Baseline Assessment – Côte d'Ivoire

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

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The Global Fund

DISCLAIMER

Towards the operationalisation 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 in Cote d'Ivoire. The views expressed in the paper do not necessarily reflect the views of the Global Fund.

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ACRONYM LIST

AFJCI	*Association des femmes juristes de la Côte d'Ivoire* [Association of Women Lawyers of Côte d'Ivoire]
ART	Antiretroviral therapy
ARV	Antiretroviral
ASC	Community health agents
BCC	Behaviour change communication
CAB	Community advisory boards
CAT	*Centre antituberculeux* [Anti-tuberculosis centres]
CBO	Community based organization
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4
CDT	*Centre de Diagnostique et Traitement* [Diagnostic and treatment centres]
CNDHCI	*Commission Nationale des Droits de l'Homme de Côte d'Ivoire* [National Human Rights Commission of Côte d'Ivoire]
COLTMER	*Collectif des ONG de lutte contre la tuberculose et les autres maladies respiratoires* [Network of NGOs to fight tuberculosis and other respiratory diseases]
CSS	Community System Strengthening
CT	*Centre de traitement* [Treatment centre]
DHS	Demographic and Health Survey
FSW	Female Sex Worker
GBV	Gender-Based Violence
GBV IMS	Gender-Based Violence Information Management System
HAI CI	Heartland International Alliance CI
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
IBBS	Integrated Biological Behaviour Survey
IPT	Intermittent Preventive Treatment
IRS	Indoor residual spraying
ITN	Insecticide-Treated Nets
LEA	Legal Environment Analysis
LGBT	Lesbian, Gay, Bisexual and Transgender
LIDHO	*Ligue ivoirienne des droits de l'homme* [Ivoirian Human Rights League]
LILO	Look In Look Out Connect
LTFU	Lost to follow up
MACA	*Maison d'Arrêt et de Correction d'Abidjan* [main prison in Abidjan]
MDR-TB	Multidrug-resistant tuberculosis
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTCT	Mother-to-child transmission
NGO	Non-governmental organization
NSP	Needle and Syringe Programme
OCAL	*Organisation du Corridor Abidjan Lagos* [Abidjan Lagos Corridor project]
OST	Opioid Substitution Therapy
OVC	Orphans and Vulnerable Children

PARECO	Harm Reduction grant in five countries in West Africa: Burkina Faso, Cape Verde, Côte d'Ivoire, Guinée-Bissau and Sénégal
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PLTB	People Living with TB
PMTCT	Prevention of mother-to-child transmission
PNLP	*Programme National de la lutte contre le Paludisme* [National Program to Fight against Malaria]
PNLS	*Programme National de la lutte contre le Sida* [National Program to fight HIV]
PNLT	*Programme National de la lutte contre la Tuberculose* [National Program to Fight against Tuberculosis]
PR	Principal Recipient
PSNLS	*Plan Stratégique National de lutte contre les IST et le Sida* [National Strategic Plan to fight AIDS and Sexually Transmitted Infections]
PWID	People Who Inject Drugs
PWUD	People Who Use Drugs
RIP+	*Réseau Ivoirien des organisations de Personnes vivant avec le VIH-Sida* [National network of people living with HIV]
ROLPCI	*Réseau des ONG de lutte contre le paludisme* [Network of organizations fighting malaria in Côte d'Ivoire]
ROPCCI	*Réseau des organisations de populations clés* [Network of NGOs working with key populations]
SOP	Standard Operating Procedure
SR	Sub-Recipient
STI	Sexually Transmitted Infection
SW	Sex Worker(s)
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	UN Refugee Agency
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development
VL	Viral Load
WHO	World Health Organization
XDR TB	Extensively drug-resistant tuberculosis

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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. It has done so because it recognizes that these programs are an essential means by which to increase the effectiveness of Global Fund grants. The programs increase uptake of and retention in health services and help to ensure that health services reach those most affected by the three diseases.

This Executive Summary sets out the findings of the baseline assessment conducted in Côte d'Ivoire 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 HIVTB services*".[1]

Though the Global Fund provides support to all recipient countries to scale up programs to remove human rights-related barriers to health services, it is providing intensive support to 20 countries to enable them to put in place comprehensive programs aimed at reducing these barriers.[2] Based on criteria involving needs, opportunities, capacities and partnerships in country, Côte d'Ivoire and nineteen other countries were selected for intensive support.

This baseline assessment is the first component of the package of support Côte d'Ivoire 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 Côte d'Ivoire with regard to human rights-related barriers to HIV, TB services and existing programs to remove them, (b) describes what comprehensive programs aimed at reducing these barriers would look like, and their costs, and (c) suggests opportunities regarding possible next steps in putting comprehensive programs in place.

During November-December 2017 data was collected for this baseline assessment through a desk review and in-country research, which comprised a total of 15 focus groups and 24 interviews involving 182 key informants in the following regions of Côte d'Ivoire: Abidjan, Agboville, Grand Bassam, Gagnoa and Jacqueville. Further research to determine historic costs and projected costs of rights-related programs was conducted in January-February 2018.

The following paragraphs summarize the baseline findings in Côte d'Ivoire 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.

Baseline HIV findings

Key and vulnerable populations

[1] *The Global Fund Strategy 2017-2022: Investing to End Epidemics*. GF/B35/02
[2] *Ibid.*, Key Performance Indicator 9.

The key populations in Côte d'Ivoire identified in the National Strategic Plan to fight AIDS and Sexually Transmitted Infections (PSNLS) 2016-2020 at highest risk of illness from HIV, low access to HIV services, and facing systematic rights violations are female sex workers (FSW), men having sex with men (MSM), people who use drugs (PWUD) and prisoners. Other vulnerable groups identified include migrants, long-distance truck drivers, uniformed services personnel and clients of sex workers.[3]

Barriers to HIV services

The most significant human rights-related barriers impeding access to HIV services for key and vulnerable populations are:

- Stigmatizing attitudes and discriminatory practices against PLHIV and key populations. This stigma and discrimination are lived in families, in school, in medical and religious contexts, by friends, peers, religious leaders, police and healthcare workers. The stigma and discrimination are related to moral judgements about their economic activity (sex work), sexual orientation, or illegal practices (consuming drugs), as well as negative perceptions related to HIV infection.
- The lack of knowledge among the personnel of the health sector on human rights and medical ethics related to HIV creates stigmatizing behaviour in the medical setting, such as unwelcoming attitudes, neglecting patients, providing a different quality of treatment based on someone's HIV status, denying care and breaching confidentiality.
- Law enforcement agents remain generally untrained and unaware on rights of key populations and on HIV/AIDS. There are numerous reports of law enforcement agents harassing, arresting, extorting and sometimes physically and sexually abusing people suspected of sex work, drug use and homosexuality. Very often these acts are perpetrated again and again with impunity.
- The low level of legal literacy of key populations means that they do not have the knowledge and tools to stand up for their rights. The Stigma Index Report on Côte d'Ivoire states that 82.6 % of PLHIV do not know about the HIV law of 14 July 2014.[4]
- Even where PLHIV and other key populations are aware of their rights, they have little access to justice and little chance of getting legal redress for HIV-related harms.[5] Although interviews with key informants from NGOs displayed their active involvement in providing legal advice and representation to PLHIV and other key populations, studies show that a high percentage of key populations have never had legal recourse when their rights have been violated, primarily because they had limited financial resources, or because they felt intimidated and did not want to be 'exposed' and were afraid of the outcome.[6]
- Problematic laws and policies include the articles in the 2014 HIV law where transmission can be criminalised, disclosure of status to a third party is allowed in certain non-medical circumstances, and parental consent is required for testing of minors; the current repressive drug law which impedes access to opioid substitution therapy, needle and syringe programs and other harm reduction programming; criminal offenses related to sex work; laws that act as a barrier to transgender women in terms of gender identity; and unavailability of the UNODC comprehensive HIV package in prison settings.

[3]Ministry of Health and Public Hygiene – Republic of Côte d'Ivoire (2016). National Strategic *Plan 2016-2020 to fight AIDS and Sexually Transmitted Infections.*

[4]Etude nationale de l'index de stigmatisation et discrimination envers les personnes vivant avec le VIH en Côte d'Ivoire, 2016

[5] UNAIDS Guidance Note 2012. Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice In National HIV Responses.

[6]Stigma index Report, Côte d'Ivoire 2016

- Another important barrier that limits ability to seek care, especially for women and girls, is gender inequality. Although laws exist that prohibit gender inequality and gender-based violence, women and girls in Côte d'Ivoire continue to suffer from both. Traditional attitudes, beliefs and practices limit the ability of women and girls to access and retain HIV services and increase their vulnerabilities to HIV.

Opportunities to address rights-related barriers to HIV services - from existing programs to comprehensive programs

This section summarizes the existing or recent programs that have been implemented in Côte d'Ivoire to remove human rights-related barriers to services and provides a summary of the proposed elements a comprehensive program, based on the seven program areas set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*.[7]

The seven program areas are:

PA 1: Programs to reduce HIV-related stigma and discrimination
PA 2: Programs to train health care workers on human rights and ethics related to HIV
PA 3: Programs to sensitize lawmakers and law enforcement agents
PA 4: Programs to provide legal literacy ("know your rights")
PA 5: Programs to provide HIV-related legal services
PA 6: Programs to monitor and reform laws, regulations and policies related to HIV
PA 7: Programs to reduce discrimination against women and girls in the context of HIV

PA 1: Programs to reduce stigma and discrimination for key and vulnerable populations

Existing programs: Programs to reduce stigma and discrimination for key and vulnerable populations are mainly based on the tool "Look In Look Out Connect" (LILO), developed by International HIV/AIDS Alliance. The LILO program started in 2015 in Côte d'Ivoire and aims to change negative perceptions about LGBT, sex work and use of drugs into positive ones. The LILO interventions target key populations to reduce self-stigma and stigma between key populations; health care workers; the police force; the media; members of parliament; lawyers; religious leaders and institutions (public and NGO) working with key populations.

In 2016 *Alliance CI* conducted the country's first PLHIV Stigma Index, and the major issues identified in the study were used to inform the development of strategies to reduce stigma and discrimination towards PLHIV. Following the stigma index findings, a mass media campaign was launched in December 2017 to address stigma and discrimination against PLHIV.

In addition, community-level work is also conducted by LGBT, SW and PWUD NGOs, which manage peer educator programs and peer support groups to build people's individual knowledge and capacity to overcome self-stigma, as well as confront stigma and discrimination. Peer education programs are made up of approximately 350 key population peer educators (MSM, SW and PWUD; this is the estimated nationwide total) and cover all health regions of Côte d'Ivoire, with a concentration around high prevalence zones.

Elements of the proposed comprehensive program in this area: Comprehensive programming would reach the following 35 sanitary districts in the first phase: Seguela, Korhogo,

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

Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouaké. Over five years, at least 60 of all 79 sanitary districts in the country should be covered, targeting the relevant institutions and stakeholders for stigma and discrimination reduction towards key populations.

The following activities are recommended:

- Reconceptualise LILO sensitization and training program and extend to 60 sanitary districts
- Reinforce peer educators training and extend to 60 sanitary districts
- Establish community advisory boards for key HIV service providers to meet quarterly in each of the sanitary districts reached with the LILO sessions
- Train key population representatives in roles of community advisory board members and as advocates
- Continue implementing Stigma Index research

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

Existing programs: Health care worker training is based on the LILO approach, which aims only at reducing stigma and discrimination towards key populations. Consequently other components related to human rights and ethics are not being comprehensively covered. The group of trainers that were trained by *Alliance CI* conducted LILO sessions targeting personnel from specialised medical centres, and at least three focal points per public hospital, to which NGOs refer clients.

Elements of the proposed comprehensive program in this area: Specific human rights and ethics training modules related to HIV must be developed and institutionalised in doctor and nurse training, in the two medical universities and three nursing schools of the country. These curricula would need to include relevant information on the same topics as they relate to TB.

When the LILO interventions target healthcare workers, the content of the training should be adapted to include discussions such as gender-based violence and clinical management of rape and violence; the clinician's role in promoting sexual health, mental health, and drug-related harm reduction; and laws and policies that protect or exist as barriers to people's access to care.

The coverage of this program area would also cover the 35 sanitary districts in the phase one and extend to 60 sanitary districts over the five-year period.

PA 3: Programs to sensitise law-makers and law enforcement agents

Existing programs: A Human Rights and HIV Observatory in the regions of Bouaké and Abidjan is operational. The project included the sensitization of law enforcement agents, setting up a key population focal point in police stations to increase key populations' access to police services if they were victim of human rights abuses, and the setting up of a pool of lawyers to offer legal support to key populations members who are victims of human rights violations.

Elements of the proposed comprehensive program in this area: To further reinforce programs to sensitise law-makers and law enforcement agents with regard to human rights issues, the following activities are recommended:

- Implement the recommendations of the evaluation of the Human Rights and HIV Observatory: increase budgets for remuneration of peer educators and communication allowances; increase the visibility of the project; provide refresher trainings to peer educators and reinforce their knowledge of human rights; separate the documentation activities from the advocacy and training activities; and revise the tools for notifying human rights violations.
- Review trainings and sensitization under the Human Rights and HIV Observatory to include a formal evaluation mechanism
- Extend the Human Rights and HIV Observatory to all 60 sanitary districts
- Advocacy to include human rights and key populations in police training
- Training and sensitization of police academy, prison personnel, members of the civil rights sub-committee of the *Commission Nationale des Droits de l'Homme de la Côte d'Ivoire* [National Human Rights Commission of Côte d'Ivoire] (CNDHCI) and Members of Parliament
- Expand the key population focal points in police stations project to the 60 sanitary districts
- Undertake an assessment of the quality and accessibility of HIV/TB services in prison and work with the prison medical personnel and related staff to monitor, mentor and advocate for possible actions to ensure the right to health among prisoners

PA 4: Programs to promote legal literacy ("know your rights")

Existing programs: Programs to promote legal literacy are mainly based on the peer education programs that operate across the country. Men who have sex with men, sex workers, people who use drugs and PLHIV peer educators are responsible for informing key populations about their rights during standard HIV prevention, referral activities, gender-based violence sensitization talks and positive health, dignity and prevention interventions held on an individual or group basis.

In 2015-16, a guide on the rights and responsibilities of key populations and PLHIV was elaborated. It covers their rights in terms of health, family life, education, insurance, work, travelling, as well as the legal mechanisms available in case of a violation of their rights, and also their responsibilities.

Elements of the proposed comprehensive program in this area: The main program to promote legal literacy is via peer educators, but stakeholder interviews concede that the delivery of this component is not comprehensive and standardised. "Know your rights" programmes are mainly focused on the HIV law and should be extended to rights of key populations (including gender-based violence and health rights), with appropriate communication materials and a system to assess the impact of the interventions.

Since key populations have many rights-related issues with law enforcement agents, a peer educator program to address this specific situation would be appropriate. To further promote legal literacy, the following activities are recommended:

- Reinforce the capacity of 500 peer educators and the other relevant community actors in the positive health, dignity and prevention program for PLHIV in legal literacy

- Assess the impact of peer education of stigma and discrimination, legal literacy, human rights and health rights among key populations
- Development of communication materials to promote legal literacy
- Set up a program to train peer educators to accompany SW and MSM detained by police to demonstrate how to advocate for their rights

PA 5: HIV-related legal services

Existing programs: Various institutions have been providing legal advice to key populations through outreach sensitization sessions. Group sessions are either about HIV and branch out into rights of PLHIV or are about another human rights-related topic such as gender-based violence. They are followed by individual sessions where participants can confidentially obtain legal advice and referral services.

The Human Rights and HIV Observatory has become, since mid-2017, one of the platforms for HIV-related legal services for key populations by documenting cases of human rights violations. All victims of human rights violations have access to legal advice, legal representation if they wish, and medical support. The observatory also holds community mediation activities when appropriate. However, there are very few cases of people who seek a legal recourse; currently only three cases are being taken to court with support from lawyers.

Elements of the proposed comprehensive program in this area: To further reinforce HIV-related legal services, the following activities related to the Human Rights and HIV Observatory are recommended:

- Expansion of HIV and Human Rights Observatory to 60 sanitary districts
- Ensure that victims of violence requiring treatment can access a specialised NGO-run medical clinic and/or partner public health centre
- Diversify means of referring cases of violations (e.g. via online telephone applications, through all relevant key population NGOs, and through the national free HIV hotline)
- Develop a solid communication strategy and campaign to diffuse the information about the observatory
- Reinforce links between the observatory, the pool of trained lawyers that supports it, and all NGOs working with key populations.

PA 6: Programs to monitor and reform laws and policies related to HIV

Existing programs: A Legal Environment Analysis (LEA) in relation to HIV is currently being finalised in Côte d'Ivoire. The study evaluated Côte d'Ivoire's legal and policy framework in relation to human rights, the level of knowledge of human rights among key populations and their access to the legal system, as well as the impact of the legal environment on access to services and on the promotion and protection of the rights of key populations. The results of this research will provide a foundation for evidence-based advocacy.

Various NGOs have disseminated information on the 2014 HIV law through outreach sensitization sessions, but these activities are not consistently held due to fluctuations in funding.

Elements of the proposed comprehensive program in this area: There is clearly a lack of capacity to conduct advocacy for law reform on the following aspects:

- articles in the 2014 HIV law where transmission can be criminalised, disclosure of status to a third party is allowed in certain non-medical circumstances, and parental consent is required for testing of minors

- reforms needed to the current repressive drug law to facilitate access to opioid substitution therapy, needle and syringe programs and other harm reduction programming
- reforms with regard to criminal offenses related to sex work
- laws that act as a barrier to transgender women in terms of gender identity
- availability of the United Nations Office on Drugs and Crime (UNODC) comprehensive HIV package in prison settings.

Therefore the following activities are recommended to have a solid monitoring and reform of problematic laws and policies:

- Using the *Réseau des organisations de populations clés* [network of key populations] (ROPCCI), train 15 persons from NGOs in strategic advocacy and lobbying, including the production of a long-term advocacy action plan
- Support 15 NGOs and the ROPCCI to conduct on-going advocacy for law and policy reform

PA 7: Programs to reduce discrimination against women in the context of HIV

Existing programs: The Ministry of Women, Child Protection and Solidarity has a network of 43 gender-based violence (GBV) coordination committees across the country. These GBV coordination committees are responsible for managing all initiatives to fight GBV at the regional level. The Ministry is planning to extend their network to 130 coordination committees for a consistent coverage of the country. Victims of gender-based violence are referred to appropriate treatment, care and support services, as well as legal advice and representation if needed. Campaigns to reduce GBV have also been conducted in the country.

