



Stigma, Discrimination, and PEPFAR Partnership Framework Agreements: An Analysis of Selected Issues in Five Agreements

Physicians for Human Rights
November 2009

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This briefing paper analyzes how PEPFAR partnership framework agreements are addressing three issues related to stigma and discrimination: legal and regulatory reform, stigma and discrimination in the health sector, and recognition of the need to address stigma and discrimination against people with disabilities. We review how the four PEPFAR framework agreements that have been finalized as of mid-November 2009 (Malawi, Swaziland, Lesotho, and Angola), as well as one agreement that was nearly final in October 2009 (Kenya), address these three issues. (See Appendix I for partnership framework agreement excerpts and country-specific analysis.)

Background

Stigma and discrimination have always been and remain significant obstacles to the fight against HIV/AIDS. As UNAIDS has reported, “experts and communities have consistently identified HIV-related stigma and discrimination as critical barriers to effectively addressing HIV.”¹ Indeed, a survey covering civil society and government stakeholders in 122 countries found that stigma and discrimination was consistently identified as one of the top five barriers to achieving universal access to HIV treatment, prevention, care and support.² And yet, “almost no country has prioritized activities to reduce or eliminate them in their national AIDS plans or programmes. Unless this changes, universal access will not be achieved.”³

Legal and regulatory reform

The first issue is the need for legal and regulatory reform. In particular, to what extent are the framework agreements addressing the need to turn legal and policy frameworks, from ones that in many countries fail to protect or even discriminate against certain populations, into protective legal and regulatory frameworks? We are particularly concerned here with issues of equity and discrimination related to women, people living with HIV/AIDS, and other marginalized populations at heightened risk of contracting HIV, such as men who have sex with men, commercial sex workers, injecting drug users, and people with disabilities.⁴

As of 2008, about 33% of countries did not have laws protecting people with HIV/AIDS from discrimination, while most countries lack this protective framework for marginalized populations. UNAIDS reported that only 26% of countries have laws protecting men who have sex with men from discrimination, 21% have anti-discrimination laws protecting sex workers, and 16% have such laws protecting injecting drug users. Meanwhile, 40% of countries have laws that interfere with the ability of NGOs to provide HIV-related services to injecting drug users, 32% have laws interfering with delivering services to men who have sex with men, and

¹ UNAIDS, *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes: A resource for national stakeholders in the HIV response* (Dec. 2007), at 7. Available at: http://data.unaids.org/pub/Report/2008/JC1521_stigmatisation_en.pdf.

² UNAIDS, *2008 Report on the Global AIDS Epidemic* (2008), at 77. Available at: http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

³ UNAIDS, *Reducing HIV Stigma and Discrimination: a critical part of national AIDS programmes: A resource for national stakeholders in the HIV response* (Dec. 2007), at 7. Available at: http://data.unaids.org/pub/Report/2008/JC1521_stigmatisation_en.pdf.

⁴ Several agreements refer to groups at particularly high risk of contracting HIV/AIDS as most at risk populations, or MARPs.

45% have laws interfering with delivering services to sex workers. UNAIDS found a strong association between a country's laws and the ability to reach these high-risk populations, with significantly higher proportions of the most-at-risk populations reached with HIV prevention services in countries with non-discrimination laws and regulations than in countries that did not have such laws and regulations.⁵ Meanwhile, laws that legislate a second class status for women in various areas (such as property rights and family law), or the failure to enforce laws providing for women's equality, contributes to the gender inequality that is a widely recognized driver of the HIV/AIDS pandemic.

Protecting the rights of marginalized populations is both an abiding concern and one that is particularly timely. In Uganda, legislation is being proposed in Parliament that would make homosexual acts a crime punishable by life imprisonment and even the death penalty.⁶ Meanwhile, in Kenya, recent data reveals that approximately 15% of new HIV infections in that country are among men who have sex with men.⁷ Prevention efforts will be severely undermined as long as men who have sex with men and other marginalized populations must remain underground.

Health sector stigma

The second issue that this briefing paper analyzes is stigma and discrimination and other mistreatment of patients within the health sector. As UNAIDS has observed, "Far too often, the health-care system itself – including doctors, nurses, and staff responsible for the care and treatment of people living with HIV – are prime agents of HIV-related stigma and discrimination."⁸ This can reduce patients' access to HIV-related health services – either because they are denied care or because poor treatment deters them from seeking care – and their ability to receive quality health care when they do access services.

