Baseline assessment-Mozambique

Scaling up programs to reduce human rights-related barriers to HIV and TB services

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The Global Fund

Disclaimer

Towards the operationalization of Strategic Objective 3(a) of the Global Fund Strategy, *Investing to End Epidemics*, 2017-2022, this paper was commissioned by the Global Fund to Fight AIDS, TB and Malaria and presents, as a working document 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 the paper do not necessarily reflect the views of the Global Fund.

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List of Acronyms

ACAM	Associacao Comunitaria Ambiente de Mafalala
ADPP	Development Aid from People to People in Mozambique
AIDS	Acquired immune deficiency syndrome
AMIMO	Associação de Mineiros Moçambicanos
AMODEFA	Asociacio Mozmbicana per a Desenvolvimento de la Familia
ART	Antiretroviral treatment
CAI	Integrated Assistance Centres
CDC	Centers for Disease Control
CNCS	Conselho Nacional de Combate ao SIDA
CRC	United Nations Committee on the Rights of the Child
CSO	Civil society organisation
DHS	Demographic and Health Survey
DIFFER	Diagonal Interventions to Fast-Forward Expanded Reproductive Health
DOTS	Directly-observed therapy short-course
FGD	Focus group discussion
FHI	Family Health International
FSW	Female sex workers
GAAC	Grupos de Apoio a Adesão Comunitária
GBV	Gender-based violence
ICRH	International Centre for Reproductive Health
HBV	Hepatitis B virus
HCT	HIV counselling and testing
HCV	Hepatitis C virus
HCW	Health care worker
HEARD	Health Economics and AIDS Research Division
HIV	Human immune deficiency virus
IBBS	Integrated biological and behavioural surveillance
INE	Instituto Nacional de Estatística

INS	Instituto Nacional de Saúde
IOM	International Organization for Migration
KAP	Knowledge, attitudes, practices
KII	Key informant interview
KPI	Key performance indicator
LAMBDA	Mozambican Association for the Defence of Sexual Minorities
LGBT	Lesbian, gay, bisexual, transgender
LHR	Lawyers for Human Rights
LINKAGES	Linkages across Continuum of HIV Services for Key Populations Affected by HIV
MMAS	Ministry of Women and Social Action
MISAU	Ministry of Health
MOT	Modes of transmission
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment
NTP	National TB Programme
OSISA	Open Society Institute for Southern Africa
OVC	Orphans and other vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV/AIDS
PrEP	Pre-exposure prophylaxis
PWID	People who inject drugs
RENSIDA	Rede Nacional de Associações de Pessoas que Vivem com HIV/SIDA
SADC	Southern African Development Community
SERNAP	Serviço Nacional Penitenciário
STI	Sexually transmitted infection
TB	Tuberculosis
TWG	Technical working group

UCSF	University of California at San Francisco
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United National Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UPR	Universal Periodic Review
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization

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I. Executive Summary

Introduction

Since the adoption of its strategy, *Investing to End Epidemics, 2017-2022*, the Global Fund has joined with country stakeholders, technical partners and other donors in a major effort to expand investment in programs to remove human-rights related barriers in national responses to HIV, TB and malaria (Global Fund, 2016a). It has done so because it recognizes that these programs 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. This report comprises the baseline assessment conducted in Mozambique as part of operationalizing Strategic Objective 3, which commits the Global Fund to Fight AIDS, TB and Malaria to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria services*".[1]

Though the Global Fund will support all countries to scale up programs to remove human rights-related barriers to health services, it will provide intensive support to 20 countries to enable them to put in place comprehensive programs aimed at reducing such barriers.[2] Based on criteria involving needs, opportunities, capacities and partnerships in country, Mozambique and nineteen other countries were selected for intensive support. This baseline assessment is the first component of the package of support Mozambique will receive and is intended to provide the country with the data and analysis necessary to identify, apply for, and implement comprehensive programs to remove barriers to HIV and TB services. Towards this end, this assessment: (a) establishes a baseline concerning the present situation in Mozambique with regard to human rights-related barriers to HIV and TB services and existing programs to remove them, (b) describes comprehensive programs aimed at reducing these barriers and their costs, and (c) suggests opportunities regarding possible next steps in putting comprehensive programs in place.

The comprehensive programs proposed are based on the seven key Program Areas identified by UNAIDS and the Global Fund for HIV programs and a set of ten TB Program Areas developed in consultation with international TB programs and technical support agencies.

These program areas include, for HIV and TB, these program areas comprise: (a) stigma and discrimination reduction; (b) training for health care providers on human rights and medical ethics; (c) sensitization of law-makers and law enforcement agents; (d) reducing discrimination against women in the context of HIV and TB; (e) legal literacy ("know your rights"); (f) legal services; and (g) monitoring and reforming laws, regulations and policies relating to HIV and TB. In addition for TB, there is the need to: ensure confidentiality and privacy related to TB diagnosis, mobilize and empower TB patient and community groups, address overly-broad policies regarding involuntary isolation or detention for failure to adhere to TB treatment, and make efforts to remove barriers to TB services in prisons.[3]

[1] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02
[2] *Ibid*, Key Performance Indicator 9.
[3] 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 on HIV, Human Rights and Gender Equality,* available at: https://www.theglobalfund.org/media/6348/core_hivhumanrightsgenderequality_technicalbrief_en.pdf and

Methodology

The assessment was conducted between February and April, 2017, and led by the Health Economics and AIDS Research Division (HEARD) at the University of KwaZulu Natal in Durban, South Africa. In addition to a comprehensive desk review, it involved interviews with 35 key informants representing 30 key stakeholders. A series of focus group discussions was also convened involving 75 representatives from key or vulnerable populations, including people living with HIV; gay, bisexual and other men-having-sex-with-men; female sex workers; people who inject drugs; prison workers; and health care workers.

Baseline findings

The following paragraphs summarize the baseline findings in 2017 in Mozambique with regard to populations affected by human rights-related barriers, the nature of the barriers, and the existing programs to reduce these barriers. The findings are separated into HIV and TB findings.

HIV findings

Key and vulnerable populations

The baseline assessments considered the following population groups as key and vulnerable populations in the HIV epidemic, based on epidemiological evidence, Global Fund criteria, and "priority populations" set out in Mozambique's National HIV Strategic Plan 2014-2019 (PEN IV) under the category of Conselho Nacional de Combate ao SIDA [CNCS], 2015; Global Fund, 2013).

Key populations are the following:

- People living with HIV;
- Female sex workers and their clients;
- Men who have sex with men;
- Transgender people;
- People who inject drugs; and
- Prisoners.

Vulnerable populations are the following:

- Women and girls, in particular, adolescent girls and young women; and
- Mobile and migrant mine workers.

The assessment identified the following barriers to access, uptake and retention in HIV services for these populations:

- There are gaps and challenges in the law and policy context such that an enabling environment is still not present to support all key or vulnerable populations to access HIV services.

Technical Brief on Tuberculosis, Gender and Human Rights, available at: https://www.theglobalfund.org/media/6349/core_tbhumanrightsgenderequality_technicalbrief_en.pdf

- There appear to be high levels of discrimination against people living with HIV and other key or vulnerable populations, often involving stigmatizing attitudes and punitive practices, in communities, in health care settings and among other service providers, including the police and judiciary.
- Despite recent changes in Penal Code provisions that decriminalised homosexuality and sex work, men who have sex with men and sex workers continue to report harassment and abuse on the part of police. People who inject drugs experience harsh treatment because of criminal laws regarding drug use.
- Knowledge of legal and human rights related to HIV, health and health services is generally low among key and vulnerable populations with the result that many people do not know when their legal or human rights have been compromised nor do they know of or have access to mechanisms by which they can seek redress.
- Finally, there continue to be significant gender dimensions to the HIV epidemic in Mozambique involving harmful gender norms and gender-based discrimination and violence. Although major efforts are underway to address these challenges, progress has been slow, particularly with regard to efforts to shift socio-cultural practices that limit the agency and autonomy of adolescent girls and young women to access relevant programmes and services.

In response to such challenges, a number of stakeholders, including those from the government sector and from non-governmental organizations, have implemented programs and activities to reduce and remove human rights-related barriers to HIV services. These recent or existing programs include:

- Interventions to address stigma and discrimination, including self-stigma, through surveys, public relations activities, peer education and outreach, and support groups
- Training and sensitisation of health care workers on professionalism and non-discrimination, as well as on the specific health-related needs of key populations
- Training and sensitisation of police officers, including with regard to responding to gender-based violence, as well as understanding and protecting human rights as articulated within the Constitution and the laws of Mozambique
- Community mobilisation and support for key populations to build networks and constituencies, to improve knowledge and awareness regarding HIV and health-related rights and entitlements, and to improve linkages with HIV and other sexual and reproductive health services.
- Interventions to address and remove gender-related barriers to health services, with a focus on adolescent girls and young women.

Gaps and challenges remain across these efforts, however. For the most part, they are not well coordinated, are of limited scale and duration, are insufficiently funded and are not routinely evaluated. The needs of certain key populations are not effectively addressed at all, particularly people who use drugs and transgender people. Furthermore, there is need for greater human rights capacity in government and the NGO and community sector to do longer-term planning and implement well-coordinated, multi-year actions to bring about sustained change in knowledge, attitudes, perceptions and practices regarding human rights-related barriers to services experienced by key and vulnerable populations. Significant and sustained investment of technical and financial resources is needed to ensure that the

approach can be fully implemented. There are several ongoing community and gender initiatives into which many of the programs described below can be integrated and expanded at lower cost.

In this context, comprehensive programs to address human right-related barriers to HIV services would include (see full rendition of comprehensive programs in Annex B):

- Conducting Stigma Index, surveys on community stigma, and stigma measurement in health care settings to address critical evidence gaps regarding impact of human rights-related barriers (stigma and discrimination, punitive laws, policies and regulations) on access to services for key population groups, with particular focus on lack of evidence and data regarding transgender people and people who use drugs
- Conducting media and community campaigns against HIV-related stigma and discrimination using among other things spokespeople among people living with HIV and other key populations
- Building the capacity and accountability of the CNCS to facilitate and ensure inter-ministerial and multi-sectoral collaboration and commitment to a rights-based, public health approach to the provision of HIV services
- Building the capacity of key population-led civil society organisations to collaborate and to consolidate human-rights-related programming for greater coverage and accessibility, and for greater impact to remove barriers
- Strengthening community networks of key and vulnerable populations with efforts to improve resilience, reduce self-stigma and empower within and beyond major urban centres
- Developing curricula for health care workers on non-discrimination, other human rights and medical ethics, and rolling this out in pre-service and ongoing service education; and developing workplace non-discrimination policies and complaint procedures
- Expanding ongoing efforts to train and sensitise local level police or judicial officers and ensure institutional change by developing police training curriculum and integrating it into pre-service and continuing education training, engaging supervisors, supporting joint activities with key populations and establishing monitoring and accountability mechanisms
- Expanding HIV-related human rights literacy and legal support through peer educators and paralegal for women and adolescent girls, engaging religious and traditional leaders to provide protection from violence and HIV-related discrimination and expanding programs and education to addressing harmful gender norms.
- Training, deploying and supporting community and peer trainers to build legal and human rights literacy among key and vulnerable populations so that they can know their HIV-related rights and mobilize around them and advocate for concrete demands
- Training, deploying and supporting community and peer paralegals, as well as identifying pro bono or low cost attorneys to back them up, to support key and vulnerable populations to know their rights; deal with stigma, discrimination, gender based violence and property grabbing; resolve disputes; and get redress, and
- Reforming key policies, regulations and laws to provide greater protection to key and vulnerable populations from discrimination, gender-based violence, illegal police practices and other punitive practices that hinder access to services.

The assessment defined specific activities (**Annex A**) in relation to these recommendations, as well as a monitoring framework for follow-up assessments to measure progress (**Annex D**). Finally, the assessment calculated a prospective cost to implement the five-year comprehensive approach. This is shown in **Table B**, below:

Table B: Resource needs for the comprehensive approach for HIV (US$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	1 915 774	1 084 163	1 521 775	872 995	1 981 340	**7 376 047**
Training of health care workers	1 348 300	479 901	833 901	137 222	864 398	**3 663 723**
Sensitisation of law-makers and law enforcement agents	450 039	173 240	278 820	291 999	285 164	**1 479 261**
Legal literacy	311 113	50 166	120 012	216 867	120 012	**818 171**
HIV-related legal services	363 681	194 591	333 791	212 525	333 791	**1 438 380**
Monitoring and reforming laws and policies	685 005	842 949	303 409	160 397	371 833	**2 363 593**
Reducing HIV-related discrimination against women	77 601	149 254	-	79 637	58 823	**365 314**
Other activities	95 857	278 768	278 768	182 910	278 768	**1 115 071**
TOTAL	**5 247 371**	**3 253 032**	**3 670 474**	**2 154 554**	**4 294 128**	**18 619 560**

The year-over-year investment needed is significantly greater than the current level of financing, which the assessment found was approximately US$430,000 for 2016 for programmes directly addressing human rights barriers. However, the country is using US$ 7.4 million in resources from the Global Fund (US$ 2.7 million from within its allocation, and US$ 4.7 million in matching funds) for the 2018-2020 period to implement some of the components of the proposed comprehensive approach. If this money goes to the right programs and the programs are implemented well and at the right cost, this would take a substantial step towards closing the resource gap and create needed momentum towards full implementation of the comprehensive approach during the five-year time frame.

Findings related to TB services

The assessment found that the human rights and gender-related dimensions of TB are not well understood or discussed across the different stakeholders in either the HIV or TB responses. The selection of key and vulnerable populations groups in the TB context was based on epidemiological trends, guidance from Global Fund and the Stop TB Partnership, and the populations included in the National TB Programme's *Strategic and Operational Plan 2018-2020* (Global Fund, 2017b; Ministry of Health [MISAU], 2017; Stop TB Partnership, 2016a-g). Key and vulnerable populations included in the context of the TB epidemic in Mozambique are: people living with TB, health care workers, mineworkers and prisoners. Although people who inject drugs are generally recognized as a key population for TB, they are not recognised as such in Mozambique, and the assessment could not comprehensively assess the situation

of this group due to their substantial marginalisation and invisibility within countrywide TB programmes. This in itself is a significant human rights issue.

The assessment identified important human rights and gender-related barriers in the context of TB services. They included:

- Measurable levels of TB-related stigma, including self-stigma, in communities, which are linked to poor knowledge and misconceptions about TB disease
- Low levels of adherence to workplace health and safety standards in health facilities creating increased risk of TB infection for health care workers, and lack of effective mechanisms for redress and improvement.
- Low levels of adherence to minimum standards for prisons, particularly severe overcrowding and poor infrastructure, that expose prisoners and prison workers to increased risk of TB infection and that prevent access to appropriate care and support for those who are TB infected.
- Poor compliance with workplace standards for migrant mineworkers that increase their risk of TB exposure and fear of discrimination based on TB status that leads to delays in seeking treatment
- High levels of poverty and inequality that limit access to TB treatment and also lead to delays in seeking care for fear of additional costs for prolonged treatment, particularly for MDR-TB. Poverty and gender-related inequalities may also be a strong factor in the significant under-diagnosis and enrolment in care of young, TB-infected children.

The assessment identified the following current or recent programs to address these challenges:

- Interventions to improve knowledge and awareness regarding TB and to address stigma and discrimination within TB-specific community mobilisation and community outreach activities
- The inclusion of components addressing human rights and medical ethics in the context of TB within guidelines and training materials for health care workers.
- Increased efforts on the part of the National TB Programme to more carefully track TB trends in key and vulnerable populations and to generate evidence to better inform analyses of barriers to effective diagnosis and treatment within these groups.
- Ongoing efforts across the health sector to improve TB-related infection control and the availability of protective equipment for health care workers
- Ongoing efforts to improve TB-related services within prisons, for both inmates and prisons staff
- Advocacy and legal services for migrant mineworkers to improve adherence to workplace health and safety standards and to secure access to compensation and other benefits, including for TB-related concerns. This work also involves monitoring compliance with the Southern African Development Community's Declaration and Code of Conduct for addressing and preventing TB in the mining sector.

Gaps and challenges remain to further address and resolve barriers to TB services. These include more in-depth data on who is most affected by TB, particularly sufficient data to map the increased burden and incidence of the disease by age and sex as well as by socio-economic and other factors. A very considerable gap is the need for more data on the burden of TB

amongst all key population groups, particularly men who have sex with men, female sex workers and people who use drugs, since HIV prevalence is highest in these groups. In addition, TB-related concerns are rarely integrated or addressed in other HIV-related work regarding human rights and gender-related barriers despite the high rate of co-infection in the country.

