Submission in re: Input to HRC resolution 47/17
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Introduction

This submission seeks to specifically emphasise the need for donors and governments to prioritise and bolster investment in community-led monitoring (CLM) systems to gather *granular, real-time and reliable* data about human rights barriers which provide crucial information to support comprehensive human rights programmes that are the means to establishing social enablers needed to overcome inequalities impeding access to HIV services and ensuring equitable rights health rights for all.

According to the UNAIDS' Global AIDS Strategy 2021 – 2026, ending inequalities underpinned by stigma, discrimination and HIV-related criminalization will be central to ending AIDS as a public health threat by 2026. Despite the progress made so far, these human rights-related barriers continue to impede access to HIV-related health services for key and marginalised populations (KMPs).[1] If the targets on societal enablers are going to be met, far greater political commitment, resource capacity, technical expertise, the meaningful involvement of communities and community health will be needed. Comprehensive programmes to remove rights-related barriers to services must be evidence based, brought to scale, well-coordinated and integrated into HIV/AIDS prevention, treatment and support services.[2] This data will also serve as evidence needed to substantiate reforms to discriminatory and punitive institutional practices and the criminalisation of key populations which are central barriers to access to services.

Recent mid-term assessments of human rights programmes in 20 implementing countries of the Global Fund's *Breaking Down Barriers* initiative found such programmes to be too small to make a significant difference, lacking technical capacity, inadequately funded, not co-ordinated and not evaluated.[3] Human rights data serves several purposes to remedy these challenges, including informing the design of such programmes such as substantiating resourcing needed to bring them to scale, informing exactly where and what kinds of human rights interventions need to be integrated into health service delivery programmes, and monitoring progress on delivery.

On the other hand, data on the rights barriers generated from CLM systems are needed because at country level, rhetoric alone does not bring about the institutional and legislative changes needed to remove these barriers. In Kenya, for example, during efforts in 2019 to repeal Sections 162 and 165 of the Penal Code, Kenya's High Court rejected the removal of colonial-era laws criminalising homosexual acts within,[4] the ruling centred itself upon the basis that "*The petitioners have failed to prove that the provisions are discriminatory. There is no evidence to show that the petitioners were discriminated, and their rights violated as they sought healthcare*".

[1] These include sex workers and their sexual partners, people who use drugs, the LGBT community, prisoners and other people in closed settings and migrants.
[2] Practical guidance developed by GIZ BACKUP, Frontline AIDS and The Global Fund
https://www.theglobalfund.org/media/9731/crg_programmeshumanrightsbarriershivservices_guide_en.pdf
[3] supra
[4] 1. Sections 162 (a) and (c) say that any person who has 'carnal knowledge against the order of nature' or permits a person to have 'carnal knowledge against the order of nature' against them has committed a crime. Section 165 states that any person who commits an act of 'gross indecency with another male person' has committed a crime. 'Gross indecency' is any sexual activity between two men that does not involve penetration, whether committed in public or in private;
https://theconversation.com/homosexuality-remains-illegal-in-kenya-as-court-rejects-lgbt-petition-112149

Based on this ruling, it is clear that with sufficient, reliable human rights data mapping out patterns of discrimination within key populations, as with members of the LGBTQ community in Kenya, there is a much stronger justification for homophobic laws like this being repealed. With enough human rights data and increased government trust in CLM systems, deniability of systematic human rights abuses can be removed and a fresh wave of repeals and laws promoting equality can be ushered in.

Human rights barriers are a double-edged sword, both impeding access to HIV services, and impeding efforts to gather the very data needed to overcome them. Most public health systems do not monitor the rights-related barriers impeding their HIV responses, and due to criminalisation and other forms of marginalisation, governments fail to collect public health data about key populations, including LGBT individuals, people who inject drugs, sex workers and sexual partners of sex workers, who globally account for two thirds of all new infections.[5] In instances where key populations are dealing with criminalisation of their lifestyles, innate qualities or inalienable characteristics, monitoring systems led by governments will be framed within a judicial lens, as opposed to the trust and approachability cultivated within CLM systems. When dealing with key populations through criminalisation or discrimination, the monitoring focus shifts away from health and human rights barriers to one of criminality and penalisation, meaning that vital data is either missed, clouded or collected within incorrect judicial or punitive data sets affecting data content, quality and consistency. This is disastrous in several ways; it prevents countries from access to vital funds from donors as the relevant data for their proposals is either non-existent or inadequate. It also impacts ongoing monitoring and evaluation efforts, preventing adequate insights into grant performance and impact evaluations. Finally, the resulting lack of necessary resources and assessment capacity of countries necessarily reduces the impact of prevention, testing and treatment of vulnerable populations.

