most interventions (CIECAs, Espaces jeunes) is limited and largely involves five provinces (Kinshasa, Nord Kivu, Kongo Centrale, Kasai and Nord Kivu) where implementation occurs mostly in cities.
- The CEICA's are not well integrated into the health system and are therefore difficult to sustain.
- Aside from the *boites a images* project which is not yet implemented, adolescent and young key populations are not specifically included in youth programmes and there is reluctance amongst stakeholders to address this with some stating that such individuals should be included under key population programmes.
- Adolescents and young people living with HIV are also not specifically included in programs for people living with HIV. Key informants working on youth programmes felt that they were addressed through HIV treatment programmes.
- Comprehensive programmes for adolescents and young people living with HIV, including components that help them address stigma and discrimination, do not exist countrywide.
- Funding amounts are small and projects are of limited duration. Almost no work is funded from domestic sources.

A comprehensive approach to addressing human rights and gender related barriers in the context of HIV for adolescents and young people, including those living with HIV, should include the following:

- In interventions providing psychosocial support to adolescents and young people living with HIV integrate human/patients rights and legal literacy information and activities. One opportunity for increased support is to equip youth organisations with needed technical and operational resources to provide these programmes.
- Provide training and support to RACOJ members and other young people networks to improve their knowledge and understanding regarding human rights, gender equality, gender, sexual orientation and diversity so that they become more inclusive of all young people. Current youth-focussed programmes must become more inclusive of all young people.
- Train and deploy young women as paralegals in communities. They should be linked to

cliniques juridiques or youth associations. Their role should be community level sensitisation on the legal and human rights of young people in addition to providing legal advice, mediation and referral. Appropriate arrangements must be in place for their security and protection as they go about this work. Sensitising and building partnership with community and religious leaders would also be important.

- Develop and implement a plan, including a monitoring framework, to shift HIV service provision, including the knowledge, attitudes and practices of health care workers, should the effort to change the age of consent for HIV services succeed. Key informants noted that this work was in progress at the time the assessment was conducted. Sufficient technical and operational resources should be mobilised to support the plan once implementation can begin.

Annex A provides some additional detail about the comprehensive approach, including an estimate of costs.

Investments to date and costs for comprehensive programming

The assessment attempted to capture data on current levels of funding for efforts to address and remove human rights and gender-related barriers to HIV services. However, participation in this component was limited with only 10 CSOs agreeing to share their data. Some additional information was available through Global Fund sources but not, however, from the two Principal Recipients (PRs) in DRC as, during the time the assessment was conducted, important transitions were occurring (grant closure for one PR and the development of an acceleration plan for the other) that prevented them from participating. What is included in this section provides only an indicative picture of some current investments in DRC and where they are focussed in terms of the seven main programme areas.

Table 9, below, shows data from the 10 CSOs that participated in this component of the assessment:

Table 9: Human rights funding for CSOs (2016)

Programme Area	**Amount for 2016 (US$)**
Stigma & discrimination reduction	73 558
Training of HCW	123 313
Sensitisation of law makers and law enforcement agents	64 657
Legal literacy	159 399
HIV legal services	13 000
Monitoring & reforming laws and policies	-
Addressing gender and HIV	38 000
TOTAL	**471 926**

As the data show, funds available for HIV-focussed human rights interventions from sources other than Global Fund or PEPFAR were few in 2016. Further detail on what these funds supported is included in **Annex C**.

Table 10, below, shows data from Global Fund sources on investments in HIV-related human rights and gender interventions over the 2015-2017 period.

Table 10: Global Fund allocations for human rights and gender (2015-2017)

Programme Area	**Amount for 2015-2017 (US$)**
Stigma & discrimination reduction	261 224

Training of HCWs	-
Sensitisation of law makers and law enforcement agents	-
Legal literacy	15 000
HIV legal services	21 000
Monitoring & reforming laws and policies	-
Addressing gender and HIV	2 361 176
TOTAL	**2 658 400**

Funded activities addressing stigma and discrimination reduction largely included work that integrated this component into other efforts, such as HIV prevention and risk reduction, but also human rights, for example. As noted under **Section 4.5.8**, above, the Global Fund, along with other partners, has prioritised protecting adolescent girls and young women from sexual and gender-based violence in its country support, and this work, as well as programmes for adolescents and young people more generally, constitutes most of what was invested in human rights or gender-focused activities over the 2015-2017 period. In addition, over a twelve-month period between 2016 and 2017, PEPFAR invested approximately US$1,8 million in programmes for key populations. However, no additional information was available on what proportion of this amount supported work on human rights barriers to services (PEPFAR, 2017).

Finally, it is worth noting that many key informants, particularly those from provincial or local level PHLIV and key population networks, expressed serious concerns about access to funding for their work, including from the Global Fund. Through these discussions, the assessment found that much of the ground-level work to address issues of human rights and gender in the context of HIV was done by these networks in local communities and that most received no direct funding for these efforts (Civil society roundtable with members and partners of the Réseau National des Organisations Non-Gouvernementales pour le Développement de la Femme [RENADEF], September 2017). Where there was access to funds, from Global Fund, for example, it was often linked to HIV testing campaigns where these entities were expected to mobilise their members to participate. There was no other funding to support other activities or ongoing organizational needs.

V. Projection of Funding Needs for Comprehensive Programmes for HIV

The final component of the assessment was to calculate the level of investment needed to implement the proposed comprehensive approach. There was a challenge to complete this component give the limited amount of data available to calculate unit costs, for example. As a result, what is shown below, for both HIV and TB, is highly indicative and will be refined should additional data become available.

Projected funding needs for HIV are shown in **Table 11**, below:

Table 11: Costing of the comprehensive approach for HIV

HIV Human Rights Barriers Program Area	Total
PA 1: Stigma and discrimination reduction for key populations	USD 2,163,67
PA 2: Training for health care workers on human rights and medical ethics related to HIV	USD 2,539,726
PA 3: Sensitization of law-makers and law enforcement agents	USD 1,418,087
PA 4: Legal literacy ("know your rights")	USD 466,583
PA 5: HIV-related legal services	USD 1,749,193
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	USD 735,035
PA 7: Reducing discrimination against women in the context of HIV	USD 2,888,049
Other activities	USD 593,578
TOTAL	**USD $12,553,930**

Table 11. Total Cost of 5-Year Comprehensive Programme for HIV. Please refer to Annex A for cost breakdown by each year.

Comprehensive programmes to address sexual and gender-based violence and to reduce HIV-related vulnerabilities for adolescent girls and young women were not costed under the programme area of "reducing HIV-related discrimination against women" due to insufficient data from current programmes. What is shown in this category are costs for programmes to improve access to HIV services for adolescents and young people more generally. The findings from the assessment on the level of current investment indicated that approximately US$1.7 million was available in 2016 for human rights and gender-related interventions, with programmes addressing sexual and gender-based violence and adolescent girls and young women accounting for 85% or more of this amount. For the 2018-2020 period, the DRC CCM has requested US$3 million in catalytic for human rights interventions (gender-related interventions were addressed in the main funding request) indicating that for period, these components of the comprehensive appear to be fully funded.

Opportunities for scaling-up interventions

The PSN 2018-2022 makes a stronger, more explicit commitment to addressing human rights and gender in the context of the national HIV response. This includes more detailed strategies for improving the legal and socio-cultural context for HIV-related interventions for key populations. This in a sense provides a 'blue print' for developing more detailed plans and strategies that take into consideration the specific recommendations for building a comprehensive approach.