However, these initiatives are not specifically to reduce discrimination against women as a barrier to HIV services and have not yet been evaluated for effectiveness. The Global Fund has stopped funding these activities as the cases were mainly related to domestic violence, and not closely linked to HIV. GBV activities are now focused on key populations.

Elements of the proposed comprehensive program in this area: The following activities are recommended to reduce discrimination against women in the context of HIV:

- Advocacy should be conducted to ensure that all gender-based programs include key populations. This would include LILO sensitization and high-level advocacy with all 130 gender-based violence coordination committees under the Ministry of Women, Child Protection and Solidarity.
- Since there exist no age-sensitive programs for adolescents who provide sex for money, training of service-delivery institutions is required so that they identify and notify these cases, and offer them an appropriate HIV service package, with additional services such as family mediation and psychosocial support.

Costing information HIV

The table below sets out the 2016 investments in human rights barriers, from different sources of funding:

HIV Human Rights Barriers Program Area	2016 (USD)
PA 1: Stigma and discrimination reduction for key populations	**56,387**
PA 2: Training for health care workers on human rights and medical ethics related to HIV	**12,115**
PA 3: Sensitization of law-makers and law enforcement agents	**20,459**

PA 4: Legal literacy ("know your rights")	**261,507**
PA 5: HIV-related legal services	**95,324**
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	**0**[8]
PA 7: Reducing discrimination against women in the context of HIV	**34,877**
Total	**480,670**

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

HIV Human Rights Barriers Program Area	**Total (USD)**
PA 1: Stigma and discrimination reduction for key populations	**3,756,591**
PA 2: Training for health care workers on human rights and medical ethics related to HIV	**49,329**
PA 3: Sensitization of law-makers and law enforcement agents	**350,102**
PA 4: Legal literacy ("know your rights")	**1,675,268**
PA 5: HIV-related legal services	**2,496,296**
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	**3,395,967**
PA 7: Reducing discrimination against women in the context of HIV	**573,357**
Total	**12,296,913**

Baseline TB findings

Key and vulnerable populations

According to the World Health Organisation (WHO), the key affected population groups in relation to tuberculosis (TB) are (i) people at increased risk of TB because of other diseases, e.g. PLHIV, (ii) people who are vulnerable because of their social conditions, behaviours or unsafe workplaces, e.g. prisoners, migrants, refugees and sex workers, and (iii) people who are underserved because of stigma, discrimination and other access barriers, e.g. people who use drugs and homeless people.[9] The key populations identified in Côte d'Ivoire are PLHIV, diabetics, miners, prisoners, people who use drugs, and people living in precarious conditions.

Barriers to TB services

The most significant human rights-related barriers impeding access to TB services for key and vulnerable populations are:

- Stigma and discrimination associated with TB, which is commonly referred to as the 'shame disease' in the community. Widespread stigma and discrimination are experienced at both the family level and the societal level, and perpetrated by members of the family, friends, religious leaders, police and healthcare workers. Stigma and discrimination are primarily related to the fear of infection and negative TB conceptions associated

[8]The figure for PA6 may not be in fact zero, but no evidence was found of amounts expended in this area.
[9]Engaging Key Vulnerable Populations in Designing, Planning and Implementing TB Community Activities. (2014). [ebook] World Health Organization. Available at: http://www.who.int/tb/tbteam/keypop.pdf [Accessed 23 Feb. 2017].

with HIV-infection i.e. TB is a 'dirty disease'. Stigma is also related to alleged immoral behaviour, incurability and death, poverty and incarceration.

- Despite TB incidence and prevalence rates being higher for males than females, TB has severe consequences for women, especially adolescent girls and young women. Factors negatively impacting on ability of women and girls to access, uptake and retain TB health services include discriminatory traditional attitudes, beliefs and practices; unequal economic power in the household; and gender-based violence as well as gender-insensitive service delivery.
- The limited level of legal literacy, the lack of information about how to seek redress in cases of human rights violations, overcrowded prisons and arbitrary arrests, and mistreatment of key populations such as sex workers and people who use drugs are major impediments to the use of TB services in Côte d'Ivoire.
- The lack of knowledge among the personnel of the health sector on human rights and medical ethics related to TB causes problems in the health care system, such as unwelcoming attitudes, nurses in hospitals refusing to provide care to TB patients for fear of infection, or patients being sent away because they are considered dirty. People co-infected with HIV and TB also experience stigmatising and discriminatory attitudes and practices from health providers in the health system. Such behaviour ranges from unwelcoming attitudes, neglecting patients, providing a different quality of treatment based on someone's HIV status, denying care and breaching confidentiality, among others.
- There is a general perception that TB treatment is not free: the confusion arises from a recently introduced system that should ensure free treatment, but this is not always applied . This confusion about which treatments and which tests are free allows some health personnel to extort money from patients for tests or refer patients in treatment failure to clinics where injections of antibiotics are not free of charge.

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

This section summarizes the existing or recent programs that have been implemented in Côte d'Ivoire to remove human rights-related barriers to services and provides a summary of the proposed elements a comprehensive program, based on the ten program areas set out in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.[10]

The ten program areas are:

PA 1: Reducing stigma and discrimination
PA 2: Training of health care workers on human rights and ethics related to TB
PA 3: Sensitization of law-makers, judicial officials and law enforcement agents
PA 4: Know your TB-related rights
PA 5: TB-related legal services
PA 6: Monitoring and reforming policies, regulations and laws that impede TB services, including involuntary isolation for treatment other than as a last resort
PA 7: Reducing gender-related barriers to TB services
PA 8: Mobilizing and empowering patient and community groups
PA 9: Ensuring confidentiality and privacy
PA 10: Programs in prisons and other closed settings

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

PA 1: Stigma and discrimination reduction

Existing programs: Programs to reduce TB-related stigma and discrimination are mainly combined with HIV-based peer education. In general the TB component is more detailed when the programs are targeting people who use drugs, such as under the harm reduction grant in five countries in West Africa: Burkina Faso, Cape Verde, Côte d'Ivoire, Guinea-Bissau and Sénégal (PARECO project) to reduce the risks related to HIV and TB among people who inject drugs, and activities are focused on health and community systems strengthening, addressing legal barriers, and conducting harm reduction interventions, including TB content throughout their work.

The *Collectif des ONG de lutte contre la tuberculose et les autres maladies respiratoires* [Network of NGOs to fight tuberculosis and other respiratory diseases] (COLTMER) has 43 NGO members across the country and they work in collaboration with the *centres antituberculeux* [Anti-tuberculosis centres] (CATs) and CDTs on community work, which includes stigma and discrimination. During home visits to patients for medical and social follow-up, community counsellors sensitise patients on self-stigma and sensitise the patients' immediate circles to reduce stigma and discrimination. However the efforts to reduce stigma and discrimination towards people with TB have been piecemeal to date.

Elements of the proposed comprehensive program in this area: Recommended activities to reduce stigma and discrimination related to TB are:

- Regular national assessments to document and measure the types and level of TB-related stigma and discrimination in healthcare settings and specific communities to enable strategic programming by implementing institutions.
- Develop terms of reference to integrate TB-related community work to HIV programming. This would address the issue of TB patients rejecting home visits out of fear of their neighbourhood knowing they have TB

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

Existing programs: Stakeholder interviews conducted found no programs to train health care providers on human rights and medical ethics related to TB, apart from the *Médecins du Monde* program to train community health workers.

Elements of the proposed comprehensive program in this area: Specific human rights and ethics training modules (including aspects related to TB) must be developed and institutionalised in doctor and nurse training, in the two medical universities and three nursing schools of the country.

LILO interventions would be re-conceptualized to address TB-related sigma and discrimination. Trainings would target all 17 CATs in phase one and 100 CDTs in phase two. These interventions would target the same 60 sanitary districts as under the HIV comprehensive approach programming.

In parallel, quality assurance advisory boards, composed of members of the medical and administrative personnel, as well as representatives of labor unions, NGOs and key populations would act as a platform to address human rights and medical ethics issues that have cropped up, as well as make suggestions on how to improve service delivery towards key populations. These would be set up following the LILO trainings.

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

Existing programs: According to stakeholder interviews, there are no programs for sensitization of law-makers, judicial officials and law enforcement agents with regard to rights-related barriers to TB services. The interventions mentioned under the HIV section occasionally also include TB information when related to people who use drugs, but these are not systematic.

Elements of the proposed comprehensive program in this area: A comprehensive approach to sensitize law enforcement agents about key populations and their specific rights-related barriers to TB services would need to start off by training organizations that are already involved in similar interventions for HIV, such as the *Ligue ivoirienne des droits de l'homme* [Ivoirian Human Rights League] (LIDHO), the *Association des femmes juristes de la Côte d'Ivoire* [Association of Women Lawyers of Côte d'Ivoire](AFJCI), and NGOs *ENDA Santé* and *Alliance CI* on rights-related barriers to TB services. By making sure that these same stakeholders are aware of the specificities of TB-related issues, joint interventions that cover both HIV and TB comprehensively can be developed.

Recommendations to reinforce sensitization of law-makers, judicial officials and law enforcement agents are as follows:

- Training of 10 institutions involved in the sensitisation of law-makers, judicial officials and law enforcement agents to integrate TB in HIV-related interventions
- Advocacy to include human rights and key populations into police training
- Training and sensitization of 200 trainees from the police academy, 65 members of the prison personnel, 15 members of the civil rights sub-committee of the CNDHCI and 100 Members of Parliament
- Extend Human Rights and HIV Observatory, including a TB component, to all 60 sanitary districts

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

Existing programs: Interviews and focus groups suggested that there is a lack of information about TB-related human rights, which leads to relatively weak 'know your rights' interventions, especially when undertaken in combination with HIV.

Elements of the proposed comprehensive program in this area: Training modules on TB should be reinforced at peer educator level (500 peer educators) to ensure that the level of knowledge of HIV and TB-related rights is comprehensive. Furthermore, developing a pool of expert patients in all of the 43 NGO members of the Network of NGOs to fight tuberculosis and other respiratory diseases (COLTMER) would also strengthen access to rights-based information for TB patients.

The recurrent issue of patients having to pay for certain services when they should be free of charge could be addressed by updating the existing chart for patients following TB treatment to include information on free services and cost of services that are chargeable. In addition, posters and leaflets on free services and cost of services that are chargeable should be produced and posted in all health centres and NGOs.

PA 5: TB-related legal services

Existing programs: Stakeholder interviews conducted found no programs that provide TB-related legal services in cases of human rights violations.

Elements of the proposed comprehensive program in this area: A comprehensive approach related to legal services could build upon the existing Human Rights and HIV Observatory, and other activities in the HIV comprehensive approach. This would include restructuring the observatory to include TB under their services: documentation of human rights violations, legal advice and assistance and community mediation. Legal assistance would also target cases of people losing their jobs because of TB or those unjustly detained for treatment, and would link patients to the Labour Inspectorate.

PA 6: Monitoring and reforming policies, regulations and laws that impede TB services

Existing programs: Stakeholder interviews found no programs for monitoring and reforming policies, regulations and laws that impede TB services. Stakeholder interviews revealed a low knowledge of potential policies, regulations and laws that impede TB services.

Elements of the proposed comprehensive program in this area: Recommendations for TB programming related to monitoring and reforming policies, regulations and laws that impede TB services are:

- Conduct a legal environment assessment for TB to identify factors related to access to diagnosis, treatment and care for those who are most vulnerable to TB
- Evidence-based ongoing advocacy activities (1 advocacy officer for every 10 NGOS - total of 5 advocacy officers for the COLTMER network)
- Capacity building of all COLTMER's 43 NGOs to ensure strategic advocacy and lobbying

PA 7: Reducing gender-based inequity in the context of TB services

Existing programs: The *Programme National de la lutte contre la Tuberculose* [National Programme to Fight Tuberculosis] (PNLT) is currently conducting a study on the gender and equity regarding access to TB health services in Côte d'Ivoire, but no details of the study are yet available.

Elements of the proposed comprehensive program in this area: Following the results of the study on gender and equity regarding access to TB health services in Côte d'Ivoire, the PNLT should follow the recommendations to reduce gender-related barriers to TB services. Workshops in each sanitary district would be organized to ensure that with various stakeholders of the PNLT to develop programs based on recommendations to reduce gender-related barriers to TB services. These should target the 18 high burden sanitary districts: Abobo Est, Abobo Ouest, Anyama, Cocody-Bingerville, Koumassi-Port-Bouet-Vridi, Marcory-Treichville, Adjame-Plateau-Attecoube, Dabou, Yopougon Est, Yopougon Ouest, Alepe, Tiassale, Yamoussoukro, Bouake Nord-Ouest, Dimbokro, Aboisso, Grand-Bassam, and Man.

PA 8: Patient and community empowerment and mobilisation

Existing programs: Stakeholder interviews found no programs that aim at patient and community empowerment and mobilisation for TB. The few examples given during interviews were

about inviting patients for testimonies during World Tuberculosis Day and encouraging TB NGOs to have patients on their boards.

Elements of the proposed comprehensive program in this area: Community systems strengthening is required to establish a strong community-based TB program that can deploy activities to support TB patients within the community. Community systems strengthening starts with building the capacity of leaders – that is, TB patients who can be advocates for their cause and participate in decision-making. Currently it is mainly NGOs serving TB patients that represent them. A comprehensive training for 120 TB patients from the most affected populations would empower them to be advocates through a set of training that starts with a foundation course on human rights, HIV and TB, stigma and discrimination and other related information. Competencies would be built through courses on self-esteem, public speaking, social transformation and other skills relevant to the local context.

PA 9: Protecting confidentiality

Existing programs: Stakeholder interviews conducted found no programs in this area.

Elements of the proposed comprehensive program in this area: Confidentiality issues are covered in PA2.

PA 10: Programs in prisons and other closed settings

Existing programs: The stakeholders interviewed mentioned no programs that specifically address TB and human rights in prisons.

Elements of the proposed comprehensive program in this area: Since there is very limited information on prisons, an assessment of the quality and accessibility of HIV/TB services in prison should be done. The MACA (Maison d'Arrêt et de Correction d'Abidjan) the main prison in Abidjan, would be assessed in the first phase, and be followed with work with the prison medical personnel and related staff to monitor, mentor and advocate for possible actions to ensure the right to health. Then the assessment should extend to all 34 detention centres in the regions of Abengourou, Aboisso, Adzope, Agboville, Bassam, Bondoukou, Bouafle, Bouake, Dabou, Daloa, Dimbokro, Divo, Gagnoa, Katiola, Korhogo, Man, Oume, Sassandra, Soubre, Tiassale and Toumodi.

Costing information TB

The table below sets out the 2016 investments in human rights barriers, from different sources of funding:

TB Human Rights Barriers Program Area	Total (USD)
PA 1: Stigma and discrimination reduction	**42,007**
PA 2: Training for health care workers (HCW) on human rights and medical ethics	**0**
PA 3: Sensitization of law-makers, judicial officials and law enforcement agents	**0**
PA 4: Knowing your TB-related rights	**54,603**
PA 5: TB-related legal services	**0**

PA 6: Monitoring and reforming laws, regulations and policies relating to TB services	**0**
PA 7: Reducing gender-based inequity in the context of TB services	**0**
PA 8: Mobilizing and empowering patient and community groups	**0**
PA 9: Ensuring confidentiality and privacy	**0**
PA 10: Programs in prisons and other closed settings	**0**
Total	**96,610**

The table below summarizes the proposed costs for a comprehensive program.

TB Human Rights Barriers Program Area	**Total (USD)**
PA 1: Stigma and discrimination reduction	**380,221**
PA 2: Training for health care workers (HCW) on human rights and medical ethics	**263,374**[11]
PA 3: Sensitization of law-makers, judicial officials and law enforcement agents	**45,747***
PA 4: Knowing your TB-related rights	**488,288**
PA 5: TB-related legal services	**0***
PA 6: Monitoring and reforming laws, regulations and policies relating to TB services	**1,134,177**
PA 7: Reducing gender-based inequity in the context of TB services	**54,414**
PA 8: Mobilizing and empowering patient and community groups	**390,162**
PA 9: Ensuring confidentiality and privacy	**0**
PA 10: Programs in prisons and other closed settings	**0***
Total	**2,756,383**

Details of yearly costs are set out in the main report below and detailed costing information is available in Annex 7.

[11]* If HIV Comprehensive Approach is fully funded - many activities in the HIV Comprehensive Approach can be extended to encompass TB related rights issues at no or low cost.

1. INTRODUCTION

Overview of the Global Fund Baseline Assessment Initiative

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 barriers to health services in national responses to HIV, TB and malaria. This effort is grounded in Strategic Objective 3 which commits the Global Fund to: "*introduce and scale up programs that remove human rights barriers to accessing HIV, TB and malaria 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*".[12]

The Global Fund has recognized that programs to remove human rights-related barriers are an essential means by which to increase the effectiveness of Global Fund grants as they help to ensure that health services reach those most affected by HIV and TB. They are indeed "critical enablers."[13] The Global Fund is working closely with countries, UNAIDS, WHO, UNDP, Stop TB Partnership, PEPFAR and other bilateral agencies and donors to operationalize this strategic objective.

Background and Rationale for Baseline Assessment in Côte d'Ivoire

The Global Fund aims to support all countries to scale up programs to remove barriers to health services, and is starting by providing intensive support in 20 countries to demonstrate the feasibility and potential approaches for the work. Criteria for country selection were developed and considered during an international consultation convened by the Global Fund and partners in April 2016. Based on these criteria, a consultative process both across the Global Fund and with technical partners resulted in the list of 20 countries and disease focus within those countries. The technical experts involved in these consultations included those from the Global Fund, UNAIDS, Stop TB Partnership, WHO, UNDP and the Office of High Commissioner for Human Rights and the Office of the US Global AIDS Coordinator.

Côte d'Ivoire was selected as one of the 20 countries based on the agreed criteria including need, opportunities, and capacity and partnerships in the country. The focus in Côte d'Ivoire is on HIV and TB.

The objectives of the baseline assessment for each country are to:

- Identify the key human rights-related barriers to health services;
- Describe existing programs 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 Strategy.

The assessments will provide a baseline of the situation as of 2017 and will be followed up by similar assessments at mid- and end-points of the Global Fund strategy in order to assess the impact of scale-up of programs to remove barriers.

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

[13] Schwartlander B, Stover J, Hallett T et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 2011; 377(9782): 2031-41.