People with disabilities

The third issue is whether the framework agreements recognize people with disabilities as a group at heightened risk of HIV/AIDS and requiring a targeted response. People with disabilities are at double the risk of contracting HIV as the non-disabled population, according to one estimate.⁹ Several factors contribute to this increased risk, including the fact that information on HIV/AIDS may not be accessible to them due to their disabilities, greater likelihood of sexual abuse, neglect and discrimination that lead to low rates of literacy especially among women with disabilities, and the stigma and discrimination that people with disabilities

⁵ UNAIDS, *2008 Report on the Global AIDS Epidemic* (2008), at 79, 83-84. Available at:

http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

⁶ Bill No. 18, The Anti Homosexuality Bill, 2009. Printed in the *Uganda Gazette*, No. 47, Sept. 25, 2009.

⁷ Nick Wadhams, "In Fight Against AIDS, Kenya Confronts Gay Taboo." *Time*. Nov. 7, 2009. Available at: <http://www.time.com/time/world/article/0,8599,1936514,00.html>.

⁸ UNAIDS, *2008 Report on the Global AIDS Epidemic* (2008), at 77. Available at:

http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp.

⁹ "Anecdotal evidence suggests a risk of HIV infection twice as high as that faced by the non-disabled population." AIDS-Free World press release, *People with Disabilities Are at High Risk of HIV but Absent from AIDS Statistics – 650 million individuals worldwide are living with a disability*, Aug. 4, 2008. Available at: <http://www.aids-free-world.org/images/stories/aidsconference/final%20press%20release%20disabilities.doc>.

already face.¹⁰ Also, health workers are often unaware of the vulnerability of people with disabilities to HIV.

PEPFAR guidance on framework agreements

PEPFAR guidance on partnership framework agreements¹¹ (see Appendix II for excerpts) varies in force with respect to these issues. It fails to require that challenging – yet vital – policy issues be addressed. In particular, while it requires a review of policy areas that include gender issues and stigma and discrimination, it recognizes the possibility of “differences of opinion between the USG and the government on certain policies.” The partnership framework may work towards addressing these issues – or avoid them entirely: “In such cases, the Partnership Framework may work toward a reform agenda around that policy and/or focus on other policy reform areas where consensus exists.”¹²

The policy areas included in the PEPFAR guidance include emphasis on women’s rights, especially property and inheritance rights, as well as the need to eliminate gender inequalities in civil and criminal codes, institutional capacity building to improve women’s rights, and legal and judicial capacity building. Guidance is weaker with respect to policy and legal reforms required to address discrimination against marginalized populations. While the policy section of the PEPFAR guidance includes a section on stigma and discrimination, it has few specifics. The framework agreements are to “describe plans to encourage leadership from governments to create non-discriminatory policies” and “address causes and consequences of HIV-related stigma.”¹³ The guidance does not specifically call for a review of, and as needed changes in, laws and policies related to the marginalized populations that are also the populations at highest risk of becoming infected with HIV. It should. The Office of the Global AIDS Coordinator should update the guidance accordingly.

The section in the PEPFAR guidance on stigma and discrimination does not specifically direct framework agreements to address health sector stigma and discrimination, though one example it gives for this section is “incorporating Prevention with Positives programs into the training of healthcare workers and lay counselors.”¹⁴ The guidance does not specifically address people with disabilities, though neither does it specifically name traditionally recognized marginalized populations such as men who have sex with men and injecting drug users. The only group specifically referenced in the policy guidance section on stigma and discrimination are people living with HIV/AIDS.¹⁵

¹⁰ *Id.* Women with disabilities are at triple the risk of rape or sexual abuse as non-disabled women, and are rarely provided sex education. *Id.*

¹¹ Office of the Global AIDS Coordinator, *Guidance for PEPFAR Partnership Frameworks and Partnership Framework Implementation Plans*, Version 2.0, Sept. 14, 2009. Available at: <http://www.pepfar.gov/documents/organization/120510.pdf>.

¹² *Id.* at 15.

¹³ *Id.* at 33.