The greater attention given to human rights and gender priorities during country dialogue and the development of the latest funding request also served to position work to address barriers more prominently and to build broader understanding and support for these priorities across the multi-sectoral response.

The national *Cellule* could function as strategic leadership group to monitor and guide a programme of work based on the PSN and incorporating the findings of the baseline assessment and the activities funded under the new Global Fund grant. Further coordination and monitoring could be done by the provincial *Groupes thématiques* with support from the provincial offices of the PNMLS.

VI. Baseline Findings: TB

The findings of the assessment for TB are presented in the same sequence as they were for HIV: an overview of the TB epidemic in DRC, with specific attention to the key and vulnerable populations included in the assessment; information on trends in access and uptake of TB and TB/HIV services to illustrate the extent of current gaps; an overview of the general context for the TB response with a particular focus on the components addressing human rights and gender; an analysis of human rights and gender-related barriers to TB services; an analysis of current efforts to address barriers, including gaps, challenges, and recommendations for a comprehensive approach; and, finally, an analysis of opportunities for scaling up current efforts over a five-year period.

The findings show that while the TB epidemic is extensive in DRC, data are generally not available to show its differential impacts on the different key and vulnerable populations identified under the TB PSN and included within this assessment. Designated TB services are not available in all parts of the country and serious health system weaknesses limit the quality and availability of these services where they are provided. The human rights and gender-related dimensions of the TB epidemic are mostly undocumented and not well understood by most TB stakeholders, including the PNLT. The assessment did, however, identify some important barriers, particularly TB stigma in communities, including self-stigma, largely related to lack of knowledge about TB and TB treatment. Fear of stigma, and internalised negative beliefs about TB, mean that individuals affected by the disease will delay seeking diagnosis or treatment until it is in an advanced stage. Users-fees for TB screening (TB treatment itself is free) in health facilities also operates as a deterrent.

Although the country has infection control and workplace health and safety standards, implementation and compliance with them are poor placing health care workers, at elevated risk of TB exposure. While key informants were of the view that TB was a major concern in the mining sector, there are no data on TB for this sector and, consequently, no ability to know the extent of human rights barriers that may arise for mineworkers needing TB services. Finally, as already noted in the findings for HIV, there are major challenges in prisons for providing HIV and TB services. The large number of prisoners in temporary detention, either awaiting trial or sentencing, has a compounding effect on TB risk. Poor physical conditions in prisons, particularly malnutrition and severe overcrowding, limit the effectiveness of the TB services that are provided.

The assessment identified a small number of interventions to address human rights-related barriers in the context of TB, work in communities and work in selected prisons, primarily, the former being done with limited or no funding support. Nevertheless, there are opportunities to expand both the understanding of the human rights and gender-related aspects of the TB situation in the country and to mount a comprehensive, five-year approach to address them. The new TB PSN recognises issues of human rights and gender, and this provides an important opportunity for anchoring the comprehensive approach. Similarly, the civil society platform for TB, should it received adequate funding, provides a mechanism through which the expanded engagement of CSOs in communities can be coordinated and monitored.

The more detailed findings are presented in the following sections, beginning with a description of the significant burden of TB disease in DRC.

Burden of TB amongst key and vulnerable populations

The DRC ranks 6th out of the 22 countries that account for 80% of the global burden of TB disease (WHO, 2017). In 2016, it had an estimated incidence of 323 per 100,000 people for all forms of TB that was equivalent to 254,000 new cases in that year, 82% of which were pulmonary TB (Ibid). Programme data from the PNLT showed that notification rates were low with only 132,515 cases notified in 2016 or 51% of the WHO estimate (WHO, 2017; PNLT, 2017). In 2015, the treatment success rate was 89% (ibid.).

There are no countrywide disaggregated data on TB incidence or prevalence with which to determine how the country's burden of TB affects different key or vulnerable population groups. A 2015 study in one prison facility in Mbuji-Mayi found a prevalence rate of 17% (130/733) which was several times higher than the national, population-level estimate (Kalonji et al., 2016). Over-crowding and malnutrition were two main predictors of TB risk. However, the extent to which this is representative of all prisons in the country is not known.

The mortality rate for all forms of TB was estimated at 67 per 100,000 in 2016 and remained the leading cause of death for people living with HIV (PNLT, 2017). In 2015, based on an HIV testing rate of 50%, 12% of patients with TB were also living with HIV (ibid). Based on a rate of 48% screening for TB of people living with HIV in 2015, 8% were diagnosed with active TB (PNMLS, 2016). TB drug resistance was estimated at 2% of new cases and 16.6% of retreated cases in 2016 (PNLT, 2017).

Trends in service uptake for TB and TB/HIV services

Programme reports from the PNLS and the PNLT show that TB patients still have limited access to HIV screening and ART (PNLS 2015, PNLT 2015). In 2016, of people identified as living with TB and also diagnosed as HIV-positive, 75% were receiving ART (PNLT, 2017). In addition, of all people living with HIV screened for TB, only 67% of those with active TB were placed on TB treatment (ibid.). No explanation was given in the reports for the differences in ART uptake between the two populations. Less than 10% of people living with HIV received isoniazid preventive therapy (IPT) in 2016, a significant gap for this high-TB-risk population in a country with such a high rate of endemic TB disease. Health system weaknesses are the primary cause of poor service coverage for both TB patients and those that are co-infected with HIV (PNLT, 2017). These weaknesses include non-availability of TB or HIV services in health facilities (only 20% provide TB diagnostic and treatment services), as well as frequent stock-outs and poorly trained health care workers (ibid.). The latest Global Fund funding request notes, "social and cultural barriers, an under-developed community system, and persistent stigma and discrimination-inducing behaviours" as other factors, but does not elaborate (DRC CCM, 2017).

In 2016, for a programme budget of US$57million, 3% was financed through domestic sources, 48% from external sources (including the Global Fund), and 49% remained unfunded (WHO, 2017).

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

The 2013 Legal Environment Assessment addressed TB only peripherally (PNUD, 2013). It included TB in the section describing laws and regulations regarding prisoners, particularly the provision where prisoners with infectious diseases are to be segregated from the general prison population in dispensaries or infirmaries, although under specific conditions where access to health care workers must be assured, and where ongoing monitoring must be done so that these individuals can be released back into the general prison population when the risk of infection of others is no longer there. The assessment found no other TB-specific laws.

The main policy document for the national TB response is the TB PSN 2018-2020 (PNLT, 2017). Its vision speaks to universal access to TB services without any form of exclusion or discrimination. The document mentions the need to protect and promote human rights in the context of the TB response. Under the section on human rights and gender, there is a proposal to sensitise people living with TB on their rights to treatment and their responsibilities to not expose others to infection. There is also a component of ensuring the rights of prisoners and other detainees to access TB treatment. Where the strategy addresses the role of communities, it is to engage them in seeking out and referring TB suspects, including contact tracing, as well as for finding individuals lost-to-follow-up. There is no mention, for example, of the role of community-based entities to address stigma and discrimination and to support people living with TB to overcome self-stigma.

Human rights and gender-related barriers to TB services

Amongst the stakeholders working within the national TB response, knowledge and understanding of the human rights or gender-related dimensions of TB programmes was very limited. In fact, some key informants held the view that the main challenges for TB were health system weakness and the inability of the PNLT given this situation to ensure service provision to all individuals in need of TB screening, diagnosis or treatment. One barrier that was frequently mentioned was the fact that TB screening was not free in all health facilities and that this, more than any other factor, deterred individuals from coming forward. While these challenges are real and substantial for DRC, the assessment nevertheless did find at least some evidence of human rights and gender-related barriers to TB services, and these are described below.