2. METHODS

Conceptual framework

The human rights-related barriers assessed in Côte d'Ivoire are those that inhibit access, uptake and retention in HIV and TB services. The general categories, as specified by the Global Fund, include those related to stigma and discrimination; poverty and economic and social inequality; punitive laws, policies, and practices; gender inequality and gender-based violence.

The focus populations for Côte d'Ivoire are key and vulnerable populations using the following criteria stipulated by the Global Fund:

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

Published evidence provides details about several key populations in Côte d'Ivoire that fit the Global Fund criteria. These include people living with HIV (PLHIV), people living with TB (PLTB), female and male sex workers and their clients, young women and adolescent girls, gay men and other men having sex with men, transgender people, people who inject drugs (including adolescents and women who inject drugs); and male and female prisoners.

Steps in the assessment

The steps in the assessment were:

- Desk review: Following the guidelines of the Global Fund and its partners for this baseline study, a comprehensive literature search was conducted in October-November 2017. As per the guidelines, the desk review collected information about HIV epidemiology and key and vulnerable populations in Côte d'Ivoire, human rights-related barriers to HIV and TB services for key populations, evidence of programs and funding currently in place, evidence of effectiveness, outcomes and impact of those existing programs, and recommendations for future programs and policies. PubMed, Embase, and PopLine were used to identify peer-reviewed literature, and Google Scholar was then to identify additional non-peer-reviewed (grey) literature. The total number of articles and published documents found on the three databases and on relevant websites was 89. The abstracts and summaries of the 89 articles were reviewed. A total of 74 articles were retained according to their relevance. After duplicates were excluded and articles published only during or after the year 2012 were retained, a total of 54 articles were obtained and included in the literature review. In addition, out of the 17 reports and publications identified (grey literature), only 12 were relevant and included in the literature review.

- Preparation for in-country work: At an inception meeting in November 2017, the project was formally presented to national stakeholders of the Country Coordinating Mechanism (CCM), explaining the role of the baseline assessment and data collection procedures,

summarising the findings of the desk review, and inviting input about the process. A team of Côte d'Ivoire researchers was then assembled to carry out the in-country tasks of the assessment. Standardized data collection instruments developed for these Global Fund assessments were translated into French and reviewed by the research team for potential adaptations to the vocabulary and context of Côte d'Ivoire.

- Researchers were then trained in the use of these instruments and were assigned to schedule, conduct and report on key informant interviews and focus groups and to collect funding and costing data. From the desk review and in consultation with the research team, a list of key informants (KIs) and types of focus groups was developed to guide data collection. The list of targeted key informants was tailored to provide a balance and adequate sample across Côte d'Ivoire's geographic regions, key and vulnerable populations, gender, and type of stakeholder (e.g., government, civil society, technical partner, key population group, program implementer). The key informant list was also reviewed for balance of HIV and TB expertise, and expertise related to program interventions.
- Data collection. In late 2017, researchers conducted key informant interviews and focus groups with key and vulnerable populations and related programs in Abidjan, Agboville, Gagnoa, Grand Bassam and Jacqueville. A total of 182 people were consulted in 15 focus groups and 24 interviews. Most interviews and many focus groups covered both TB and HIV or were more generally about rights-related barriers and legal justice. Data was collected about:
  - Human rights-related barriers to HIV and TB services
  - Key and vulnerable populations most affected by these barriers
  - Programs carried out currently or in the past that have been found through evaluation or through agreement by many KIs to be effective in reducing these barriers
  - What is needed to comprehensively address the most significant barriers for all groups most affected by these barriers
  - Funding of all such programs (for 2016 financial year) and
  - Costing of effective[14] programs carried out presently or in the past.

- Data analysis. All interviews and focus group reports were compiled and analysed, in combination with compiled programmatic costs and findings from the desk review, to summarize a baseline situation: i.e., populations of concern; important rights-related barriers faced by these populations; existing programs that address these rights-related barriers; and an outline of a proposed comprehensive response, i.e., priority rights-related interventions, perspectives on the most urgently needed and feasible pathways to bring those rights-related programming to scale in Côte d'Ivoire, potential costs of that program implementation, and potential indicators of implementation, outcomes and impact.

- This report was then compiled using a standardized Country Report Outline and provided as the basis for discussion in the GF Secretariat between the Côte d'Ivoire Country Team and Community, Rights and Gender staff, before being brought to Côte d'Ivoire stakeholders for further discussion.

Costing methodology

Three sets of costing processes were undertaken for this assessment.

[14] Effectiveness is determined either by evaluation or by broad agreement among KIs that a program is/was effective.

First, all donors and funders who were discovered to have financed any activities in the program areas for HIV or TB were asked to supply details of the amount of funding provided and the program areas in which funding was provided and, if possible, to state the type of activities and reach or coverage of funded activities. This approach was largely successful for HIV, in that most donors were able to state which program areas were supported but did not provide details of the funded activities or their reach. For TB, the situation was more difficult, with one funder (Global Fund) providing only overall amounts and, through discussion with researchers, agreeing to apportion these funds to some program areas. In some cases for TB, donors were known to exist and to be funding activities, but they provided no details.

Second, we approached a wide range of implementers and undertook a costing process to understand how much it cost to carry out specific interventions. These processes followed the Retrospective Costing Guidelines (available from Global Fund on request). The individual costing sheets for services provided by each of the above organizations were provided to the Global Fund and translated into French for the purpose of data collection.

Third, from the results of the first two processes, prospective costing was carried out. For each type of intervention, an intervention-level cost was assembled. For example, many of the activities included national or regional trainings. The costs for these were found to be similar, no matter what topic was being discussed. For these and for other key interventions such as outreach work and training of health-care workers, intervention-level costs were constructed. For interventions that were new or had not been implemented in recent years, assumptions were made about the ways that these differed from interventions of which costs were known. These costs were used to construct calculation tables (see HIV and TB calculation tables in Annex 3). In these calculations, the number of services to be provided/people to be reached/ trained etc were multiplied by the intervention-level cost to provide an annual cost for each activity. (Annual costs are required because some activities only take place every 3 years, such as use of the Stigma Index, and others require capacity building or other activities in the first year, which are not needed in later years.)

In each case, HIV and TB, these calculation tables were used to provide overall program area and activity/sub-activity budgets, for each of 5 years as well as a 5-year total. These are the budgets that are used to construct the 5-year totals provided in costing columns in the latter parts of this report.

Limitations

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

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

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

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

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

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

3. BASELINE FINDINGS: HIV

Overview of epidemiological context and focus populations

As of 2016, approximately 460,000 people in Côte d'Ivoire were living with HIV, including 250,000 women, 170,000 men, and 36,000 children. The adult population prevalence was 2.7%, and HIV incidence per 1,000 population was 0.86%. In 2016, the number of deaths due to AIDS was 25,000, and during the same year 20,000 people were newly infected with HIV. In

the general population, 58% of people living with HIV know their status and 41% are accessing HIV treatment.[15]

The Government of Côte d'Ivoire has adopted the "90-90-90" UNAIDS treatment target and has made the commitment to reach this objective in its *Plan Stratégique National de lutte contre les IST et le Sida* [National Strategic Plan to fight AIDS and Sexually Transmitted Infections] (PSNLS), 2016-2020. The intended impact, as stated in the PSNLS, is, by 2020, to (i) decrease the rates of new HIV infections and AIDS-related deaths by 50% and 75%, respectively, (ii) implement an efficient continuum of care for PLHIV, orphans and vulnerable children (OVC) and their families, and (iii) improve the efficiency of the national response to the HIV epidemic. The key populations identified in the *Programme National de lutte contre le Sida* [National Program to fight AIDS] (PNLS) are female sex workers (FSW), men having sex with men (MSM), people who use drugs (PWUD) and prisoners. Other vulnerable groups identified include migrants, long-distance truck drivers, uniformed services personnel and clients of sex workers.[16]

Female sex workers: The number of female sex workers in the city of Abidjan was estimated at 9,211 in 2014.[17] There is, however, no recent estimate of the population size of female sex workers in Côte d'Ivoire. A 2014 biological and behavioural survey estimated the HIV prevalence among female sex workers in Côte d'Ivoire at 11.4%.[18,19,20]

In 2012, data from the Implementing AIDS Prevention and Care (IMPACT) Project showed that the locality of Abobo in Abidjan had the highest HIV prevalence among female sex workers at 29%, followed by the Yamoussoukro region with an HIV prevalence of 18%; Bouaké region with 17%; and Marcory locality with 15%.[21] According to the CAP-PUMLS (2010) study by the World Bank, in 2011, 81% of female sex workers reported using a condom with their last client. A much lower percentage reported using a condom with their non-paying sex partners.[22] During the period 1976-1985, female sex workers were associated with 95% of all new infections in Côte d'Ivoire but only 19% in 2005-2015 due to HIV interventions.[23]

Prevalence estimates of both physical and sexual violence are high among female sex workers in Abidjan. Physical violence, defined as ever having been violently pushed, shoved, slapped, hit, kicked, choked, or otherwise physically hurt, with a prevalence of 60.6%, was reported to be perpetrated by spouses, boyfriends, sexual partners, clients or uniformed police officers. Sexual violence, defined as

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[15]UNAIDS Country Fact Sheet, Côte d'Ivoire, 2016

[16]Ministry of Health and Public Hygiene – Republic of Côte d'Ivoire (2016). National Strategic *Plan 2016-2020 to fight AIDS and Sexually Transmitted Infections.*

[17] UNAIDS (2016). *UNAIDS Country factsheets - Côte d'Ivoire 2016*. [online] Available at: http://www.unaids.org/en/regionscountries/countries/ctedivoire [Accessed 22 Feb. 2018].

[18]Etude Biologique et Comportementale des IST/VIH/SIDA chez les Professionnels du sexe du district d'Abidjan, MSLS, 2014

[19] Lyons CE, Grosso A, Drame FM, et al. Physical and Sexual Violence Affecting Female Sex Workers in Abidjan, Côte d'Ivoire: Prevalence, and the Relationship with the Work Environment, HIV, and Access to Health Services. *JAIDS* 2017;75(1):9-17.

[20]Ministry of Health and Public Hygiene – Republic of Côte d'Ivoire (2016). National Strategic *Plan 2016-2020 to fight AIDS and Sexually Transmitted Infections.*

[21]Etude Biologique et Comportementale des IST/VIH/SIDA chez les Professionnels du sexe du district d'Abidjan, MSLS, 2014

[22]CAP-PUMLS, Comportement, Attitude et Pratique (CAP) du Programme d'Urgence Multisectorielle de Lutte contre le sida (PUMLS), World Bank, 2010

[23]Maheu-Giroux M, Vesga JF, Diabate S, et al. *Changing dynamics of HIV transmission in Côte d'Ivoire: modeling who acquired and transmitted infections and estimating the impact of past HIV interventions (1976-2015)*. *JAIDS* 2017 Apr 26. doi: 10.1097/QAI.0000000000001434 (epub)

ever experiencing forced sex through physical force, coercion, or penetration with an object against one's will, was reported to be most commonly perpetrated by clients and has a prevalence of 44.1%.[24]

Gay and other men who have sex with men: Establishing the size of the population of men who have sex with men in Côte d'Ivoire is challenging due to the high levels of stigma towards this population.[25] However, in the 2016 Integrated Biological Behaviour Survey (IBBS) among men who have sex with men in 5 towns in Côte d'Ivoire, the population was estimated, through extrapolation, at 59,040.[26] According to the 2016 IBBS, the HIV prevalence among men who have sex with men was estimated at 11.57%. More than half (54%) of those surveyed reported having been tested for HIV in the last 6 months. Some 84% stated that they used a condom during their last anal sex with a male partner, and 88% of men who have sex with men who engage in sex work (10% of the whole population) reported the use of condoms with their clients. A high proportion of those surveyed reported having been victims of physical violence at least once in their lifetime: 66% in Agboville, 53% in Yamoussoukro and 47% in Abidjan. Sexual violence is also common among men who have sex with men, with 18% of those surveyed reporting having ever experienced sexual violence perpetrated by sexual partners and law enforcement agents, among others.[27]

People who use drugs: In 2014, a survey conducted by *Médecins du Monde* estimated the number of people who use drugs in Abidjan to be 3,521, a somewhat low figure compared to the estimate of 6,000 obtained from the exploration phase of the survey.[28] Most of the people who use drugs smoke cocaine and heroin; only a small number inject drugs, an estimated 119. Drug injection is more stigmatised than other modes of consumption among both people who use drugs and the community at large. Sex work was reported by 15.8% of the people who use drugs (13.7% of the men), and 10.2% of the men reported sexual relations with other men. While the HIV prevalence among people who use drugs was 9.5%, and 5.3% among people who inject drugs. HIV prevalence among people who use drugs was estimated at 26.5% among women and 7.7% among men, i.e. women were 3.4 times more likely to be infected than men. A study conducted in 2014 by the Ministry of Health revealed that only 6.6% of the surveyed people who use drugs had accurate and complete knowledge about HIV transmission and prevention; 50% had more than one sexual partner, with whom only 23% regularly used condoms; and 38.1% had been tested for HIV at least once.[29]

[24] Lyons CE, Grosso A, Drame FM, et al. *Physical and Sexual Violence Affecting Female Sex Workers in Abidjan, Côte d'Ivoire: Prevalence, and the Relationship with the Work Environment, HIV, and Access to Health Services. JAIDS* 2017;75(1):9-17.

[25]Muraguri, N., Temmerman, M. and Geibel, S. (2012). A decade of research involving men who have sex with men in sub-Saharan Africa: Current knowledge and future directions. *SAHARA-J: Journal of Social Aspects of HIV/AIDS*, 9(3), pp.137-147.

[26]Etude biologique et comportementale des IST, du VIH et du sida chez les Hommes ayant des rapports Sexuels avec des Hommes des villes d'Abidjan, Agboville, Bouaké, Gagnoa, et Yamoussoukro, Ministère de la Santé et de l'Hygiène Publique, 2016

[27]Ibid.

[28] Bouscaillou J, Evanno J, Prouté M et al. Santé des personnes usagères de drogue à Abidjan en Côte d'Ivoire. Paris: Médecins du Monde, 2014.

[29]Ministère de la Santé et de l'Hygiène Publique (2016). *Plan Stratégique National 2016-2020 de Lutte contre le SIDA et les IST (PNLS)*. Côte d'Ivoire.

Prisoners: The size of the prison population in Côte d'Ivoire is estimated at 12,369.[30]Lack of access to HIV prevention and care services, high risk of HIV and low awareness of risk of HIV infection are prevalent in the prison environment in the country.[31] In a study conducted in 2014 among 370 new detainees at the *Maison d'Arrêt et de Correction d'Abidjan* [main prison in Abidjan](MACA), it was found that 13% of inmates used drugs, of whom 8.3% used injectable drugs. The vast majority of respondents (97.3%) experienced sexual intercourse, and 31.9% had multiple sexual partners; 50.6% did not use condoms, and among those who used condoms, 73.6% used them irregularly. Overall, 7.9% were HIV-positive.[32]

Overview of the law, policy, political and strategy context for human rights and HIV

Côte d'Ivoire is a constitutional republic with a legislature, executive branch and independent judiciary. The Constitution of Côte d'Ivoire adheres to liberal democratic principles and inalienable human rights, including the right to education and health, freedom of religion, freedom of association, and equal treatment under the law.[33]

The *Commission Nationale des Droits de l'Homme de Côte d'Ivoire* [National Human Rights Commission of Côte d'Ivoire] (CNDHCI) is the highest-ranking institution in the country for the promotion, and protection of human rights. It has an advisory, consultative and evaluative role; acts to ensure that laws and regulations are in line with international treaties; and also receives complaints for violations of human rights and investigates them. The CNDHCI produces an annual report of its activities and the situation in Côte d'Ivoire with regard to human rights. A technical committee on human rights and HIV, under the aegis of the Ministry of Justice and Human Rights, was set up in 2017. Its role is to coordinate all activities linked to human rights with regard to HIV.

The health service delivery system in Côte d'Ivoire is made up of both the public and the private sector. Although the public health sector is larger, the private health sector is growing steadily. The country is divided into 82 health districts. The public health sector comprises health facilities at 3 levels: 1,967 primary health institutions including urban, rural and community health centres; the secondary health institutions with 68 general hospitals, 17 regional hospitals and 2 specialised hospitals, and the tertiary health institutions, namely, 4 university hospitals and 5 national specialised health institutions. As of 2011, the booming private health sector comprised 2,036 institutions, including private clinics, private health centres, and pharmacies, among others. Community organisations and religious associations also provide some level of health care to the population, although only at the primary care level, totalling 49 health facilities.[34]

The armed conflict (2010-11) had major consequences for the country's health infrastructure and services. There were significant reductions of health staff and other resources, including

[30]UNAIDS AIDS Info, 2016
[31]PNLS, op.cit.
[32]Aké-Tano Sassor Odile Purifine, Konan Yao Eugène, et al.. *Seroprevalence of HIV Infection and Associated Factors Among Newly Incarcerated Prisoners in Abidjan, Ivory Coast*. Science Journal of Public Health. Vol. 5, No. 5, 2017, pp. 377-382. doi: 10.11648/j.sjph.20170505.13
[33]Oxford Business Group. (2018). Overview of Côte d'Ivoire's legal system and recent reforms. [online] Available at: https://oxfordbusinessgroup.com/analysis/judicial-framework-overview-legal-system-and-recent-reforms [Accessed 20 Feb. 2018].
[34] Ministère de la santé et de l'hygiène publique. (2016). *Plan National de Développement Sanitaire 2016-2020 - Draft Consolidé*. [online] Available at: http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/Côte_divoire/pnds_2016-2020.pdf [Accessed 20 Feb. 2018].

stocks of medical supplies and equipment. An analysis of the health challenges in conflict-ridden Côte d'Ivoire showed that "by April 2011, more than 70% of the population lacked access to health services and there were an estimated 800,000 internally displaced people throughout Côte d'Ivoire. Health facilities faced critical shortages of medical supplies caused by disruptions in the supply chain".[35]

Despite the country's steady recovery from the 2010-2011 crisis, gaps remain in restoring basic services such as healthcare.[36] Côte d'Ivoire continues to record high child and maternal mortality despite free healthcare for children and mothers. Moreover, the health profile of Ivoirians is characterised by a life expectancy at birth of around 53 years; a high non-communicable disease burden, including cancers and cardiovascular diseases, which account for 31% of deaths; and a high prevalence of HIV and TB. Communicable diseases remain the main cause of death of Ivoirians.[37]

Although the legal framework is well defined, its implementation by the judicial system remains problematic.[38] The law on HIV/AIDS of July 2014 guarantees the rights of people living with HIV, their access to treatment and care, and protection against stigma and discrimination.[39] Nevertheless, many Ivoirians lack access to HIV treatment and care services.