To effectively address these gaps, a comprehensive approach should include the following:

- Capacity-building across all TB stakeholders to understand and effectively act on human rights or gender concerns related to TB
- Reform to (1) include people who use drugs as a key population for TB and integrate their needs across national TB programming; (2) reduce pre-trial detention and divert non-violent offenders from prison so as to reduce over-crowding in prisons and the high risk of TB this generates; and (3) ensure adequate social/health protections for poor communities in the context of TB.
- Stigma and discrimination reduction interventions country-wide and across communities to address TB-related stigma and discrimination and to empower more people living with TB to resist stigma
- Integration of TB related concerns regarding TB based stigma and discrimination and workplace protections into training of health care workers, pre-service and continuing education.
- Integration of TB related human rights issues into HIV-related human rights efforts
- Legal/human rights literacy interventions among individuals working in situations of high TB risk (mines, prisons, health care facilities, poor communities), to increase awareness of and mobilize and advocate for adequate workplace and community protections and social benefits
- Expanded legal support through peer paralegals and access to pro bono/low cost attorneys for people living with TB to seek redress for harmful working conditions that expose them to TB, and
- Integration into ongoing programs for the empowerment of women and adolescent girls of legal/human rights literacy for women and ado girls vulnerable to or living with TB.

The assessment defined specific activities (**Annex B**) in relation to these recommendations as well as a monitoring framework for follow-up assessments to measure progress (**Annex D**). Finally, the assessment calculated a prospective cost to implement the five-year comprehensive approach. This is shown in **Table C**, below:

Table C: Resource needs for the comprehensive approach for TB (US$)

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	*TOTAL*
Stigma and discrimination reduction	771 842	654 896	654 896	654 896	771 842	***3 508 372***
Training of health care workers	12 468			12 468		***24 937***
Sensitisation of law-makers and law enforcement agents	8 320	4 148		8 320	4 148	***24 937***

Legal literacy	32 196	7 515	19 715	15 836	19 715	***94 977***
TB-related legal services	5 000	5 000	5 000	5 000	5 000	***25 000***
Monitoring and reforming laws and policies	42 895	42 895	42 895	42 895	9 150	***180 732***
Addressing issues of gender	192 310		21 091		138 037	***351 438***
Other activities		139 155	43 755	43 755	139 155	***365 821***
TOTAL	**1 065 032**	**853 610**	**787 352**	**783 171**	**1 087 047**	***4 576 213***

Due to a low response rate for the financial analysis component of the baseline assessment for TB it was not feasible to calculate a current level of investment in programmes to address human rights or gender-related barriers to TB services. However, given the findings highlighted above regarding issues of knowledge, awareness or commitment to human rights in the context of TB in the country, this level is likely to be very low. It will be necessary to mobilise the resources required to implement and sustain the comprehensive approach over the five-year period.

II. Introduction

This report comprises the baseline assessment carried out in Mozambique 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 the *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 services";* 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.*" 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. The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB, PEPFAR and other bilateral agencies and donors to operationalise this Strategic Objective.

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

Objectives and Expected Results

The objectives of the baseline assessment were to:

- Identify the key human rights and gender-related barriers to HV and TB services in Mozambique
- Describe existing programs put in place to reduce such barriers
- Indicate what a comprehensive response to existing barriers would comprise in terms of the types of programs, 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 Mozambique. 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 programs to remove human-rights related barriers to HIV and TB services in Mozambique. Similar follow-up assessments will be conducted in the other countries of the 20-country cohort.

III. Methodology

The baseline assessment for Mozambique was conducted between March and April 2017 according to the following methodology:

Conceptual framework

The conceptual framework that guided the assessment was as follows:

- In Mozambique, as in other countries regionally and globally, there exist human rights and gender-related barriers to 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-related program areas comprising 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 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 to the HIV and TB epidemics.
- These efforts to remove barriers will also protect and enhance Global Fund investments, and strengthen health and 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 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).

UNAIDS, the Global Fund, and the Stop TB Partnership have identified the following main programmatic areas by which to address and remove barriers (UNAIDS, 2012; Global Fund, 2017a,b):

- 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, some 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.

These programmatic approaches can either be adapted as focused interventions or included as components of or integrated into broader HIV or TB programmes.

Key and vulnerable populations included in the assessment

The baseline assessment included key and vulnerable populations based on:

- Global Fund and Stop TB Partnership criteria for identifying key and vulnerable populations for HIV and TB (Global Fund, 2013; Global Fund, 2017b); and,
- The *Plano Estratégico Nacional de Resposta ao HIV e Sida 2015 - 2019* (PEN IV), and the National TB Programme's *Strategic and Operational Plan 2018-2020* (CNCS 2015; MISAU, 2017).

Key populations for HIV are the following:

- People living with HIV;
- Female sex workers and their clients;
- Men who have sex with men;
- Transgender people;
- People who inject drugs;
- Prisoners

Vulnerable populations for HIV are the following:

- Mobil and migrant mine workers;
- Women and girls, in particular, adolescent girls and young women
- Key populations for TB are the following:
- People living with TB
- Health care workers;
- Mineworkers;
- Prisoners
- People who inject drugs

These populations represent groups whose access to HIV or TB services is affected by human rights or gender equality-related barriers. Some groups whose access is affected by such barriers are not yet recognized as key populations in the national response. Such populations include transgender individuals and male sex workers for HIV and people who inject drugs for TB. To the extent that information was available, the assessment included these groups as a way of beginning to address the information and data gaps concerning them.

Data collection and analysis

The assessment was conducted by the Health Economics and AIDS Research Division (HEARD) of the University of KwaZulu Natal, in Durban, South Africa, under contract to the Global Fund. The assessment team comprised one lead researcher from HEARD and one national consultant. A project leader, research assistant and costing expert from HEARD also supported the assessment.

Data collection and analysis involved the following main steps:

- A comprehensive **desk review** was completed in March 2017 that included both published and 'grey' literature in English and Portuguese. In-country partners assisted with sourcing relevant material not available through web-based searches. In-country document collection was particularly important for gathering sources from key and vulnerable populations themselves, including those in which their voices and experiences were highlighted. A bilingual summary of the desk review findings (English and Portuguese) was shared with key stakeholders to help define and validate specific priorities for further investigation during the fieldwork stage.

- **In-country research** was carried out in March and April 2017. The emphasis of this work was to engage with key stakeholders in the national HIV and TB responses, particularly those addressing human rights and gender-related barriers to services. Data collection involved key informant interviews using a standard interview guide. Data collection also involved focus group discussions, convened by local organisations, with representatives of men who have sex with men, female sex workers, people who inject drugs and prison workers using a discussion guide that was similar in content and structure to the interview guide. Overall, the fieldwork included 35 key informants representing 30 stakeholders. A total of 75 individuals participated in focus group discussions.

- A separate component of the fieldwork involved collecting information from key stakeholders on **sources and uses of funds** for their programmes aimed at reducing human rights and gender-related barriers to services. However, participation in this aspect of the assessment was very low, partly for reasons of reluctance to share such data; and, partly for reasons of unavailability or easy availability of specific costing data as human rights or gender-related interventions were often components of broader health programmes. Of 14 stakeholders approached to provide costing data, only 4 responded despite repeated follow-up attempts.

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

- **Review of outcomes of the assessment is** done in different stages. Very preliminary findings and observations were shared with stakeholders at the end of data collection in April, 2017; draft reports were reviewed by internal and external experts at the Global Fund between May and June 2017; and, finally, the draft report was shared with country stakeholders for inputs during the preparation of the revised catalytic funding for human rights request in September, 2017. Further discussion and validation will happen in

country, both by seeking additional comments on this draft by a wide range of stakeholders and at a multi-stakeholder consultation that will take place in the spring of 2018.

- Ethics clearance for HEARD's five-country baseline assessment project was provided by UKZN. A letter of endorsement was issued by the Ministry of Health (MISAU) to allow the assessment to proceed in Mozambique without requiring additional ethics clearance at country level.

Links with other relevant processes

At the time the assessment was conducted, important, related processes were underway. These included:

- The preparation of the Global Fund funding request, including the catalytic funding components for addressing human rights and gender-related barriers, and for addressing the needs of adolescent girls and young women. A technical working group convened under the CNCS was guiding the preparation of the catalytic funding component for human rights and also assisted with the baseline assessment process. A number of outputs were shared with the assessment team, including a mapping of stakeholders involved in HIV-related human rights activities and the preliminary draft of activities to be included in the funding request.
- UNAIDS Rapid Assessment of HIV prevention strategies, systems and implementation approaches in Mozambique (2017), which highlighted gaps in service coverage, barriers to services and key recommendations.

The assessment took account of these activities and, to the extent they were available, included their outputs in the analysis.

In the sections that follow, the assessment findings are presented in two main sections, the first on HIV, and the second on TB.

IV. Findings for HIV

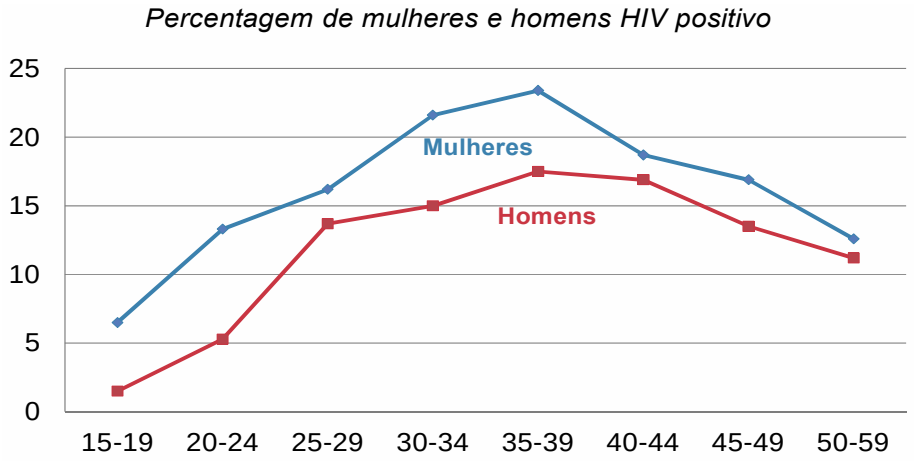
The findings for HIV are presented as follows: (a) an overview of the HIV epidemic in Mozambique, with specific attention to the key and vulnerable populations included in the assessment; (b) information on trends in access and uptake of HIV services to illustrate the extent of current gaps; (c) an overview of the general context for the HIV response with a particular focus on the components addressing human rights and gender; (d) an analysis of human rights and gender related barriers to HIV services; (e) an analysis of current efforts to address barriers, including gaps, challenges, (f) a description of a comprehensive set of programs; and (g) an analysis of opportunities for scaling up current efforts over a five-year period.

Even though the general context for the HIV response in Mozambique is becoming more enabling, most of the groups included in the assessment who also carry the highest burdens of HIV disease continue to experience human rights and gender-related barriers. These barriers include: (a) stigma and discrimination in personal and community settings, especially for key populations; (b) lack of confidentiality and privacy in HIV services; (c) abusive and illegal practices by police (mostly involving bribery and extortion), particularly against men who have sex with men, female sex workers, transgender people and people who inject drugs, despite recent changes to the Penal Code; (d) harmful gender norms that, amongst other things, fuel sexual and gender-based violence against adolescent girls and young women and limit their agency and autonomy to seek needed health services; and (e) barriers related to poverty to the extent that HIV services are inaccessible for some or unaffordable given a prevailing practice of extra charges for health services that are legally required to be provided free-of-charge. While there are current interventions in the country to address many of these barriers, they are not yet implemented at sufficient scale and scope to achieve and sustain positive change.

Overview of epidemiological context

The HIV epidemic in Mozambique does not affect all people equally. In 2015, amongst a population of 28,8 million, the overall adult (15-49 years) HIV prevalence rate was estimated at 13.2% (MISAU/INS and INE, 2017. However, there were significant variations by age, gender and location. For example, adult HIV prevalence was 15.4% for females versus 10.1% for males. Figure 1, below, further illustrates these differences.

Figure 1: HIV prevalence by age and sex



Source: MISAU/INS and INE, 2017.

In addition, there were substantial differences in HIV prevalence by gender across all age groups but particularly in the 20-24-year age band (13.3% for females versus 5.3% for males). HIV prevalence was also higher in urban than in rural areas (20.5% versus 12.6% for females), and highest among females in the southern region, particularly in Gaza (28.2%) and Maputo (29.6%) provinces (ibid).

As of 2017, the total population of people living with in Mozambique was estimated at 2,160,076, of which 56.8% were female adults and 7.8% were children under the age of 15 years (Spectrum Estimates for 2017). There were an estimated 120,577 new HIV infections in 2017 along with 67,754 AIDS-related deaths (ibid). This represented a 27% and 18% decline, respectively, since 2010. The rapid scale-up of anti-retroviral treatment (ART) could have attributed to the decline over the same period.

A Modes of Transmission (MOT) analysis conducted in 2013 suggested that 29% of all new infections occurred amongst female sex workers and their clients, as well as among men who have sex with men; 26% occurred amongst people in stable relationships, this latter result due in large part to high rates of sero-discordance (17% of all couples tested in 2015), and low rates of condom use amongst couples (Amin et al., 2013). People in multiple concurrent partnerships contributed to 23% of new adult infections. One of the parameters used in the model is population size estimate and to the extent that such estimates are not accurate or available, projections of new infections, particularly among key populations, will also not be accurate. The model also does not measure links between groups; for example, how many males in sero-discordant couples are also clients of sex workers or are married men who have sex with men; or, how many multiple concurrent partnerships amongst males include regular contact with female sex workers.

While the most recent data on HIV prevalence rates among men who have sex with men and female sex workers were not available at the time of the assessment, currently, the IBBS for female sex workers and their clients is being conducted and the IBBS for men who have sex with men is planned for 2018. The general consensus among key stakeholders was that these rates remained among the highest countrywide. According to integrated bio-behavioural and sero-prevalence (IBBS) surveys conducted during 2011-12, the estimated HIV prevalence among female sex workers was 23.6% in Beira, 31.2% in Maputo, and 17.8% in Nampula (INS

et al., 2013a), 2-3 times higher than women in the general population. In the same period, prevalence of HIV among men who have sex with men was estimated at 9.1% in Beira, 8.2% in Maputo, and 3.7% Nampula, consistent with the general male population (Nala et al., 2015). However, the HIV prevalence is much higher among older men who have sex with men (over 25 years old) with 33.8% in Maputo city, 32.1% in Beira, and 10.3% in Nampula. (IBBS, 2011) There are no specific prevalence estimates for transgender people.

Recent data on people who inject drugs have shown very high rates of HIV prevalence, which increases with the age of these individuals (Teodoro et al., 2015). For example, in Maputo, HIV prevalence was 30% amongst males 18-24 years, 46% amongst those 25-34 years, and 50% amongst those 35 years and older. In Nampula/Nacala, HIV prevalence reached 73% amongst males 35 years and older. The survey also revealed high levels of co-infection with Hepatitis B (HBV) and/or Hepatitis C (HCV). For example, as many as 36% of participants in Nacala were infected with HBV and as many as 77% with HCV.

HIV prevalence amongst prison inmates was estimated at 23% for males and 36% for females in 2013 (SERNAP, 2013). HIV prevalence was highest in facilities in Gaza (32%), Sofala (35%) and Maputo (29%) provinces. Syphilis prevalence was 15.6% for males and 26% for females.

With regard to vulnerable populations, an IBBS conducted in 2012 reported that HIV prevalence amongst Mozambican mineworkers working in South Africa was 22.3% (MISAU et al., 2013b; Baltazar et al., 2015). A similar study amongst long-distance truck drivers showed a prevalence of 22% amongst Mozambican nationals (just over half the sample) and 9% amongst drivers of other nationalities (Botao et al., 2016).

The available prevalence data confirms that female sex workers, people who inject drugs, prison inmates, adolescent girls and young women, older men who have sex with men and migrant mineworkers have higher HIV burdens than other groups. However, these data are not current and IBBS for key populations are planned for 2018.

Current trends in access and uptake of HIV services

Current trends in access and uptake of HIV services for the specific populations groups included in the assessment are mostly unknown except for some information on adolescent girls and young women. Using HIV testing and uptake of HIV treatment as measures of access to HIV services, current trends include the following:

- As of 2015, amongst females aged 15-49 years, 58.3% had ever been tested for HIV and received their test results, 28.9% in the past 12 months. For males the rates were 38% and 19.2%, respectively (MISAU and INE, 2016).[4]
- Among adolescent and young females (15-24 years), 55.3% had ever been tested for HIV and received their results, 32.3% in the past 12 months. For males the rates were 27.7% and 15.5%, respectively. Amongst young people (20-24 years), 72% of females had ever been tested and received results, 40% in the past 12 months; for males, the rates were 41% and 22%, respectively (Ibid.).

[4] Lower rates of HIV testing amongst males is also a regional trend and, in some cases, reflects the fact the females have more opportunities for testing, particularly in the context of prevention-of-mother-to-child transmission of HIV (PMTCT) programmes.

- With regard to access to HIV treatment, by the end of 2016, there were 990,085 people living with HIV on anti-retroviral treatment (ART), 8% of whom were children (0-14 years) (CNCS, 2017). Treatment coverage was estimated at 55% of all people living with HIV and 65% of all eligible people living with HIV according to national guidelines in place at the time (CD4<500). Coverage was 64% for adults and 70% for children. No further age and sex-disaggregated data were available. Retention in HIV care at the end of 2015 was 70% after 12 months, and 52% and 49% at 24 and 36 months, respectively (Ibid, PEPFAR, 2017).