Stigma and discrimination

Comprehensive evidence about TB-related stigma and discrimination is lacking in DRC. No knowledge, attitudes, practices (KAP) survey has been undertaken to measure TB-related stigma in personal and community environments (although the PNLT is considering carrying out such a study). Key informants had differing views on whether stigma and discrimination occurred to any significant degree. Key informants from CSOs working with people who had been diagnosed and treated for TB, including people with TB and HIV co-infection, had the strong view that TB-related stigma was significant and that it largely arose from ignorance about the disease and from local cultural meanings attached to it (e.g. that it was witchcraft) (KIIs with LINAC, CAD and PNLT, September-October 2017).

Key informants also described how, for some individuals, TB was associated with HIV and that they would deny their TB status for fear that others would think that they were also HIV-positive (KIIs with LINAC, CAD and PNLT, September-October 2017). Lack of comprehensive knowledge about TB in communities also drives self-stigma, according to key informants, whereby individuals internalised the negative cultural beliefs about TB, for example, and delayed seeking diagnosis and treatment until TB disease is well advanced and many others in their personal and community environments have been exposed (KIIs with LINAC and CAD, September-October 2017). However, for other key informants, particular those working within TB programmes nationally or provincially, an individual's reluctance to seek screening and diagnosis was also as result of both lack of awareness about TB, lack of easy access to health facilities offering these services, and lack of funds to pay for some services once they had arrived there. TB-related stigma or discrimination was not a primary factor in their view.

Punitive laws, policies and practices

The assessment did not identify TB-specific punitive laws or policies. However, within prison settings, major challenges were observed in both the desk review and the fieldwork (although limited) regarding the implementation of laws, policies and standards for minimum prison conditions and for ensuring access to health care services, including those for HIV and TB.

The PNLT, in its new strategic plan, identifies the main challenges for effective TB control, including for the diagnosis and treatment of prisoners who contract TB. These challenges are severe overcrowding, unsanitary conditions (which cause the spread of cholera as well as TB and other contagious diseases), poor nutrition, and the high-rate of turnover amongst the prison population (PNLT, 2017; see also Kalonji et al., 2016). As already noted, the inability of the MOJ to meet legally mandated minimum standards for prison facilities and to fulfil the legal rights of prisoners, largely due to lack funding, was raised by a number of key informants (KIIs with LINAC, CAD and MOJ representative in Goma, September-October 2017).

Issues included in the findings under HIV will also apply in the case of TB to some people who live with HIV and key population groups, particularly those that are co-infected. Punitive laws or policies that deter such individuals from using health services generally will clearly also affect their health-seeking behaviour in the context of TB.

Poverty and socio-economic inequality

Similar to the findings for HIV, poverty-related inequalities affect access to health services across the population, mainly because of user-fees. While TB treatment is free, TB screening is sometimes subject to charges (key informants noted that, from facility to facility, user-fee charges can vary significantly based on the attitudes and practices of health care workers). In addition, according to key informants, at community level, the fact that TB treatment is free is not widely known. There are other economic challenges linked to household income loss while an individual is on TB treatment, an event that has a particularly severity in DRC given the high level of endemic poverty across the population. The PNLT has a plan to conduct a study on the catastrophic cost of TB illness; however, at the current time, there is no comprehensive evidence on the extent of these challenges and how they affect uptake and retention in TB services.[21]

Harmful working conditions and exploitation

Key informants, including the PNLT, raised two main issues regarding working conditions. Within the prison system, prison conditions also affect prison workers and position them at high risk of TB exposure along with the inmates they supervise (KIIs with PLNT, and with prison officials, Goma, October 2017). Within health facilities, although there is a national policy regarding infection control, which includes components related to TB, implementation is weak with the main factors being the condition of health facilities themselves, lack of supplies of personal protective equipment, and weak supervision and accountability mechanisms for alignment with the guidelines. The PNLT understands these issues but, at the moment, comprehensive data are not available on the extent of risks for health care workers or on the burden of TB amongst this group.

Some key informants were also working in the mining sector, including the 'artisanal' or informal mining sector. These individuals spoke about TB risks in this sector and the general lack of interventions to address them. Some described how individuals will hide their TB diagnosis or deny their symptoms for fear of losing their employment in the formal sector, or for fear of losing their places at informal mining sites. In addition, in some locations where mining takes place, there are no accessible health facilities, compounding challenges for addressing all aspects of the disease in this sector. The PNLT noted that it is aware of these issues but that it has not yet been able to do comprehensive work to more fully understand the full extent of TB-related challenges for mineworkers. It intends to start to address this gap under the new TB PSN should sufficient resources be available (KII with PNLT, October 2017).

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

The assessment found that, while there is growing multi-sectoral engagement within the national TB response, there are almost no specific, human-rights-or-gender-focused interventions in the context of TB in DRC. Four main CSOs are active in the community component of the national TB programme which are Club des Amis Damien (CAD), a national network of people living with or recovered from TB; Fondation Femme Plus (whose TB-related activities complement their programmes for people living with HIV and key populations); la Ligue Nationale Antituberculeux et Anti-lépreuse du Congo (LNAC); and, l'Association des Communicateurs en Santé. Starting in 2016, these groups received funding from WHO and

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[21] The WHO tool for this type of study is available at: http://www.who.int/tb/advisory_bodies/impact_measurement_taskforce/meetings/tf6_background_5a_patient_cost_surveys_protocol.pdf

the Stop TB Partnership to establish a civil society platform with the secretariat based at CAD.[22] UCOP+ also addresses TB for people living with HIV through its member associations. Finally, through the *Centres conviviaux*, screening for TB and referral for treatment are components of the service package.

Besides the Global Fund, there are other funders and partners working with the PNLT to implement TB programmes. These include a USAID-supported TB Challenge Grant, implemented through the country office of the International Union Against Tuberculosis and Lung Disease, and supporting CAD, Fondation Femme Plus and LINAC, amongst others, to implement community-level TB activities.

Through Cordaid and SANRU, Global Fund is also supporting community-level engagement programmes. However, there are no specific components in these funded programmes addressing human rights or gender-related issues. Rather, the resources are directed at community-level follow-up activities, which include identifying and referring 'TB suspects' to health facilities, and assisting to trace and find individuals lost-to-follow-up for TB care. Although one of the objectives of the civil society platform is to support rights-based advocacy on TB, the participating groups struggle for financing to move forward on this component.

Despite such limitations, all of the civil society key informants spoke about their efforts to integrate some human rights components as unfunded 'add-ons' into their community-level work, particularly the component of stigma reduction through improving community knowledge and awareness regarding TB. LNAC, through its advocacy work, tries to increase government awareness and commitment to strengthen its response to the disease, including its financial commitment; however, it receives no specific funding for this work.

A component of UCOP+'s *Observatoire* is monitoring access to TB screening for people living with, including availability of the service and fees charged. In June 2017, for example, UCOP+ reported that the average cost of TB screening was CDF7,535 or US$5 in Kashasa but offered mostly free-of-charge in facilities observed in the Mbuji-Mayi and Goma (UCOP+, 2017). The report does not explain the differences.