The Human Rights Watch World Report of 2016 highlighted problems of political interference and corruption that continue to plague the judiciary in Côte d'Ivoire. Although the law guarantees to every citizen the right to a fair trial and judgement given within a reasonable time, "prolonged pre-trial detention remained the rule rather than the exception and most prisons are overcrowded and lack adequate nutrition, sanitation, and medical care."[40]

Côte d'Ivoire does not criminalise same-sex conduct; however, same-sex couples can be prosecuted for public acts of indecency under Article 360 of the penal code. To date, no law prohibits discrimination on the grounds of sexual orientation, gender identity, or intersex status.

Gender-based violence (GBV) and gender inequality are prevalent in Côte d'Ivoire. The country in 2016 had a Gender Inequality Index ranking of 171 out of 188 countries.[41] Some 80% of girls and young women aged 15-19 years and 72% of women aged 20-24 years do not have a final say on their own health care.[42] Côte d'Ivoire has ratified several international conventions and agreements that recognise the civil, political and socio-economic rights of women, including the Plan of Action of the Beijing Conference in 1995. However, because of strong cultural and religious attitudes and beliefs, Ivoirian women still face gender-based discrimination and violence,

[35] Gaber S, Patel P. Tracing health system challenges in post-conflict Côte d'Ivoire from 1893 to 2013. Global Public Health. 2013;8(6):698-712.
[36] WHO. (2011). Thousands without adequate health care in Western Côte d'Ivoire _ WHO scales up its operations. Retrieved from: http://www.who.int/hac/crises/civ/sitreps/18april 2011/en/index.html
[37] World Health Organization. (2016). *Country Cooperation Strategy - Côte d'Ivoire*. [online] Available at: http://apps.who.int/iris/bitstream/10665/137146/1/ccsbrief_civ_en.pdf?ua=1 [Accessed 22 Feb. 2018].
[38] Oxford Business Group. (2018). Overview of Côte d'Ivoire's legal system and recent reforms. [online] Available at: https://oxfordbusinessgroup.com/analysis/judicial-framework-overview-legal-system-and-recent-reforms [Accessed 20 Feb. 2018].
[39] Journal official de la République de Côte d'Ivoire, Numéro spécial, 15 July 2014
[40] Human Rights Watch, World Report 2016
[41] World Bank. (2017). *Côte d'Ivoire*. [online] Available at: http://www.worldbank.org/en/country/Côtedivoire [Accessed 20 Feb. 2018].
[42] UNAIDS (2014). *The Gap Report*. Geneva: UNAIDS.

such as female genital mutilation/cutting.[43] According to the Human Rights Watch World Report of 2018, "although the UN reported in January 2017 that the number of reported cases of sexual and gender-based violence has progressively decreased since 2014, social stigma and widespread impunity prevent many victims from reporting abuses". Côte d'Ivoire registered at least 80 cases of rape and other sexual abuses in the first five months of 2015, an underestimated figure as fear of stigma still prevents victims from reporting rape cases.[44,45]

The LGBT community in Côte d'Ivoire is particularly at risk of gender-based violence. In spite of the absence of a law criminalising homosexuality, diversity of gender and sexual orientation is not accepted. In January 2014, homophobic attacks were perpetrated against *Alternative CI*, an organisation in Abidjan working for the rights of the LGBT community. The attackers used rocks, garbage and graffiti, damaging the building. The offices were ransacked, the security officer severely beaten, and the house of the director attacked.[46]

Poverty undermines human rights, including the right to access HIV prevention, treatment and care services. Moreover, the lack of educational and economic opportunity also undermines people's ability to realize their right to HIV services. Many Ivoirians live in extreme poverty, especially in rural areas, where the challenges are improper housing, inadequate water and sanitary facilities, among others.[47] Although the unemployment rate in the country is only 5.3%, the challenge for most Ivoirians is not to find employment but to find employment that will earn them a decent income: 80% of workers in the Ivoirian labour market are self-employed and work in household enterprises or farms, earning less than the equivalent of $120 per month.[48] The literacy rate is 43.1% among people aged 15 and older.

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

Barriers related to stigma and discrimination

Stigma can lead to discrimination and other human rights violations, which can significantly undermine the welfare of people living with HIV.[49] In Côte d'Ivoire, although the 2014 HIV law expressly condemns all forms of discrimination against PLHIV, in reality, stigma and discrimination still prevail. Data from recent surveys reveal that 25-49% of men, women and young people aged 15-49 years hold discriminatory attitudes towards PLHIV. Many persons with HIV choose

[43] Ministère de la justice et des droits de l'homme, LIDHO. (2016). *Projet de renforcement du système judicaire et pénitentiaire et de la protection des droits de l'homme en Côte d'Ivoire - Je connais mes droits – Lutte contre le traite des personnes et la violence basée sur le genre.*
[44] Human Rights Watch, World Report 2016
[45] Human Rights Watch, World Report 2018
[46] Amnesty.org. (2018). *Côte d'Ivoire: Activists in hiding after wave of homophobic attacks.* [online] Available at: https://www.amnesty.org/en/latest/news/2014/01/Côte-d-ivoire-homophobic-attacks/ [Accessed 13 Mar. 2018].
[47] Habitat for humanity. [online] Available at https://www.habitatforhumanity.org.uk/country/Côte-divoire/
[48] Morisset, J. (2018). *The challenge of creating quality jobs in Côte d'Ivoire*. [online] Brookings. Available at: https://www.brookings.edu/blog/future-development/2015/12/17/the-challenge-of-creating-quality-jobs-in-Côte-divoire/ [Accessed 20 Feb. 2018].
[49] UNAIDS (2005). HIV - *Related Stigma, Discrimination and Human Rights Violations. Case studies of successful programmes.* [online] Geneva: UNAIDS. Available at: http://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf [Accessed 21 Feb. 2018].

not to reveal their status to their immediate circles of family or friends for fear of stigmatisation.[50,51]

According to the PLHIV Stigma Index, 40.4% of PLHIV have experienced stigma in Côte d'Ivoire. PLHIV report that they have been refused access to health services because of their HIV status. Many have also experienced self-stigma.[52] According to reports from NGOs in Grand Bassam, self-stigma is a serious obstacle to the uptake of HIV services as the person suffering from it may be in denial and then may not seek treatment. Although discrimination against PLHIV is covered by the 2014 HIV law, in practice access to certain jobs in the public administration is denied to PLHIV, for instance in the National Police. Access to bank loans and insurance also remain problematic for PLHIV.[53]

The key populations in all focus group discussions in all regions covered by the study spoke of widespread stigma and discrimination in their families, in school, in medical and religious contexts, by their friends, peers, religious leaders, police and healthcare workers. This stigma and discrimination are related to moral judgements about their economic activity (sex work), their sexual orientation, or illegal practices (consuming drugs), as well as negative perceptions related to HIV infection.

The stigma in medical settings leads to discriminatory behaviour such as refusing to touch men who have sex with men because of religious beliefs; morally questioning the practices of female sex workers and men who have sex with men; disclosing the person's HIV status; testing female sex workers without their consent; and refusing treatment to people who use drugs because they are "dirty" or transgender persons because they are "against nature". Generally, these abuses are more present in public health services, and even more so in rural settings. Key populations report experiencing lower levels of stigma in community-based health centres, but some key populations, such as men who have sex with men, report that they still feel stigmatized in these health centres, especially by the way the receptionists look at them and comments from other patients on their gender. Sex workers mentioned that the questions the health care workers ask for monitoring and evaluation purposes are too intrusive, and they feel embarrassed by them. Many of the people who use drugs in Abidjan live in poor and precarious communities, primarily because of the stigma they face.[54]

Barriers related to fulfilment of human rights in the health care system

A lack of knowledge among the personnel of the health sector on human rights and medical ethics related to HIV can act as a significant barrier for the uptake and retention of HIV treatment services. This situation prevails in almost all care settings in Côte d'Ivoire. Health care workers lack training and knowledge about the specific care needs of female sex workers and men who

[50] UNAIDS (2017). *Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond*. Geneva: UNAIDS.
[51] US Department of State. (2015). *Côte d'Ivoire 2015 Human Rights Report*. [online] Available at: https://www.state.gov/documents/organization/252885.pdf [Accessed 28 Oct. 2017].
[52] Etude nationale de l'index de stigmatisation et discrimination envers les personnes vivant avec le VIH en Côte d'Ivoire, 2016
[53] Baseline Evaluation Report - Africa Regional HIV Grant: Removing Legal Barriers, Institute for Global Health, University of Southern California
[54] Bouscaillou et al., op.cit.

have sex with men who come to seek treatment. PLHIV report that health care providers are unable to provide correct information to their queries regarding their health problems.[55]

Consequently, PLHIV and other key populations experience stigmatising and discriminatory attitudes and practices from health providers in the health system. Such behaviour includes unwelcoming attitudes, neglecting patients, providing a different quality of treatment based on someone's HIV status, denying care and breaching confidentiality, among others. There have been reports of many doctors refusing to provide treatment to men who have sex with men because of their sexual orientation. In focus group discussions, sex workers report that the judgemental attitude of doctors is a discouraging factor, leading them to stopping their treatment. Gay men and other men who have sex with men avoided or delayed health care visits due to fear of stigma from health care providers.[56]

Barriers related to knowledge, attitudes and practices of law-makers and law enforcement agents

In-country interviews revealed a widespread lack of genuine understanding of human rights among people involved in the HIV response within the government of Côte d'Ivoire. Interviewees reported that there is a general absence of understanding on the right to health in particular, which undermined this component of the National Strategic Plan to fight HIV and AIDS in Côte d'Ivoire.[57]

In Côte d'Ivoire, law enforcement agents remain generally untrained and unaware of rights of key populations and on HIV/AIDS. There are numerous reports of law enforcement agents harassing, arresting, extorting and sometimes physically and sexually abusing people suspected of sex work, drug use and homosexuality. Very often these acts are perpetrated over and over with impunity.

Female sex workers in Abidjan report experiencing high levels of harassment, intimidation, blackmail, both physical and sexual violence and limited protection by uniformed officers.[58] Focus group discussions and interviews revealed that law enforcement agents adopt unlawful practices towards key populations. Female sex workers from the area of Abobo in Abidjan reported that members of the police perpetrate sexual violence, including rape, and extortion is common practice. The *Brigade Mondaine* (vice squad) is reportedly the main perpetrator of violence and extortion. The extortion system is so embedded that female sex workers have to pay a weekly sum to keep the vice squad of their locality at bay, but are then extorted by the vice squad of another locality that raids their site. Foreign sex workers, such as Nigerians, report having to pay more than their peers since they are vulnerable to deportation. Other female sex workers report having been arrested by the police and stripped of all their belongings.

Focus group discussions with people who use drugs revealed cases of police raids in 'ghettos'--informal meeting places to consume drugs that serve occasionally as a shelter for homeless people who use drugs. During raids, the police burn their drugs and drug paraphernalia, along with

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[55]Facteurs Influençant la Sortie des Patients Vivant avec le VIH du Circuit de Traitement en Côte d'Ivoire, MSLS, 2014

[56] UNAIDS (2017). *Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond*. Geneva: UNAIDS.

[57]Baseline Evaluation Report - Africa Regional HIV Grant: Removing Legal Barriers, Institute for Global Health, University of Southern California

[58]Lyons, C., Grosso, A., Drame, F. et al. (2017). Physical and Sexual Violence Affecting Female Sex Workers in Abidjan, Côte d'Ivoire. *Journal of Acquired Immune Deficiency Syndromes*, 75(1):9-17.

all their belongings and their HIV medication. As a result, people who use drugs move to another location and are lost to follow-up by peer educators. When they are arrested and imprisoned at the MACA, people who use drugs who with HIV reported not having regular access to their ARV treatment. Men who have sex with men from Port-Bouët in Abidjan said that during police arrests they are often humiliated and prevented from accessing health services since the police officers believe they are "not worthy to be alive because of their unnatural behaviour".

Barriers related to legal literacy among key and vulnerable populations

Many in-country interviews summarise how the law is viewed by the population in Côte d'Ivoire: "the laws that exist are not extremely problematic: it is how the laws are applied and how little of what good law exists is known". Côte d'Ivoire has a literacy rate of 43.1%. This low level of literacy undermines people's understanding of existing laws. In 2014, Côte d'Ivoire adopted the HIV law. However, according to a 2016 political analysis conducted by ENDA Santé, the general population knew little about the HIV law three years after its passage.[59]

While the HIV law provides protection to PLHIV, prisoners, women and children, it does not specifically mention other key populations. There are other human rights instruments, treaties and conventions to which Côte d'Ivoire is a party that guarantee protection to key populations. Furthermore, Côte d'Ivoire established the PNLS in 2015, and the CNDHCI in 2004, both of which specifically target key populations. In spite of these strong commitments to human rights, the information on rights does not permeate to all levels of the Ivoirian society. The Stigma Index Report on Côte d'Ivoire states that 74.8% of PLHIV have never heard of the UN Declaration of Commitment on HIV/AIDS, and 82.6 % of PLHIV do not know about the HIV law of 14 July 2014.[60]

Barriers related to availability and accessibility of HIV-related legal services

According to interviews and focus group discussions with key populations and NGOs in Côte d'Ivoire, HIV-related discrimination, injustices and human rights violations include: breaches of privacy and confidentiality, as exemplified by the participants in a focus group who referred to health care providers disclosing the HIV status of a patient to his relatives in the town of Tiapoum; illegal action and violence by the police during police raids of 'ghettos' of people who use drugs; discrimination in health services, for instance when health care providers refuse to treat female sex workers and men who have sex with men; discrimination in employment, education, housing and social services; denial of inheritance rights; and gender-based discrimination and violence, including women being ejected from their houses by their husbands after learning about the women's HIV status.

Even where PLHIV and other key populations are aware of their rights, they have little access to justice and little chance of getting legal redress for HIV-related harms.[61] Although interviews with key informants from NGOs displayed their active involvement in providing legal advice and representation to PLHIV and other key populations, studies show that a high percentage of key populations have never had legal recourse when their rights have been violated, primarily because they had limited financial resources, or because they felt intimidated and did not want to

[59]Analyse Politique de la Côte D'Ivoire. ENDA Sante, Kouassi G., July 2016
[60]Etude nationale de l'index de stigmatisation et discrimination envers les personnes vivant avec le VIH en Côte d'Ivoire, 2016
[61] UNAIDS Guidance Note 2012. Key Programmes To Reduce Stigma And Discrimination And Increase Access To Justice In National HIV Responses.

be 'exposed' (reported by men who have sex with men living with HIV in Abidjan) and were afraid of the outcome.[62] Other forms of legal services that seem to be lacking in Côte d'Ivoire are alternative/community forms of dispute resolution; and engaging religious or traditional leaders and traditional legal systems (e.g. village courts) with a view to resolving disputes and changing harmful traditional norms.

Barriers related to laws and policies and HIV

The legal system in Côte d'Ivoire is a mix of civil and customary law. Although Côte d'Ivoire does not directly prohibit homosexuality, Article 360 of the Penal Code of 31 August 1981 referred to it (until recently) by defining the crime of "public indecency" as "an indecent act or act against nature with an individual of the same gender". The crime is subject to a term of imprisonment of up to two years. This article was recently revised to remove the part about "individual of the same gender", but it is too early to say what effect this change will make on policing practices.[63]

One interviewee reflected on the need to explicitly name key populations in the HIV Law both for their protection and to facilitate the ability to work with and provide services to them.[64] Also, Article 4 of the HIV law, which denies access for minors less than 16 years old to HIV testing without the consent of the parents, is a barrier to young PLHIV accessing HIV services.[65,66]

Punitive practices, policies and laws in Côte d'Ivoire drive key populations away from health care. Although in Côte d'Ivoire trading sex for money is not explicitly unlawful, soliciting in public areas is penalised and its prohibition is widely enforced, which has a negative impact on HIV prevention and care among sex workers. Focus groups among key populations told of harsh policing and illegal practices by police such as harassment, extortion, arbitrary arrests and violence, including sexual violence, against people who use drugs, sex workers and LGBT people. These practices force sex workers and their clients, LGBT people and people who use drugs to go underground, avoid health services and/or engage in risky practices.[67]

Many reports from focus group discussions and interviews described illegal practices in the health system, such as lack of informed consent and confidentiality or mandatory testing. Demands for bribes or high fees and policies allowing for discriminatory treatment of key populations were commonly raised in focus groups.

Application of customary law is widespread in rural areas, which can be detrimental to the rights of women and girls. Some cultural traditions, which form part of the customary law, continue to constitute barriers to access to HIV services for many people including key populations. Female genital mutilation/cutting is still a serious problem in some parts of the country, especially in rural areas in the northern and north-western regions, where more than 75% of women had been subjected to the practice.[68] Other harmful traditional practices include dowry deaths (the

[62] Stigma index Report, Côte d'Ivoire 2016
[63] Baseline Evaluation Report - Africa Regional HIV Grant: Removing Legal Barriers, Institute for Global Health, University of Southern California
[64] Ibid.
[65] ILO (2017). *Loi du 11 juillet 2014 portant régime de prévention, de protection et répression en matière de lutte contre le VIH et le SIDA*. [online] Available at: http://www.ilo.org/aids/legislation/WCMS_250391/lang--fr/index.htm [Accessed 27 Oct. 2017].
[66] UNAIDS (2014). *The Gap Report*. Geneva: UNAIDS.
[67] The Global Fund to Fight AIDS, TB and Malaria, *HIV, Human Rights and Gender Equality Technical Brief*, Geneva, 2017.
[68] US Dept. of State, op.cit.

killing of brides over dowry disputes), levirate marriage (forcing a widow to marry her dead husband's brother) and sororate marriage (forcing a woman to marry her dead sister's husband).[69]

The law does not specifically penalise spousal rape nor does it specifically outlaw domestic violence, which are widespread in the country. Victims seldom report domestic violence due to cultural barriers. Police often ignore women who report spousal rape or domestic violence. Visibly pregnant adolescent girls are denied access to schools. Gender-discriminating laws and policies lead to an unequal power relationship between men and women and gender-related vulnerabilities such as lack of autonomy, unequal access to educational and economic opportunities, and forced or early marriage. These deny women and girls the right to negotiate for safer sex, limit their access to health care and expose them to the risk of HIV infection, with significant negative public health consequences.[70]

There also exist overly-broad laws criminalising transmission of HIV that make people fearful of getting tested or informing their sexual partners of their HIV status. Moreover, people in police custody and prisons are routinely denied access to condoms, harm reduction measures and other forms of HIV prevention, as well as being denied treatment in some places.[71]

Migrants, especially undocumented migrants, face legal barriers to health service access and do not have the same entitlements to health care as citizens. They are denied access to HIV prevention and treatment that is available to citizens.[72]

At the beginning of 2017, the number of refugees and asylum seekers was estimated at 1,604 by the UNHCR. Moreover, 2.3 million people had been internally displaced since 2002, out of whom a total of 300,889 were still living in internal displacement as of mid-2014.[73] Statelessness persists in Côte d'Ivoire, with an estimated 700,000 stateless persons, including 300,000 orphans not recognised by law and 400,000 historical migrants and their descendants.[74,75]These populations have few or no entitlements to health care in Côte d'Ivoire and face difficulty in accessing health services in the country. There is however a lack of information regarding specific legal barriers to accessing healthcare by migrants and internally displaced people in Côte d'Ivoire.