¹⁴ *Id.*

¹⁵ *Id.*

Summary of findings

The framework agreements reviewed tend to recognize in principle the importance of addressing stigma and discrimination, but either do not address the need for legal and regulatory change, or address this need only in vague terms. Several agreements indirectly address health sector stigma and discrimination, but by and large the agreements do not address this issue, nor do they address people with disabilities as a group at high risk of becoming infected with HIV.

The Office of the Global AIDS Coordinator has indicated that the partnership framework agreements are broad frameworks, with details to be included in the partnership framework implementation plans. We believe that the issues above should be addressed more directly in the framework agreements themselves. To the extent that they have not been, however, it is critical that as PEPFAR and partner countries ensure that they are directly and fully covered by the partnership framework implementation plans.

1. Addressing stigma, discrimination, and gender inequality among the principles of the framework agreements: Most of the agreements recognize the need to address stigma and discrimination, and gender inequality, in principle. Three of the agreements (Kenya, Swaziland, Angola) included addressing these issues among the overarching principles of the agreements, while one (Lesotho) that did not include this as a principle did in a strategic overview section recognize the need to address stigma and discrimination and gender inequalities.
2. Commitments to legislative and policy change to reduce discrimination and achieve equality: Only two of the agreements directly address the need to change policy related to discrimination and gender inequality. In one case (Kenya), the framework call for the country government to “conduct a legislative and policy review to identify and address gaps in property rights and harmful traditional practices” – an important commitment, though not comprehensive across all relevant areas. Another agreement (Angola) is vaguer (for example, not clearly addressing legislation) though possibly more comprehensive, committing the government to “develop policies to reduce women and girls’ inequality, stigma and discrimination.”
3. Support to civil society to promote human rights: All five partnership framework agreements, in various ways, include strengthening the capacity of civil society organizations, in most cases (all but Swaziland) specifically including to address stigma and discrimination or related issues. In three of the agreements (Kenya, Lesotho, Angola), the United States has committed to supporting civil society organizations advocating in these areas (specifically, human rights and the “optimal policy environment” in Kenya, “un-biased services for people infected and affected by HIV and AIDS” in Lesotho, and “the right to live free of stigma and discrimination” in Angola). In Kenya, support extends not only to civil society organizations but also to communities themselves advocating for human rights. In the other two countries (Swaziland and Malawi), it is either the host country government (Malawi) that commits to such support (“to build capacity of leaders and communities to speak against harmful practices and norms”) (Kenya’s government also commits, along with the U.S. government, to build

capacity of community organizations for advocacy purposes), or a U.S. commitment that is less specific to human rights and issues of stigma and discrimination (in Swaziland, “capacity development support to local NGOs working on the HIV response”; in Angola, the United States has also committed to “[s]upport capacity building of local NGOs to manage action in the fight against AIDS”).

Where specific types of civil society organizations are mentioned, they are networks of people living with HIV/AIDS (Kenya, Angola), while in other (and in one case overlapping) instances the agreements refer to organizations working on or leading the AIDS response (Swaziland, Angola). They do not refer to organizations working specifically on the rights of marginalized populations or of women, though such organizations – which may very likely also be working on the AIDS response and have close ties to networks of people living with HIV/AIDS – have a crucial role to play in both the legal and norm change required to end discrimination against marginalized groups and women.

4. Health sector discrimination: No agreement directly and fully addresses health sector stigma and discrimination and lack of respect for patients’ rights, though two agreements (Kenya, Lesotho) address health sector stigma less directly or more narrowly. Kenya’s agreement goes furthest, with an objective of “Interventions (including human rights promotion) for MARPs developed and implemented across health sector.” While not addressing discrimination against PLWHA or discrimination and mistreatment of women in the health sector, and though specific U.S. and Kenyan government commitments do not specifically address human rights, this is the only direct connection in the agreements reviewed between the health sector and human rights. Lesotho’s agreement includes U.S. government support to civil society organizations to lobby for un-biased services for people infected and affected by HIV/AIDS, which would necessitate advocacy to address stigma and discrimination within the health sector, where many of these services are provided. There is scope for addressing health sector stigma in broad language around stigma and discrimination in Angola’s agreement, which recognizes the need to address stigma and discrimination and gender inequality through a multi-sectoral approach.
5. Targets for most at risk populations and PMTCT: Three of the agreements (Lesotho, Angola, Kenya) have the objective of increasing coverage of prevention interventions for most at risk populations, with one of these agreements (Lesotho) including a specific numerical target. This is significant for legal and regulatory change and for addressing health sector stigma because among the measures required to reach most at risk populations are creating an enabling legal environment and addressing health sector stigma. Similarly, all of the agreements but one (Swaziland) have targets on increased PMTCT uptake. Increasing health workers’ respect for the rights and dignity of women, as part of a comprehensive approach to addressing health sector stigma and respect for patients’ rights, should advance this objective.
6. People with disabilities: Only one agreement mentions people with disabilities as among most at risk populations (or otherwise). Lesotho’s agreement lists people with mental disabilities as one of a number of high-risk groups for which strategic messages and services are needed.