As noted under **Section 3.3**, above, at the time the assessment was carried out, a TB/HIV gender assessment was underway. The findings of the assessment, when available, will be an important source of guidance on how to strengthen the gender component of both the HIV and TB responses.

Finally, a number of international and local partners are working with the MOJ to support TB programmes in prisons with activities that are largely focused on TB screening. This work has a component of improving knowledge and awareness about TB that also helps to reduce TB-related stigma. However this work does not have, as it primary objective, addressing stigma or other human rights concerns. The exception is the work of the International Union Against Tuberculosis and Lung Disease which has a component of improving the delivery of TB care in the Central Prison at Mbuji-Mai, one of the country's largest facilities. While these are important projects, they do not fall under the Global Fund 10-key program areas to address human rights-related barriers in the context of TB.

A comprehensive approach to addressing human rights and gender-related barriers to TB services should include the following components:

PA 1: Stigma and discrimination reduction

- `. The PNLT with its technical partners should conduct a KAP study and develop an action plan to address the results.[23] The KAP study should focus on those areas in the country where the TB burden is highest.

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[22] See https://7sur7.cd/new/2016/09/loms-sengage-a-soutenir-la-lutte-contre-la-tuberculose-en-rd-congo/

[23] The WHO tool for this type of study is available at: http://apps.who.int/iris/bitstream/10665/43790/1/9789241596176_eng.pdf

- Measure TB-related stigma and discrimination in different sectors. Additional, focussed KAP studies should be done in the mining sector, the health sector, and the law and justice sectors (police, prisons, the military).
- Implement community level activities to reduce TB stigma and discrimination. Through the civil society platform, there is a structure in place to coordinate this work. Human rights literacy regarding TB and work to reduce stigma and discrimination could be integrated into community-level TB programs by engaging people living with/affected by TB to work in communities for community education and stigma reduction. This is the role of CAD, for example, with other CSOs and this work should be expanded with appropriate funding support.
- Based on the results of the KAP studies, implement workplace programmes on TB awareness and stigma reduction. This work should have an initial focus on the mining sector (which the PNLT has identified as a priority), the health sector, the police and prisons.
- Measure TB-related stigma for people living with HIV and other key and vulnerable populations. Ensure that the next *PLHIV Stigma Index* survey and studies on stigma, discrimination and violence amongst key populations include questions on TB-related stigma and discrimination.
- Integrate content on TB-related stigma and discrimination into efforts to reduce HIV-related stigma and discrimination. This should be done where feasible, especially in programmes working directly with PLHIV and key populations who are also at high risk for TB.

PA 2: Training of health care providers on TB-related human rights and medical ethics

- Include content regarding TB and human rights in TB training for health care workers. Where TB is addressed, in either pre-service or in-service training, content on the human rights dimensions of TB and the role of health care workers should be included and receive sufficient time and emphasis.
- Strengthen the capacity of the PNLT to identify and address the human rights and gender dimensions of TB. The PNLT from the national to the local levels must be equipped with knowledge and mechanisms to identify human rights or gender barriers and to guide health care workers, community health outreach workers and others in responses to reduce them.
- Strengthen TB-specific workplace policies and practices for health care workers. While the PNLT moves to gather data on the situation of health care workers and TB, it should, at the same time, work with the MSP to strengthen protective policies and practices for health care workers, including putting in place complaints procedures and systems of workplace compensation.
- Monitor the availability of personal protective equipment and compliance with other infection control standards for TB in health facilities. This could be added to the UCOP+ *Observatoire*, for example, or become a collaborative venture of the TB civil society platform with the PNLT.

PA 3: Sensitization of law-makers and law enforcement agents

- Include TB-related human rights issues in HIV training for police, lawyers and magistrates. The HIV and human rights training manual can be expanded to include a section on TB and training work based on the manual expanded accordingly.
- Based on the findings of the KAP study (noted above), develop and roll out guidelines for the management of TB-related stigma and discrimination in police and prison facilities for

both staff and detainees. As already noted, there is a knowledge gap regarding TB in the context of police facilities and prisons which should be closed.

PA 4: Legal literacy- Knowing your TB-related rights

- Develop and distribute user-friendly TB-focused rights/responsibilities literacy materials in communities. This should be an activity for the members of the civil society platform. Distribution of materials can be integrated with the community-level stigma reduction activities noted above.
- Integrate TB topics within legal literacy materials and human rights and paralegal activities for HIV. As legal literacy, human rights and paralegal activities are strengthened and expanded for HIV, topics addressing TB should be fully integrated.
- Train health care workers, police, prison workers, miners and others on workplace health and safety laws, policies, procedures in the context of TB. The PNLT should lead this effort to ensure that these different cadres of workers can know about, push for and benefit from accountability measure in workplaces that prevent TB exposure and also protect and support workers who contract TB.

PA 5: TB-related legal services

- Include TB-related issues in training for lawyers providing legal services for people living with HIV and other key and vulnerable populations. The training can be based on the revised HIV and human rights training manual noted above.
- Ensure that community level *Clinique juridiques* can also provide advice and support for claims regarding TB. This can occur as part of the training lawyers working in the clinics receive for HIV and sexual and gender-based violence.
- Train and deploy paralegals in communities to provide information on TB-related legal and human rights, to do mediation, and to link to legal services. These paralegals can be part of the cadre of peer educators working in communities to reduce stigma and discrimination. They can also be attached to *Cliniques juridiques* as outreach workers.
- Integrate TB concerns in the engagement and sensitization of religious and community leaders for dispute resolution, reduction of stigma and discrimination and gender-based violence related to HIV.
- Monitor and issue reports on TB-related human rights trends, and on access to justice. This should be a function of the civil society platform.

PA 6: Monitoring and reforming TB-related laws, policies and regulations

- Address the recommendations of the Legal Environment Assessment planned by Stop TB to be conducted in the DRC As already noted, the 2013 LEA did not address TB. However, Stop TB plans an LEA, and human rights funding should be made available to operationalize its recommendations, including a programme for monitoring and reforming laws and policies in ways that reduce human rights and gender-related barriers to TB services.

PA 7: *Reducing gender-related barriers to TB services*

Respond to the findings of the TB/HIV gender assessment. As information on gender-related barriers to TB services, including gender-disaggregated data on the burden of TB more generally, is non-existent at the present time, the results of the assessment should inform that development of a programme of action to both address this gap and take action on the barriers it identifies.

PA 8: Ensuring confidentiality and privacy

- Undertake an assessment on confidentiality and privacy knowledge and practices across the national TB response. The assessment should incorporate the activities of CSOs and others, for example, which support the national TB response as well as what takes place in health facilities.
- Based on the results of the assessment, develop a plan to strengthen confidentiality and privacy of health information across the national TB response, in particular ensuring that confidentiality and privacy issues are integrated and addressed holistically across the TB and HIV responses. In addition to actions to strengthen practices in health facilities, guidelines and tools should also be developed/strengthened for CSOs and other partners. Where there are HIV-related efforts to strengthen confidentiality, privacy and reduce stigma and discrimination at health care settings, TB-related barriers should be integrated in such efforts.
- Equip CSOs and people living with/affected by TB in communities to monitor confidentiality and privacy in provision of TB services. This should be a component of what the civil society platform undertakes and should be done in collaboration with the expanded *observatoires* noted under HIV, above.