Barriers related to gender norms and gender-related vulnerabilities related to HIV

Another important barrier that limits ability to seek care, especially for women and girls, is gender inequality. Although laws exist that prohibit gender inequality and gender-based violence, women and girls in Côte d'Ivoire continue to suffer from both. Traditional attitudes, beliefs and practices limit the ability of women and girls to access and retain HIV services and increase their vulnerabilities to HIV.

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[69] Ibid.
[70] Ibid.
[71] Human Rights Watch, Côte d'Ivoire, Human Rights Report 2015
[72] UNAIDS (2014). *The Gap Report*. Geneva: UNAIDS.
[73] UN High Commissioner for Refugees (UNHCR), *Côte d'Ivoire - COI Compilation*, 31 August 2017, available at: http://www.refworld.org/docid/59cc9fb14.html [accessed 28 October 2017]
[74] Sturm, N. (2018). Reducing statelessness in Côte d'Ivoire one case at a time. [online] UNHCR. Available at: http://www.unhcr.org/afr/news/latest/2016/2/56cef0d79/reducing-statelessness--divoire-case-time.html [Accessed 28 Oct. 2017].
[75] US Dept. of State, op.cit.

Human Rights Watch has reported early and forced marriages; parental preference for educating boys rather than girls, particularly in rural areas; prohibiting access to schools for pregnant girls; patterns of inheritance excluding women; threats or violence from husbands or family members when seeking family planning or health services; rape including spousal rape which is not specifically penalised by the law; female genital mutilation/cutting; traditional practices, such as dowry deaths and levirate and sororate marriage.[76]

In Côte d'Ivoire, many adolescent girls and young women do not have a final say on their own health care. Moreover, studies have shown that many girls and young women had their first sexual experience before the age of 15.[77] The restricted access to youth-friendly or age-adapted sexual and reproductive health services result in adolescent girls and young women in Côte d'Ivoire not being properly equipped to manage their sexual health or to reduce potential health risks, including HIV infection.[78] A high pregnancy rate observed among 15-19 year old HIV-positive adolescents on ART in Abidjan suggests that the sexual and reproductive health needs of adolescent girls are unmet in Côte d'Ivoire.[79]

Furthermore, many women in Côte d'Ivoire are victims of gender-based violence. Female sex workers are exposed to violence in their place of work by different perpetrators, including clients and police officers. Many adolescent girls exchange sex for money, mainly in the suburbs of Abidjan, because of their precarious financial situation where they often have to cater for the needs of members of their family. They are very vulnerable to violence and HIV, since they are often less literate on HIV and their rights and are less able to insist on safer sex with their clients. There is currently no age-sensitive programming to cater for their needs.[80]

Focus group discussions with sex workers, men who have sex with men and transgender people reflect the high rate of gender-based violence, including physical, sexual and verbal violence. Women who use drugs also report being victims of sexual violence by the police during raids of 'ghettos'. Similarly, lesbians report being sexually abused by health care personnel during gynaecological check-ups.

Intimate partner violence against women is also a critical health hazard in Côte d'Ivoire and has been shown to undermine women's ability to insist on safer sex with their partners or to use HIV prevention and treatment services.[81]

Existing interventions, ongoing gaps and insufficiencies and a proposed comprehensive approach

[76] Human Rights Watch, Côte d'Ivoire Human Rights Report 2015
[77] UNAIDS (2014). *The Gap Report*. Geneva: UNAIDS.
[78] Ibid.
[79] Arikawa, S., Eboua, T., Kouakou, K. et al. (2016). Pregnancy incidence and associated factors among HIV-infected female adolescents in HIV care in urban Côte d'Ivoire, 2009–2013. *Global Health Action*, 9(1), p.31622.
[80]Analyse situationnelle des facteurs de vulnérabilité socioéconomiques des jeunes filles victimes d'exploitation sexuelle face au VIH/SIDA, de leur accès aux services de santé de la reproduction et au planning familial dans le cadre de la mise en œuvre du Programme du Fonds Mondial VIH Volet communautaire, MSLS, 2016
[81] UNAIDS (2017). *Confronting discrimination: overcoming HIV-related stigma and discrimination in health-care settings and beyond*. Geneva: UNAIDS.

This section summarizes the existing or recent programs that have been implemented in Côte d'Ivoire to remove human rights-related barriers to services and provides a summary of the proposed elements of a comprehensive program, based on the seven program areas set out in the Global Fund *HIV, Human Rights and Gender Equality Technical Brief*.[82]

The seven program areas are programs to:

PA 1: Reduce HIV-related stigma and discrimination
PA 2: Train health care workers on human rights and ethics related to HIV
PA 3: Sensitize lawmakers and law enforcement agents
PA 4: Provide legal literacy ("know your rights")
PA 5: Provide HIV-related legal services
PA 6: Monitor and reform laws, regulations, policies and official practices related to HIV
PA 7: Reduce discrimination against women and girls in the context of HIV

PA1: Programs to reduce stigma and discrimination for key and vulnerable populations

Existing interventions

The *Programme National de lutte contre le Sida* [National Program to fight HIV] (PNLS) was created in 2014 to coordinate the HIV response. The key populations department of the PNLS is responsible for contributing to the reduction of stigma and dissemination towards key and vulnerable populations. The PNLS is the government Principal Recipient (PR) and *Alliance Côte d'Ivoire* (Alliance CI) is the NGO PR for the Global Fund HIV grants the country receives. *Alliance CI* manages all the Global Fund funded community interventions towards key populations.

Programs to reduce stigma and discrimination for key and vulnerable populations are mainly based on the tool "Look In Look Out Connect" (LILO), developed by the International HIV/AIDS Alliance. The LILO program started in 2015 in Côte d'Ivoire and aims to change negative perceptions about LGBT, sex work and use of drugs into positive ones. The 3-day course includes information on HIV and rights and testimonies of key populations A pool of approximately ten trainers, mainly NGO staff and members of key populations, has been established. The LILO interventions target key populations to reduce self-stigma and stigma among key populations, health care workers, the police force, the media, members of parliament, lawyers, religious leaders and institutions (public and NGO) working with key populations. Since religious leaders have a key role to play in community life, *Alliance CI* is currently developing, in collaboration with the association of religious leaders, a guide for these leaders on how to support key populations.

In 2016, *Alliance CI* conducted the country's first PLHIV Stigma Index study, which was used to inform the development of strategies to reduce stigma and discrimination towards PLHIV. Following the Stigma Index findings, a mass media campaign was launched in December 2017 to address stigma and discrimination against PLHIV.

In addition, community-level work is also conducted by LGBT, SW and PWUD NGOs such as *Espace Confiance, Ruban Rouge CI, ASD Divo, SA Pharm, DED Toulepleu, IDE Afrique, IDEAL Korhogo, IDEAL Boundiali, Blety Odiene and Asal Tingrela, La Fontaine, Anonyme, Parole*

[82] Global Fund to Fight AIDS, TB and Malaria, *Technical Brief HIV, Human Rights and Gender Equality,* Gevena, 2017.

Autour de la Santé, Foyer du Bonheur and *La Relève*. These NGOs manage peer educator programs and peer support groups to build people's individual knowledge and capacity to overcome self-stigma, as well as to confront stigma and discrimination. Peer education programs are made up of approximately 350 key population peer educators (SW, MSM and PWUD) and cover all health regions of Côte d'Ivoire, with a concentration around high prevalence zones.

The key population Global Fund SR, Heartland Alliance International Côte d'Ivoire (HAI CI), also conducted sensitization and advocacy sessions with medical personnel and religious leaders on diversity of gender. The NGO also holds community dialogue sessions between village councils, youth and women movements, teachers and religious leaders about gender-based violence with regard to women, MSM and SW.

Focus	Summary	Scale	Budget USD	Location	Implementer
Community mobilisation & education on stigma & discrimination	Information on stigma and discrimination is given to key populations during HIV screening and counselling (both mobile and fixed), outreach awareness activities by peer educators, and during support groups for PLHIV. Advocacy activities also target members of the wider community to sensitize them about the rights of key populations and how to reduce stigma and discrimination towards them.	1,836 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	10,449	Alépé Adiaké Bassam	Espace Confiance
		Not available	Not available	Treichville-Marcory Koumassi-Port-Bouet-Vridi Yopougon-Ouest-Songon Dabou	Espace Confiance
		1,152 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	6,598	Adzopé Agboville	Ruban Rouge CI
		Not available	Not available	Yopougon-Est	Ruban Rouge CI
		6,062 people sensitised on human rights of key populations	6,062	Divo	ASD Divo

		during BCC and advocacy sessions and HIV screening			
		771 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	6,755	Séguéla	SAPHARM
		319 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	3,115	Toulepleu	DED Toulepleu
		1,457 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	8,204	Bangolo Danané Biankouma	IDE Afrique
		Not available	Not available	Man Bangolo	IDE Afrique
		881 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	5,107	Korhogo	IDEAL Korhogo
		568 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	4,064	Boundiali	IDEAL Boundiali
		301 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	3,097	Odienné	BLETY Odienné
		Not available	Not available	Yopougon-Est	BLETY Odienné

		277 people sensitised on human rights of key populations during BCC and advocacy sessions and HIV screening	2,936	Tingrela	ASAL Tingrela

The total amount for programs to reduce stigma and discrimination for key and vulnerable groups in 2016 was USD 56,387.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The evaluation of the LILO interventions highlighted how at an individual level those who had experienced LILO felt a "higher level of acceptance and commitment towards key populations and reinforced self-esteem of key populations".[83] Impact on the family and community levels was mainly through "renewing dialogue between family members and feeling more equipped to face adversity".[84] At the institutional level, where the leaders (management and board) of an entire organisation participate in the program and can bring policy changes in their institution, the LILO interventions "developed a stronger commitment to addressing key population issues and practical changes such as an evolution in the language used by NGO employees have been noticed".[85] The method of the evaluation was purely qualitative, based on 15 key informant interviews and one focus group discussion with key populations, NGOs working for key populations, healthcare personnel, religious leaders and the Principal Recipients for the Global Fund grant. Although the method focused more on documenting the positive impact of LILO, rather than determining its shortcomings, stakeholders interviewed during the data collection for the baseline study also confirmed that they believe LILO is a program that should be replicated.

The main key gap at the level of the LILO intervention is the limited impact it has on certain stakeholders. Some men who have sex with men reported during focus group discussions that the training clearly didn't work with religious leaders, as there is still a lot of stigma at that level. In addition, once LILO sessions are conducted, there is no follow-up to determine the impact the interventions have had, and what further reorientations are required.

Although LILO is relatively new in the country (implemented since 2015), the general support it generates among stakeholders creates an opportunity to build upon an accepted existing intervention to further strengthen interventions to reduce stigma and discrimination towards key populations. The program should be reconceptualised as a more comprehensive training process, rather than a one-off intervention to ensure effective behavioural change. A formal mechanism to monitor the impact at the level of institutions following the program would enable regular reviews and potential reorientations if required. The pool of trainers should also be enlarged so that more trainers from the specific targeted population can conduct the sessions. In this way, for example, religious leaders themselves would be facilitating sessions with other religious leaders, actively contributing to adapting the sessions to the specificities of their peers, and potentially increasing the impact of the program. Community dialogue sessions with different stakeholders could also be integrated into the intervention, as and when needed, to create more debate and exchanges on the roles of each stakeholder.

[83] Alliance-CI & KP Connect (2017). *LILO CONNECT en Côte d'Ivoire – Rapport d'impact Comment LILO Connect contribue à réduire la stigmatisation et la discrimination envers les Populations clés en Côte d'Ivoire*. Abidjan.
[84] Ibid.
[85] Ibid.

The reconceptualised program should then be up scaled up to cover the following 35 sanitary districts in the first phase: Seguela, Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouaké. Over five years, at least 60 of all 79 sanitary districts in the country should be covered, targeting the relevant institutions and stakeholders for stigma and discrimination reduction towards key populations.

With respect to peer education programs, the main gap identified is the lack of comprehensive training on human rights for all peer educators. Only 24 peer educators associated with the Human Rights and HIV Observatory project (see PA 5) received training on how to identify human rights violations and refer cases to the observatory. Other peer educators have limited knowledge on human rights issues specific to their target population. Peer educator training should be reinforced so that there is a comprehensive training on rights for all peer educators, and an assessment of their level of understanding should be conducted at the end of each training and/or refresher session. In addition, it should be ensured that an adequate supervision system is in place to evaluate peer education on stigma and discrimination. One of the aims of this form of peer education should be the reduction of stigma and discrimination among and between key populations.

The establishment of Community Advisory Boards (CAB) for key HIV service providers would ensure that stigma and discrimination issues are dealt with through dialogue with the key populations served by the providers. This mechanism would work in a similar manner to the mechanism of the 43 GBV coordination committees that are under the aegis of Ministry of Women, Child Protection and Solidarity. These GBV committees are responsible for coordinating all initiatives to fight GBV at the regional level through monthly meetings. Members of the coordination committees are key stakeholders from the medical, religious, legal and law enforcement spheres, and NGOs working with key populations. Victims of gender-based violence are referred to appropriate treatment, care and support services, as well as legal advice and representation if needed. The Community Advisory Boards, composed of key stakeholders from all the relevant spheres, would meet quarterly in each of the sanitary districts reached with the LILO sessions.

Capacity development of members of key populations to be advocates for their cause and participate in Community Advisory Boards is essential for addressing stigma and discrimination. Currently it is mainly NGOs working with key populations that represent them. A comprehensive training for a group of sex workers, men who have sex with men, people who use drugs, transgender women and PLHIV should empower them to be advocates through a set of trainings that starts with a foundation course on human rights, HIV and TB, stigma and discrimination and other related information. Competencies would be built through courses on self-esteem, public speaking, social transformation and other relevant skills to the local context.

Lastly, implementation of the PLHIV Stigma Index should occur every three years.

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

Existing interventions

There are no programs to train healthcare workers on human rights and ethics related to HIV. Health care worker training is based on the LILO approach. The group of trainers that were trained by *Alliance CI* conducted LILO sessions targeting personnel from specialised medical

centres, and at least three focal points per public hospital, to which NGOs refer clients. The main key population Global Fund sub-recipient (SR), HAI CI, piloted a project in three public healthcare centres where they sensitized healthcare workers about 'diversity of gender' and referred MSM for medical care to the structures where health workers were trained. HAI CI then monitored the level of satisfaction of the MSM they referred. The MSM reported being very satisfied with the quality of services and attitude and behaviour of healthcare personnel towards them. Based on the successful results of the pilot, the NGO extended this model, training 46 healthcare personnel across 17 sanitary districts where there are no specialised centres present. To increase access to services, a small number of NGO-run centres were equipped with adequate equipment for STI diagnostic and treatment for men who have sex with men.

Focus	Summary	Scale	Budget USD	Location	Implementer
Training individual health care providers	Training individual health care providers	763 individual healthcare providers trained on human rights of MSM and SW	12,115	Not available	Espace Confiance

The total amount for programs to train health care workers on human rights and ethics related to HIV in 2016 was USD 12,115 (beyond the costs of the LILO work which is captured in PA1).

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The key gap in the training of health care workers is that it is primarily based on the LILO approach and/or similar approaches, which aim only at reducing stigma and discrimination towards key populations. Consequently other components related to human rights and ethics are not being comprehensively covered. Specific human rights and ethics training modules related to HIV must be developed and institutionalised in doctor and nurse training, in the two medical universities and three nursing schools of the country. The curricula would include human rights and ethics knowledge, attitudes and practices, standards of informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights, and meaningful participation of both patient and medical personnel in decision-making about care. These curricula would need to include relevant information on the same topics as they relate to TB.

When the LILO interventions target healthcare workers, the content of the training should be adapted to also include discussions such as gender-based violence and clinical management of rape and violence, the clinician's role in promoting sexual health, mental health, and drug-related harm reduction, and laws and policies that protect or exist as barriers to people's access to care.

Training of healthcare workers already working in the medical structures should be based on the newly developed training modules and cover the following 35 sanitary districts: Seguela, Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouake.

PA 3: Programs to sensitise law-makers, judicial officials, and law enforcement agents

Existing interventions

The *Ligue ivoirienne des droits de l'homme* (Ivoirian Human Rights League) (LIDHO) was created in 1987 and has been involved in HIV, human rights and gender-based violence programs since 2016 through the GF-funded regional *Organisation du Corridor Abidjan Lagos* [Abidjan-Lagos Corridor] project (OCAL), and since 2017 with the local branch of *ENDA Santé* in the Human Rights and HIV Observatory in the regions of Bouaké and Abidjan. This project is detailed in the section on PA 5. LIDHO and *ENDA Santé* sensitized law enforcement agents, targeting the police academy, where 200 police officers attended a 2-day seminar on HIV and human rights, including a recreational day with members of key populations to reduce prejudice against key populations.

Furthermore, 24 police officers nominated as focal points for the project in 12 police stations from the southern region of Abidjan and 10 police officers nominated in Bouaké were trained over 2 days on HIV and human rights. The main responsibility of these 34 focal points was to increase key populations' access to police services if they were victim of human rights abuses. If a member of a key population was brought to the police station, the focal point had the responsibility of ensuring that the person's rights were respected, and that there were no abuses, such as cases of arbitrary arrests. They were also responsible for ensuring that members of key populations requiring police assistance (for example in cases of rape of SW) could easily access this service without stigma and discrimination. Sex workers in focus group discussions reported this programme as being successful since focal points negotiated their release when they were unfairly detained in police stations.