For as long as criminalisation, stigma, discrimination continue to exist, communities most affected by inequalities are best placed to monitor the nature of rights-related barriers to services experienced themselves. This begins with communities being owed the autonomy to collect data and help influence decisions that will affect them primarily, instead of relying on external recording mechanisms that often lack the contextual knowledge held by communities most affected themselves. Additionally, community led monitoring (CLM) systems provide localised expertise and leadership in effective implementation, complimented heavily by their contextual knowledge and community trust and rapport. This facilitates the successful introduction of human rights-based monitoring programmes, giving back power to communities and making the most effective use of the skills, knowledge and leadership already best positioned. CLM systems are best placed to monitor service availability, accessibility, acceptability, affordability, quality, and advocate for improvement. This is what also allows CLM systems to carry a level of trust within key and marginalised populations which have historically provided more challenges when trying to collect sufficient data, their strategic positioning and roots within localised communities is what facilitates these relationships and allows for the best chance at capturing sufficient data within these populations.

> The impact and value of work completed by CLM systems is echoed internationally, with civil society organisations stating that this data "*will empower us to come to those spaces with evidence and advocate for changes to behaviour, policies or law, reducing human rights violations within the LGBT community*."[6] The data collected will also create up the "*opportunity to have a conversation with national stakeholders* [through

[5]Global Fund. 2020. **Data saves lives. To end HIV, we must improve key population data collection now.** https://www.theglobalfund.org/en/blog/2020-12-17-data-saves-lives-to-end-hiv-we-must-improve-key-population-data-collection-now/

[6]Programme Officer, LAMBDA, Mozambique, Rights and Reactions Handbook page 28. Accessible at: https://frontlineaids.org/wp-content/uploads/2021/09/Rights-and-REActions-results-and-lessons-from-REAct_Sep2021.pdf

evidence-informed advocacy by opening the door] *to conversations about the decriminalization of LGBT people, sex workers and people who use drugs*." [7]

Background work being done

The growing call for the introduction and enhancement of CLM systems is reflected in both the Political Declaration on HIV and AIDS[8] and Human Rights Council Resolution[9], with many of the practical steps laid out in the Global AIDS Strategy 2021 – 2026 referencing the importance of CLM systems in leveraging human rights data and its role in creating more targeted human rights responses.[10]

Despite being under-utilized, CLM plays a significant role in monitoring communities' access to HIV-related services, and a particularly crucial role in monitoring access by key and marginalised populations who may avoid public health facilities in favour of services sought from community-led service providers and other civil society organisations. A significant number of country implementers and civil society organisations are beginning to implement CLM to address various data gaps. National and regional Global Fund grant recipients are introducing systems for monitoring human rights barriers to HIV, TB and other health services into their national HIV and TB programmes and policies, many through the *Breaking Down Barriers Initiative*, in which countries access additional match funding earmarked for bolstering capacity in human rights programmes specifically.[11] Also, several organisations are implementing various CLM interventions, including: The Stop TB Partnership are conducting community-based monitoring of the TB response;[12] Expertise France conducted a Report on Community Health Observatories;[13] PEPFAR have developed a set of Community-Led Monitoring Tools;[14] ITPC's Regional Community Treatment Observatory in West Africa and the Missing the Target;[15] the French 5% Initiative;[16] and the ITPC's Community-Led Monitoring and Advocacy for Health report.[17]

The Frontline AIDS Partnership have a strategic focus on implementing human rights CLM systems and leveraging the data for local-to-global advocacy. In 2021, 120 civil society organisations in 14 countries across Africa and Eastern Europe and Asia had implemented our programme, Rights-Evidence-Action (REAct)[18], a human rights CLM system for documenting human rights barriers to health and justice, facilitating client service provision and referrals, and providing robust data to inform programmes and reform policies and laws. Since it began in 2013, REAct has been implemented by 140 community-based organisations in 31 countries in Africa, the Middle East, central Asia and eastern Europe. The vast majority of our and our partners' funding is from Global Fund, Swedish International Development Agency and Department of Foreign Affairs of Ireland.