PA 9: Mobilizing and empowering patient and community groups

- Support the civil society platform to mobilise networks of people living with/affected by TB in communities for mutual empowerment and support, joint action around human rights advocacy, and activities to reduce TB-related stigma and discrimation. This should be a component of the programme of work for CSOs in communities

PA 10: Programmes in prisons and other closed settings

- Equip national TB-focused CSOs to monitor the quality of services in prisons, advocate to reduce human rights-related barriers to services and to support prisoners to access TB screening/treatment. More CSOs should become involved in supporting the PNLT and the MOJ to address TB in prisons.
- Sensitise judicial officers at all levels to the effects of pre-trial detention on overcrowding and the increased risk of TB. The MSP (with PNLT) and the MOJ should collaborate on a programme of sensitisation of judicial officers on the public health impacts of over-reliance on pre-trial sentencing and engage them in the project of reform (see below).
- Advocate for alternatives to temporary detention in order to reduce overcrowding. The PNLT and its partners should engage with the MOJ on reforms to pre-trial sentencing from the public health perspective of reducing the spread of TB in prisons and in their surrounding communities.
- Put in place policies and procedures to treat prisoners with TB in adjacent health facilities. There has been some success with this through the Union project. Countrywide policies and procedures should be put in place to make this option routine when treating these individuals within prisons will jeopardise their own and others' health.
- Review policies/practices for TB screening and treatment in prisons to ensure alignment with TB-related human rights standards. The MSP (with the PNLT) and the MOJ should collaborate to undertake the review and to revised TB prevention, treatment and management guidelines where needed.

- Train prison workers at all levels on the public health benefits of the human-rights-based approach to TB prevention and management in prisons. Staff in prisons should see this approach as benefiting their own health as well as that of the prisoners they supervise.
- Train prisoners on their TB-related human rights and responsibilities. TB-focussed CSOs should be equipped to provide the training in collaboration with the PNLT and the MOJ. Among other things, it should involve recruiting peers human rights educators among prisoners.
- Undertake a multi-sectoral advocacy effort to improve general conditions in prisons. This would be a long-term effort using the current situation of TB as one of the main rationales for the urgent need to effect these changes.

Annex B provides some addition detail about the comprehensive approach, including an estimate of needed funds to fully implement it.

Current funding for programmes to remove barriers to TB services

Only one CSO provided data on funding for TB interventions addressing human rights and gender-related barriers to services. This was an amount for 2016 of US$27,876 to undertake community-level interventions on stigma reduction for HIV and TB in two provinces. For the 2015-2017 period, US$28,000 of Global Fund resources were used for TB education and sensitisation activities in one prison.

VII. Costs for comprehensive programs to remove human rights related barriers to TB services

The final component of the assessment was to calculate the level of investment needed to implement the proposed comprehensive approach to remove human rights related barriers to TB. There was a challenge to complete this component give the limited amount of data available to calculate unit costs, for example. As a result, what is shown below, is highly indicative and will be refined should additional data become available.

Projected funding needs for TB are shown in **Table 12**, below:

Table 12: Costing of the comprehensive approach for TB

TB Human Rights Barriers Programme Area	**TOTAL**
PA 1: Stigma and discrimination reduction	**1,780,077**
PA 2: Training of health care workers on human rights and ethics	**156,469**
PA 3: Sensitisation of law-makers and law enforcement agents	**-**
PA 4: Legal literacy	**145,198**
PA 5: TB-related legal services	**431,396**
PA 6: Monitoring and reforming laws and policies	**379,731**
PA 7: Reducing discrimination against women in the context of TB	**157,912**
PA 8: Improving confidentiality and privacy	**157,912**
PA 9: Community mobilisation for people living with TB	**1,745,920**
PA 10: Improving TB services in prisons	**494,573**
Other activities	**350,789**
TOTAL	**5,799,976**

The assessment found very little costing data for TB-related human rights interventions. As a result, costing data from the HIV component was used to calculate needed investments for the comprehensive approach. As already noted, in 2016, only US$50,000 was identified in terms of current investments. This was not surprising given that, as the assessment results demonstrated, issues of human rights or gender are not yet fully incorporate within the national TB response. The country has some distance to go, then, to mobilise sufficient resources to address this gap and to begin to implement the comprehensive approach to these issues that the assessment has outlined.

Opportunities for scaling-up interventions to remove human rights-related barriers to TB

Opportunities for scaling up human rights and gender-related programmes in the context of TB in DRC are limited, largely because core components of TB programme remain unfunded, including much of what is directed towards community-level interventions. Where there can be opportunities is through greater integration of human rights components in the TB interventions that are implemented. However, this will require a much stronger technical knowledge and commitment amongst all TB stakeholders, particularly the PNLT, to the human rights dimensions of the TB epidemic and the national TB response.

There are opportunities within the HIV response to integrate issues for TB in the scale-up of human rights and gender-related interventions since a number of groups these efforts address are also risk populations for TB, particularly PLHIV, PWID and prisoners. While there is already some momentum towards doing this, more effort will be needed to build the technical capacity of HIV-focussed stakeholders on the TB-related challenges for their focus populations and on efficient ways to include TB concerns in their work as they seek to expand human rights programmes for HIV.

It was not clear from the assessment whether TB-related activities were included in the catalytic funding request for human rights and gender. To the extent that this was not the case, it represents a missed opportunity.

VIII. Limitations and Next Steps of the Baseline Assessment

Limitations

- As indicated under **Section 3.3**, above, there were other processes underway at the same time the assessment was conducted that also addressed issues of human rights and gender in the context of HIV and TB. This caused some confusion amongst some stakeholders. However, with some additional explanation by the assessment team to distinguish the assessment from these other efforts, stakeholder participation in data collection was not significantly affected.
- While the component of the assessment involving Kisangani shed some light on the realities for people living with HIV and other key and vulnerable populations in areas where there are few partners and even fewer key-population-specific interventions, there was nevertheless a bias in the findings towards those locations in DRC where partners and key population constituencies are more active and where there is more investment in making HIV or TB services available.
- As stated above, the assessment team did not collect data in conflict-affected areas for reasons of security and accessibility. As a result, this important feature of the context for HIV and TB services in DRC was not included in the assessment findings.
- Some important stakeholders did not participate in data collection due to competing priorities. This 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 partners are currently funding or undertaking directly.

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 comprehensive programs to remove human rights and gender-related barriers to HIV and TB services in DRC. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in the coming months in order to share the assessment results for consideration and discussion towards using existing opportunities to include and expand programs to remove barriers to services.

The Global Fund will also use the assessment as a basis to support country partners to develop a 5-year plan to move from the current level of programming to remove barriers towards the achievement of the comprehensive approach described in this report. In this 5-year plan, it is envisioned that the country will set priorities as well as engage other donors to fully fund the comprehensive programmes involved.

Finally, in order to build the evidence of impact regarding programmes to reduce barriers to HIV and TB services, the Global Fund will commission follow up studies at mid- and end-points of the 2017-2022 strategy to assess the impact on access to HIV and TB services of the expanded programmes put in place under the 5-year plan.