The framework agreements are not set in stone. Three explicitly recognize the possibility of modifying them by mutual consent;¹⁶ Lesotho's agreement recognizes that it is "a living document" (page 4). PEPFAR's guidance on partnership frameworks calls for the agreements to include "a clause allowing for future modification of the Partnership Framework . . . [to] allow for flexibility as the environment changes (e.g., elections, new national strategic plans, etc)."¹⁷

Implications and recommendations

Protective legal and policy frameworks and health sector discrimination

Importantly, addressing legal and regulatory changes and health sector stigma is within the scope of most of these framework agreements. In some cases and to varying degrees, these issues are addressed directly. Where not addressed directly or by direct implication (such as a multi-sectoral approach to reducing health sector stigma, which would include the health sector), there may be other entry points for addressing these issues, such as based on general principles in the agreements or targets on increased coverage for interventions targeting most at risk populations and for increasing coverage of PMTCT services. Where agreements do not more directly address health sector stigma and laws and policies that discriminate against women and marginalized populations, the partnership framework implementation plans should seize on these principles and targets to include specific activities around health sector stigma and creating protective legal and policy frameworks for marginalized populations and women. Indeed, all partnership framework implementation plans should be more comprehensive and specific with respect to legal and regulatory change and health sector stigma than the framework agreements reviewed here.

Yet even with the potential and need to address these issues more directly in the implementation plans, the common failure to explicitly address discriminatory laws and health sector stigma in the partnership framework agreements themselves represents a missed opportunity, in several ways.

First, especially with respect to laws and policies, the framework agreements are an important point of leverage for the U.S. government. Given the connection between discriminatory laws and policies and HIV transmission, and the control that countries have over these laws and policies, the United States should take advantage of any possibility it has to advocate for laws and responses to HIV/AIDS that respect the rights of all people, including populations traditionally (and presently) disfavored in these countries. In a document that lays out the obligations of both partners (i.e., PEPFAR and the host country government), the United States should make this expectation clear.

We recognize that these laws often address sensitive social-cultural issues where meaningful change must come from within and cannot be seen as being imposed from outside. We further

¹⁶ These include three of the four finalized framework agreements: Swaziland, Lesotho, and Angola.

¹⁷ Office of the Global AIDS Coordinator, *Guidance for PEPFAR Partnership Frameworks and Partnership Framework Implementation Plans*, Version 2.0, Sept. 14, 2009, at 13. Available at: <http://www.pepfar.gov/documents/organization/120510.pdf>.

recognize that laws alone cannot change attitudes and people's action, and that protective legislation is a critical but hardly sufficient component of reducing stigma and discrimination, and must be accompanied by effective enforcement as well as other measures to change attitudes. And even then, changing entrenched views can take time.

That does not mean that these issues cannot be addressed in the framework agreement, however. While we encourage as forceful a use of the framework agreements as possible to get commitments to establish and enforce a protective, rights-based legal framework, where PEPFAR teams in combination with local civil society determine that this may not be possible, the framework agreements could at the least take important steps in this direction. For example partner governments could commit to: 1) review laws and policies for their consistency with respect to the rights of women, PLHWA, and other marginalized (or most at risk) groups; 2) identify gaps in the laws and policies; 3) change these laws and policies to be consistent with human rights, and; 4) take necessary measures to enforce these reformed laws and policies, as well as to enforce already existing laws and policies that protect the rights of women and marginalized groups. This is the approach Kenya takes, in part, with respect to a somewhat narrower set of issues, "property rights and harmful traditional practices."