Coverage and uptake of HIV services for the general population is continually improving in Mozambique, and in an effort to further accelerate progress, MISAU began a phased roll-out of the 'test and start' approach beginning in August, 2016, with the intention of county-wide implementation starting in 2018. Other efforts to improve uptake and retention on HIV treatment currently include a transition to 3-month scripts for stable patients, increased availability of viral load testing, and reduced frequency of clinic visits for patient monitoring (PEPFAR, 2017).

With regard to coverage and uptake of HIV services for key populations, available data is neither current nor comprehensive. In the 2011-2012 period, for example, it was estimated that between 29%-34% of female sex workers and 30%-42% of men who had sex with men had been tested for HIV. During the same period, ART coverage was estimated at between 27%-55% for female sex workers (MISAU et al., 2013a; Nala et al., 2013). No data were available for other key populations. This presents a challenge for understanding the nature and extent of current barriers and for measuring future progress should such barriers be reduced or removed for these groups.

Overview of country context for HIV-related human rights

The findings under this section describe the country context for Mozambique for HIV-related human rights and gender concerns. They address law, policy and strategy issues as well as more general considerations regarding the political and social context for HIV-related human rights. There are important changes occurring across these domains towards a more enabling and protective environment for people living with HIV and other key and vulnerable populations. However, effective implementation remains challenging, in part because of factors within the political and social environment that limit how changes in laws or policies are realized for the specific key or vulnerable populations to which they apply.

Legal framework for HIV-related human rights

The legal framework in Mozambique with regard to HIV and human rights consists of the country's Constitution, and both HIV-specific and other laws addressing health and related issues. It also consists of international legal instruments to which the country is a signatory.

The *Constituição da República de Mocambique 2004* defines and protects the fundamental human rights and freedoms of all people in the country (Republic of Mozambique, 2004). It states that the interpretation of human rights should be aligned with the *Universal Declaration of Human Rights* and acknowledges the role of international norms and standards in the interpretation of its provisions (Article 17). Article 36 provides for the equality of men and women before the law and across political, economic, social and cultural

domains. Articles 89 and 116 speak to the right to health care stipulating that: "the State shall promote the extension of medical and health care and equal access to all citizens in the enjoyment of this right." The Constitution further provides for mechanisms enabling citizens to bring legal action on issues such as public health, although there have been no recorded cases (Feinglass et al., 2016).

In 2014, an amended HIV law was passed that superseded previous versions from 2002 and 2009 (Eba, 2015). While these earlier versions had positive aspects, including provisions against HIV-related discrimination in employment and other settings, for example, they also criminalised HIV transmission. The new law removed this problematic provision and also addressed previously discriminatory provisions against female sex workers by stipulating that this group should not be prevented from accessing condoms, as well as HIV testing and treatment services. The revised law maintained protections for people living with HIV including penalties for HIV-related discrimination across the public and private sectors. It also maintained provisions requiring informed consent for HIV testing and the protection of confidentiality of HIV status, as well as prohibiting HIV testing as a condition of employment.

Furthermore, in 2015, a revised Penal Code came into force which, among other things, removed provisions criminalising homosexuality and sex work, and clarified legal provisions for more effectively addressing sexual assault (AIDS Rights Alliance for Southern Africa [ARASA], 2016; Republic of Mozambique, 2014). It also made provisions for the reform of the penal system by providing alternatives to imprisonment such as community service.

Examples of other laws relevant to human rights and gender concerns in the context of HIV include the Family Law (2004) which sets the legal age of marriage at 18 years but with provisions for 16 years in certain limited circumstances (the age of consent for sexual activity is 16 years); the Labour Law (2007) which addresses gender equality and special rights for women in the workplace (e.g. for pregnant women) as well as the need to protect employees from discrimination on the basis of sexual orientation; the Promotion and Protection of the Rights of the Child Act (2008) which seeks to domesticate the provisions of the Convention on the Rights of the Child; the Domestic Violence against Women Act (2009); and the Protection of the Rights of All Migrant Workers and Members of Their Families Act (2013) (ARASA, 2016; Open Society Institute for Southern Africa [OSISA], 2012).

HIV-related policies, strategies and guidelines

Linked to the legal framework, Mozambique has introduced policies that further aim to address the provision of HIV-related health services for key and vulnerable populations. With regard to HIV, the PEN IV is the main policy instrument that sets out a human-rights-based approach to the national HIV response, including an emphasis on addressing HIV-related stigma and discrimination and removing barriers to HIV services. Not all groups are specifically addressed in the details of the strategy. As already noted, transgender individuals are not yet recognized (because of lack of data, according to key informants) and, despite designating them as a key population for the national HIV response, no harm reduction interventions were being implemented for people who inject drugs at the time of the assessment.[5]

[5] At the time the assessment took place, the operational planning process for the PEN IV was not yet concluded. According to key informants, these plans will include interventions for PWID but it was not clear whether harm reduction would be addressed. It was said that a pilot needle and syringe exchange programme was under discussion but no further details were available.

Mozambique has adopted the Southern African Development Community's (SADC) *Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region* which, amongst other objectives, aims to protect the human rights of prisoners and other detainees in the context of access to HIV and other services (SADC, 2009). At the time of the assessment, SERNAP was developing standard operating procedures for the delivery of HIV and TB services in prisons to align its efforts with the SADC document.

Finally, as envisioned under the PEN IV, MISAU has developed a *Guideline for the Integration of HIV and AIDS Prevention, Care and Treatment Services for Key Populations* (MISAU, 2016). It recommends scaling up access to HIV services for key populations, primarily FSW and MSM, using a treatment as prevention approach (there are no components for transgender or PWID). It stipulates that each province should have two health centres providing a full package of support for key populations, with staff trained in all areas of sexual and reproductive health, including STIs and anal health (KII MISAU, April 2017). There are a number of gaps, however, and no specific provisions address human rights concerns. At the time of the assessment, implementation of the guideline had not started.

Political, social and economic context for the national HIV response

The HIV response in Mozambique generally has strong political support although it is heavily dependent on external financing (see below) which affects how the country prioritises and directs its actions. The national, multi-sectoral response is led by the CNCS which itself is overseen by a governing board chaired by the Prime Minister. It is important to note that the national HIV response takes place within a wider context of social and health challenges. The Human Development Index ranks Mozambique at 180 out of 187 countries (UNDP, 2016). Sixty percent of Mozambicans live on less than US$1.25/day, 70% of Mozambicans are estimated to be poor, and 37% destitute (Oxford Poverty and Human Development Initiative, 2016).

There are major health system challenges, including limited financing, inadequate infrastructure, and shortages of human resources. Over 90% of the population lives in an underserved primary health care area defined as over a one-hour walk from a primary health care centre (Luis and Cabral, 2016). MISAU estimates that, in 2014, there were 100.2 health care workers per 100,000 people, far below the minimum of 230 recommended by the WHO (PEPFAR, 2017).

Finally, there is a larger context for the protection and promotion of human rights in the country that many view as mixed in terms of progress and challenges (United Nations Human Rights Council, 2016; United Nations Joint Country Team, 2016). There are significant concerns regarding women's equality, the rights of refugees and asylum seekers, the conduct of security forces, and the inability of many Mozambicans to access adequate food, shelter and nutrition.

The national HIV response in Mozambique is almost exclusively financed from external sources. According to the most recent National AIDS Spending Assessment (NASA) for 2014, of the annual expenditure of US$330.0 million, 62% was financed through PEPFAR, 25%

through the Global Fund, 9% through other donors, and 3% from the Government of Mozambique (CNCS, 2016).

Overall the national HIV response is constrained by these challenges that affect all of Mozambique's population, including the specific key and vulnerable populations included within this assessment.

Human rights and gender-related barriers to HIV services

Overview

The findings in this section consolidate information derived from the desk review as well as from key informant interviews and focus group discussions. Overall, stigma and discrimination against people living with HIV and other key and vulnerable populations remains the dominant barrier for access and uptake of HIV services. This includes the challenges of self-stigma where feelings of shame and fear of discovery of personal information (being a member of a key population, for example, or being a sexually active adolescent) deter individuals from seeking needed services. While instances of discrimination in health services and poor service quality for people living with HIV are generally declining in Mozambique, more substantial challenges remain for other key populations. Laws against drug use limit the development of harm reduction interventions for people who inject drugs. Poor conditions in prisons, specifically severe overcrowding and the inability of SERNAP to provide for the basic welfare of detainees, constrains both the availability and the accessibility of HIV interventions. Finally, harmful gender norms and gender inequality, coupled with severe poverty, continue to place adolescent girls and young women at high risk of HIV infection and also limit their ability to use HIV and other services when they need them.

Stigma and discrimination

While HIV-related stigma and discrimination continues to occur in Mozambique, its effects on access to services vary considerably by populations or sub-groups. The latest HIV Stigma Index survey was conducted in 2013 amongst 741 people living with HIV of which less than 10% were members of other key and vulnerable populations. No participants identified themselves as men who had sex with men or transgender, for example, and only 2 participants identified themselves as people who inject drugs. (Rede Nacional de Associações de Pessoas que Vivem com HIV/SIDA [RENSIDA], 2013). The survey found that 24% of participants had experienced some form of discrimination, largely in their personal or community environments. With regard to access to health services, only 3.4% of respondents stated that they had been denied services during the past 12 months. However, the results should be interpreted with a caution given the limited scope of the study participants.

According to key informants, however, these data may not describe the overall situation in Mozambique. Participant recruitment for Stigma Index Surveys is usually done through existing networks of PLHIV whose members may be more empowered and assertive than individuals that do not participate is such structures. These key informants described a number of ongoing challenges related to stigma and discrimination, including high levels of self-stigma and fears of disclosure of HIV status that, amongst other things, affect uptake

and retention in HIV treatment and that may be a factor in the country's low retention rates on ART noted in Section 4.2, above. The organisation of HIV services at health facilities was also raised as a barrier in that PLHIV are often singled out in special queues or special rooms that has the effect of disclosing their HIV status to others. It was stated, for example, that for women initiated on ART through the PMTCT programme, some will drop out of HIV care once they must transfer to an ART clinic from the anti-natal care service.

Quantitative data for female sex workers and men who have sex with men are not current and pre-date important changes in the country context, especially amendments to the Penal Code and the launch of the PEN IV. With regard to female sex workers, in 2011 it was found that the majority of female sex workers in Maputo (57.9%), Beira (64.8%), and Nampula (61.6%) did not seek assistance from any health professional in the 6 months preceding the survey (MISAU et al., 2013; Langa et al., 2014). However, among female sex workers who did seek such assistance, 9 out of 10 had no difficulty obtaining care in Maputo. In the same year, with regard to men who had sex with men, it was found that over three-quarters of these who sought health care in the 12 months preceding the survey did not have difficulty obtaining services in the three urban areas (Nala et al., 2015). What female sex workers and men who had sex with men described in interviews and focus group discussion, however, contradicted some of these data, as described below.

As detailed in a national consultation convened by UNAIDS in 2016, and as further elaborated during the in-country research of this assessment, barriers remain in access to health services, both in terms of expectations of negative experiences as well as actual instances stigma, discrimination or poor service provision.

- Some men who have sex with men, for example, stated that the health services they were offered were not necessarily relevant to their specific needs and, as a result, they would only seek services, including treatment for diseases, when at an advanced stage of ill health (UNAIDS Mozambique, 2016; FGD MSM representatives, April 2017).
- Some people who inject drugs in Maputo reported negative experiences with healthcare staff, particularly as many were both HIV-positive and had TB and so needed treatment on a regular basis. According to one representative of this population: "Some people treat us like dirt." However, other representatives stated that they could address these challenges by sharing information amongst each other regarding where more friendly healthcare centres were located (FGD PWID representatives, April 2017).
- Experiences of stigma and discrimination amongst female sex workers varied by location as well as by social status. Female sex workers in Maputo and Tete reported fewer challenges, largely, in their view, as a result of capacity-building efforts at health centres around professionalism and the ethical treatment of patients. Experiences of undocumented, migrant sex workers in and around Moatize were considerably different where they faced significant barriers in regards to stigma and discrimination, particularly with regard to pharmacy staff and the request for extra payments or bribes to be able to receive their medications (FGD FSW representatives in Tete, April 2017).

Self-stigma was also frequently raised amongst the fieldwork participants as a barrier to health-seeking behaviour, particularly with regard to motivation to attend health services when there was a need. Some men who had sex with men stated that they and others that

they knew would not go to health centres for fear that they would be judged or treated badly because of their sexual identities or behaviours. Similarly, some female sex workers were reluctant to attend health services for fear that their status as sex workers would be inadvertently disclosed. Amongst HIV-positive men who have sex with men and female sex workers, self-stigma also limited disclosure of their sero-status to partners or family members for fear of negative beliefs or judgements about how they contracted HIV and for fear of rejection or abandonment (FGD MSM representatives, April 2017; FGD FSW representatives, April 2017).

Representatives of people who inject drugs encountered the opinion among health care providers that drug dependency was a mental illness and that drug users required clinical interventions to 'cure' them of their addiction. In their view, such attitudes negatively affected their motivation to access services, including those related to HIV. These participants also noted that, although people who inject drugs have been identified as a key population in the national HIV response since 2010, there were still no harm reduction interventions in Mozambique and there was only one detoxification programme provided through the main psychiatric hospital in Maputo about which participants expressed uniformly negative views (FGD PWID representatives, April 2017).

According to prison workers who participated in the assessment, among prisoners there was reluctance to disclose their HIV or TB status when entering the prison system for fear it would reflect badly on them (KIIs with SERNAP and medical staff at Machava prison, April 2017). These findings aligned with the assessment undertaken in 2013 regarding HIV and TB-related knowledge, attitudes and practices within the prison system (SERNAP, 2013). One additional finding discussed by key informants, and detailed in the 2013 assessment, was the contradiction between tacit acknowledgement of same-sex sexual activity and drug use in the prison system but the lack of official recognition of this situation preventing the implementation of comprehensive programming (e.g. distribution of lubricants as well as condoms) (KIIs with SERNAP and medical staff at Machava prison, April 2017; SERNAP, 2013).

Finally, the assessment identified through the desk review and across all groups of key informants that significant health system challenges in the country affect the quality and availability of services for most of the population, including key and vulnerable populations. Confidentiality and privacy are critical challenges in facilities that are generally overcrowded and lack adequate infrastructure. Consequently, for example, patients may lack a private space within which to discuss their health concerns (Namati, 2017). While these problems affect all health system users, they present a greater barrier for key populations who already fear discussing their sexuality or sexual behaviour due to stigma (Lafort et al., 2016). In particular, men who have sex with men are likely to avoid situations where their consultations are not conducted in private (KII MSM CSOs, April 2017). If a prisoner must attend a health visit outside the prison, the individual must always be handcuffed and accompanied by prison guards, including in consultation rooms, removing any privacy they may have in their medical examination (KII SERNAP, April 2017; SERNAP, 2016). Finally, representatives of people living with HIV spoke about how the organisation of HIV services in health facilities can expose them, when they must come on designated days for services, for example, or when they must collect their medications from designated rooms that other patients know to be the place where ART is dispensed (KII PLHIV representatives, April 2017).

Punitive laws, policies and practices

There are contradictions in the legal environment for HIV services in Mozambique, both in the laws themselves, and in how they are applied. Despite an improving law and policy environment, many limitations are present in the country regarding the implementation of the laws as well as with regard to effective mechanisms for accountability and legal redress. Findings from the desk review and key informant interviews point to the following as the main challenges limiting the effectiveness of laws and policies: (a) poor dissemination of the content of laws; (b) poor enforcement, sometimes arising from lack of knowledge about laws and policies amongst law enforcement agents themselves; (c) low levels of legal literacy across the population; (d) poor access to legal services; and (e) prevailing socio-cultural norms that result in preference for traditional dispute resolution mechanisms rather than using the formal legal system (Feinglass et al., 2016).

Although same-sex sexual behaviour and sex work are no longer criminalised in Mozambique, widespread socio-cultural prejudices remain and, according to a number of assessment participants, this continues to fuel on-going harassment and abuse by law enforcement agents. According to published sources and the views of fieldwork participants, harassment of men who have sex with men and female sex workers by the police is one of the more enduring human rights concerns for these groups. Fear of stigma, discrimination and abuse drives reluctance to disclose personal information even within health care services and contributes to an overall atmosphere of suspicion and distrust within public services (FGDs with FSW, MSM and PWID representatives, April 2017; UNAIDS Mozambique, 2016).

Drug use is criminalised in Mozambique, and people who inject drugs are routinely harassed and incarcerated by police, this latter practice often occurring on a temporary basis as a way to extort money for release rather than to initiate criminal processes. For people who inject drugs, there was fear that if the police found them with a syringe they would be required to pay bribes in order to avoid arrest (FGD with PWID representatives, April 2017). Although women who inject drugs are present in Mozambique, no detailed information about them was captured by the assessment, this being part of the larger overall gap in information about people who inject drugs.