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X. ANNEX A: COMPREHENSIVE PROGRAMMES TO REDUCE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO HIV SERVICES

Summary for HIV

Programme Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
Stigma and discrimination reduction	358,336	358,336	544,336	358,336	544,336	**2,163,678**
Training of health care workers on human rights and medical ethics	887,573	7,777	749,024	146,326	749,024	**2,539,726**
Sensitisation of law-makers and law enforcement agents	435,163	283,950	293,560	168,139	237,274	**1,418,087**
Legal literacy	131,455	66,476	107,436	46,339	114,876	**466,583**
HIV-related legal services	354,050	347,031	347,031	354,050	347,031	**1,749,193**
Monitoring and reforming laws and policies	176,576	137,249	112,966	155,541	152,704	**735,035**
Reducing HIV-related discrimination against women	689,666	536,920	520,005	623,953	517,505	**2,888,049**
Other activities	7,200	160,989	132,200	160,989	132,200	**593,578**
TOTAL	**3,040,019**	**1,898,728**	**2,806,559**	**2,013,672**	**2,794,951**	**12,553,930**

Summary for TB

Programme Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**TOTAL**
Stigma and discrimination reduction	510,301	279,836	364,734	339,429	285,778	**1,780,077**
Training of health care workers on human rights and ethics	63,290	-	29,890	33,399	29,890	**156,469**
Sensitisation of law-makers and law enforcement agents	-	-	-	-	-	**-**
Legal literacy	60,506	11,160	-	62,372	11,160	**145,198**
TB-related legal services	86,279	86,279	86,279	86,279	86,279	**431,396**
Monitoring and reforming laws and policies	123,320	44,364	44,364	123,320	44,364	**379,731**
Reducing discrimination against women in the context of TB	19,363	-	-	138,549	-	**157,912**
Improving confidentiality and privacy	78,956	-	-	78,956	-	**157,912**
Community mobilisation for people living with TB	349,184	349,184	349,184	349,184	349,184	**1,745,920**
Improving TB services in prisons	101,760	173,825	136,157	49,212	33,620	**494,573**
Other activities	39,400	116,294	39,400	116,294	39,400	**350,789**
TOTAL	**1,432,357**	**1,060,942**	**1,050,008**	**1,376,994**	**879,675**	**5,799,976**

Ref	Programme Area	Ref	Activity	Assumptions	Main Implementers	Cost
1	Stigma and discrimination reduction	1.1	Measure current levels of stigma and discrimination--Stigma index survey with strong KP component.	Year 3.	UCOP+ and partners.	300,000
		1.2	Develop coordinated, country-wide, multi-year action plans to reduce stigma and discrimination against PLHIV and other key and vulnerable populations.	Planning and monitoring each year.	KP networks	902,075
		1.3	Support the work of openly disclosed PLHIV and KPs working in communities to reduce stigma and discrimination--Recruitment/training/on-going support	10 per 5 provinces; 20 for Kinshasa (2 trainings per year of 30 pax each)	UCOP+ and KP networks.	351,650
		1.4	Scale up interventions in communities to engage local leadership, including cultural and religious leaders, in stigma and discrimination reduction.	8 per year, 20 pax, per 5 provinces. 16 per year for Kinshasa. Total is 56 per year.	UCOP+ and KP networks.	31,360
		1.5	Scale up psycho-social and other support to address the negative consequences of stigma, discrimination and violence for KPs.	Training of 25 centre conviviaux peer educators in advanced counselling support. Repeat annually.	PSSP and others supporting centres conviviaux.	35,825
		1.6	Support participation in national/provincial stigma reduction events.	Provincial/national participation in WAD, IDAHOT, etc.	All partners.	153,750
		1.7	Project management and M&E	24% of total activity cost.		389,018
			SUB-TOTAL			2,163,678
2	Training of health care workers on human rights and medical ethics	2.1	Training HCW on human rights and medical ethics.	*20 HCW per 243 health zones in Years 1, 3 and 5.*	PNLS	1,793,340

		2.2	Measure changes in knowledge, attitudes and practices of HCWs following training interventions-undertake baseline and follow-up KAP study.	Follow-up in Year 4.	PNLS	223,466
		2.3	Monitor the experiences of PLHIV and key populations using health care services and use the data for advocacy and for improving interventions to reduce stigma and discrimination.	Included in Item 5.2below.	UCOP+, KP networks, MOJ, PNMLS, others.	-
		2.4	Scale up activities that forge collaborative relationships between HCWs in facilities, PLHIV and members of key population groups.	8 per year, 20 pax, per 5 provinces. 16 per year for Kinshasa. Total is 56 per year.	UCOP+, KP networks, PNMLS, PNLS	31,360
		2.5	Project management and M&E	24% of total activity cost.		491,560
			SUB-TOTAL			2,539,726
3	Sensitisation of law-makers and law enforcement agents	3.1	Evaluation of MOJ-led training and address results--evaluation and modification of training programme, including materials update.	Follow-up in Year 4.	UCOP+, UNDP, PNMLS	301,718
		3.2	Support the provincial *Groupes Thématiques* to develop proactive monitoring and response mechanisms	4 meetings of 20 pax, 1 day, per year in each of 11 provinces.	KP networks, CNDH, MOJ, PNMLS	132,000
		3.3	Measure police abuses and other human rights violations, studies, assessments.	No cost. Included under *observatoires* below.		-
		3.4	Train police on HIV, key populations and human rights.	25 pax in 5 day sessions, 1 session in each of provinces 11 . Repeat in Years 2,3 and 5.	PNMLS, MOJ, CSOs	193,600
		3.5	Train military on HIV, key populations and human rights.	25 pax in 5 day sessions, 1 session in each of provinces 11 . Repeat in Years 2,3 and 5.	PNMLS, MOJ, CSOs	193,600

		3.6	Training prison staff on HIV and human rights.	15 pax for 2 days for each of 22 prisons. Repeat in Years 3 and 5.	PNMLS, MOJ, CSOs	107,004
		3.7	Develop tools, materials and strategies to introduce harm reduction approaches-situational assessment and development of tools/strategies.	International consultant to develop strategy and material. Update material in Year 4.	Led by PNMLS	61,520
		3.8	Develop a multi-year strategy to engage senior policy makers/parliamentarians in law and policy for key populations--strategy development	National planning meeting and monitoring.	KP networks	154,177
		3.9	Project management and M&E	24% of total activity cost.		274,469
			SUB-TOTAL			1,418,087
4	Legal literacy	4.1	Develop legal literacy tools for key populations.	Review/revision in Year 4.	KP networks	57,940
		4.2	Expand the content of interventions for key populations to include legal and human rights literacy using the tools--training peer educators.	20 peer educators per 9 centres conviviaux	PSSP and others supporting centres conviviaux.	201,240
		4.3	Train CSOs and NAC provincial offices on human rights.	1 training in each province. Repeat in Year 3 and 5.	UCOP+, MOJ, KP networks	145,200
		4.4	Project management and M&E	24% of total activity cost.		62,203
			SUB-TOTAL			*466,583*
5	HIV-related legal services	5.1	Develop and maintain a roster of lawyers and magistrates that have been trained.	National consultant. Review design in Year 4. Up-keep through office of National Focal point. Cost under Programme Management.	MOJ and UNDP	11,320