Such an approach does not include the specifics, that is, which particular laws or policies affecting which groups need to be changed, and which laws or policies already exist to protect people's rights but need to be more effectively implemented. These are critical details and they should be included in the framework agreements (and implementation plans) wherever possible. Yet even the approach above, which lacks this specificity, would place national leadership publically on the side of human rights and properly frames these issues as ones of human rights. It has the potential to catalyze a positive chain of action, empowering those within government who support these changes, and helping to develop the national leadership that is critical for change.

Along with helping provide the impetus for these changes, PEPFAR can have an important role in supporting the development and implementation of laws and policies that protect people's rights, including through such measures as legal training for lawyers and judges; support for legal aid; technical advice on turning laws into specific policies and regulations; media campaigns and other educational efforts to inform people of their rights, and; increased support for local civil society organizations, government agencies and programs, and media campaigns working to change people's attitudes, and ultimately societal norms. The PEPFAR guidance on partnership frameworks envisions these types of activities.

We do recognize that existing laws and policies vary considerably by country, including the degree to which they harm or assist the HIV response. In some countries, protective legal and policy frameworks already exist and may be effectively enforced. This could explain and justify, including in some of the partnership framework agreements presently analyzed, the absence of these issues in the agreements. By and large, however, in these countries and beyond, while some populations (such as people living with HIV/AIDS) may well be protected by law, this is not true across the range of populations considered, and enforcement is a common challenge.

A second concern arising from the general lack of explicit recognition of the need to replace discriminatory legal and policy frameworks with protective ones, and to address health sector stigma, is that it raises the question of whether PEPFAR and partner countries will in fact address these issues. They might, but they might not. There may then be gaps not only in the partnership frameworks, but also in PEPFAR and country action in the coming years. As described above, a strong case may well be possible that such actions would be within the scope of the framework agreements, at the least due to the connection between these issues and the actions needed for increased coverage of HIV services, or due to general principles. Yet the lack of explicit recognition could lead governments that would rather not touch sensitive issues to argue that legislative and policy reform were not part of the agreement, and to avoid changes in these areas.

A third concern about the lack of more express recognition of these issues is that directly addressing issues of discriminatory laws and health sector stigma would signal that these are clear priorities. Their absence suggests that if they are addressed, they may be approached as only secondary matters.

Indeed, to date, addressing stigma and discrimination within the health sector does not appear to be a PEPFAR focus, given its absence from all five of the partnership framework agreements (other than being indirectly addressed in Kenya's and Lesotho's agreements) and other PEPFAR documentation. PEPFAR does offer some support that will assist in this area, such as through workplace health and safety programs¹⁸ and support for universal precautions through PEPFAR's effort to address medical transmission of HIV. In some countries, PEPFAR programs are adopting additional measures to address health sector stigma, including relevant training and sensitization for health workers. And broader anti-stigma and discrimination efforts could also impact the health sector.

What is required but what is absent, however, is systematic, program-wide encouragement and guidance on taking a comprehensive approach to health sector stigma and discrimination. This approach should be captured in framework agreements far more than it is at present, even if the agreements are not the place for fully detailing the approach. The approach should include training health workers on and sensitizing them to the rights and needs of women and girls, and of marginalized groups (including PLWHA) and of all people, including treating all patients respectfully, protecting confidentiality and informed consent, and ensuring privacy. Furthermore, pre-service training curricula should address confidentiality, non-discrimination, and respect for the dignity of all patients.

Activities should also include any needed legal and policy change (including supporting developing institutional policies and policies that define and effectively secure patients' rights), educating patients on their rights, strengthening the capacity of health worker management and leadership to address health sector stigma and discrimination, and developing accountability mechanisms to address instances where patients' rights have been violated (including support for patients to know about and use these mechanisms).

¹⁸ PEPFAR's human resources for health technical considerations, guidance provided to the field, offers free AIDS treatment for health workers and their families as an example of a retention strategy.