Female sex workers reported that police were often unsympathetic to issues they faced, would not protect them against violent clients, and, in some cases, were the perpetrators themselves of violence and theft against them (UNAIDS Mozambique, 2016). Although some female sex workers reported that they faced fewer arrests as a result of changes to the Penal Code, they still related stories about violence, not only from their clients but also as a result of their contact with the police. The crime - offences against public decency - is frequently used by police to harass and detain female sex workers and some men who have sex with men, as well. Representatives of female sex workers described how social perceptions of them as immoral fuelled police abuse and lack of community concern for their welfare (FGD with FSW representatives, April 2017). While female sex workers were aware that such forms of assault and abuse were against the law and that they had the right to seek justice, few believed they would receive justice or were concerned that clients they had complained against would seek some form of retribution in the future (FGD with FSW and CSO representatives, Tete, April 2017).

Mozambique's ongoing challenges with corruption and abuse within the prison system, including physical and sexual abuse, have been well documented and were highlighted again

by key informants (KIIs with SERNAP and medical staff at Machava prison, April 2017; SERNAP, 2013). According to these individuals, these realities continue to limit the effectiveness of HIV and TB interventions and prevent both inmates and staff from accessing services. Overcrowding, and population mixing, both young and old, as well as pre-trial and pre-sentencing detainess with those who have received convictions, is the main overall challenge according to key informants. Particularly for those in temporary custody, interruptions of HIV or TB treatment are common, sometimes for extended periods due to the difficulty of accessing health care services (KIIs with SERNAP and medical staff at Machava prison, April 2017; SERNAP, 2013, 2016).

It was noted during stakeholder interviews that the National Human Rights Commission (NHRC) has limited influence in law enforcement and in relation to the protection and promotion of human rights, both in the context of HIV and elsewhere. For example, the NHRC can investigate abuses and recommend interventions, but it has little effective ability to follow up on its recommendations or to monitor whether its findings are being addressed by the relevant government agencies (OSISA, 2012; United Nations Human Rights Council 2013).[6]

Gender inequality and gender-based violence

A comprehensive assessment of the gender dimensions of the HIV epidemic in Mozambique and the effectiveness of the national HIV response to address them was beyond the scope of this assessment. As described in previous sections, above, Mozambique continues to make efforts to improve the protective environment for women and girls, both in the context of HIV and more broadly. However, progress is slow as the HIV epidemic maintains a significant gender dimension with adolescent and young girls being the group with the highest levels of overall vulnerability and, consequently, the highest incidence of new infections. The factors driving this have been well documented and include poverty, and harmful socio-cultural and gender norms and practices that continue to position women as inferior to men, trends that are similar across neighbouring countries in the region (Tvedten, 2011; Estavela and Fleury Seid, 2015). Gender-related vulnerabilities to HIV include: (a) marriage of children before the age of 15 years and early entry into child-bearing (despite the fact that such marriages are illegal); (b) frequency of age-disparate sexual partnerships and transactional sexual activity; (c) frequency of violence, particularly sexual violence; (d) low levels of comprehensive knowledge regarding HIV; and (e) low levels of condom use (CNCS, 2015).

Among men who have sex with men, prevailing gender norms regarding masculinity coupled with stigma and discrimination against homosexuality influence sexual identity and sexual practice in ways that increase the vulnerability of both men and women. For example, almost half of the participants in the 2011-12 survey who were men who have sex with men identified as bisexual, with a majority having both male and female partners (Nala et al, 2015; Sathane et al., 2016). Only 33% of participants who had female partners used condoms during their last sexual contact (ibid). Representatives of men who have sex with men who were interviewed described increasing social pressures to marry as they and their peers grew older. Because of this, such individuals were not found in HIV-related programmes for men who have sex with men, a particularly important gap given the increasing prevalence of HIV

[6] A previous version of the report noted the ongoing refusal by the Ministry of Justice to issue a legal registration for LAMBDA. However, in November 2017, the legal provision that the Ministry was relying on for its refusal was declared unconstitutional by the Constitutional Council. LAMBDA has re-submitted its registration request but has not yet received a new decision. See, for example, http://clubofmozambique.com/news/mozambique-clause-used-to-deny-registration-to-lgbt-association-declared-unconstitutional/

associated with age among this group (FGD with MSM peer educators, April 2017; Nala et al., 2015). Other gender-related findings influencing access and uptake of HIV services included the difficulty of directly acknowledging same-sex sexual behaviour amongst men in prisons, as already noted, and the limitation this placed on offering effective HIV prevention interventions and of addressing HIV-related stigma (KIIs with SERNAP and medical staff at Machava prison, April 2017).

Poverty and socio-economic inequality

As already noted, Mozambique continues to struggle with deeply entrenched poverty. With regard to access to HIV services, the assessment identified two main poverty-related concerns.

Firstly, there is a widespread practice across the health sector (and across the public sector generally) of requiring additional payment for services that are legally to be provided free- of-charge (Namati, 2016). Such payments can be made by health system users to shorten waiting times, for example, or are demanded by health care workers as a way of supplementing low wages.

Secondly, despite the government's best efforts with support from external partners to address the challenge, most Mozambicans do not have easy access to health facilities (dos Anjos Luis and Cabra, 2016). Costs for transport for routine appointments needed for HIV care, for example, were raised by some key informants as ongoing barriers to HIV services for people living with HIV in these circumstances.

Efforts to address and remove human rights-related barriers to services

Overview

While significant human rights and gender-related barriers to access and uptake of HIV services persist in Mozambique, there are a growing number of efforts underway across the multi-sectoral HIV response to try to address them. There are also a number of opportunities for expanding this work towards a more comprehensive and higher impact approach.

Current or recently completed human rights and gender-related interventions are described in the sections that follow according to the seven key program areas described by UNAIDS (2012). In some cases, efforts to address human rights barriers were components of broader HIV or sexual health programmes and sometimes combined activities from more than one program area. The assessment identified a number of gaps and challenges across current efforts. These included:

- Amongst many stakeholders in the national HIV response, knowledge about human rights and gender in the context of HIV, particularly how to develop interventions to address human rights-related barriers to services, is insufficient and limits the range, scale and quality of what could be done to address such barriers.
- There is very little cross-constituency, cross-sectoral or coordinated work on human rights or gender-related barriers. Individual stakeholders or constituencies work on their own

priorities and current efforts are fragmented and appear to have limited ability to achieve change.
- Many activities are of limited scale (in terms of beneficiaries) and geographic reach, largely as a result of the difficulty of securing sufficient funding. However, there also appeared to be a gap in technical capacity to plan multi-year interventions.
- Despite recognition of the importance of human rights-related barriers for key and vulnerable populations in the PEN IV, an operational plan or detailed strategy has not yet developed to address them.
- Representation of some important key population constituencies at the national level is either weak or absent. While there are organisations led by female sex workers in Mozambique, their organisational and technical capacities need improving to enable them to have a stronger presence and voice. People who inject drugs and transgender people do not have effective representation in their own right.

The findings of the assessment underscore the need for all stakeholders in Mozambique to adopt a more strategic, comprehensive, sustained and better-coordinated approach to addressing and removing human rights and gender-related barriers to HIV services. How this can occur is included in the more detailed discussion that follows. In addition to the description in each section of a comprehensive approach, **Annex A** lists the specific activities that will be required.

Stigma and discrimination reduction

Recent and current efforts to address stigma and discrimination, particularly for people living with HIV and other key populations, involve a number of components. These include broad national efforts as well as focused interventions for groups and individuals to address self-stigma and to build personal resilience and agency.

At the *national level*, for example**:**

- **RENSIDA** works with stakeholders and technical partners such as **UNAIDS** and **UNDP** to change public attitudes and beliefs regarding people living with HIV. However, this work has not been supported to the extent that it can be sustained at sufficient scale to achieve major changes in attitudes around HIV and people living with HIV.
- **LAMBDA,** through its advocacy and media relations work, continuously brings attention to LGBT-related stigma and discrimination. This has included a survey of public attitudes towards homosexuality conducted in 2013 that the organisation plans to repeat once it can mobilise sufficient funding.

At the *individual and community levels*, peer education is a strategy employed by many civil society organizations to help reduce self-stigma through including human rights components within the package of interventions that are provided:

- In 2010, **MISAU** began convening ***Grupos de Apoio a Adesão Comunitária*** **(GAACs)** or Community Adherence Support Groups whereby, amongst other functions, people living with HIV on ART organize themselves so that, on a rotational basis, one member collects ARVs from a health facility on behalf of the group. A national scale-up plan was rolled out starting in 2015. The GAACs have other important functions including stigma reduction, peer support, personal empowerment and positive living.

- **LAMBDA** trains peer educators to work at community level on HIV prevention, care and treatment services and the legal rights of men who have sex with men around their sexual health.
- **Tyiane Vavassate** is a community-based organization led by female sex workers in Maputo and helps build the confidence of sex workers through solidarity, legal rights training and advocacy.
- **The International Centre for Reproductive Health (ICRH)** supports a project for female sex workers in Tete where women are trained as peer educators to support sexual and reproductive health and rights, including HIV-related support groups to help address self-stigma. Peer educators also work in communities with the police to reduce discrimination and abuse.
- **Pathfinder** has been training peer educators within the prison system in collaboration with SERNAP, following MISAU guidelines. One aim is to reduce HIV-related stigma amongst prisoners; however, men who have sex with men-related stigma is not addressed.
- **UNIDOS** and **ACAM** are both working to challenge stereotypes around people who inject drugs and to empower them to resist stigma and discrimination. UNIDOS is also working with community organisations to improve their ability to support people who inject drugs.

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

- National level interventions to raise issues of stigma and discrimination for people living with HIV and other key populations are not comprehensive. They occur only on an episodic basis and have limited ability to sustain positive shifts in problematic attitudes and practices.
- Quantitative data on stigma and discrimination is outdated. For example, the LAMBDA survey pre-dates important changes in the legal context for men who have sex with men.
- Stigma reduction interventions are fragmented across different implementers. There are no common approaches, and coordinating structures, such as CNCS, are not playing an active role to address fragmentation.
- Interventions to address self-stigma, through community-mobilisation and peer education, are small in scale and have not been formally evaluated in order to document their effectiveness or to capture best-practice components for scaling-up.

A comprehensive approach to reducing stigma and discrimination for people living with HIV and other key populations should include the following:

- Measure stigma and discrimination to update data and for advocacy and planning**.** Stigma and discrimination should be measured in the community and in key workplaces. The country is in the process of undertaking new IBBS surveys amongst key populations and also has a plan to undertake a new PLHIV Stigma Index survey. These important efforts, should be consolidated into an overall strategy to reduce stigma and discrimination, particularly as it relates to access to health services. The strategy should include stepped-up efforts to ensure that evidence regarding stigma and discrimination is gathered as well outside of urban centers and is effectively communicated across different channels and to different audiences so that steps can be taken to address the stigma and discrimination where it occurs. The policy briefs produced by Namati or LAMBDA are good examples of

how such evidence can be communicated and can specify what actions are required to improve the situation.

- Conduct regular and coordinated campaigns at national and community levels to reduce stigma and discrimination**.** Key-population-led civil society organizations should consolidate and coordinated their current efforts into a well-coordinated multi-year action plan involving a broad range of programs to reduce stigma and discrimination to positively shift knowledge, attitudes and practices towards key populations country-wide. These should involve media campaigns, community dialogues, engagement of traditional leaders and celebrities. These efforts should be taken outside of major urban centres to districts where key and vulnerable populations also reside.
- Capacitate and utilize key and vulnerable population spokespersons. Key-population-led CSOs, RENSIDA, MISAU and others should support more people living with HIV and representatives of other key and vulnerable populations, to function as spokespersons and role models. The sharing of personal stories and face-to-face encounters are effective ways to address stigmatising attitudes and beliefs. This can be done through media as well as through community level meetings and discussions. Appropriate strategies for protection and support for these individuals must also be in place should there be negative reactions against them in their personal or community environments.
- Strengthen and sustain the psycho-social support component of HIV interventions for key populations. Given the strong role that self-stigma continues have in limiting access, uptake and retention in HIV programmes, the psycho-social support component of peer education and outreach programmes, should be reviewed for its technical efficacy to address self-stigma and build resilience. MISAU and key-population-led CSOs should take the lead on this work.
- Incorporate/expand stigma reduction efforts in the GAACs**.** Community-based support structures are highly effective ways of building networks and improving individual resilience and agency to confront stigma and discrimination. The GAAC model has worked well in Mozambique and should be expanded to address stigma and discrimination as a core part of its work. These efforts should be supported by MISAU, RENSIDA, key-population-led civil society organizations and others to insure the GAACs are inclusive and more fully utilize representatives of people living with HIV and other key populations.

Training for health care providers on human rights and medical ethics related to HIV

The assessment identified some interventions that related directly to training of health care workers on human rights and medical ethics. Improving the skills of health care workers and improving linkages between people living with HIV and other key populations and local health facilities were the main focus of most of the activities identified which all had components of non-discrimination. Recent and ongoing programs included the following:

- **MISAU** has a sectoral policy on "humanization and quality of services" which is meant to address issues regarding discrimination, confidentiality and medical ethics. It has also developed a policy on illicit charges at the health facility, as well as guidelines for the provision of HIV and other health services for key populations that include components addressing professionalism and non-discrimination in the provision of services. Training

of health care workers on the guidelines had not yet started by the time the assessment was completed. Partner organisations have been working with MISAU on modules and materials for training. In 2006, MISAU adopted a *Charter on Patients' Rights and Obligations* that was meant to prohibit discrimination on the basis of health status and provide further protections for confidentiality and privacy in health services. However, the assessment found little information that the Charter is well known or followed (Feinglass et al., 2016). This is potentially an effort that could be strengthened and expanded.

- **ADPP** has implemented community-level interventions aimed at strengthening linkages between health services and people living with HIV in communities. This work has recently been extended to include other key populations. The interventions intend to empower communities to be more aware of HIV and other health priorities and to support people living with HIV and other individuals to access and remain in health programmes.
- **AMODEFA** has worked with MISAU to train health care workers in specific facilities to provide caring and respectful HIV and sexual and reproductive health services for female sex workers. With additional funding from the International HIV/AIDS Alliance, it intends to expand this work to cover other key population groups.
- **Pathfinder** has been working with SERNAP to improve the quality of HIV and TB services in prisons, including working with health care workers on technical competencies as well as overall attitudes and professionalism.
- **ICRH** has a component of its project in Tete that works with government health facilities to improve provision of services to female sex-workers through training focal point nurses who work to improve access and uptake of HIV prevention and treatment services for this group.
- **MSF** has also been supporting access to health services for female sex workers, particularly migrants, in the central provinces, including Manica, Sofala and Tete.
- **Namati** has developed a network of grass-root advocates monitoring the provision of health services in communities. These advocates are trained in the country's health-related laws and policies and in additional skills such as mediation, adult education, and advocacy. The advocates provide ways that individuals, including people living with HIV and members of other key populations, can raise problems with health care service delivery in communities and can support individuals to address them through problem-solving dialogues and other means. The organisation periodically aggregates these experiences to inform national level advocacy interventions, such as their recent campaign highlighting the practice of extra payments for services across the public health system (Namati 2015, 2016, 2017).

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

- There have been no assessments amongst health care workers to determine whether their knowledge and practices regarding human rights and medical ethics has improved.
- Interventions to improve health care worker skills and attitudes in the provision of services to key populations are limited in scale and scope, and there was no evidence regarding common approaches.

1. The ability of MISAU to lead and coordinate efforts to improve the skills of health care workers is very limited.[7]

A comprehensive approach to improving the skills, support and motivation of health care workers regarding human rights and medical ethics should include the following interventions:

- Measure stigma and discrimination in health care facilities and develop of facility policies against discrimination**.** Steps should be taken to gather existing data of stigma and discrimination in health care facilities and to conduct operational research at key facilities to establish a baseline of data on current levels of stigma and discrimination in health care. This should include concerns of health care workers regarding their fears of infection and lack of infection control. Any data collection should inform facility policies against discrimination. In this regard, the Charter described above might could be updated and rolled out among health care workers and posted publicly for patients as a basis for a non-discrimination/patients' rights policy.
- Develop/update curriculum on human rights and ethics with attention to HIV, TB and the needs and rights of those affected by these diseases. MISAU together with representatives of key populations, including people living with HIV, should be supported to review existing curricula and update these as necessary for finalization and integration into health care worker training efforts.
- Roll out of the curriculum in pre-service and continuing education training of health care workers, with the latter focused on health care provision in districts of high impact of HIV and TB**.** In addition to the integration of the curriculum into current pre-service training, efforts should be mainly based on the results of measurement of stigma and discrimination and on other indicators, including high prevalence or incidence or retention efforts, to roll out training among health care workers in particular districts. Such training should involve managers as well as administrative staff.
- Develop a monitoring and accountability strategy aligned to the key population guidelines to measure improvements in uptake and retention in HIV services for key populations**.** MISAU and key-population-led CSOs, technical partners and other stakeholders should collaborate to develop and implement a comprehensive monitoring and accountability strategy linked to the new guidelines. The strategy should include ways to routinely measure the quality and comprehensiveness of service provision particularly from the perspective of key population constituencies themselves. The strategy should also provide for opportunities to revise and expand the content of the guidelines, particularly to address the needs of those key populations not yet fully included (transgender, for example). This could perhaps be built on or linked to the work of Namati to expand the network of grassroots monitors and support linkages with other community monitors from key population networks.
- Assess the modalities of HIV and TB health care provision to ensure confidentiality**.** MISAU should be supported to examine, with representatives of people living with HIV and other key populations, the nature and logistics of health care provision, create an acceptable and feasible model, and improve current provision logistics according to the model so that people living with HIV and TB do not indicate their status by being required

[7] While the assessment has not identify the specific capacity building needs for MISAU in this regard, the need to strengthen its capacity to lead and coordinate the work has been raised during the assessment.

to form lines or go to publicly designated areas. Other concerns involving confidentiality and informed consent should also be addressed in this assessment.