		5.2	Put in place a system to track and monitor legal and human rights cases.	Observatoire: national coordination, 'observers' country-wide.	UCOP+, MOJ, KP networks, UNAIDS, UNDP, CNDH	1,013,600
		5.3	Scale up free or low cost legal services for PLHIV and key populations.	25 cases per year. Coordination included under Programme Management.	UCOP+, MOJ, KP networks	281,250
		5.4	Develop and deploy paralegals who are PLHIV or members of key populations.	10 per each of six provinces. 5 day national training (2 trainings of 30 pax each). Repeat each year.	UCOP+, MOJ, KP networks	71,650
		5.5	Roll out the *'accompagnement juridique'* component of the *centres conviviaux* model.	Do be done by paralegals. Legal support under 5.2 above.	UCOP+, MOJ, KP networks	-
		5.6	Expand the *ligne verte* at UCOP+ to be a service for both PLHIV and key populations--operational cost	Telephone system cost. Coordination under Programme management.	PLHIV and KP networks, legal networks	229,000
		5.7	Project management and M&E	24% of total activity cost (excludes observatoire)		142,373
			SUB-TOTAL			*1,749,193*
6	Monitoring and reforming laws and policies	6.1	Identify opportunities in existing laws and policies to improve legal and human rights protections for key populations--Assessment	Expert consultant. Repeat in Year 4 to measure progress.	KP networks, UNDP, UNAIDS, CNDH	58,598
		6.2	Develop background papers, legal briefs and other materials to support efforts for law and policy reform for key populations.	2 briefs per year in Years 1, 3 and 5.	UCOP+, MOJ, KP networks, UNAIDS, UNDP, CNDH	3,000
		6.3	Engage parliamentarians on law reform	1 day advocacy sessions.	UCOP+ and KP networks.	54,000

		6.4	Undertake advocacy campaigns for law reform.	1 campaign per year.	UCOP+ and KP networks.	178,886
		6.5	Improve the technical capacities of key-population-led organisations to play leadership roles in efforts to secure law and policy reform.	National training sessions in Years 1, 3 and 5.	Led by UNAIDS.	21,495
		6.6	Map out and implement a process to put in place a supportive policy framework for the introduction of harm reduction programmes.	Expert consultant. Review in Year 4.	UNODC and CSOs.	65,495
		6.7	Strengthen the capacity of the CNDH	Stakeholder engagement in 11 provinces.	PNMLS	155,800
		6.8	Support civil society participation in ACHPR and UPR processes.	Development of briefs and stakeholder engagement in Years 2 and 5.	PLHIV and KP networks, legal networks	55,496
		6.9	Project management and M&E	24% of total activity cost.		142,265
			SUB-TOTAL			*735,035*
	Reducing HIV-related discrimination against women	7.1	Study on gender barriers to HIV services.	Repeat in Year 4.	PNMLS, Ministry of Gender, UNAIDS, RENADEF	223,466
		7.2	Sustain and scale-up programmes in communities that address harmful gender norms and prevent SGBV.	Community engagement sessions in 243 health zones. 2 dialogues per year.	Global Fund implementers.	272,160
		7.3	Sustain comprehensive, country-wide services for survivors of SGBV.	Legal support. 100 cases per year.	Global Fund implementers.	562,500
		7.4	Develop and deploy paralegals who are youth and women living with HIV--training	10 per each of 11 provinces. 5 day national training (5 trainings of 25 pax each). Repeat in Years 3 and 5.	UCOP+, ICW, RACOJ, legal networks	619,125
		7.5	Engage local cultural and religious leaders to sensitise communities on gender equality, SGBV	Training of trainers of leaders. 5 for each of 11 provinces (2 trainings of 25	PNMLS, Ministry of Gender, RENADEF, RACOJ	178,290

			prevention and supporting women's access to HIV services, including PMTCT.	pax per year). Repeat in Years 3 and 5		
		7.6	Develop and implement gender sensitivity training for all stakeholders in the national HIV response.	Materials development and training.	PNMLS, Ministry of Gender, RENADEF, RACOJ	44,744
		7.7	Support women living with HIV to take-up and remain in leadership positions within the national HIV response--leadership development.	5 day national workshop for 30 pax each year.	UCOP+, ICW, FFP+	35,825
		7.8	Scale up and sustain interventions providing psycho-social support adolescents and young people living with HIV.	Advanced training in counselling for peer educators. 20 per 11 provinces.	UCOP+, ICW, FFP+, SJS, RACOJ	242,000
		7.9	Integrate the needs of adolescents and young people from key populations into youth-focussed programmes addressing HIV--training and sensitisation.	3 day national workshop for 30 pax in Year 1, 3 and 5.	KP networks with RACOJ	56,250
		7.10	Develop plan, including a monitoring framework, should the effort to change the age of consent for HIV services succeed.	National planning session, provincial sensitisation meetings.	PNLS, RACOJ	72,950
		7.11	Supporting monitoring of laws and legal standards, including CEDAW and CSW comments/reports.	Development of briefs and stakeholder engagement in Years 2 and 5.	PNLS, RACOJ	21,762
		7.12	Project management and M&E	24% of total activity cost.	RENADEF, RACOJ, UNIFEMME, others.	558,977
			SUB-TOTAL			*2,888,049*
8	Other activities	8.1	Support evaluations of interventions to address human rights barriers	National projects	External TA (such as International HIV/AIDS Alliance)	192,236
		8.2	Provincial	Provincial/local projects	PNMLS, Ministry of Gender, UNAIDS, RENADEF	115,342

		8.3	Convene Cellule droit et VIH to monitor/guide comprehensive approach implementation.	Quarterly meetings for 50 pax.	Led by MOJ.	36,000
		8.4	Conduct mid- and end-term follow-up baseline assessments for HIV and TB.	Years 3 and 5.	DRC CCM	250,000
			SUB-TOTAL			*593,578*
			TOTAL			**12,553,930**

XI. ANNEX B: COMPREHENSIVE PROGRAMMES TO REDUCE HUMAN RIGHTS AND GENDER-RELATED BARRIERS TO TB SERVICES

Ref	**Programme Area**	**Ref**	**Activity**	**Assumptions**	**Main Implementers**	**TOTAL**
1	Stigma and discrimination reduction	1.1	Measure TB related stigma--KAP studies (national)	Repeat in Year 4.	PNLT	223,466
		1.2	Measure TB related stigma--KAP studies (sectors)	(Mining, etc.)	PNLT and sector associations.	191,022
		1.3	Workplace programmes	1 per year for different sectors. Costed as community interventions. No other data available	Led by PNLT.	67,500
		1.4	Community interventions to address stigma	1 per year in each of 11 provinces.	Members of National TB Coalition	742,500
		1.5	TB stigma reduction campaign--national	Repeat in Year 3 and 5.	Led by PNLT.	205,398
		1.6	Measure TB-related stigma for PLHIV and key populations	Included under PLHIV stigma index.	LINAC, CAD	-
		1.7	Integrate TB content in HIV stigma reduction efforts.	Technical consultant to undertake review and	PNLT, PNMLS, LINAC, CAD	5,660

				assist with necessary adaptations.		
		1.8	Project management and M&E	24% of total activity cost.		344,531
			SUB-TOTAL			*1,780,077*
2	Training of health care workers on human rights and ethics	2.1	Reinforce of ethics/human rights components of training curricula (pre- and in-service)	Repeat in Year 4.	PNLT	53,870
		2.2	Training HCW on TB and human rights	Included under HIV, Item 2.1.	PNLS and PNLT	-
		2.3	Assessment gaps workplace policies for HCWs and develop action plan.	Situational assessment and national planning meeting.	PNLT	72,315
		2.4	Monitoring of infection control supplies/compliance	Part of National TB Coalition observatory.		-
		2.5	Project management and M&E	24% of total activity cost.		30,284
			SUB-TOTAL			*156,469*
3	Sensitisation of law-makers and law enforcement agents	3.1	Address TB issues in training for magistrates, lawyers, military, police, etc.	Costed under HIV budget.	*MOJ*	
			SUB-TOTAL			-
4	Legal literacy	4.1	Develop and distribute TB-focussed legal literacy materials	Content development, validation, printing/dissemination.	*LINAC, CAD, other CSOs*	*111,435*
		4.2	Integrate TB content in HIV legal literacy materials	Technical consultant to undertake review and assist with necessary adaptations.	*UCOP+, MOJ, PNMLS*	*5,660*