The impact and value of the work implemented by our partners can be seen first-hand. Alliance for Public Health's (APH) 'Decoration of Human Rights' campaign maps out just some of the recent

[7] Rights and Reactions Handbook page 27
[8] Paras 64&69
[9] Paras 24-28
[10] Page 52, 64, 67, 70, 71, 88, 113, 119, 125, 127
[11] Community-based monitoring: An Overview, The Global Fund, May 2020
[12] The Stop TB Partnership: Community-based monitoring of the TB response, using the OneImpact digital platform OneImpact Investment Package)
[13] Expertise France: Report on Community Health Observatories
[14] PEPFAR: Community-Led Monitoring Tools Community Led Tools: https: //www.pepfarsolutions org/tools-2/2020/3/12/community-led-monitoring-implementation-tools
[15] ITPC's Regional Community Treatment Observatory in West Africa and the Missing the Target
[16] https://www.initiative5pour100.fr/sites/default/fi les/ressourcedoc/2019-10/Community-health-observatories-capitalization_0.pdf
[17] ITPC, Community-Led Monitoring and Advocacy for Health (PDF)
[18] REAct landing page can be found at: https://frontlineaids.org/our-work-includes/react/

examples of success within their CLM system,[19] including; the successful disruption of an abusive and exploitative dynamic between a police officer and sex worker in Russia, providing them with emergency care and legal counsel;[20] the successful facilitation of an asylum claim and dismissal of police officers after the unlawful detention, duress and abuse suffered by a man in Kyrgyzstan at the hands of State police;[21] and the successful renewal of ART and HIV treatment for a man who was unlawfully being denied freedom of movement and residence within Ukraine.[22] APH's human rights CLM efforts have had even greater impact at institutional and legislative levels. For example, Moldova where in the city of Orhei, 27 cases were recorded of people who use drugs having to travel to another city, 50 km away, every day to receive opioid substitution treatment (OST). Using this evidence, negotiations were launched with the Ministry of Health about the opening of an OST site in Orhei.

Recommendations

We recommend that the Office of the High Commissioner for Human Rights should advocate for:

1) Donors and governments to recommit to the Fast Track Targets set in 2016 to invest at least 6% of all global AIDS resources for social enablers, including advocacy, community and political mobilization, community monitoring, outreach programmes and public communication by 2020, and ensure that at least 30% of all service delivery by 2030 is community-led.
2) Governments to:
    a. To commit to investing in CLM systems as a key feature of their systems for health, expressed in HIV national response plans, policies and budgets
    b. Open spaces for civil society organisations to report CLM data and welcome its consideration in all decision making relating to public health priority setting and the necessary reforms in policy and law to enable key and marginalised populations to access equitable health care and justice, including repeal of provisions of criminal law that impede public health outcomes.
    c. Repeal all punitive practices, regulations, policies and legislative provisions criminalising key and marginalised populations underpinning the justification for social and systemic manifestations of stigma, discrimination and violence against such groups.
    d. Ensure that all HIV prevention and treatment programmes are implemented with due respect and protection of the human rights of key and marginalised populations, including the establishment of harm reduction programming as a primary HIV prevention strategy for people who use drugs. Criminalisation and other punitive measures are not reasonably justifiable and cannot continue to stand in the way of efforts to end AIDS as a global public health threat.

[19] https://declaration.react-aph.org/
[20] https://declaration.react-aph.org/article-7-legal-equality/
[21] https://declaration.react-aph.org/article-3-life-liberty-and-security/

[22] https://declaration.react-aph.org/article-13-domestic-and-international-mobility/