Sensitization of law-makers and law enforcement agents

Between 2010 and 2015, **UNDP** supported training of approximately 3,000 police officers on HIV and GBV (UNDP 2016a). However, there was no comprehensive evaluation of this effort and no additional information on its sustainability. The assessment did not find any current interventions specifically working with law enforcement agents other than what was described in sections above, under ICRH.

A comprehensive approach to working with the law and justice sector regarding human rights concerns for people living with HIV and other key populations should include the following:

- Develop and implement revised curriculum and other approaches for improving knowledge and behaviour of the police and police management regarding the law and policy context for HIV, human rights and key populations**.** The assessment has shown varying levels of knowledge and awareness of, and professional commitment towards, existing and new laws and policies for HIV and for key populations. Based on the results of the evaluation, both the content and approaches for working with the police and judiciary should be revised. A critical component of more work in this area should be the direct engagement of key populations constituencies, including those living with HIV, in the revised training and skills development programmes. CNCS should work with key-population-led civil society organizations, Ministry of Interior and police leadership in these activities.
- Improve institutional mechanisms within police services for monitoring and promoting good practices regarding HIV, human rights and key populations. Technical support should be provided where necessary to strengthen institutional mechanisms across the police force, starting with recruitment and training practices that promote and recognize good practices with regard to respecting the country's human rights commitments, particularly in the context of HIV and key populations.
- Strengthen and scale up community level interventions that build positive relationships between local police and judiciary and key population constituencies**.** Such work is already taking place in Mozambique and should be sustained and extended across the country. However, there should be more emphasis and support for monitoring and measuring the effectiveness of this work in reducing stigma, discrimination and abuse.
- Develop and implement a comprehensive strategy to change knowledge and perceptions regarding people who inject drugs amongst police and judicial officers**.** Work should be intensified and expanded to engage the law and justice sector in a process of education and commitment to harm reduction for people who inject drugs. CSOs and technical partners should be actively engaged in these efforts along with the active participation of people who inject drugs themselves.

Legal literacy

The assessment identified a number of initiatives led by civil society organizations to improve knowledge about legal and human rights among key populations.

- **RENSIDA, LAMBDA, OMES,** and **Tyiane Vavassate,** among other organisations, have all undertaken interventions aimed at improving legal and human rights literacy with different key population constituencies.
- Organisations such as **LAMBDA** and **ICRH** support interventions among their target populations regarding legal and human rights literacy. However, these efforts largely reach groups and individuals in urban settings, or within a project's specific catchment areas, and do not reach key populations in rural areas, for example.
- As described above, **Namati** includes components of law and human rights literacy within its training programme for advocates, and this includes specific issues for key populations.
- The **Liga dos Direitos Humanos** has also undertaken legal literacy work but on the broader level of general human rights protections in Mozambique and not necessarily specific to issues for key populations.
- As the assessment was being completed, the **International HIV/AIDS Alliance** was beginning to support a new program for legal literacy for key populations. The details of scope and coverage were, however, not yet available.
- **FHI 360** has partnered with smaller national civil society organizations, some of which are key-population-led, such as **Tyiane Vavassate** (female sex workers), or community specific such as **ACAM** (working with people who inject drugs and orphans and other vulnerable children in Mafalala). The approach is comprehensive and includes a component on legal literacy and improving linkages with a range of service providers including legal and social services.

There are some gaps to address, however, in order to make these efforts more comprehensive and effective:

- It was not clear from the assessment how legal literacy training for key populations had incorporated changes in the Penal Code and what additional legal and human rights these entailed for these groups.
- There appeared to be no standard minimum content for legal literacy interventions.
- There appeared to be insufficient patients' rights efforts.
- There have been no evaluations of activities to determine which approaches are more effective and, whether such training results in more people living with HIV or individuals from other key populations organizing and mobilizing around their rights, and feeling empowered to find redress.

A more comprehensive approach to improving legal literacy amongst people living with HIV and other key populations should include the following:

- Develop patient rights materials for posting and distribution in communities and at health centers**.** Such material should be developed in a way to reach both literate and illiterate clients, explain what they have a right to expect from health care providers, explain their responsibilities as patients and provide a link to a complaints mechanism. Different materials will need be developed for women in prenatal/maternity settings.
- Select, train and support peer human rights educators among people living with HIV and other key and vulnerable populations. Building on existing work, networks should be supported to build a cadre of peer human rights/legal literacy educators to assess and

improve existing materials, tailor them to the needs and realities of the particular population and roll them out in communities. This would include support to key populations which do not benefit from any legal literacy, such as transgender people and people who inject drugs. A coordinated strategy should be developed among networks and key-population-led organizations to ensure comprehensive coverage of such materials across all of the populations that need them. The objectives of such training are to empower individuals and groups, lead to mobilization and advocacy around specific needs, and increase access to justice.

- Integrate human rights/legal literacy competency into GAACs. CNCS and RENSIDA should strengthen the capacity of GAACs to support their members to improve knowledge and understanding of their HIV-related legal and human rights. GAACs already include a component of legal and human rights literacy in their content and structure. A standard approach should be developed that includes a strong focus on non-discrimination and inclusion within GAACs themselves as well as consistent information on the law and policy context for the protection and promotion of human rights for PLHIV and all other key and vulnerable populations.
- Build community safety and rapid response systems. Key and vulnerable populations that are faced with violence and other forms of abuse should be supported to create community safety systems that allow them to avoid violence where possible and/or reduce its harmful effects. For key populations facing violence from the community or from police in the form of illegal police practices (harassment, extortion, arbitrary arrest, assault, rape), this might take the forms of simple know your rights and laws brochure, telephone contact systems for emergency assistance, links to paralegals, friendly police and psychosocial support. For women facing intimate partner violence, this might involve information on ongoing progams and shelters being placed in health centers addressing TB, HIV, antenatal and maternal and child health.

HIV-related legal services

Only one organisation was identified by the assessment that specifically provides human rights-related legal services, including some cases related to HIV and key populations.

- **Liga dos Direitos Humanos** monitors human rights in the country, advocates for change and provides legal services. It offers legal services, including mediation and representation, to key population constituencies. It has uncovered, for example, cases of children procured for men in jails, and of sexual violence and abuse in the women's prisons by guards, or coerced sex in exchange for food. It reports on these cases to the media and brings them to the attention of the relevant authorities including Parliament. It also uses the evidence it has collected to advocate for improvements in the laws and to strengthen law enforcement. It has not yet taken up any cases specifically addressing access to HIV services for key populations. Also, at the time the assessment was conducted, the organisation was struggling to continue operating as it had lost a substantial amount of its funding.

The fact that there are no other legal services available to people living with HIV and other key and vulnerable populations is a significant gap for the country, particularly for women who face gender-based violence and for men who have sex with men, transgender people, sex workers and people who use drugs who experience abuse and violence at the hands of the

community or the police. A more comprehensive approach to the provision of HIV-related legal services in Mozambique should therefore include:

- Select, train and support peer paralegals**.** Support should be given to key population-led organizations and networks, as well as to those with paralegal expertise to develop a cadre of peer paralegals to provide legal support to their respective constituencies. Organisations that provide these services currently operate mainly in Maputo. There is need to extend such services to people living with HIV and other key population constituencies across other regions of the country using also other mechanisms such as 'virtual' strategies for rapid response and the provision of legal advice.
- Train and support traditional, community and religious leaders to provide dispute resolution and redress from discrimination, violence, harmful gender norms, and other human rights-violations. For many, it is easier and more culturally appropriate to turn to such leaders in the community. In districts hardest hit by HIV and TB these community leaders should be recruited and trained to understand HIV and TB related discrimination and other human rights issues and to assist in resolving disputes and addressing discrimination.
- Develop access to a network of *pro bono* or low cost lawyers with knowledge and commitment to respond to the legal needs of people living with HIV and other key populations. Current efforts should be strengthened and expanded with regular opportunities for peer-to-peer exchange to build knowledge and skills and to discuss joint strategies. The network should be developed to ensure that technical competencies exist to address all key population needs, including for people who inject drugs and prisoners.

Monitoring and reforming laws, regulations and policies

At the time of the assessment, the **Ministry of Justice**, was drafting the *2nd National Action Plan for the Implementation of the UPR Recommendations, 2018-2020* which included a section on addressing stigma and discrimination against people living with HIV, but it was not clear if it would extend to other areas of concern for other key populations highlighted under the Universal Periodic Review (UPR) process. Also, at the time of the assessment, **UNDP** was in the early stages of preparing a Legal Environmental Assessment. Aside from these two items, no other activities were identified. A more comprehensive approach to policy and law monitoring and reform should include the following:

- Support participation in and follow up to the UNDP Legal Environment Assessment**.** Support should be given to follow up from the results of the LEA by determining which policies, regulations and laws, as well as areas of law enforcement, are of high priority in terms of acting as barriers to HIV services and can realistically be changed and improved. Strengthening the scope enforcement of anti-discrimination protections, as well as hate crimes and protections from violence should be considered to benefit women, sex workers, men who have sex with men, transgender people, people who use drugs and the disabled.
- Develop and implement a multi-year plan for the introduction of comprehensive harm reduction interventions for people who inject drugs, including those in prison. While activities to strengthen commitment across sectors to harm reduction interventions are included under other programme areas, an over-arching strategy is needed to address all

issues in a comprehensive and coordinated manner. CNCS, representatives of people who inject drugs and technical partners should take the lead on this work.

- Advocate for and implement changes to the justice system that reduce pre-trial and pre-sentencing detention as well as provide for diversion and other forms of sanction for nonviolence offenders to relieve overcrowding in prison facilities. Overcrowding and substandard conditions are major vulnerabilities to HIV and TB infection inside prison as wells as in the wider community as prisoners are released. The Ministry of Justice is putting in place district tribunals as one way to address this, and this work should be expedited. CNCS and technical partners should work with Ministry of Justice to expedite agreed upon changes and explore additional policies.
- Develop, implement and monitor a strong health policy and programme for inmates that addresses current gaps, including HIV, TB prevention and treatment and harm reduction, as well as protection from discrimination and violence. The assessment identified the need for stronger interventions to address stigma and discrimination (for both inmates and prisons staff), to improve prevention interventions (particularly consistent availability of condoms and lubricants and to provide harm reduction services), and to ensure that there are no service interruptions for prisoners on HIV or TB treatment, including those on temporary remand or being held in police cells. CNCS and technical partners should support SERNAP and MISAU to jointly develop and implement these programs.
- Monitor the human rights of people living with HIV and other key populations, for example, by the National Human Rights Council and the Liga dos Direitos Humanos. Support should be given to train and ensure integration of HIV and TB-related human rights issues and monitoring into the more general human rights work of these two bodies.

Addressing gender inequality in the context of HIV, including gender based violence

Within its national HIV response, Mozambique is currently mounting a comprehensive response to gender inequality and gender-based violence, with the specific focus being adolescent girls and young women. The country is contributing its own resources to support this as well as receiving significant investments through the DREAMS initiative, the Global Fund, UN agencies and other technical partners. Mapping the entirety of this response was beyond the scope of the assessment. Through key informant interviews and the desk review, some other important efforts were identified:

- **N'weti** has been using social media to increase knowledge of health and rights in Mozambique for over 10 years. They have been active in challenging gender-based violence and harmful social norms, and linking this to strengthening health policies to reduce human rights-related barriers. They are also involved in health budget monitoring to determine how resources are allocated against existing gender-related policy, plans, and commitments. At the time of the assessment, it had projects operating in Nampula, Sofala, Maputo, Gaza, Cabo Delgado, and Niassa provinces.
- **MMAS** is working closely with **USAID** and **UNICEF** to develop and strengthen its child protection systems, including work to provide social safety nets for vulnerable children

and to prevent their becoming sexual exploited, coming into conflict with the law, or becoming street-involved.

- The country has been establishing **Integrated Assistance Centres** with support from donors and technical partners to address gender-based violence and women and children's health more generally, including access to HIV services. These are meant to be integrated service centres for women and children and include health and social services as well as links to police and legal services. Particularly for gender-based violence, they are linked with victim support units in police stations.

The following activities describe a more comprehensive approach to addressing human rights issues for women and girls, in the context of HIV and more broadly:

- Expand the number Integrated Assistance Centres and broaden their scope to members of key populations who also experience physical and sexual violence. This model is considered by country stakeholders to be a best practice for Mozambique and can be strengthened to ensure that its programmes and services are relevant to all populations.

- Develop and implement comprehensive approaches to addressing violence within key population programmes**.** In addition to the action above, key population-led civil society organizations and other partners doing programming for these groups should ensure that addressing violence is part of a comprehensive package of services. PEPFAR, through the global LINKAGES initiative, has developed suitable models that can be adapted for Mozambique (LINKAGES, 2016).
- Expand selection criteria for HIV and social protection schemes for adolescent girls and young women to ensure that are fully inclusive of adolescent girls who are sexually exploited, and for young female sex workers. This must be part of a comprehensive approach to mitigate poverty as a driver of transactional sex and sex work, as well as poverty as a barrier to access to HIV and other sexual and reproductive health services. In many cases, these young women also have children who should be fully included in social protection measures for other vulnerable children with appropriate measures in place to prevent stigma and discrimination against them. CNCS should work with relevant partners to carry this effort forward.
- Integrate rights and legal literacy and paralegal support into ongoing programs for adolescent girls and young women**.** There are a number of initiatives in Mozambique that utilize mentor and community-based support for adolescent girls and young women. Support should be given to ensure that these programs include rights and legal literacy, as well as patients' rights for these young people and provide for peer paralegals to help them address HIV and TB-related stigma and discrimination, property-grabbing, denial of health care and violence.

Funding for interventions to address barriers

Available sources on funding for human rights interventions show that investment is low in Mozambique. Results from the National AIDS Spending Assessment (NASA) for 2014 were released in 2016 (CNCS, 2016). They showed that in 2014 there was a total expenditure of US$3.5 million on programmes for key populations, with the largest proportion (US$2.86

million) addressed towards prevention programmes for female sex workers and their clients. In addition, there was a small expenditure of US$170,804 directly related to human rights programming. Sources of these funds is shown in **Table 2**, below.

Table 2: Sources of funds for human rights expenditures

Funding source/institution	US$
Central / National State budget	**56,808**
Other bilateral	**6,083**
Governo da Suiça	*6,083*
All other international	**107,913**
Oxfam Novib (African Transformation)	*58,720*
Namati Internacional	*47,506*
OSISA - Open Society Initiative for Southen Africa	*1,349*
Afrikagrupperna	*338*
Grand Total	**170,804**

What was not detailed in the analysis was how the funds were allocated amongst implementers and human rights programme areas. It was notable, however, that approximately 30% (US$56,808) of the funds were identified as coming from Government sources.

Funding data collected during the assessment showed a greater investment in human rights programming for 2016, most of which came from the United States Government (USG) or through the Global Fund. **Table 3**, below, shows the funding by programme area and source.

Table 3: Funding by programme area and source for 2016 (US$)

Programme Area	DFID	UN	USG	Global Fund	Total
Stigma and discrimination reduction	169 466	281 893	0	54,000	505,359
Training of health care workers on human rights and medical ethics			235,235	0	235,235
Sensitisation of law and justice sector			39,628	0	39,628
Legal literacy			0	15,000	0
HIV-related legal services			0	0	0
Monitoring/reforming laws/policies			0	0	0
Reducing HIV-related discrimination against women			0	0	0
				Total	**780,222**

For those implementers that provided information for the financing component of the baseline assessment, in 2016, most funds were directed towards training of health workers on human rights and medical ethics (PA2) and legal literacy (PA4). Under the 2015-2017 Global Fund grant, some funds were allocated to address human rights related concerns for key populations but without specific details. These are shown in **Table 4**, below.

Table 4: Allocation for human rights related concerns for key populations **under Global Fund 2015-2017 (US$)**

Programme area	Activities	2015	2016	2017
Prevention programs for sex workers and their clients	Training and payment of activists*	$232,130	$184,048	$92,204
	Other sundry amounts	$1,310		
Prevention programs for men who have sex with men and transgender people	Training and payment of activists*	$136,938	$113,758	$56,879
TOTAL		**$370,378**	**$298,166**	**$149,083**

*The term 'activists' was not defined in the documentation.