		4.3	Project management and M&E	24% of total activity cost.		*28,103*
			SUB-TOTAL			*145,198*
5	TB-related legal services	5.1	Lawyers, cliniques juridiques can support for TB-related legal issues.	Support for TB specific cases.	*Groups supporting cliniques juridiques*	*56,250*
		5.2	Training and deploy paralegals	Recruitment and training. Deployment covered under 9.2 below.	*Members of National TB Coalition*	*291,650*
		5.3	Monitor and report on TB -related human rights/legal issues--national observatory.	Included under HIV, Item 5.2.	*National TB Coalition*	-
		5.4	Project management and M&E	24% of total activity cost.		*83,496*
			SUB-TOTAL			*431,396*
6	Monitoring and reforming laws and policies	6.1	Undertake TB-specific LEA and address results	LEA. Follow-up Year 4.	PNLT, MOJ and National TB Coalition	*127,348*
		6.2	Advocacy for government accountability for TB.	Focussed advocacy campaigns led by National TB Coalition.	National TB Coalition	*178,886*
		6.3	Project management and M&E	24% of total activity cost.		*73,496*
			SUB-TOTAL			*379,731*
7	Reducing discrimination against women in the context of TB	7.1	Respond to findings of the HIV/TB gender assessment--national planning and monitoring	Planning and follow-up in Year 1 and 3.	PNLT, Ministry of Gender, Gender-focussed CSOs.	*31,230*
		7.2	Repeat HIV/TB gender assessment	Year 4	PNLT, Ministry of Gender, Gender-focussed CSOs.	*96,118*

		7.3	Project management and M&E	24% of total activity cost.		*30,564*
			SUB-TOTAL			*157,912*
8	Improving confidentiality and privacy	8.1	Undertake national situational assessment and develop action plan based on results	Year 1 with follow-up in Year 4.	Led by PNLT.	127,348
		8.2	Project management and M&E	24% of total activity cost.		30,564
			SUB-TOTAL			*157,912*
9	Community mobilisation for people living with TB	9.1	Create/sustain support groups for people living with TB	20 per province, 10 per group, for 11 provinces.	National TB Coalition	66,000
		9.2	Support People living with TB as spokespersons/role models in communities.	25 per 11 provinces. Annual provincial level training and monitoring and monthly stipends.	National TB Coalition	1,342,000
		9.3	Project management and M&E	24% of total activity cost.		337,920
			SUB-TOTAL			*1,745,920*
10	Improving TB services in prisons	10.1	Support CSOs to monitor human rights trends in prisons-training	Members of national TB coalition. 3 day workshop for 25pax. Repeat each year.	UNDP, MOJ, PNLT, National TB Coalition	21,495
		10.2	Sensitise judicial officers on effects of overcrowding--meetings	1 day meeting per province. Repeat in Years 3 and 5.	UNDP, MOJ, PNLT, National TB Coalition	19,800
		10.3	Advocacy for pre-trial detention reform.	Advocacy campaign.	National TB Coalition, UNODC, other partners addressing prison conditions.	71,555

		10.4	Policy development for treatment in health facilities.	Policy development	PNLT, PNLS	39,548
		10.5	Train prison workers on TB-related human rights.	2 day training for 20 pax in 22 Prisons.	PNLT, MOJ, PNMLS	68,750
		10.6	Train prisoners on TB-related human rights/responsibilities.	1 day training for 40 pax in 22 prisons	PNLT, MOJ	12,320
		10.7	Advocacy for improvement of prison conditions.	National advocacy campaign.	National TB Coalition, UNODC, other partners addressing prison conditions.	165,382
		10.8	Project management and M&E	24% of total activity cost.		95,724
			SUB-TOTAL			*494,573*
11	Other activities	11.1	Programme evaluations	National and provincial/local level projects.	PNLT and National TB Coalition	153,789
		11.2	Strengthen capacity of PNLT	TB human rights focal point.	PNLT	72,000
		11.3	Support National TB Coalition	General operational support.	National TB Coalition	125,000
			SUB-TOTAL			*350,789*
			TOTAL			**5,799,976**

XII. Annex C: Costing of the Comprehensive Approach

(Attached as a separate excel)

XIII. ANNEX D: BASELINE INDICATORS AND VALUES FOR MEASURING PROGRESS REGARDING REMOVAL OF HUMAN RIGHTS-RELATED BARRIERS TO HIV AND TB SERVICES

Below is a proposed set of indicators for measuring the quantitative aspects of progress towards the removal of human rights-related barriers to access and uptake of HIV services in DRC. The proposed indicators are in addition to coverage and uptake indicators across the continuum from HIV services, and including harm reduction interventions, with each being disaggregated by age, sex and population groups, as are required or recommended by the Global Fund for its grant receiving countries (Global Fund, 2016b). As the table shows, there is almost no current data to provide baselines for the indicators. A number of recommended actions arising from the assessment specifically address these gaps.

Proposed monitoring indicators for HIV

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Indicator	Baseline value	Source/Year
Stigma and discrimination		
Percentage of people living with HIV who report experiences of HIV-related discrimination in health- care settings	6%	UCOP+ 2012
Avoidance of health care among key populations because of stigma and discrimination (% of defined study population disaggregated by key population group).	No quantitative data.	An IBBS is planned for 2018.
Violence and abuse		
% of population reporting instance of physical or sexual violence in past 12 months (disaggregated by population and perpetrator)	No quantitative data.	An IBBS is planned for 2018.
% of population reporting instances of abuse/extortion by police in past 12 months (disaggregated by population)	No quantitative data.	An IBBS is planned for 2018.
Training and sensitization activities		
# and % of HCWs trained on human rights and medical ethics	No available data.	
# and % of police trained on legal and human rights of PLHIV and other key and vulnerable populations.	No available data.	
# and % of judicial officers trained on legal and human rights of PLHIV and other key and vulnerable populations.	1,300 in 2016. No denominator available.	UCOP+, UNDP
Access to justice		

# of lawyers, paralegals, and advocates trained to provide legal assistance	Subset of above. No denominator available.	UCOP+, UNDP
Law and policy reform		
# and type of laws and policies promoting/protecting HIV-related rights of PLHIV and other key and vulnerable populations.	Law on the Rights of People living with HIV	

Below is a proposed set of indicators and baselines for measuring progress towards the removal of human rights and gender-related barriers to access and uptake of TB services. The proposed indicators are in addition to coverage and uptake indicators across the continuum from TB services as are required or recommended by the Global Fund (Global Fund, 2016b). The lack of data is more acute than for HIV services. However, similarly, the assessment recommends a number of actions to address these gaps.

Proposed monitoring indicators for TB

Indicator	Baseline value	Source/Year
Stigma and discrimination		
# and % of individuals diagnosed with TB experiencing stigma/discrimination in health care settings.	No data.	
# and % of individuals diagnosed with TB experiencing poor service, including lack of confidentiality	No data.	
Training of HCWs		
# and % of HCWs trained on human rights and ethics in the context of TB.	No consolidated data.	
Legal services and access to justice		
# of lawyers and paralegals trained and available to offer TB-related legal services	No data.	
# of individuals diagnosed with TB experiencing discrimination in the workplace	No data.	