Following the 2014 attack on *Alternative CI*, an LGBT NGO in Abidjan, where no lawyers could be found to defend the victims of violence, a pool of lawyers friendly to key populations was identified and trained by LIDHO to offer legal support to key populations members who are victims of human rights violations. These 16 trained lawyers created the Network of HIV Lawyers, and are currently offering pro bono legal services to key populations that have gone to court in relation to human rights violations. There are currently three such cases in court in Côte d'Ivoire. There were only a small number of cases that did go to court due to the fear of KPs of being exposed during court cases.

LIDHO, assisted when required by the network of HIV lawyers, intervened as mediators on numerous occasions, for example negotiating the release of KPs arbitrarily arrested or when the police exceeded the authorized time limit of keeping someone in police custody. LIDHO acknowledged that not all trained lawyers were active, mainly due to the low number of cases appearing in court and the limited budgets to cover expenses (transport, administrative documents) of the lawyers, reducing their geographical scope to Abidjan and its surroundings.

Focus	**Summary**	**Scale**	**Budget USD**	**Location**	**Implementer**
Sensitization and training of law enforcement agents on HIV and	Sensitization and training of law enforcement agents on HIV and human rights	25 law enforcement agents sensitised and trained on HIV and human rights	8,345	Abidjan	LIDHO
		763 law enforcement agents sensitised on HIV and human rights	12,115	Not available	ESPACE CONFIANCE

human rights					

The total amount for programs to sensitize lawmakers, judicial officials and law enforcement agents in 2016 was USD 20,460.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The 2017 activity report of the Human Rights and HIV Observatory, conducted by *ENDA Santé* and all stakeholders involved in the observatory, highlights the following recommendations: increase budgets for remuneration of peer educators and communication allowances; provide refresher trainings to peer educators and reinforce their knowledge of human rights; organise separate field visits to either address documentation activities or advocacy and training activities; and revise the tools for notifying human rights violations.[86]

In addition, the method for police academy sensitization should be reviewed in view of possibly decreasing the number of participants per session to encourage more interaction and increased participation of the KP community, as well as including a formal evaluation system to assess the change in the level of stigma and discrimination towards key populations.

The program to establish focal points in police stations was successful, according to stakeholder interviews, but since police officers were nominated as focal points to participate in the programs, this created different levels of participation with some officers very involved in this work and some not involved at all. Being one of the few existing programs that key populations could name as having a direct positive impact on their relations with a generally repressive police force, it should be strengthened and extended. More emphasis should be put on stigma and discrimination and dialogue with key populations during training to ensure that the police officers who have negative perceptions about key populations have an opportunity to voice them out and are exposed to the LILO approach. A system to evaluate focal points' adherence to a non-judgemental approach should be set up.

In terms of expansion of program, it should be linked to ongoing advocacy to integrate a human rights and vulnerable population's module in the official training curriculum of police officer trainings. The expanded program should cover all police stations of known hot spots for key populations in the following 35 sanitary districts: Seguela, Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouake. Strategies to include members of the vice squad, which is the perpetrator of most violations against key populations, could be explored to reduce violence against key populations.

The pool of key population-friendly lawyers should be expanded and budgets provided to cover administrative costs and a fee for the legal services provided. Training and sensitization in this domain should also target prison personnel, members of the civil rights sub-committee of the CNDHCI and Members of Parliament.

Since there is very limited information on prisons, an assessment of the quality and accessibility of HIV/TB services in prison should be undertaken. The MACA would be examined in the first

[86] ENDA Santé (2017). *Observatoire des violations des droits humains en Cote d'Ivoire Rapport d'activités (Draft)*.

phase, and this study would be followed with work with the prison medical personnel and related staff to monitor, mentor and advocate for possible actions to ensure the right to health among prisoners. Then the assessment and follow-up training should extend to all 34 detention centres in the regions of Abengourou, Aboisso, Adzope, Agboville, Bassam, Bondoukou, Bouafle, Bouake, Dabou, Daloa, Dimbokro, Divo, Gagnoa, Katiola, Korhogo, Man, Oume, Sassandra, Soubre, Tiassale and Toumodi.

PA 4: Programs to promote legal literacy ("know your rights")

Existing interventions

Programs to promote legal literacy are mainly based on the peer education programs that operate across the country. Men who have sex with men, sex workers, people who use drugs and PLHIV peer educators are responsible for informing key populations about their rights during standard HIV prevention, referral activities, gender-based violence sensitization talks and positive health, dignity and prevention interventions held on an individual or group basis.

These sessions are conducted by NGOs such as *Espace Confiance, Ruban Rouge CI, ASD Divo, SA Pharm, DED Toulepleu, IDE Afrique, IDEAL Korhogo, IDEAL Boundiali, Blety Odienné and Asal Tingrela, La Fontaine, Anonyme, Parole Autour de la Santé, Foyer du Bonheur, La Relève* and *RIP+*, the *Réseau Ivoirien des organisations de Personnes vivant avec le VIH-Sida* [National network of people living with HIV]. The coverage of these programs is national.

In 2015-16, a booklet for key populations and PLHIV on the promotion of their rights and responsibilities was elaborated. It covers their rights with respect to health, family life, education, insurance, work, travelling, as well as the legal mechanisms available in case of a violation of their rights, and also their responsibilities. Its main aim is to answer questions that key populations and PLHIV have about their rights to enable them to live in a society without stigma and discrimination. It is a comprehensive guide, which has been useful an NGO level, but it is not considered as friendly to key populations with regard to the level of language and format. At 54 pages, the document is neither discreet nor easy to carry around. It is written in French, with no translations into local languages.

Focus	Summary	Scale	Budget USD	Location	Implementer
Empowerment of key populations in relation	Empowerment of key populations with regard	1,722 members of key populations (MSM and SW) trained with regard to their rights	9,802	Alépé Adiaké Bassam	Espace Confiance

to their rights	to their rights (mainly SW and MSM for these implementers) is done during activities done by peer educators, and during support groups for PLHIV among key populations.	Not available	Not available	Treichville-Marcory Koumassi-Port-Bouet-Vridi Yopougon-Ouest-Songon Dabou	Espace Confiance
		1,083 members of key populations (MSM and SW) empowered with regard to their rights	6,204	Adzopé Agboville	Ruban Rouge CI
		Not available	Not available	Yopougon-Est	Ruban Rouge CI
		585 members of key populations (MSM and SW) empowered with regard to their rights	5,682	Divo	ASD Divo
		681 members of key populations (MSM and SW) empowered with regard to their rights	5,967	Séguéla	SAPHARM
		306 members of key populations (MSM and SW) empowered with regard to their rights	2,984	Toulepleu	DED Toulepleu
		1,387 members of key populations (MSM and SW) empowered with regard to their rights	7,810	Bangolo Danané Biankouma	IDE Afrique
		Not available	Not available	Man Bangolo	IDE Afrique
		836 members of key populations (MSM and SW) empowered with regard to their rights	4,844	Korhogo	IDEAL Korhogo

		516 members of key populations (MSM and SW) empowered with regard to their rights	3,689	Boundiali	IDEAL Boudiali
		250 members of key populations (MSM and SW) empowered with regard to their rights	2,572	Odienné	BLETY Odienné
		Not available	Not available	Yopougon-Est	BLETY Odienné
		268 members of key populations (MSM and SW) empowered with regard to their rights	2,843	Tingrela	ASAL Tingrela
Institutions strengthening on legal literacy	Information sessions on rights of PWUD targeted various institutions	Knowledge and capacity of 4,158 people from various institutions were strengthened about legal literacy of key populations	35,977	Abidjan	Médecins du Monde
Community mobilization and education to key populations on "knowing your rights"	Information on "knowing your rights" is included in HIV prevention sessions, during pre- and post- counselling in testing activities and also during home visits to key populations found positive.	11,842 MSM were sensitized on their rights	75,217	Treichville-Marcory Koumassi-Port-Bouet-Vridi Yopougon-Ouest-Songon Dabou	Espace Confiance
	Strengthen the capacities of individuals in organisations combatting HIV/AIDS to defend	Not available	12,046	Alépé Adiaké Bassam	Espace Confiance

	the human rights of MSM				
	Information on "knowing your rights" is communicated during BCC interventions, HIV testing and in support groups for PWUD	3,691 PWUD have been reached with "know your rights" information	28,901	Abidjan	Médecins du Monde
	Information on "knowing your rights are included in HIV prevention sessions, during pre and post counselling in testing activities and also during home visits to key populations found positive.	7,342 MSM were sensitized on their rights	28,428	Yamoussoukro Divo Bouaflé Daloa Issia Oumé Sinfra Abengourou Bondoukou Tanda Bongouanou	Alternative CI
	Supervision of the activities of MSM NGOs, located in the interior of the country, are conducted to provide coaching for the smooth running of	10 MSM NGOs were supported to inform MSM on their rights	6,524	Not available	Alternative CI

	their activities. Text messages are sent to all MSM to sensitise them on HIV and human rights. Moreover, coordination committee meetings are organised for the sharing of experiences between the key population structures, focusing on HIV and human rights.				
	Information on "knowing your rights are included in HIV prevention sessions, during pre and post counselling in testing activities and also during home visits to key populations found positive.	1,517 MSM were sensitized about their rights	22,016	Not available	Alternative CI

The total amount for programs to promote legal literacy among key populations in 2016 was USD 261,506.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Interviews and focus group discussions showed that key populations have limited knowledge about their rights. The main gap in "know your rights" programs is that the delivery of this component is not comprehensive and standardised. "Know your rights" programmes are mainly focused on the HIV law and should be extended to rights of key populations (including rights related to gender-based violence and health rights). The training of peer educators could be reinforced to cover all these aspects and specific indicators developed to monitor how much the communities are effectively being empowered according to their rights. The whole pool of 350 key population (SW, MSM, PWUD) peer educators and the other relevant community actors in the positive health, dignity and prevention programs for PLHIV would need this comprehensive training. All communication materials produced to promote legal literacy should be adapted to the needs and specificities of the key population targeted.

An additional strategy for dealing specifically with police harassment and abuse is to assign peer educators to accompany sex workers and men who have sex with men detained by police and demonstrate how to advocate for their rights. This action would seek to empower these populations to deal with concrete situations of intimidation and extortion. This program would require the development of a security protocol in addition to the above training, and would be linked with the network of lawyers for potential legal support in police stations if required. A comprehensive effort could start with the known hot spots for sex work in Abidjan (877 sites), Bouake (82 sites) and San Pedro (35 sites), and in Abidjan, Agboville, Bouake, Gagnoa and Yamoussoukro for men who have sex with men. The expanded program should then cover all known hot spots for key populations in the additional 17 sanitary districts: Seguela, Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo and San Pedro.

PA 5: HIV-related legal services

Existing interventions

Various institutions, such as NGOs *Espace Confiance, Ruban Rouge CI, ASD Divo, SA Pharm, DED Toulepleu, IDE Afrique, IDEAL Korhogo' IDEAL Boundiali, Blety Odiene and Asal Tingrela, La Fontaine, Anonyme, Parole Autour de la Santé, Foyer du Bonheur, La Relève* and *RIP+* have been providing legal advice to key populations through outreach sensitization sessions. The NGOs collaborate with associations specialised in the legal sector, such as the LIDHO and the *Association des femmes juristes de la Côte d'Ivoire* [Association of Women Lawyers of Côte d'Ivoire] (AFJCI). These group sessions are either about HIV, and branch out into rights of PLHIV, or are about another human rights-related topic such as gender-based violence. They are followed by individual sessions where participants can confidentially obtain legal advice and referral services. Each institution has varying or non-existent budgets for legal representation.

The Human Rights and HIV Observatory is, since mid-2017, one of the platforms for HIV-related legal services for key populations. The observatory documents cases of human rights violations through reports that 12 trained peer educators submit via an online platform and which two supervisors investigate. In 2017, the observatory documented 41 cases of human rights violations, and currently three cases are being taken to court with support from lawyers. All victims of human rights violations have access to legal advice, legal representation if they wish and medical support from the NGO-run clinic *Espace Confiance*. Many of the victims chose not to accept legal assistance out of fear and because of family pressure.[87] The scope of the observatory is Abidjan and Bouaké.

[87] Observatoire des violations des droits humains en Cote d'Ivoire Rapport d'activités (2017)

The observatory also holds community mediation activities when appropriate. One such example is of a young boy in Bouaké who was a victim of physical and psychological violence from peers because he was suspected of being gay. The families and relevant community members were met together with the focal point police officer to address the issue, and this successfully eliminated the acts of violence. This form of mediation was also seen by several key informants as a successful way to prevent future forms of human rights violations due to the involvement of a wide number of community stakeholders.

Focus	Summary	Scale	Budget USD	Location	Implementer
Training of paralegals and other service providers to work with key populations	Setting up of networks of lawyers to work on human rights issues for key populations in the wake of the Abidjan-Lagos Corridor project, on HIV/AIDS, human rights and gender-based violence	49 paralegals and other service providers trained to work with key populations	8,345	Abidjan and Bouake - other regions not available	LIDHO
Documentation and investigation of rights abuses among key populations	Documentation of human rights abuses among key populations through a human rights and HIV observatory	41 cases of rights abuses documented and investigated upon	13,575	Abidjan and Bouake - other regions not available	LIDHO
Legal Information and referrals for	Legal advice and counselling sessions	1,475 MSM and SW provided with legal information	18,045	Alépé Adiaké Bassam	Espace Confiance

key populations	are conducted for SW/MSM who wish to be advised on legal issues and their rights (welcoming of participants, consultation, guidance and support in their legal procedures; legal information on their rights; guidance on lawyers', attorneys' and judicial officers' services; support and legal counselling to victims; handling of minor disputes). These are conducted in groups or in individual sessions	2,533 MSM and SW provided with legal information	11,410	Treichville-Marcory Koumassi-PortBouet-Vridi Yopougon-Ouest-Songon Dabou	Espace Confiance
		880 MSM and SW provided with legal information	5,039	Adzopé Agboville	Ruban Rouge CI
		Not available	Not available	Yopougon-Est	Ruban Rouge CI
		582 MSM and SW provided with legal information	5,653	Divo	ASD Divo
		752 MSM and SW provided with legal information	6,590	Séguéla	SAPHARM
		419 MSM and SW provided with legal information	4,088	Toulepleu	DED Toulepleu
		1,075 MSM and SW provided with legal information	5,951	Bangolo Danané Biankouma	IDE Afrique
		Not available	Not available	Man Bangolo	IDE Afrique
		814 MSM and SW provided with legal information	4,720	Korhogo	IDEAL Korhogo
		584 MSM and SW provided with legal information	4,181	Boundiali	IDEAL Boudiali
		380 MSM and SW provided with legal information	3,905	Odienné	BLETY Odienné
		Not available	Not available	Yopougon-Est	BLETY Odienné

		360 MSM and SW provided with legal information	3,823	Tingrela	ASAL Tingrela

The total amount for HIV-related legal services in 2016 was USD 95,325.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The Human Rights and HIV Observatory requires strengthening and expansion. In addition to the recommendations of the evaluation, the following strategies could reinforce the quality and scope of its services:

1. Strengthen and expand the pool of key population peer educators trained to document cases of human rights violations. Training of peer educators should be planned regularly due to their high turnover. Expand the number of supervisors by using the 61 sections of the LIDHO in each sanitary district, and provide budget lines for the additional work and field costs.
2. Ensure that victims of violence requiring treatment can access a specialised NGO-run medical clinic and/or partner public health centre. Key populations reported that they felt it was useless to come forward with their complaints since they were only documented and they had no immediate access to free services to treatment of their injuries. This was a great source of discouragement and could potentially threaten the programme if urgent needs are not catered for.
3. The means of referring cases of violations should be diversified from solely relying on peer educators. Other ways of denouncing cases would include via online telephone applications, through all relevant key population NGOs, and through the national free HIV hotline 160, hosted by the NGO *Ruban Rouge CI*. This would require building capacity of the NGOs to be able to handle the cases. A solid referral network would have to be set up so that all respondents, including the hotline operators, know what information to give in terms of referral services or emergency situations requiring crisis management.
4. A solid communication strategy to ensure that key populations know about the observatory's services is required. A community-based strategy, including leaflets, radio spots on community-based radio stations and social media, would be appropriate for a discreet but effective diffusion of the services available for key populations.
5. Reinforce links between the observatory, the pool of trained lawyers that supports it, and all NGOs working with key populations. This is vital both for the referral of cases and for the diffusion of information concerning legal services available for key populations.

The observatory could then be expanded to the following 35 sanitary districts: Seguela, Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouake. In the long term, the Human Rights and HIV Observatory should cover at least 60 of all 79 sanitary districts.

PA 6: Programs to monitor and reform laws and policies related to HIV

Existing interventions

An HIV Legal Environment Analysis (LEA) is currently being finalised in Côte d'Ivoire. The study evaluated Côte d'Ivoire's legal and policy framework in relation to human rights, the level

of knowledge of human rights among key populations and their access to the legal system, as well as assessing the impact of the legal environment on access to services and on the promotion and protection of the rights of key populations. The results of this LEA will contribute to a foundation for evidence-based advocacy.

LIDHO successfully lobbied the Ministry of Justice during the revision of the penal code to remove the added penalty for people of same sex caught for public indecency under Article 360. The revised penal code has not yet been re-introduced. All lobbying efforts were kept very low-key and discreet so as not to create a national debate in which religious and conservative stakeholders would strongly oppose this revision.

Various NGOs such as RIP+ and AFJCI have disseminated information on the 2014 HIV law through outreach sensitization sessions, but these activities are not consistently held due to fluctuations in funding.

According to stakeholder interviews, no other activities to monitor and reform laws and policies related to HIV currently exist in Côte d'Ivoire. Key population groups and NGOs are not aware the specific needs for law reform and how to translate the needs into programs. In 2016, there was no expenditure on activities to monitor and reform laws and policies related to HIV.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

There is clearly a lack of advocacy for law reform on the following aspects:

- articles in the 2014 HIV law where transmission can be criminalised, disclosure of status to a third party is allowed in certain non-medical circumstances, and parental consent is required for testing of minors
- reforms needed to the current repressive drug law to facilitate access to opioid substitution therapy, needle and syringe programs and other harm reduction programming
- reforms with regard to criminal offenses related to sex work
- laws that act as a barrier to transgender women in terms of gender identity
- availability of the UNODC comprehensive HIV package in prison settings.