Human rights-related interventions may be captured under other program areas within the Global Fund grant but not specifically identified. This observation also applies to PEPFAR investments for key populations over this same period that, although substantial at over US$4 million, do not identify any specific human rights related components (PEPFAR, 2017). In general, however, across all periods, investments in human rights programming are limited, and there is some distance to go to reach an adequate level at which a more comprehensive approach to addressing and removing barriers will be both successful and sustainable. The level of funding needed is discussed in **Section 6**, below.

Opportunities for scaling-up interventions

Should sufficient investments be made, the expanded content in the PEN IV on human rights and gender-related priorities in the context of HIV offers the opportunity for all stakeholders to increase their engagement on these issues and to expand their collective efforts to address them. As the country moves towards to a more comprehensive approach, the following items should be taken into account:

- Addressing critical evidence gaps for specific populations (transgender, for example) and for trends in uptake and retention in HIV services by key population groups
- Strengthening the accountability of the CNCS to facilitate and ensure inter-ministerial and multi-sectoral collaboration and commitment to the human-rights-based, public health approach to the provision of HIV services for key populations as it is stated in the PEN IV
- Placing a strong emphasis on the need for key populations-led civil society organizations to collaborate and to consolidate human-rights-related programming for greater coverage and accessibility, and for greater impact to remove barriers
- Highlighting the need for longer-term planning and well-coordinated, multi-year actions to bring about sustained change in knowledge, attitudes, perceptions and practices regarding key populations
- Placing a strong emphasis on evaluation, learning and continuous improvement for the design and delivery of interventions to remove barriers; and
- Making the case for sustained investment of needed technical and financial resources to ensure that the approach can be fully implemented.

These recommendations are meant to address these items:

- Technical partners should strengthen the role and improve the accountability of CNCS to lead multi-sectoral approaches for the reduction of human rights-related barriers to HIV services**.** The implementation of a comprehensive approach to address and remove human rights and gender-related barriers to HIV services will require effective leadership and coordination. Technical partners such as UNAIDS and UNDP can collaborate with CNCS to ensure that it has the technical and operational capacity to provide this leadership.
- CNCS, technical partners, key population-led CSOs and others should urgently address gaps in data/evidence on access, uptake and retention in HIV services by population group. The assessment has identified these gaps: current data on uptake of HIV services by men who have sex with men, female sex workers, people who inject drugs, transgender and people with disabilities. They should be addressed through collaborative approaches that combine more complex studies such as IBBS surveys with rapid situational assessments. In all cases, members of the groups to be studied/assessed should be involved in all stages of design and implementation.
- All stakeholders should work with technical partners and funders to routinely evaluate interventions addressing human rights-related barriers, focussing on effects on uptake and retention in HIV services. A national consultation should be convened to identify a group of 'core' or priority human rights-related interventions to evaluate leading to the identification of suitable methodologies and a one-year action plan for undertaking the evaluations. Based on the findings, key-population-led civil society organizations and other stakeholders should work together to launch a continuous learning and quality improvement process, including embedding routine evaluation in all further work to address human rights and gender-related barriers.

V. Findings for 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 Mozambique, 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, followed by a description of a comprehensive approach; and finally, an analysis of opportunities for scaling-up current efforts over a five-year period.

Overall, TB remains a significant health concern for the country with Mozambique continuing to rank amongst the three highest TB burden countries in Southern Africa. There is a significant overlap in the TB and HIV epidemics, meaning that a number of human rights and gender-related barriers identified under HIV also apply in the context of TB. Understanding of human rights and gender equality-related barriers in the context of TB is low amongst most stakeholders limiting how barriers to TB services are understood and addressed. The assessment found that: (a) TB-related stigma and discrimination is present in communities and negatively influences health-seeking behaviour; (b) there is a lack of compliance with workplace health and safety standards placing health care workers and others at high risk of TB; (c) severe overcrowding and poor standards of hygiene and nutrition fuel TB transmission in prisons; and (d) there are on-going cross-border issues regarding the legal entitlements of migrant miners who contract TB leading to avoidance of seeking TB treatment in workplaces for fear of discrimination and job loss. In response to these challenges, there are some efforts underway to address them; however, most are small in scale or address human rights or gender concerns in the context of TB only in a peripheral sense. More detail on these issues is provided in the following sections.

Overview of epidemiological context

In the World TB Report 2017, WHO estimated an incidence rate of 551 new TB cases per 100,000 members of the population. Also according to WHO estimates, in 2016, 44% (284/550) of new TB infections were among people living with HIV (WHO, 2017). Mozambique is among the three African countries (including South Africa and Lesotho) with the highest TB incidence rates worldwide at >500 per 100,000 (WHO, 2017). Intensified efforts are needed to control the co-epidemics of HIV and TB in Mozambique

There are limited data describing TB prevalence and TB mortality in Mozambique. There is no national level vital registration system to provide data on mortality attributable to TB and/or HIV. MISAU is preparing to conduct a national TB prevalence survey in 2018, with results expected to be available in 2019. In 2017, WHO Global Tuberculosis Report indicated a national total of 71 842 new and relapsed TB cases, or 47% % of the 154,000 new TB cases estimated by WHO. The greatest gap was among new TB cases in adults, with an estimated 82,000 adult TB cases not identified.

There is evidence of a high burden of TB and lower TB case detection rates among children younger than 3 years (Lopez-Varela, 2015). In 2015, the NTP revised TB surveillance forms to disaggregate data by sex and age, allowing for improved monitoring in the future of trends

in TB by sex and in children under 5. The upcoming TB prevalence survey will also provide more detailed information regarding TB distribution by age, sex, and location. There is an expectation that the situation in Mozambique will be similar to other countries in the southern African region where there is both a higher burden of disease and a greater detection gap among males, indicating a need to improve men's access to TB diagnostic and treatment services (WHO, 2016).

In the absence of more current information on TB prevalence, some limited information is available from older sources on TB trends amongst the groups included in this assessment (there is no information available for people who inject drugs):

- **Miners:** Miners comprise near 70,000 workers who migrate annually to South Africa's mining industries, with 35,000 formally registered and recognized as working there, while a similar number is estimated to be working informally (Barwise et al., 2013). The incidence of TB among this population has been estimated at 4-5% per year (Stuckler et al., 2011). Mozambican miners returning home with TB are frequently diagnosed in Gaza Province, which also has one of the highest HIV prevalence rates.
- **Prisoners:** The 2013 assessment survey indicated that 966 prisoners out of a prison population of 58,175 (1.5%) were diagnosed and reported with TB (SERNAP, 2013). This amounted to a notification rate of 1,665/100,000, or more than eight times greater than the general population. TB in prisons is detected by screening on entry and through passive case finding among resident prisoners. In 2014, among 13,000 inmates who had previously received information and education about TB, 5,275 presented with presumptive TB and 667 (12.6%) of them were diagnosed with TB (all forms), corresponding to a notification rate of 5,130/100,000 or 22 times higher than the national rate for that period (NTP programme data 2014).
- **Health workers** are at increased risk of TB infection due to workplace exposure (Bella and Naidoo, 2017). Infrastructure often does not meet the minimum standards for effective infection control measures, while simple administrative interventions for TB infection control are not implemented or adhered to (Brower et al., 2014). According to NTP data, the number of notified TB cases amongst health care workers increased from 144 in 2013 to 182 in 2014 (a notification rate of 461/100,000 and an estimated 39,700 health care workers nationally). While the increase is partly due to increased screening efforts, it likely remains a significant underestimation of the real disease burden as the number of health care workers screened represented only 9% of the total group.

Despite the limitations of the age and comprehensiveness of available data, there is enough evidence to show that these populations bear the highest burden of TB disease. What is known about their access and uptake of TB services is discussed in the next section.

Trends in service update for TB and TB/HIV services

Disaggregated data on service uptake for key and vulnerable populations for TB in Mozambique are not currently available. In 2015, the country had an overall treatment success rate of 88%, including for TB-HIV co-infected individuals (WHO, 2017). The NTP has also achieved high coverage of HIV services in TB clinics: in 2015, 95% of registered TB patients knew their HIV status (above the WHO target of ≥90%) and 92% of TB patients living

with HIV were initiated on ART (Manhica, 2017). Data on TB screening for people living with HIV were not available.

There have been recent efforts to expand TB screening, diagnosis, and treatment for vulnerable populations (Manhica, 2017). The NTP has established a Prison Health Technical Working Group and periodic screening of TB in prisons has been conducted. TB screening for health workers has also expanded. The NTP has also adapted TB registers to collect information on occupation in order to improve surveillance and document services provided to health workers, miners, and former miners. Until such data are available, however, it will be difficult to measure the extent of human rights barriers as well as progress made under interventions to address and remove the barriers.

Law and policy context for TB-related human rights

The legal context of the national TB response in Mozambique does not differ substantially from that governing the national HIV response, and the rights to health and health care more generally. It is worth noting that, specifically for the mining sector, Mozambique is a signatory to the SADC *Declaration on Tuberculosis in the Mining Sector* and the *Code of Conduct on Tuberculosis in the Mining Sector*.

The overarching policy context for the national TB response is set by the *Programa Nacional de Controlo da Tuberculose. Plano Estrategico e Operacional 2014 – 2018* (MISAU 2014). It contains some elements that address human rights related concerns for TB. It takes a 'rights and responsibilities' approach to people living with TB, meaning that they should be free of stigma and discrimination but also have responsibility for ensuring that others around them are not infected with TB. In this latest strategic approach, there is more emphasis on social and economic protection for TB-affected individuals and families as well as the determinants of TB risk, which include poverty, food insecurity and harmful working conditions, among others. There is also a stronger emphasis on addressing TB in closed settings, particularly prisons and across the mining sector.

Factors in the broader health system environment that affect HIV programmes also affect those for TB. These were discussed in **Section 4.3**, above.

Human rights and gender-related barriers to TB services

Introduction

As a general finding, there was much less information, as well as awareness and discussion, regarding human rights or gender-related considerations in the context of TB in Mozambique as compared to HIV. The TB-specific barriers that were identified by the assessment included stigma around the disease in personal and community environments, largely due to lack of sufficient and accurate knowledge about TB and, as a result, the prevalence of negative cultural meanings. These cause individuals to hide their diagnosis or to deny their symptoms and to delay seeking services. The provision of TB services in prisons encounters many of the same challenges as for HIV with the added dimension that overcrowding and constant turnover of detainees results in very high risk of TB exposure as well as barriers to diagnosis and treatment.

Due to health system weaknesses, infection control standards in health facilities are not adhered to, and there are almost no opportunities for health care workers to seek compensation or redress if infected by TB on the job. Many Mozambican men work as migrant miners in South Africa, and when they acquire TB, avoid seeking treatment for fear of losing their employment and being returned to Mozambique because they are deemed unfit for work. Finally, as with HIV, poverty limits access to TB services for reasons of distance to places where TB services are available as well as practices regarding additional payments for health care services. More detailed descriptions of these barriers are set out in the sections below.

Stigma and discrimination

Mozambique conducted a TB-related knowledge, attitudes, and practices (KAP) study in three provinces in 2013 (FHI360-TB Care, 2013). It identified that TB-related stigma and discrimination were present in Mozambique, particularly at community level. Stigma and discrimination were more prevalent in areas where individual and community knowledge about TB disease was low, and popular misconceptions about TB were strong. These latter included that TB was in some senses disease involving "immorality" and that it was linked with HIV infection and the stronger, negative implications this carried.

Self-stigma was also prevalent whereby individuals were reluctant to acknowledge the signs and symptoms of TB, and subsequently delayed seeking treatment, for fear of negative consequences should their diagnosis be discovered by others. Fear of stigma and discrimination was also a factor hindering men from accessing TB services, since the disease was linked to weakness and negative cultural connotations about masculinity. Finally, the study also noted that fears of poor service, or of treatment not being available, also hindered access, leading many individuals to delay seeking medical care and to prefer instead their traditional health practitioners (FHI360-TB Care, 2013).

With regard to stigma and discrimination in health care settings, the NTP has developed TB and MDR-TB guidelines that include components regarding human rights and ethics for TB patients. With support from partners, health care workers are trained to apply the guidelines in their work with TB patients. However, according the NTP, funds are not always available to conduct planned trainings (KII NTP, March 2017). There are also no mechanisms in place to monitor the provision of TB services from the point of view of human rights and ethics.

It has been documented among miners across the SADC region that individuals often hide their TB diagnosis, or are reluctant to seek care in their workplaces, for fear of negative consequences, particularly job loss. Such trends have also been found amongst Mozambican miners. In addition, for migrant miners working in South Africa, fear of poor treatment, largely arising from xenophobia, have meant that TB-infected individuals may delay diagnosis and treatment until they are able to return to their home communities in Mozambique (Mogeni, 2015; Barwise et al., 2013).

There was some evidence to suggest that TB-related stigma and discrimination are also prevalent within prisons in Mozambique. An assessment conducted in 2013 showed high levels of knowledge about TB disease, including modes of transmission amongst both inmates and prisons staff (SERNAP, 2013). However, key informants suggested that self-stigma may be involved when a prisoner does not disclose his or her TB status on entering prison for fear

of negative consequences (KII SERNAP, April 2017). Some informants suggested that TB-related stigma was stronger than HIV-related stigma in prison settings, largely due to increased knowledge regarding HIV and the presence of more services and activities related to HIV.

Harmful laws, policies and practices

The assessment identified the following issues related to laws and policies in Mozambique that limit access to, and uptake of, TB services. A high proportion of detainees in Mozambican prisons is on remand and is incarcerated for short periods of time (Lorizzo, 2017). Some of these individuals experience treatment interruptions as health services for TB (as well as for other illnesses) are not readily available, not just for this transient population but for inmates more generally (SERNAP, 2013; KII SERNAP, April 2017). The large population of inmates on remand has contributed to significant overcrowding in some prisons. Machava prison, for instance, was built for 800 prisoners but, at the time of the assessment, there were 3,400 prisoners staying in 10 sleeping blocks, putting their health at risk, particularly regarding TB and other airborne diseases (KII Machava Prison, April 2017).

Although there is provision in the new Penal Code to provide alternatives to incarceration and to limit the number of individuals held on remand, these have not yet been fully implemented (SERNAP, 2016). Similar to the HIV context, where prison health services are not available, inmates are taken to local hospitals for treatment, usually shackled, which exposes them to harsh treatment from hospital staff and from other patients who are disturbed by their presence (KII SERNAP, April 2017; SERNAP, 2016). It also clearly limits privacy and confidentiality of medical treatment for these inmates since a guard must be present at all times.

Gender considerations

As described in sections above, there is a significant gender dimension to the burden of TB in Mozambique, as well as for access and uptake of TB services. TB incidence is highest amongst males in the country. This fact is in part driven by the high burden of disease amongst miners and male inmates. A further analysis of gender considerations was not possible during the assessment since, as noted above, the NTP has only recently adjusted its data collection tools to more fully capture disaggregated data related to age and sex.

Another gender consideration may relate to the estimated under-representation of children, particularly very young children <3 years of age, in the diagnosis and treatment of TB. Given that children's access to health services is dependent on parents and that traditionally the mother is responsible for the health needs of children, women's access to health services overall will influence this trend. As noted in **Section 4.4.4**, above, it has been documented in numerous sources in Mozambique that women's autonomy for decision-making around health and health care access is limited by traditional cultural norms that give such decision-making power to men.

Finally, there are considerations related to the spouses and female companions of miners. Amongst this group it has been shown that information about TB and TB risk is lacking and that there is low perception of the risk of TB infection from their male partners. While programmes and services are provided for miners themselves, these do not always reach their spouses or companions in communities (Barwise et al., 2013).

It should be noted that often in TB, the TB incidence rate is higher among men compared to women, but the diagnosis and access to treatment of men is lower due to differences in health seeking behaviours. Also stigma and discrimination attached to TB status often affects women more severely than men. It was not possible to explore these potential aspects of the TB situation in Mozambique.

Poverty and socio-economic inequality

TB incidence and notification rates have been linked to areas of the country where there are similar high burdens of HIV and to areas where there is high migration of mineworkers. However a similar effort has not yet been undertaken to link TB to areas or regions of the country based on issues of poverty or socio-economic inequality. It is expected that the TB prevalence survey will assist in this regard.

The KAP study found that perceptions regarding the length and expense of TB treatment were a barrier to seeking TB care in local health facilities (FHI360-TB Care, 2013). Distance to health facilities, and the cost of transport, as well as long waiting times and the opportunity cost associated with this, were also identified as issues hindering access to TB care.

Harmful working conditions and exploitation

Prisoners, prison workers, health care workers and miners are all at elevated risk of TB infection because of unsafe working conditions. Mozambique has laws and policies related to workplace health and safety. Equally, the South African mines, where Mozambican miners work, are governed by similar laws and policies in South Africa. However these laws and policies are inadequately implemented and enforced (Mogeni, 2015).

Although SERNAP acknowledges that severe overcrowding is a main driver of TB for both inmates and staff in prisons, it lacks sufficient resources to address this issue through capital development. Similarly, the Ministry of Justice lacks sufficient resources to fully implement reforms aimed at limiting the numbers of individuals held on remand (SERNAP, 2016).