Civil society support to advocacy for human rights, gender equity, and ending discrimination

A critical aspect to securing legal and policy reform is an active and empowered civil society. This is important in all cases, and especially so where the framework agreements do not adequately cover issues of stigma and discrimination, including legal and policy reform and health sector stigma and discrimination. The United States should provide significant capacity-building and financial support to local civil society that can advocate for these reforms, hold the health sector accountable, and catalyze the norm changes among the population that will create the local ownership and support for greater equality in the law, the health sector, and beyond.

Commendably, all partnership agreements analyzed include support for civil society organizations, in most cases specifically addressing advocacy around stigma and discrimination and related human rights issues. It is critical that in implementing the partnership agreements, this is a major focus of support. And PEPFAR must ensure that where framework agreements do not specify support for advocacy in these areas, in implementing the agreements, the U.S. support does encompass advocacy on issues of stigma and discrimination and respect for human rights for women, PLWHA, and other marginalized populations. The United States should ensure that the partnership framework implementation plans expressly incorporate strong civil society support, including for advocacy in these areas.

Several good practices for future agreements can be garnered from the agreements analyzed here. The focus in Kenya's partnership framework agreement not only civil society organizations but also on mobilizing communities to realize their rights should serve as a model, as should the joint U.S. government and Government of Kenya commitment to build the capacity of community organizations for advocacy purposes. Agreements should also be specific in committing to supporting advocacy of civil society organizations and networks, including advocacy with respect to securing the rights of and ending discrimination against people living with and affected by HIV/AIDS, specifying that this includes women and marginalized populations. In addition, future agreements should specify support for organizations working to secure the rights of and end discrimination against marginalized populations, as well as to achieve gender equality.

People with disabilities

The partnership framework agreements almost uniformly fail to recognize people with disabilities as a high risk group. Lesotho's agreement, to its credit, includes people with mental disabilities in its list of high-risk groups requiring strategic messages and services. All framework agreements should specifically recognize the risks people with disabilities face, and the need for targeted interventions, as Lesotho's does (though they should address people with physical disabilities as well). Failing this, at the absolute minimum the agreements should recognize that any list they include of most at risk populations is not exhaustive, thus creating the programmatic space for the need for targeted measures to meet the needs of other populations at heightened risk, including people with disabilities. The need for such interventions with respect to people with disabilities, and for laws and policies to protect their rights, should then be incorporated into the partnership agreement implementation plans.

Appendix I: Country analysis

This appendix includes the pieces of each of the five partnership framework agreements most relevant to issues of discriminatory laws and policies and health sector stigma, as well as a brief analysis of these provisions. As noted above, only Lesotho's agreement references people with disabilities, so it is the only country for which the relevant provision and analysis are included in this appendix. Where relevant objectives in the partnership agreements are accompanied by pertinent commitments from the U.S. government or host country government, these are included as well (where USG denotes the U.S. commitment and GO_ denotes the commitment of the government of the partner country).

Kenya

(Final version submitted to OGAC, Oct. 13, 2009)

Discriminatory laws and policies

The partnership framework agreement

Principle (page 3): *Increasing focus on a human rights-based approach to reduce stigma, discrimination, and the disproportionate impact of HIV on women and girls and other vulnerable groups*

Objective (2/3.4.1) (page 14): *Strengthen community mapping, outreach and mobilization enabling 80% of communities to demand comprehensive HIV prevention, treatment, care and support services and realize implementation of their rights, as well as 80% of PLHIV networks and associations to engage in policy and program development (USG: Seek to support strengthened advocacy for better access to services and protection of human rights) (GOK: Empower communities to advocate for and better access health services at the community level through effective implementation of and linkages to the Community Strategy) (USG & GOK: Jointly build capacity and provide information to community groups for advocacy purposes)*

Objective (4.1.1) (page 15): *Foster a fully supportive and enabling legislative and policy environment for KNASP III implementation by 2013 (USG: Seek to support continued progress in establishing the optimal policy environment for the HIV response by investing in strengthened capacity of CSO/PLHIV networks to demand, monitor and promote supportive policies and in strengthened GOK capacity to develop, implement, and monitor their application) (GOK: Seek to conduct a legislative and policy review to identify and address gaps in property rights and harmful traditional practices; human resources for health; and workplace policies for all sectors)*