By linking the Human Rights and HIV Observatory to the various key population NGOs, a channel of information could be created to enable evidence-based advocacy. The *Réseau des organisations de populations clés* [Network of key populations] (ROPCCI) would be an appropriate platform to centralise information and spearhead coordinated multi-partner advocacy actions. This network regroups the NGOs working with SW, MSM and PWUD. Capacity building of all NGOs linked to ROPCCI is essential, however, to ensure strategic advocacy and lobbying. The capacity building program should focus on understanding the long-term impact of law reform and on giving participants tools to produce concrete deliverables adapted to their context. The training could result in the production of a budgeted multi-stakeholder advocacy plan that takes into consideration local specificities in the choice of strategies and activities. The training should target at least 30 participants from NGOs and members of key populations.

As documented in the focus groups, key populations clearly see the value of NGO-provided clinical and other health services. NGOs should be funded to advocate for an up scaling of such services and to ensure that a comprehensive package of services is offered in all of them.

PA 7: Programs to reduce discrimination against women in the context of HIV

Existing interventions

The Ministry of Women, Child Protection and Solidarity has a network of 43 gender-based violence (GBV) coordination committees across the country. These GBV coordination committees are responsible for managing all initiatives to fight GBV at the regional level. They aim to effectively ensure prevention of GBV and facilitate and monitor the response to GBV in their region. They are under the direct responsibility of the prefectural authorities. Members of the coordination committees are key stakeholders from the medical, religious, legal and law enforcement spheres, and NGOs working with key populations. The coordination committees meet every month to monitor the cases of GBV in the region and the management of GBV victims and to analyse the specificities of GBV in the region. The committees also collect data to populate the country's Gender-Based Violence Information Management System (GBV IMS). The regularity of meetings of the coordination committees differs greatly, and stakeholders estimate only half of the 43 GBV coordination committees are operational. The Ministry is planning to extend their network to 130 coordination committees for a consistent coverage of the country.

The Ministry also launched a national media campaign 'He for She' to reduce gender-based violence in Côte d'Ivoire at the end of 2017. All these efforts are based on the national strategy to fight gender-based violence. However, they are not specifically to reduce discrimination against women as a barrier to HIV services and have not yet been evaluated for effectiveness.

The NGO RIP+ conducted a program on the rights of women living with HIV but it was discontinued due to lack of funding.

Focus	Summary	Scale	Budget USD	Location	Implementer
Community mobilization and education about gender and HIV including engagement with religious and traditional leaders about gender and HIV	Project on: (1) information and sensitisation on violence against women and girls, and (2) provision of care and treatment to women and girls victims of violence.	8,313 people sensitized on violence against women and girls	34,877	Not available	Ruban Rouge CI

The total amount for programs to reduce discrimination against women in the context of HIV in 2016 was USD 34,877.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The gender-based violence services do not consider cases of violence against men who have sex with men and transgender women. Advocacy should be conducted to ensure that all gender-based programs include these populations. This would include LILO sensitization to challenge the stigma associated with key populations and inform the committee members on the rights of KPs. High-level advocacy with all 130 GBV coordination committees under the Ministry of Women, Child Protection and Solidarity would also be required to ensure that policy changes are introduced and implemented for the inclusion of KPs.

Since there exist no age-sensitive programs for adolescents who sell sex, training of service-delivery institutions is required so that they identify and notify these cases and offer them the standard HIV service package, with additional services such as family mediation and psychosocial support. To provide these services to adolescents who sell sex in the 52 identified hotspot sites in the region of Abidjan, at least 1 sex worker NGO per sanitary district of the region needs to be trained. Although these NGOs have been identified in only 10 sanitary districts in Abidjan, a comprehensive approach would include all 12 sanitary districts to cater for potential displacement of sites.

Costing and budget

Costs for the recommended interventions for the five-year HIV comprehensive program set out are set out in the table below. Details of intervention costs are set out in Annex 3.

HIV Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction for key populations	1,000,167	1,275,072	506,091	506,091	469,170	3,756,591
PA 2: Training for health care workers on human rights and medical ethics related to HIV	49,329	-	-	-	-	49,329
PA 3: Sensitization of law-makers and law enforcement agents	79,164	128,942	61,482	20,255	41,921	350,102
PA 4: Legal literacy ("know your rights")	386,839	328,214	329,843	315,186	315,186	1,675,268
PA 5: HIV-related legal services	361,340	431,382	485,148	581,787	636,639	2,496,296
PA 6: Monitoring and reforming laws, regulations and policies relating to HIV	692,503	675,866	675,866	675,866	675,866	3,395,967
PA 7: Reducing discrimination against women in the context of HIV	84,053	95,711	95,711	141,337	156,545	573,357
Total	2,653,395	2,935,187	2,154,141	2,240,522	2,295,327	12,296,913

3. BASELINE FINDINGS: TUBERCULOSIS

Overview of epidemiological context and focus populations related to TB and human rights

Côte d'Ivoire has the highest tuberculosis prevalence in the world at 153 cases per 100,000 inhabitants. An estimated 8,400 people died from TB in 2016, corresponding to a mortality rate of 35 per 100,000 population. TB disease affects men more than women.

The TB burden is heavy partly due to the high burden of HIV in the country, with an estimated 2,800 TB-related deaths among people living with HIV. TB is the deadliest opportunistic infection for PLHIV in Côte d'Ivoire. Poverty and HIV infection are among the major factors contributing to the spread of TB.[88] The following TB incidence rates were recorded in Côte d'Ivoire in 2016:

	TB incidence (including HIV)	**TB incidence (HIV-positive)**	**TB incidence (MDR/RR-TB)**
Number	36,000	7,900	2,100
Prevalence (per 100,000 population)	153	33	8.9

Côte d'Ivoire adopted the WHO-recommended TB directly observed treatment strategy in 1995. The treatment success rate was approximately 80% in 2015 for new and relapse TB cases and 85% in 2014 for multidrug-resistant tuberculosis (MDR/RR-TB). However, the loss to follow-up remains high.[89]

In 2001, the Government of Côte d'Ivoire created the *Programme National de lutte contre la Tuberculose* [National Programme to Fight against Tuberculosis] (PNLT) to reduce TB morbidity and mortality rates through awareness, prevention, care and treatment activities and research. As a result, through its National Strategic Plan, the PNLT has set up the following public health institutions to provide TB services to the public: (i) 17 *centres antituberculeux* [Anti-tuberculosis centres] (CAT), each managed by a physician; (ii) 228 *Centres de diagnostique et traitement* [Diagnostic and treatment centres] (CDT) centres, each managed by a physician, and *Centres de traitement* [Treatment centres] (CT); (iv) 3 pneumo-phthisiology departments in 3 university hospitals, in Bouaké, Treichville and Cocody; and (v) a network of laboratories located in CATs and CDTs and other public health institutions across the country. The programme also catered for the training of 1,642 health personnel, 353 NGO staff and 753 community health agents (ASC) in the identification and referral of suspected TB cases and in the follow-up of patients on treatment.[90]

[88] Global Fund (2016). *Removing Human Rights Barriers to End the HIV Epidemic*. [online] Available at: https://www.theglobalfund.org/en/blog/2016-03-15-removing-human-rights-barriers-to-end-the-hiv-epidemic/ [Accessed 23 Feb. 2017].
[89] WHO, Global Tuberculosis Report 2017, Geneva
[90] Plan Stratégique National 2012-2015 De Lutte Contre La Tuberculose, MSLS/Atélier de bilan 15.06.17 PNLT

Côte d'Ivoire's national strategy to fight TB is two-fold. Firstly, there is a passive strategy, where people voluntarily come for screening and treatment when they have TB symptoms; and secondly, an active strategy for key populations, which includes verbal screening, microscopy and the GeneXpert TB test, depending on the case. According to WHO, the key affected population groups in relation to TB are (i) people at increased risk of TB because of other diseases, e.g. PLHIV, (ii) people who are vulnerable because of their social conditions, behaviours or unsafe workplaces, e.g. prisoners, migrants, refugees and sex workers, and (iii) people who are underserved because of stigma, discrimination and other barriers, e.g. people who use drugs and homeless people.[91] The key populations identified in Côte d'Ivoire are PLHIV, diabetics, miners, prisoners, people who use drugs, people living in precarious conditions, and TB contacts, of whom PLHIV, miners, prisoners, people who use drugs and people living in precarious conditions are regarded as key populations for this assessment.

People living with HIV: TB is the leading cause of death among PLHIV in Côte d'Ivoire. An estimated 460,000 people in Côte d'Ivoire are living with HIV and are at high risk of developing TB. Key populations at high risk of HIV in Côte d'Ivoire—including female sex workers, men who have sex with men, people who use drugs and prisoners -- are particularly vulnerable to TB infection. There are an estimated 7,900 PLHIV co-infected with TB.[92]

Miners: It is known that miners who are exposed to silica dust have a higher risk of developing silicosis and consequently pulmonary tuberculosis (silicotuberculosis).[93] TB is a significant problem in the mining industry in Côte d'Ivoire. WHO recommends active TB screening for all miners. Some mining companies in Côte d'Ivoire have well-established health services for their workers. However, is not clear how many Ivoirians constitute this high TB risk group and have access to TB services.

Prisoners: A recent study at the MACA, the country's largest prison, estimated the prevalence of TB among prison inmates to be around 9.3% in 2017, and 53% of isolated strains were resistant to at least one TB drug, including 37% that were multi-drug resistant (MDR). One of the reasons put forward for this high MDR-TB burden was overcrowding. MACA's population in 2015 was approximately 4,600, whereas it was built to hold 1,500. Another reason behind the high rate of MDR-TB is cited as the "difficulty in getting access to health care facilities while being in prison", which "increases the risk of poor adherence to treatment and of developing secondary resistance to TB drugs".[94]

People who use drugs: People who use drugs are particularly at risk for TB. The prevalence of active pulmonary TB among drug users in Abidjan has been estimated at 2.9% and was primarily associated with their precarious living conditions. More than half of the surveyed people who use drugs reported in 2014 having been incarcerated, which is a risk factor for TB.[95]
People living in precarious conditions: TB transmission is enhanced by poor living conditions, including overcrowding and poor ventilation. In Côte d'Ivoire, 'ghettos' of people who use drugs,

[91]Engaging Key Vulnerable Populations in Designing, Planning and Implementing TB Community Activities. (2014). [ebook] World Health Organization. Available at: http://www.who.int/tb/tbteam/keypop.pdf [Accessed 23 Feb. 2017].
[92] Dybul M (2016). *Removing Human Rights Barriers to End the HIV Epidemic*. [online] Available at: https://www.theglobalfund.org/en/blog/2016-03-15-removing-human-rights-barriers-to-end-the-hiv-epidemic/ [Accessed 23 Feb. 2017].
[93] Yarahmadi A, Zahmatkesh MM, Ghaffari M, et al. Correlation between silica exposure and risk of tuberculosis in Lorestan Province of Iran. *Tanaffos*. 2013;12(2):34–40.
[94] Séri, B., Koffi, A., Danel, C., Ouassa, T., et al. (2017). Prevalence of pulmonary tuberculosis among prison inmates: A cross-sectional survey at the Correctional and Detention Facility of Abidjan, Côte d'Ivoire. *PLoS One*, 12(7), p.e0181995.
[95] Bouscaillou et al., op.cit.

often located in unsanitary dilapidated buildings with poor ventilation, are a fertile ground for TB transmission.

Overview of the law, policy, political and strategy context for human rights and TB

Article 9 of the Constitution of Côte d'Ivoire guarantees all Ivoirians equal access to health services. However, unlike for HIV, there is no law on TB that guarantees the rights of people with TB, their access to treatment and care, and protection against stigma and discrimination. TB is subject to obligatory notification to an employer so that the employee can receive time off from work to follow his/her treatment.

One of the key interventions of the Ivoirian government in the attainment of its objective to reduce the incidence of MDR-TB in new TB cases to 1%, is to conduct advocacy for the adoption of a law on TB and TB/HIV co-infection in order to, *inter alia*, protect TB and TB/HIV patients from stigma and discrimination. Although the legal framework is relatively well defined in Cote d'Ivoire, there is no TB law similar to the HIV Law. Many Ivoirians lack access to TB treatment and care services. Interviews conducted in Côte d'Ivoire with NGOs reveal that people with TB experience significant stigma and discrimination in their communities and other settings. In health care settings it is reported that people who use drugs seeking TB services are often refused treatment and care. In these cases, peer educators have to intervene on their behalf with the health personnel.

The Côte d'Ivoire Ministry of Health recommends, based on WHO guidelines, that all PLHIV be screened for TB symptoms at each clinical visit before starting ART.[96] However, analysis of data from 34 ART facilities in Côte d'Ivoire showed that there was non-adherence to this national TB screening policy at most ART facilities. Documentation of TB screening before ART initiation was missing in most of the ART facilities, with only 36% of medical records documenting the screening of at least one TB symptom and only 11% of medical records documenting screening for all the five most common symptoms. This is suggestive of the inefficiency and underperformance of the ART facilities, which hinder the uptake of quality TB health services for PLHIV.[97]

Poverty and low socioeconomic status undermine human rights, including the right to access TB prevention, treatment and care services. In spite of the fact that TB medication is free of charge in Côte d'Ivoire, there are other direct and indirect costs for a patient. According to the International Treatment Preparedness Coalition, sex workers co-infected with HIV and TB are forced to stop working for a while, and thus have no money for their transport costs to seek health services.[98] There are fewer CATs and CDTs in rural areas, and patients have limited access to CTs. Interviews with the health personnel of CATs reported that because of this situation, patients are more likely to be lost to follow-up because they lack financial means to pay for transport expenses.

The internal conflicts from 2002 to 2011 in Côte d'Ivoire had a significant impact on the country's health system, including disruptions in the control of epidemics like TB.[99] Even though

[96] Gupta RK, Lucas SB, Fielding KL, Lawn SD (2015) Prevalence of tuberculosis in post-mortem studies of HIV-infected adults and children in resource-limited settings: a systematic review and meta-analysis

[97] Auld, A., Blain, M., Ekra, K., et al. (2016). Wide Variations in Compliance with Tuberculosis Screening Guidelines and Tuberculosis Incidence between Antiretroviral Therapy Facilities — Côte d'Ivoire. *PLoS ONE*, 11(6), p.e0157059.

[98] International Treatment and Preparedness Coalition (2017). *Baseline study: Regional Community Treatment Observatory in West Africa to Increase Access to HIV Services for People Living with HIV*.

[99] Niyongabo T, NDayiragije A, Larouze B, Aubry P. Burundi: l'impact de dix années de guerre civile sur les endémoépidémies. Med Trop 2005;65:305—12.

there was no epidemic of TB during the period of armed conflict in Côte d'Ivoire, the country nonetheless suffered from a significant disturbance in its TB management, with disruptions in screening and treatment interventions. During that period, lower than average rates of therapeutic success and lower than average rates of success to retreatment, and higher rates of loss to follow-up were recorded.[100]

People who are diagnosed with TB face serious violations of their rights in their access to, uptake and retention in TB services. This is because, although formal laws, policies and systems are in place in Côte d'Ivoire, they are not always enforced. Moreover, aggravating factors include: (i) widespread corruption in several institutions; (ii) under-resourced systems; and (iii) the prevalent unfavourable socio-economic environment.

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

Barriers related to stigma and discrimination

Interviews with NGOs and health personnel of CATs revealed that people with TB experience stigma and discrimination. Informants reported that TB is commonly referred to as the 'shame disease' in the community and people known to have TB are stigmatised, leading to denial. They then delay or avoid screening, preventing timely diagnosis and effective treatment. They do so to prevent social rejection and discrimination from the community.

In focus group discussions across the various regions, representatives of the key populations affected by TB related stories of widespread stigma and discrimination at both the family level and the societal level, perpetrated by members of the family, friends, religious leaders, police and healthcare workers. Stigma and discrimination are primarily related to the fear of infection and negative TB conceptions associated with HIV-infection -- i.e., TB is a 'dirty disease'. Stigma is also related to alleged immoral behaviour, incurability and death, poverty and incarceration.

Key informants from Koumassi in Abidjan shone the light on TB-related stigma and discrimination in employment, sometimes leading to dismissal. Stigma at family level often takes the form of a refusal to take care of a family member. In medical settings, it is reported that nurses in hospitals refuse to give injections to TB patients for fear of infection. People who use drugs from Abidjan report feeling unwelcome at CATs because of the discriminating attitudes of the heath care personnel.

People co-infected with HIV and TB experience higher levels of stigma and discrimination. Key populations report that they face even more stigma and discrimination because of their economic activity (sex work), and/or their sexual orientation and illegal practices (consuming drugs).

The stigma faced by the key populations also operated at the individual level as self-stigma, which is often a consequence of the discrimination experienced at the family and societal level. Informants reported feelings of low self-esteem and shame, which led to isolation and ultimately to a poorer quality of life and social status. As a result of their social exclusion, they were not adhering to TB treatment. In addition, the services of health counsellors who conduct TB home-based care are rejected because patients fear their family finding out they have TB, and this can lead to people dropping out of treatment.

[100] Daix, A., Bakayoko, A., Coulibaly, G., et al.. (2013). Effets de la guerre sur le contrôle de la tuberculose en Côte d'Ivoire de 2002 à 2007. *Revue de Pneumologie Clinique*, 69(5), pp.237-243.

Barriers related to gender inequality and barriers for adolescent girls and young women

Despite TB incidence and prevalence rates being higher for males than females, TB has severe consequences on women, especially adolescent girls and young women. Factors negatively affecting the ability of women and girls to access, uptake and retain TB health services include discriminatory traditional attitudes, beliefs and practices; unequal economic power in the household; gender-based violence; and gender-insensitive service delivery.

In a focus group discussion conducted in the Abidjan suburb of Adjamé, it was reported that female TB patients had been thrown out of their houses by their partners and were refused help and accommodation by families, leading them to stop treatment. Other focus groups revealed that many Ivoirian women infected with TB do not disclose their TB status to their husbands or partners for fear of abandonment, separation from their children and loss of financial support. The lack of financial independence of many Ivoirian women results in a burden of TB that falls more heavily on them than on men.

Interviews also highlight the issue of gender-insensitive service delivery. NGO representatives in Abidjan reported having no skills and resources to provide TB services to pregnant people who use drugs, for example. Inadequate support for pregnant women with TB has been shown to produce adverse health outcomes for mother and child, and collaboration between TB and maternal and child health service providers is crucial to optimise women's access to TB services and information.[101]

Barriers related to limited legal literacy, legal services, and functionality of the legal justice system

While health regulations and national law in Côte d'Ivoire guarantee full access to prevention, treatment and care, many TB patients are unaware of these rights. The low level of legal literacy rate in Côte d'Ivoire is a major impediment for the enjoyment of all rights-related services. Article 6 of the Constitution Côte d'Ivoire allows the most vulnerable populations free access to legal aid as per the code of civil procedure no. 75-317 of May 1975. However, it is reported that TB patients who have been confronted with problems of access to health services due to their HIV/TB status, and who already face marginalisation and discrimination, do not know where and how to seek information and demand redress.