With regard to health care settings, health care infrastructure is inadequate to meet even minimal standards of infection control; and workplace measures, such as the '3Is', are not consistently followed. One example of this is the irregular supplies of masks and other protective devices for both TB patients and health care workers (Brauwer et al., 2016).

TB infection is also driven by poor conditions of work for miners as well as inadequate access to health services and programmes for contract workers. A World Bank assessment has shown that in Mozambique, as in other countries sending mine workers to South African gold mines, prolonged exposure to silica dust in mine shafts without adequate protective equipment; poor access to routine health services, particularly among contract workers; accommodation in overcrowded hostels; and, circular migration between communities and mine locations increases the risk of TB transmission, treatment interruption and treatment failure (Mogeni, 2015).

Efforts to address and remove barriers

Overview

The assessment identified some interventions addressing human rights and gender-related barriers to TB services, either directly or as part of more comprehensive approaches to community participation and engagement in TB prevention and care. No data were available on funding for these activities. TB continued to be perceived largely as a public health challenge to be addressed by stronger service provision, through case detection and treatment, for example. There was very little attention paid to the importance of community interventions to mobilize and empower at-risk groups and to address human rights or gender-related barriers. The sections that follow describe current efforts as well as a more comprehensive approach to addressing and removing human rights-related barriers to TB services. In addition, **Annex B** lists the specific activities that will be required.

Reducing stigma and discrimination

Current efforts to address TB-related stigma and discrimination use integrated approaches. The **NTP**, for example, has issued guidelines and tools for advocacy, communication and social mobilisation activities, as well as for community participation in DOTS, both of which have components addressing community-level stigma regarding TB.

In addition to the NTP, a number of partners include activities or interventions to address TB-related stigma and discrimination in broader work for community mobilisation and community engagement in TB prevention and care. These include:

- **ADPP** which, through its Total Control-TB (TC-TB) project, funded under a USAID-supported TB Challenge Grant until 2014, mobilised teachers and students to improve knowledge and awareness about TB within communities and to assist in finding and referring individuals suspected of TB infection to health facilities. A component of the training addressed TB-related stigma reduction through improving knowledge and awareness about the disease, particularly regarding TB treatment and the fact that it was a curable condition.
- **FHI360** includes community level interventions within its current USAID-supported TB Challenge programme implemented in partnership with KNCV. The package of community interventions includes components to address and reduce community-level stigma and misunderstanding regarding TB disease.

As is evident, interventions to address stigma and discrimination are not countrywide and almost non-existent outside of the NTP training and the FHI360 intervention. A more comprehensive response would involve the following activities:

- Measure TB-related stigma and discrimination. NTP and its partners, including civil society organizations, should continually monitor TB-related stigma at community and health care facility levels and report on the results. The KAP study should be repeated on a routine basis (every 2-3 years) but with more focused attention to the development of a time-bound action plan to address the findings. In addition, more comprehensive

communications strategies should be implemented to more widely share the results of the study and to engage the public in efforts to reduce TB-related misperceptions and stigma.

- Conduct stigma and discrimination reduction campaigns**.** Campaigns to reduce stigma and discrimination-related to TB should be carried out at the national and community levels. Both types of campaigns should dispel myths regarding TB and should explicitly address the harm of TB-related discrimination. Community-level interventions to address TB-related misperceptions should be strengthened and sustained particularly in geographic regions with high TB incidence and amongst key populations for TB. NTP and CSOs should collaborate to increase community-level activities to improve knowledge and awareness regarding TB and to reduce stigma.
- Conduct community interventions to build the resilience of individuals living with TB to resist stigma. Engaging people living with TB in community support groups, particularly GAACs since many will also be PLHIV, is an effective strategy for addressing and resolving self-stigma as well as the negative impacts of community-level stigma. A complementary strategy would involve encouraging individuals successfully treated for TB to share their stories and to ensure that there is broad representation of diversity across the different populations most affected by the disease.

Training of health care workers on human rights and ethics related to TB

In order to improve health care worker competencies and accountabilities for human rights and ethics in the provision of TB services, a more comprehensive approach should include the following:

- Develop/improve curriculum on TB-related human rights and ethics**.** Support should be given to the NTP to develop and update content addressing human rights and ethics in pre-service and in-service guidelines and training for health care workers. The pre-service component is most important as it is an effective way of addressing the challenge of turn-over and rotation of health care workers in facilities who receive such training after they are deployed. This training should include information on the rights of health care workers to safe working places and the knowledge and means to avoid infection.
- Roll out training on human rights and ethics in health care facilities in districts hard hit by TB. Training should be supported for health care workers providing services where TB is prevalent. Such training should be extended to management and administrative staff. Training should be followed up by assessments of impact in terms of changes in attitudes and practices. This could be done in collaboration with civil society organizations working in communities who can monitor the quality of TB services and then work with local facilities to address issues and concerns as they arise.

Sensitization of law-makers and law enforcement agents

No current TB-related interventions were identified by the assessment. To address this gap, the following actions should be included in a comprehensive response:

- Develop and roll out curriculum for police on TB-related human rights. Content related to TB should be developed and integrated within activities to sensitize police on human rights in the context of HIV. Basic TB awareness training should also be provided so that police and other law enforcement agents can understand their role in managing and preventing TB in police holding cells both for themselves and for the individuals they detain. TB

sensitisation training should also address TB treatment, in particularly what the medications look like so that they are not confiscated by police when they arrest and detain individuals.

- Sensitize magistrates on TB-related concerns and human rights. Content related to TB should be developed and included in efforts to increase the capacity of magistrates and others on HIV-related human rights. It should include content on the current challenge of managing TB in prisons so that magistrates and others are aware of the public health implications of pre-trial sentencing and overcrowding.

TB-related rights literacy

The assessment identified no specific interventions on human rights literacy in the context of TB except for the efforts of **Namati** which include TB-related issues in its health advocacy and accountability interventions (Namati, 2016).To address this gap, the following should be included in a comprehensive response:

- Select, train and support peer, as well as traditional, religious and community, educators on TB and human rights. Civil society organizations and networks working with people living with TB should recruit and train peer educators in the communities to address TB-related stigma and discrimination. As there is high-levels of co-infection with HIV, many of the same HIV human rights educators can assist with TB-related rights.
- Develop and disseminate patients' rights materials related to TB. Materials should be developed for patients with TB disease that are accessible to literate and illiterate people and should be distributed and posted in health care facilities dispensing TB treatment. These materials should make it clear what a patient has a right to in terms of treatment, conduct of health care workers, and freedom from discrimination, as well as the nature of the responsibilities of people living with TB.
- Disseminate workplace protections in workplaces with high TB risk. The NTP should collaborate with Ministry of Labour, civil society organizations and others to strengthen knowledge and awareness about laws and policies for workplace health and safety for TB-specific key populations. Health care workers, prison workers, mineworkers and others should be routinely made aware of existing laws and policies for workplace health and safety as well as regarding mechanisms for claiming compensation and for seeking redress for violations of laws and policies.

TB-related legal services

The assessment did not identify any specific interventions for TB-related legal services. However, **Namati** in its broader health advocacy work provides support for TB-related grievances. In addition, the partnership project with **AMIMO, Lawyers for Human Rights (LHR) and International Organisation for Migration (IOM)** provides access to legal services for migrant miners that includes issues related to TB. However, there was low awareness among health care workers and prison workers (as compared to the awareness levels of mineworkers) of the role of advocacy and legal redress to address unsafe working conditions.

- Select, train and support peer paralegals for TB-related legal services. In strengthening and expanding access to legal services for people living with HIV and other key populations, specific components addressing TB-related discrimination should be included. This means that peer paralegals among groups affected by HIV should have TB-

related human rights competency. Similarly where traditional, religious and community leaders are utilized for HIV-related legal support against discrimination and for dispute resolution, TB competency should be included in their training.

- Expand access to paralegals and/or attorneys for workplace protection against TB. Specific TB-related competencies should include addressing workplace discrimination, bringing claims against employers for hazardous working conditions and lack of protective devices, and for ensuring access to compensation and other benefits, including in the event of death.

Monitoring and reforming laws, policies and regulations

- Support monitoring of the Declaration and the Code of Conduct on TB in the Mining Sector. Mozambique participates in SADC fora to monitor implementation of the *Declaration* and adherence to the *Code of Conduct* on TB in the mining sector. Support should be given to this work to ensure it is rigorous, sustained and has results. This might include further support to the partnership project with **AMIMO, LHR and IOM** which monitors improvements in the application of laws and policies for workplace health and safety and conditions of work for migrant miners, including improvements in the accessibility and uptake of TB prevention and treatment interventions. The partnership also monitors access to compensation for workplace related injury and disability, some of which is TB-related.
- Support advocacy and reform of sentencing and incarceration laws, policies and regulations. Support should be given overcoming challenges to the full implementation of reforms regarding on remand and sentencing so at to avoid or reduce any pre-trial and pre-sentencing detention for non-violent offenders and to utilize alternatives to detention where appropriate.

Addressing issues of gender

Interventions in prisons and the mining sector specifically target men with the aim of increasing uptake and retention in TB prevention and treatment programmes. However, the assessment did not identify other interventions addressing other dimensions of gender in the TB context. This gap was largely due to the limited understanding of gender in the context of TB across all stakeholders. However, all interventions f to reduce discrimination against women in the context of HIV described above should have TB-related human rights information and activities integrated into them.

- Conduct a gender assessment of the national TB response**.** Support should be given to undertake a gender assessment of the needs of men and women in the national response to TB. This could be done by the CNCS and the NTP using the UNAID/Stop TB Partnership tool (UNAIDS and Stop TB Partnership, 2016). A multi-year action plan can then be developed to address the results. The results can be joined with the earlier Global Fund-supported country case study on gender and the HIV response conducted by the Technical Evaluation Reference Group (ongoing in 2017). Care should be taken that the human rights-related barriers of all women living with HIV are addressed through activities under the key program areas.

Addressing issues of poverty

The assessment identified no current interventions addressing issues of poverty as barriers to access to and retention in TB services.

- Develop and strengthen social protection interventions to address 'catastrophic' costs of TB illness for the poorest TB-affected households. Temporary financial assistance schemes or practical support interventions are known to improve access and uptake of TB services, particularly with regard to MDR-TB. The NTP, through MISAU and relevant ministries, should develop such schemes.

Programs for people in prisons

SERNAP continues to work with a number of partners to improve health services within prisons. They include **FHI360, Jhpiego, Friends in Global Health** and **Pathfinder**. **Pathfinder,** in addition to its HIV related interventions, supports TB prevention and awareness interventions as a component of their work that has, as one objective, the reduction of TB-related stigma and discrimination in prison settings.

- Expand efforts to reduce TB-related stigma and discrimination to all prisons.
- Support the NTP and its partners to ensure sufficient technical and operational resources for the Prison Health Technical Working Group.

The recommendations regarding prisons under the previous section also apply in the context of TB.

Programs for mineworkers

There are important efforts underway to support the legal and human rights of mineworkers in the context of TB. These include:

- AMIMO undertakes both advocacy and programmatic interventions to support the health and rights of mineworkers, including those currently employed, those that have been retrenched, and their communities and families, especially widows. Their advocacy work includes sensitisation and accountability of employers for fair conditions of work, including health and safety protections. Their programme interventions include income generation and other social protection schemes for retrenched minors and their families. Although not specific to TB, this type of support is available for mineworkers affected by the disease.

- In partnership with the South Africa-based **LHR and IOM**, AMIMO is also participating in a EU-funded initiative to improve the protection and advocacy capacity of migrant mine-workers and their families in Southern Africa, including for Mozambique. The project has three components: institutional capacity-building for AMIMO; facilitating legal services and counselling for mine workers and their families, together with LHR; and, advocacy and communications at the national and regional levels to spur dialogue with stakeholders and inform beneficiaries of their rights.

- Mozambique is a participant in the 10-country **TB in the Mines in Southern Africa (TIMS)** initiative funded under the Global Fund. The components of the project include legal environmental assessments, KAP studies, and mapping of key populations in order

to improve access and uptake of TB services, to reduce TB incidence, and to improve the law and policy environment across the sector, with an emphasis on workplace health and safety, labour rights, and social protection.

To achieve a more comprehensive response, these programmes should be sustained.

Opportunities for scaling-up interventions

Given the large overlap in HIV and TB-affected populations in Mozambique, there are strong opportunities for integration of responses to remove barriers to access to services. For TB-specific approaches to achieve greater comprehensiveness, work needs to be done to improve the technical capacity across all TB stakeholders, in particular the NTP, to understand and act effectively on human rights and gender-related concerns. In addition, stronger collaboration is essential across HIV and TB stakeholders as it is often the same individual facing barriers to either HIV or TB services or both.

- Build the TB-related human rights and gender capacity of the NTP**.** To take things forward, technical partners, including WHO and others, should working with NTP and its partners to increase knowledge and understanding regarding human rights-related components of effective TB programming. Excellent resources are now available through the Global Fund, WHO, Stop TB Partnership and others to guide this work (Global Fund, 2017b; Stop TB Partnership, 2015).

Projection of Funding Needs for Comprehensive Programs to Remove Barriers

The projected funding needs for comprehensive programmes to address human rights and gender-related barriers to HIV and TB services are shown below. The detailed calculations showing how these estimates were derived are included in **Annex C**. **Table 5**, below, shows the projected funding needs for comprehensive programmes to address barriers to HIV services.

Table 5: Estimated funding needs for comprehensive programming for HIV

Programme Area	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
Stigma and discrimination reduction	1 915 774	1 084 163	1 521 775	872 995	1 981 340	**7 376 047**
Training of health care workers	1 348 300	479 901	833 901	137 222	864 398	**3 663 723**
Sensitisation of law-makers and law enforcement agents	450 039	173 240	278 820	291 999	285 164	**1 479 261**
Legal literacy	311 113	50 166	120 012	216 867	120 012	**818 171**
HIV-related legal services	363 681	194 591	333 791	212 525	333 791	**1 438 380**
Monitoring and reforming laws and policies	685 005	842 949	303 409	160 397	371 833	**2 363 593**
Reducing HIV-related discrimination against women	77 601	149 254	-	79 637	58 823	**365 314**

Other activities	95 857	278 768	278 768	182 910	278 768	**1 115 071**
TOTAL	**5 247 371**	**3 253 032**	**3 670 474**	**2 154 554**	**4 294 128**	**18 619 560**

The year-over-year investment needed is significantly greater than the current level of financing, which, as noted above, the assessment found was approximately US$430,000 for 2016 for programmes directly addressing HIV-related human rights barriers. However, the country has allocated approximately US$ 7.4 million in additional resources from the Global Fund for the 2018-2020 period to implement many of the components of the proposed comprehensive approach. This comprises a substantial step towards closing the resource gap and will create needed momentum towards full implementation of the comprehensive approach during the five-year time frame

Table 6 below, shows the projected funding needs for comprehensive programmes to address barriers to TB services.

Table 6: Estimated funding needs for comprehensive programming for TB (US$)

Programme Area	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	***TOTAL***
Stigma and discrimination reduction	771 842	654 896	654 896	654 896	771 842	***3 508 372***
Training of health care workers	12 468			12 468		***24 937***
Sensitisation of law-makers and law enforcement agents	8 320	4 148		8 320	4 148	***24 937***
Legal literacy	32 196	7 515	19 715	15 836	19 715	***94 977***
TB-related legal services	5 000	5 000	5 000	5 000	5 000	***25 000***
Monitoring and reforming laws and policies	42 895	42 895	42 895	42 895	9 150	***180 732***
Addressing issues of gender	192 310		21 091		138 037	***351 438***
Other activities		139 155	43 755	43 755	139 155	***365 821***
TOTAL	**1 065 032**	**853 610**	**787 352**	**783 171**	**1 087 047**	***4 576 213***

As already noted, due to a low response rate for the financial analysis component of the baseline assessment for TB, it was not feasible to calculate a current level of investment in programmes to address human rights or gender-related barriers to TB services. However, given the findings highlighted above regarding gaps in knowledge, awareness or commitment to human rights in the context of TB in the country, this level is likely to be very low. An effort will need to be made then to mobilise the resources needed to implement and sustain the comprehensive approach over the five-year period.

Monitoring Progress

Monitoring progress on the human rights and gender-related dimensions of the HIV and TB responses requires both quantitative and qualitative components. **Annex D** gives a proposed

set of indicators and baselines for measuring the quantitative aspects of progress towards the removal of human rights and gender-related barriers to access and uptake of HIV and TB services.

With regard to the qualitative aspects of subsequent assessments, the following items should be considered:

- A comprehensive desk review to capture new sources on efforts to address human rights and gender-related barriers as well as new sources on on-going challenges for key and vulnerable populations. Particular attention should be paid to capture the results of evaluations and demonstrated best-practice models.
- Key informant interviews and focus group discussions with relevant stakeholders probing:
    - Changes in the overall programme environment and perceptions whether the status of human rights-related barriers has improved or deteriorated;
    - Qualitative data contextualizing changes in levels of service uptake and retention; and,
    - Changes in experiences with the accessibility, quality and acceptability of services provided.

The same conceptual framework used for this baseline assessment should guide data analysis and the development of recommendations.

Limitations

There were some important limitations to the assessment process. For the **desk review component**, data on some key populations, e.g. men who have sex with men and female sex workers, was collected in 2011 and may not reflect current realities given changes in the legal and programmatic context in Mozambique starting from 2015. No comprehensive HIV- or TB-specific information on human rights related barriers was available for transgender individuals, people with disabilities or male sex workers.

With regard to the **fieldwork component**, not all of the voices and experiences of the different sub-groups of key and vulnerable populations in the country who experience human rights-related barriers to services were included despite best efforts to do so. Noted gaps were transgender individuals, men who have sex with men living in rural areas, sexually exploited adolescents, young female sex workers, prisoners themselves, and prison workers outside of Maputo province. They also included people living with TB who are not yet organised in Mozambique as an accessible national constituency.

Costing limitations

The costing component of the baseline assessment was 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 organisations 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 anonymised at the implementer level.
- Some organisations 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.

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 Mozambique. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in the coming months in order to share a summary of the assessment results for consideration and discussion towards using existing opportunities to include and expand programs to remove barriers to services. In the case of Mozambique, for HIV this will involve rationalization of the recommendations in this document with the human rights programs set forth in the allocation and matching fund application. In these terms, 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 a fully comprehensive approach, as detailed 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 base regarding programmes to reduce barriers to HIV and TB services, the Global Fund will commission follow-up studies at mid- and end-points of its 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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Annex A: Recommended Comprehensive Programs to Reduce Human Rights and Gender-related Barriers to HIV services

Ref	Programme Area	Ref	Activity	Location/coverage	Main Implementers	Cost (US$)
1	Stigma and discrimination reduction	1.1	Undertake PLHIV stigma index--survey and develop action plans to address results.	National survey in Year 1 and Year 5.	CNCS and RENSIDA	721 233
		1.2	Develop multi-year action plan for KP networks to coordinate activities	Country-wide. Action plan in Year 1, follow-up in Year 3 and 5	CNCS, LAMBDA and partner networks	133 459
		1.3	Conduct assessment of GAACs for inclusiveness and develop action plan to address results.	Country-wide. Assessment and action plan in Year 2	CNCS, RENSIDA, LAMDDA and other KP networks	90 872
		1.4	Deploy PLHIV/KP peer educators outside of Maputo	5 per district	RENSIDA, LAMDDA and other KP networks	3 543 750
		1.5	Community dialogues for PLHIV and key populations	2 dialogues per 90 districts	CNCS, RENSIDA, LAMBDA and other KP networks	178 200
		1.6	Media campaigns on HIV and human rights for PLHIV and key populations	Provincial and national campaigns in Years 1,3 and 5.	CNCS, RENSIDA, LAMBDA and other KP networks	1 364 786
		1.7	Integration of stigma reduction/human rights components in to school SRHR programmes	Curriculum change in Year 1. Follow-up and revision in Year 4.	MISAU	13 640
		1.8	Deployment of PLHIV/KPs in ART centres	30 PLHIVs/KPs country-wide in prioritised ART centres. Included under 1.4.	MISAU, RENSIDA, LAMBDA and other KP networks	-
		1.9	Support PLHIV/KPs as spokespersons/role models	10 country-wide. Selection/location to be made by RENSIDA, LAMBDA and other KP networks. Included under 1.4.	RENSIDA, LAMBDA and other KP networks	-
		1.10	Programme management support	22% of activity cost.		1 330 107
			SUB-TOTAL			**7 376 047**
2	Training of health care workers	2.1	Training and follow-up on KP guidelines	Country-wide. 500 health care workers as TOTs, mentors in Year 1, 3 and 5	MISAU and KP networks	912 785
		2.2	Reinforce of ethics/human rights components of training curricula (pre-service)	Curriculum change in Year 1. Follow-up and revision in Year 4.	MISAU	24 500
		2.3	Training/retraining on medical ethics/human rights (in-service)	TOT approach. 20 per province in Year 1, 3 and 5	MISAU	912 785
		2.4	Revision and dissemination of patient charter	Country-wide. Revision and dissemination of charter. Training for health advocates on mobilisation and	MISAU, NAMATI	447 290

				dissemination. Community sensitisation sessions.		
		2.5	Community meetings with KPs and health facilities	Country-wide. 10 sessions per province in Years 1-3.	LAMBDA and other KP networks	133 650
		2.6	Train CSOs on medical ethics/human rights	Provincial workshops in 5 priorityprovinces Year 1 and Year 3.	NAMATI	380 327
		2.7	Evaluation of changes in attitudes/quality of service (baseline & follow-up)	Country-wide baseline in Year 1, follow-up in Year 4.	CNCS, LAMBDA and other KP networks	191 715
		2.8	Programme management support	22% of activity cost.		660 671
			SUB-TOTAL			**3 663 723**
3	Sensitisation of law-makers and law enforcement agents	3.1	Evaluation/KAP study on HIV, human rights, key populations (baseline and follow-up)	Country-wide. Follow-up assessment in Year 4.	CNCS, MOJ	191 715
		3.2	Develop revised strategy/approach for training/sensitisation for police.		CNCS, MOJ	88 973
		3.3	Continuing education seminars for police supervisors on human rights	50 supervisors per year in 1 day sessions.	CNCS, MOJ	495 000
		3.4	Update police training curricula-programme development		CNCS, MOJ	25 600
		3.5	Update training curricula for judicial officers/magistrates and produce training materials.		CNCS, MOJ	22 600
		3.5	Training for prisons (management and staff) on HIV/TB human rights	10 staff as TOT for 16 prisons. Year 1, 3 and 5.	SERNAP	331 922
		3.6	Community dialogues with police and KPs	10 sessions per province.	CNCS, LAMBDA and other KP networks	56 700
		3.7	Programme management support	22% of activity cost.		266 752
			SUB-TOTAL			**1 479 261**
4	Legal literacy	4.1	Support PLHIV networks to develop and distribute simplified language materials, with images on relevant policies, regulation, laws and rights-materials development	Country-wide. Development and dissemination of materials.	RENSIDA	80 460
		4.2	Capacitate PLHIV and KP peer educators to roll out human rights/patient rights education, integrating where possible into existing groups/mechanisms.	Country-wide. Training for same peer educators under 1.4.	NAMATI	231 752

		4.3	Strengthen capacity of CSOs working with prisons on rights literacy.	National workshop for 50 CSO participants in Year 1 and Year 4.	SERNAP, UNODC, FHI360, Patherfinder, others	140 456
		4.4	Roll-out literacy on policies, regulation, laws and rights to prisoners.	40 prisoners per facility as peer educators, 2 trainings per year.	CSOs trained in item 4.3	105 600
		4.5	Build and strengthen community organisations, institutional and human resource capacity to provide peer-to-peer trainings on human rights and legal literacy to other community and peer-led organisations, to form networks, and to strengthen ties with regional networks for mutual support and capacity building.	National and provincial level coordinators to facilitate coordination and network development.	RENSIDA, KP networks with external partners (ARASA)	112 364
		4.6	Programme management support	22% of activity cost.		147 539
			SUB-TOTAL			**818 171**
5	HIV-related legal services	5.1	Train and support cadres of peer paralegals and health defenders for PLHIV, women, sex workers, PWID, MSM and transgender to do community education and support on relevant laws/regulations; mediate, negotiate, resolve disputes; support access to health services; refer cases to lawyers.	Training on-going supervision/mentoring of 50 paralegals country-wide.	LAMBDA and other KP networks, NAMATI, RENSIDA	772 506
		5.2	Train traditional and religious leaders to know relevant rights and laws related to women, PLHIV and KPs; resolve disputes; and, reduce discrimination, stigma and violence.	National workshops in Year 1, 3 and 5.	CNCS and CSOs	342 294
		5.3	Support development of rapid response mechanisms for sex workers, MSM, trans and PWID to protect against harassment, violence, extortion, arbitrary arrest.	Provincial and national level coordinators. Support for legal services.	LAMBDA and other KP networks, NAMATI, RENSIDA	34 800
		5.4	Sensitize and strengthen the capacity of the National Human Rights commission to respond to HIV related Human Rights violations and conduct trainings	External technical assistance for training and support.	CNCS, UNDP	29 400
		5.5	Monitoring access to justice by Human Rights Commission	National focal point for PLHIV/KPs.	CNCS, UNDP	-
		5.6	Programme management support	22% of activity cost.		259 380
			SUB-TOTAL			**1 438 380**

6	Monitoring and reforming laws and policies	6.1	Development of an national HIV and workplace policy.	Policy development and training/sensitisation for employers.	CNCS	703 973
		6.2	For PLHIV and key populations, support advocacy/mobilization for strengthened implementing regulations against discrimination based on HIV or social status.	National advocacy campaign.	LAMBDA and other KP networks, RENSIDA	288 433
		6.3	For PWID, support development of and advocacy for regulatory framework supporting harm reduction	National advocacy campaign.	CNCS, MISAU, PWID networks, MOJ	138 325
		6.4	Support monitoring of HIV Law 19/2014 by PLHIV, women and key populations.	Covered under 6.8		
		6.5	Support follow up advocacy regarding results of pending Legal Environment Assessment;	National advocacy campaign.	UNDP and KP networks	44 486
		6.6	For prisoners, support advocacy and mobilization with MOH, MOJ, MOI regarding provision of health services and protection in prisons;	National advocacy campaign.	CNCS and CSOs trained uder item 4.3.	138 325
		6.7	Support sensitization of cross party Parliamentary Committees on HIV and on Human Rights and as well as Fast Track city councils	1 day sessions for 50 parliamentarians in Year 1 and 2.	UNAIDS, UNDP, RENSIDA, CNCS	82 000
		6.8	Build and strengthen institutional capacity of community-based and/or key population organisations to monitor, document and report on human rights violations.	Capacity development workshops.	LAMBDA and other KP networks, RENSIDA	128 186
		6.9	Establish KP-led human rights observatories.	1 per province with national coordination/reporting mechanism.		212 500
		6.10	Support civil society participation in ACHPR and UPR processes	Development of briefs and stakeholder engagement.	LAMBDA and other KP networks, RENSIDA	112 171
		6.11	Support domestication of international and regional minimum standard for provision of HIV+TB services in prisons	National advocacy campaign.	CNCS and CSOs trained under item 4.3.	88 973
		6.12	Programme management support	22% of activity cost.		426 222
			SUB-TOTAL			**2 363 593**
	Reducing HIV-related discrimination	7.1	Support integration of legal/rights literacy into AGYW mentor, peer	Technical consultancy.	MMAS, N'weti, others?	29 400

	against women		educator, and sexual education efforts.			
		7.2	Develop cadre of peer paralegals for young women and for women--programme description and materials	Selection, training and deployment of 55 paralegals. Part of group in 1.4 above.	N'weti, others?	6 820
		7.3	Integrate rights in programs to reduce of harmful gender norms, including among men and boys.	Technical consultancy.	UNICEF, MMAS	9 800
		7.4	Integration of programs to reduce sexual exploitation/harassment in schools--policy/programme development.	Technical consultancy and training/sensitisation.	UNICEF, MMAS	81 553
		7.5	Review regulations excluding pregnant girls and development revised policy.	Development of new policy and training/sensitisation.	CNCS	75 435
		7.6	Roll out rights literacy and patients' rights information and training for women in context of PMTCT.	Covered under 2.4	CNCS, MISAU	-
		7.7	Supporting monitoring of laws and legal standards, including CEDAW and CSW comments/reports.	Development of briefs and stakeholder engagement.	N'weti, others?	96 430
		7.8	Programme management support	22% of activity cost.		65 876
			SUB-TOTAL			**365 314**
	Other activities	8.1	Undertake assessment of current levels of HIV service uptake by key populations to inform follow-up baseline assessment.	Country-wide studies in Year 1 and Year 2.	MISAU and KP networks	191 715
		8.2	Support evaluations of interventions to address human rights barriers	3 per year starting in Year 2.	CNCS and technical partners.	731 641
		8.3	Conduct mid- and end-term follow-up baseline assessments	Year 3 and Year 5.	CNCS and CCM.	191 715
			SUB-TOTAL			**1 115 071**

Annex B: Recommended Comprehensive Programmes to Reduce Human Rights and Gender-related Barriers to TB Services

Ref	Programme Area	Ref	Activity	Location/coverage	Main Implementers	Cost
1	Stigma and discrimination reduction	1.1	Repeat the KAP study	Country-wide.	NTP, WHO	191 715
		1.2	Expand community interventions to address stigma and discrimination	Support for provincial campaigns.	NTP, ADPP, other CSOs	951 500
		1.3	Create support groups for people living with TB	Support for provincial coordinators. Costs under programme management below.	ADPP, other CSOs	-
		1.4	Support People living with TB as peer educators/spokespersons/role models in communities.	Support for 20 peer educators per province.	ADPP, other CSOs	1 732 500
		1.5	Programme management support	22% of activity cost		632 657
			SUB-TOTAL			***3 508 372***
2	Training of health care workers	2.1	Reinforce of ethics/human rights components of training curricula (pre-service)	Technical consultancy.	NTP, WHO	13 640
		2.2	Reinforce of ethics/human rights components of training curricula (in-service)	Technical consultancy.	NTP, WHO	6 800
		2.3	Programme management support	22% of activity cost		4 497
			SUB-TOTAL			***24 937***
3	Sensitisation of law-makers and law enforcement agents	3.1	Update police training curricula-programme development	Technical consultancy.	MOJ, MOI	13 640
		3.2	Update training curricula for judicial officers/magistrates-programme development	Technical consultancy.	MOJ	6 800
		3.3	Programme management support	22% of activity cost		4 497
			SUB-TOTAL			***24 937***
4	Legal literacy	4.1	Activities to strengthen knowledge and awareness regarding laws and policies	Country-wide. Materials development, dissemination,	CNCS, NTP, Namati, AMIMO, others?	77 850

			for workplace health and safety in the context of TB.	training/sensitisation sessions in provinces.		
		4.2	Programme management support	22% of activity cost		17 127
			SUB-TOTAL			***94 977***
5	TB-related legal services	5.1	Sustain, scale-up legal services for people living with TB.	Training and deployment of paralegals and support for legal services. Training and deployment under HIV budget.	Namati	25 000
			SUB-TOTAL			***25 000***
6	Monitoring and reforming laws and policies	6.1	Sustain monitoring project of miners' legal rights and SADC compliance	National level monitoring.	NTP, AMIMO, others?	37 500
		6.2	Support Prison Health Technical Working Group	Quarterly meetings for 10 people.	MISAU and SERNAP	110 641
		6.3	Programme management support	22% of activity cost		32 591
			SUB-TOTAL			***180 732***
7	Addressing issues of gender	7.1	Undertake gender assessment of HIV/TB response using UNAIDS tool and develop action plan (follow-up in Year 4)	Assessment, action-planning Year 1; follow-up in Year 4	UNAIDS, WHO, NTP, CNCS	288 064
		7.2	Programme management support	22% of activity cost		63 374
			SUB-TOTAL			***351 438***
8	Other activities	8.1	Programme evaluations	3 per year in Year 2 and Year 5		365 821
			SUB-TOTAL			***365 821***
			TOTAL			**4 576 213**

Annex C: Draft Baseline Indicators and Values for Measuring Progress

Below is a first draft of a proposed set of indicators and baselines for measuring the quantitative aspects of progress towards the removal of human rights and gender related barriers to access and uptake of HIV services. This will be substantially revised over the next months, as the 5-year plan will be developed. 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).

Table 7: Proposed monitoring indicators for HIV

Indicator	Baseline value	Source/Year
Stigma and discrimination		
% of population reporting denial of a health care service (disaggregated by population)	Awaiting new data.	
% of population reporting poor treatment in health services, including lack of confidentiality (disaggregated by population)	Awaiting new data.	
Violence and abuse		
% of population reporting instance of physical or sexual violence in past 12 months (disaggregated by population and perpetrator)	Awaiting new data.	IBBS, Stigma Index
% of population reporting violence that sought and received treatment/redress (disaggregated by population)	New indicator. No data.	
% of population reporting instances of abuse/extortion by police in past 12 months (disaggregated by population)	Awaiting new data.	
% of population reporting abuse that sought/received redress (disaggregated by population)	New indicator. No data.	
Training and sensitization activities		
# and % of HCWs trained on human rights and medical ethics	No consolidated data.	
# and % of police trained on legal and human rights of PLHIV and key populations.	No consolidated data.	
# and % of judicial officers trained on legal and human rights of PLHIV and key populations.	No consolidated data.	
Access to justice		
# of individuals provided with legal services to address legal/human rights challenges.	No consolidated data.	
# of lawyers/paralegals/advocates trained to provide legal assistance	No consolidated data.	

Law and policy reform		
# and type of laws and policies promoting/protecting HIV-related rights of PLHIV and key and vulnerable populations.	No consolidated data.	

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).

Table 8: 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.	
# of individuals reporting treatment interruptions in police or prison settings.	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/paralegals trained and available to offer TB-related legal services	No data.	
# of individuals diagnosed with TB using a legal service in the past 12 months	No data.	
# of individuals diagnosed with TB experiencing discrimination in the workplace	No data.	
# of individuals experiencing discrimination that sought and received redress	No data.	