Key populations such as sex workers and people who use drugs with HIV/TB are often targeted by the police and are subjected to arbitrary arrests and mistreatment. They are held in overcrowded detention centres with deplorable conditions; the prison settings are deprived of proper amenities and facilities to access treatment for TB. There are several reports that denounce the long period of pre-trial detention, without access to a hearing from a judge or magistrate within a reasonable time. These key populations are often poor and marginalised and find it difficult to pay the fees for legal services in order to exercise their rights.[102]

Barriers related to fulfilment of human rights within the health care system

Focus group discussions with key populations highlighted the lack of knowledge among healthcare providers on human rights and medical ethics related to TB, which is a significant

[101] *Global Fund to Fight AIDS, TB and Malaria. Tuberculosis, Gender and Human Rights Technical Brief. Geneva, 2017.*

[102] Baseline Evaluation Report - Africa Regional HIV Grant: Removing Legal Barriers, Institute for Global Health, University of Southern California

barrier for the uptake and retention of TB services. It is reported that nurses in hospitals refuse to provide care to TB patients for fear of infection. Key populations seeking TB services report feeling unwelcomed at CATs because of the discriminating attitudes of the health care personnel. This is extremely common among people who use drugs, who reported being sent away because they are too 'dirty and badly dressed', as well as being lectured about being late for their appointments by health care personnel.

People co-infected with HIV and TB also experience stigmatising and discriminatory attitudes and practices from health providers in the health system. Such behaviour includes unwelcoming attitudes, neglecting patients, providing a different quality of treatment based on someone's HIV status, denying care and breaching confidentiality, among other harmful practices.

In addition, stakeholders report a lack of resources and medical personnel to be able to offer quality services. The decentralisation process through CDTs and CTs has helped to cater for the needs of rural settings in only a limited manner, since patients still need to travel to CATs for more advanced tests and follow-up. The CATs are stand-alone health structures, and it is highly stigmatising to frequent these centres since anyone seeing people go there will know they have TB.

Stakeholders also report that there is a general perception that TB treatment is not free. There is a great level of confusion among all stakeholders about which treatments and which tests are free or not, and health personnel take advantage of this to extort money from patients for tests, or refer patients in treatment failure to clinics where injections of antibiotics are not free of charge.

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

The following section summarises existing and proposed interventions to address human rights-related barriers to TB services, set out under the ten rights-related TB Program Areas defined in the Global Fund Technical Brief *Tuberculosis, Gender and Human Rights*.[103]

The ten program areas are:

PA 1: Reducing stigma and discrimination for key populations
PA 2: Training of health care providers on human rights and ethics related to TB
PA 3: Sensitization of law-makers, judicial officials and law enforcement agents
PA 4: Know your TB-related rights
PA 5: TB-related legal services
PA 6: Monitoring and reforming policies, regulations and laws that impede TB services
PA 7: Reducing gender-based inequity in the context of TB services
PA 8: Patient and community empowerment and mobilization
PA 9: Protecting confidentiality
PA 10: Programs in prisons and other closed settings

PA 1: Reducing stigma and discrimination for key populations

Existing programs

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

Programs to reduce TB-related stigma and discrimination are mainly combined with HIV-based peer education. In general the TB component is more detailed when the programs are targeting people who use drugs, through NGOs such as *La Fontaine, Anonyme, Parole autour de la Santé, Foyer du Bonheur, La Relève, Fraternité, Croix Bleue* and *UNICO*.

The international NGO *Médecins du Monde* implements the harm reduction grant in five countries in West Africa: Burkina Faso, Cape Verde, Côte d'Ivoire, Guinée-Bissau and Sénégal (PARECO). The objectives of PARECO are to reduce the risks related to HIV and TB among people who inject drugs, and activities are focused on health and community systems strengthening, addressing legal barriers, and conducting harm reduction interventions, including TB content in the work.

The *Collectif des ONG de lutte contre la tuberculose et les autres maladies respiratoires* [Network of NGOs to fight tuberculosis and other respiratory diseases] (COLTMER) is made up of 43 NGOs. All the member organisations are connected to a CAT/CDT/CT or hospital to work in collaboration with healthcare workers. These NGOs search for and refer suspected TB cases, through outreach strategies such as home visits, for early screening, sputum collection and conveying. The community health agents from the NGOs visit people living with TB in their homes to encourage adherence to treatment (including giving health advice on subjects such as hygiene and nutrition), to inform patients about their rights and to sensitise the patients' immediate circles to reduce stigma and discrimination related to TB. There are also former patients involved in the NGOs, but this is not systematic. COLTMER also mobilises financial resources for its members, advocates for the rights of people living with TB, and organises events such as World Tuberculosis Day. The COLTMER NGO members address stigma and discrimination in their community work.

Focus	Summary	Scale	Budget USD	Location	Implementer
Community mobilization& education on stigma & discrimination	Education on stigma and discrimination is done during community awareness sessions; field investigations; and especially during home visits, where community counsellors address issues on rights of patients, sensitize patients on self-stigma and sensitize the patients' immediate circles on their rights and on the rights of patients.	933 people sensitized on their stigma and discrimination during home visits and BCC	14,112	Yopougon	TUBCI
		372 people sensitized on their stigma and discrimination during home visits and BCC	6,477	Treichville	IACI
		507 people sensitized on their stigma and discrimination during home visits and BCC	7,684	Abidjan Koumassi	SOLFEV
		811 people sensitized on their stigma and	13,735	Adjamé	FRATERNITE

		discrimination during home visits and BCC			

The total amount for programs to reduce discrimination with regard to TB in 2016 was USD 42,008.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

The efforts to reduce stigma and discrimination towards people with TB have been piecemeal to date. A first step in improving the situation is to evaluate the efforts carried out to date by HIV and TB NGOs, revise stigma and discrimination programming in light of this evaluation, and ensure that all HIV and TB NGOs nationwide have the resources to work on these issues.

One key gap in efforts against stigma and discrimination related to TB is that Côte d'Ivoire does not have a regular system to generate data to monitor stigma and discrimination experienced by TB patients. The national programme (PNLT) could conduct regular national assessments to document and measure the types and level of TB-related stigma and discrimination in healthcare setting and specific communities. This exercise, similarly to the HIV Stigma Index, would provide evidence to guide the development of strategic interventions to reduce stigma and discrimination in specific settings.

To address the issue of the community-based follow up of TB patients inadvertently causing stigma and discriminations in their homes, work on this issue could be assigned to other NGO community programs that already exist for HIV. Community counsellors would then not be openly associated with a single pathology.

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

Existing programs

Stakeholder interviews found no programs to train health care providers on human rights and medical ethics related to TB apart from the *Médecins du Monde* program to train community health workers. The details of this budget are included under PA 4.2 below.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Specific human rights and ethics training modules related to TB must be developed and institutionalised in doctor and nurse training, in the two medical universities and three nursing schools of the country. The curricula would include human rights and ethics knowledge, attitudes and practices, standards of informed consent, confidentiality and privacy, patient-centred care, patient rights and workers' rights, and meaningful participation of both patient and medical personnel in decision-making about care. These curricula would need to include relevant information on the same topics as they relate to HIV. The LILO approach should be restructured to address negative perceptions associated with TB, and interventions should target five healthcare providers (doctor, social worker, nurses and community counsellor) in the 17 CATs in phase one and at least 100 CDTs in phase two.

Training of healthcare workers already working in the medical structures should be based on the newly developed training modules and cover the following 35 sanitary districts: Seguela,

Korhogo, Ferkessedoukou, Touleupleu, Odienné, Bangolo, Biankouma, Dadane, Agboville, Adzope, Alepe, Adiake, Grand Bassam, Aboisso, Boundiali, Tingrela, Divo, San Pedro, Gagnoa, Yamoussoukro and the 12 sanitary districts of Abidjan region, as well as the 3 sanitary districts of Bouake. Following this training, Quality Assurance Advisory Boards -- composed of medical and administrative personnel, as well as representatives of worker unions, NGOs and key populations -- could be set up. Quarterly meetings would be a platform to address issues that have cropped up, as well as make suggestions on how to improve service delivery towards key populations.

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

Existing programs

According to stakeholder interviews, there are no programs for sensitization of law-makers, judicial officials and law enforcement agents with regard to rights-related barriers to TB services. The interventions mentioned under the HIV section occasionally also include TB information when related to people who use drugs, but these are not systematic. In 2016, there was no expenditure on sensitization of law-makers, judicial officials and law enforcement agents related to TB.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

A comprehensive approach to sensitize law enforcement agents about key populations and their specific rights-related barriers to TB services would need to start off by training institutions that are already involved in similar interventions for HIV such as *LIDHO, AFJCI, ENDA Santé* and *Alliance CI* on rights-related barriers to TB services. By making sure that these same stakeholders are aware of the specificities of TB-related issues, joint interventions that cover both HIV and TB comprehensively can be developed.

HIV programming where TB would be included to sensitize law-makers, judicial officials and law enforcement agents include:

- Training of 10 institutions involved in the sensitisation of law-makers, judicial officials and law enforcement agents to integrate TB in HIV-related interventions
- Advocacy to include human rights and key population issues in police training
- Training and sensitization of police academy (200 in all) including prison personnel (65), members of the civil rights sub-committee of the CNDHCI (15) and Members of Parliament (100)
- Extend Human Rights and HIV Observatory with a TB component to all 60 sanitary districts
- Undertake an assessment of the quality and accessibility of HIV/TB services in prison and work with the prison medical personnel and related staff to monitor, mentor and advocate for possible actions to ensure the right to health among prisoners

PA 4: Knowing your TB-related rights

Existing programs

The NGO PR *Alliance CI* developed a chart for patients receiving TB treatment that describes in general terms their rights with regard to their treatment, their dignity, access to information,

choice of medical interventions, confidentiality, justice, security and community mobilisation, as well as their responsibilities.

Focus	Summary	Scale	Budget USD	Location	Implementer
Institutions strengthening on legal literacy	Trainings are organised for community health workers and members of institutions on various topics, including human rights issues of key populations (HIV and TB)	718 members from political, religious and medical institutions trained on human rights	11,037	Abidjan - other regions not available	MEDECINS DU MONDE
Empowerment of people living with and affected by TB in relation to their rights	During home visits, people living with and affected by TB are informed of their rights and responsibilities by community health workers	977 people living with and affected by TB trained in relation to their rights	14,788	Yopougon	TUBCI
		388 people living with and affected by TB empowered in relation to their rights	6,758	Treichville	IACI
		514 people living with and affected by TB empowered in relation to their rights	7,796	Abidjan Koumassi	SOLFEV
		839 people living with and affected by TB empowered in relation to their rights	14,224	Adjamé	FRATERNITE

The total amount for knowing your TB-related rights programs in 2016 was USD 54,603.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Interviews and focus groups suggested that there is a lack of information about TB-related human rights among key populations, which leads to relatively weak 'know your rights' interventions, especially when done in combination with HIV. Training modules on TB should be reinforced at peer educator level to ensure that the level of knowledge of HIV and TB-related rights is comprehensive. Furthermore, developing a pool of expert patients in all of the 43 NGOs of the national network (COLTMER) would also strengthen access to rights-based information for TB patients.

The recurrent issue of patients having to pay for certain services when they should be free of charge could be addressed by updating the existing chart for patients following TB treatment to

include information on free and payable services. In addition, posters and leaflets on free and payable services and cost of services should be produced and posted in all health centres and NGOs.

PA 5: TB-related legal services

Existing programs

Stakeholder interviews found no programs that provide TB-related legal services in cases of human rights violations, so in 2016, there was no expenditure on TB-related legal services.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

A comprehensive approach related to legal services could build upon the existing Human Rights and HIV Observatory, and other activities in the HIV comprehensive approach. This would include restructuring the observatory to include TB under their services: documentation of human rights violations, legal advice and assistance and community mediation. Legal assistance would also target cases of people losing their jobs because of TB and those involuntarily detained for treatment, and would link patients to the Labour Inspectorate.

PA 6: Monitoring and reforming policies, regulations and laws that impede TB services

Existing programs

Stakeholder interviews conducted found no programs for monitoring and reforming policies, regulations and laws that impede TB services, so in 2016, there was no expenditure on monitoring and reforming policies, regulations and laws that impede TB services.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Stakeholder interviews revealed a low knowledge of potential policies, regulations and laws that impede TB services. Therefore a legal environment assessment (LEA) for TB would be required to identify the multiple policy and legal issues affecting access to diagnosis, treatment and care for those who are most vulnerable to TB. Evidence-based advocacy could then be undertaken to address all these barriers related to the legal framework of Côte d'Ivoire.

Capacity building of all NGOs linked to the TB NGO network COLTMER is essential to result in strategic advocacy and lobbying. The capacity building program should focus on understanding the long-term impact of law reform and give participants tools to advocate for better laws, policies and practices. The training could result in the production of a budgeted multi-stakeholder advocacy plan that takes into consideration local specificities in the choice of strategies and activities. The training should target at least 2 participants from each of the 43 NGOs in the TB NGO network.

PA 7: Reducing gender-based inequity in the context of TB services

Existing programs

The PNLT is currently conducting a study on the gender and equity regarding access to TB health services in Côte d'Ivoire, but no details of the study are yet available. There was no expenditure on activities to reduce gender-related barriers to TB services in 2016.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Following the results of the study on gender and equity regarding access to TB health services in Côte d'Ivoire, the PNLT should follow the recommendations to reduce gender-related barriers to TB services. These recommendations should target the 18 high-burden sanitary districts: Abobo Est, Abobo Ouest, Anyama, Cocody-Bingerville, Koumassi-Port-Bouet-Vridi, Marcory-Treichville, Adjame-Plateau-Attecoube, Dabou, Yopougon Est, Yopougon Ouest, Alepe, Tiassale, Yamoussoukro, Bouake Nord-Ouest, Dimbokro, Aboisso, Grand-Bassam, and Man.

PA 8: Patient and community empowerment and mobilisation

Existing programs

Stakeholder interviews found no programs that aim at patient and community empowerment and mobilisation. The few examples given during interviews were about inviting patients for testimonies during World Tuberculosis Day, and encouraging TB NGOs to have patients on their boards. In 2016, there was no expenditure on activities to empower and mobilise the patient and TB community.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Patient empowerment would require capacity development of TB patients to be advocates for their cause and participate in decision-making. Currently it is mainly NGOs working for TB patients that represent them. A comprehensive training for a group of TB patients from the most affected populations would empower them to be effective advocates through a set of training that starts with a foundation course on human rights, HIV and TB, stigma and discrimination and other related information. Competencies would be built through courses on self-esteem, public speaking, social transformation and other skills relevant to the local context.

PA 9: Protecting confidentiality

Existing programs

Stakeholder interviews found no programs in this area, so in 2016, there was no expenditure on activities to protect confidentiality.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Confidentiality issues are covered in PA2.

PA 10: Programs in prisons and other closed settings

Existing programs

The stakeholders interviewed mentioned no programs that address TB and human rights in prisons, but referred the team to the French technical development agency *Expertise France*. This stakeholder could not be met at the time of the baseline assessment.

Ongoing gaps and insufficiencies, and recommendations for comprehensive programming

Since there is very limited information on prisons, an assessment of the quality and accessibility of HIV/TB services in prison should be done. The MACA, the main prison in Abidjan, would be assessed in the first phase, followed by work with the prison medical personnel and related staff to monitor, mentor and advocate for possible actions to ensure the right to health. Then the assessment should extend to all 34 detention centres in the regions of Abengourou, Aboisso, Adzope, Agboville, Bassam, Bondoukou, Bouafle, Bouake, Dabou, Daloa, Dimbokro, Divo, Gagnoa, Katiola, Korhogo, Man, Oume, Sassandra, Soubre, Tiassale and Toumodi.

Costing and budget

Costs for the recommended interventions for the five-year TB comprehensive program set out are set out in the table below. Details of intervention costs are set out in Annex 3.

TB Human Rights Barriers Program Area	Year 1	Year 2	Year 3	Year 4	Year 5	Total
PA 1: Stigma and discrimination reduction	108,471	85,268	42,007	102,468	42,007	380,221
PA 2: Training for health care workers (HCW) on human rights and medical ethics	36,922*	54,152*	73,843*	49,229*	49,229*	263,375[104]
PA 3: Sensitization of law-makers, judicial officials and law enforcement agents	16,846*	16,846*	0*	0*	12,055*	45,747*
PA 4: Knowing your TB-related rights	160,309	60,630	54,603	54,603	158,143	488,288
PA 5: TB-related legal services	0*	0*	0*	0*	0*	0*
PA 6: Monitoring and reforming laws, regulations and policies relating to TB services	289,344	211,208	211,208	211,208	211,208	1,134,176
PA 7: Reducing gender-based inequity in the context of TB services	27,207	27,207	0	0	0	54,414
PA 8: Mobilizing and empowering patient and community groups	195,081	195,081	0	0	0	390,162
PA 9: Ensuring confidentiality and privacy	0	0	0	0	0	0
PA 10: Programs in prisons and other closed settings	0*	0*	0*	0*	0*	0*
Total	834,180	650,392	381,661	417,508	472,642	2,756,383

Costing limitations

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

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

[104]* If HIV Comprehensive Approach is fully funded. Many activities in the HIV Comprehensive Approach can be extended to encompass TB related rights issues at no or low cost.

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

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

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

The prospective costing of the comprehensive response to removing human rights-related barriers will inform the development of the five-year strategic plan and will therefore likely to change throughout the country-owned participatory plan development process.

4. NEXT STEPS

This baseline assessment will be used as the basis for dialogue and action with country stakeholders, technical partners and other donors to scale up to comprehensive programs to remove human rights related barriers to services. Towards this end, the Global Fund will arrange a multi-stakeholder meeting in-country to which it will present a summary of the key points of this assessment for consideration and discussion towards using existing opportunities to include and expand programs to remove human rights-related barriers to HIV and TB services. Depending on the country's status in the funding cycle, these opportunities might comprise matching fund applications, funding proposal development, grant negotiation, grant implementation and reprogramming.

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 to comprehensive programs to remove barriers. In this five-year plan, it is envisioned that the country will set priorities as well as engage other donors to fully fund the comprehensive programs involved. Finally, in order to build the evidence base regarding programs to reduce barriers to HIV and TB services, the Global Fund will commission follow-up studies at mid- and end-points of the strategy to assess the impact on access to services of the expanded programs put in place under the five-year plan.