Annex: Text from KNASP [Kenya National HIV and AIDS Strategic Plan] III on Vision, Impact Results and Strategies and Pillars and Lead Governmental Organisations: Strategy 4: All stakeholders coordinated and operating within a nationally owned strategy and aligned results framework, grounded in mutual accountability, gender equality and human rights: (page 24) *Cutting across all of these four strategies will be a central focus on MARPs and vulnerable groups. This will directly address existing epidemiological evidence and the sources of new HIV infections. In drafting this plan, there was consensus that more could be achieved by having*

most-at-risk and vulnerable populations as crosscutting target groups, rather than having a stand-alone strategy for them. This will likely involve a number of interventions within each of the proposed strategies (especially Strategies 1 and 3) addressing the specific needs of sex workers and their clients, MSM, prisoners, and IDU, as well as vulnerable populations (uniformed services, humanitarian and mobile populations, orphans, widows and people with disabilities). Two approaches will be used to ensure effective support for most-at-risk and vulnerable populations. First, strong advocacy, grounded in evidence, will be used to solicit support from policy makers to create an enabling policy environment for HIV interventions that target these populations. Second, priority support will be given to civil society organisations and other actors with a track record in removing barriers and providing essential services to MARPs and vulnerable groups.

Analysis

The principle on a human rights approach to reducing stigma and discrimination and the focus on human rights and gender equality set up a conducive environment for developing and enforcing a protective legal framework for marginalized populations and women. Several objectives in the framework agreement reflect this focus.

The objective on legislative and policy review is significant and comprehensive, and potentially has within its scope broad action to address discriminatory and other harmful policies. The specific commitments, though, are narrower. Besides Kenya's commitment to review property rights and harmful traditional practices, it would also be desirable to have a review of possible discriminatory laws and policies – or gaps in enabling laws and policies – to protect MSM, IDU, and sex workers (and people with disabilities and possibly other marginalized populations), as well as PLHIV and women (beyond laws related to property rights and harmful traditional practices – for example, inheritance rights, family law). It will also be necessary to address gaps in enforcing protective laws and policies.

The objective on community mobilization is highly commendable, and is indeed critical to securing human rights – even as a higher target level (above 80% of communities and PHIV networks and associations) would be better. The objective's focus on PLHIV networks raises questions about other marginalized communities and supported them in achieving their rights, though the connections PLHIV networks have with these communities – by the nature of the heightened vulnerability of MARPs and women, they will be important members of PLHIV networks – likely will mean that PLHIV networks will contribute to this task. The objective would be stronger, though, if this support for PLHIV networks also specifically included support for CSOs engaged with and comprised of MARPs (including people with disabilities; the list of MARPs in objective 1.1.9 [page 7] specifies three groups, MSM, IDU, and CSWs) and women and girls. That said, U.S. support for “CSO/PLHIV” networks does suggest support for other civil society beyond PLHIV, potentially including civil society organizations focused on these other populations.

The agreement's principle on a human rights approach to stigma and discrimination and the impact of HIV on women further sets up the potential to address these issues and creates the

possibility for leverage in the coming years, even as the United States has not fully deployed that leverage in the framework agreement itself.

Health sector stigma

The partnership framework agreement

Objective (1.1.2) (page 5): *4.3 million women (80% of expected pregnancies) benefit from PMTCT interventions during plan period (USG: Endeavor to support 100 percent coverage of PMTCT interventions (not including family planning prong outside of PEPFAR manageable interest) in ANC settings by 2010; maintain 100 percent coverage throughout period of the Framework)*

Objective (1.1.9) (page 7): *Interventions (including human rights promotion) for MARPs developed and implemented across health sector (USG: Seek to increase support for prevention interventions focusing on youth and most-at risk groups (men who have sex with men [MSM], intravenous drug users [IDU], sex workers)) (GOK: Provide leadership in disseminating policy and guidelines, community mobilization re: prevention for/with MARPs in health settings; Develop a minimum of five new IDU rehabilitation facilities (average one per year) during the term of the Partnership Framework)*

Analysis

The agreement addresses health sector stigma, and though not very directly and not comprehensively. Human rights promotion of MARPs in the health sector should include addressing discrimination and mistreatment within the health sector, but this is not clear from the expected contributions of any partner in this area. Further, this item addresses only MARPs, not also women, PLHWA, and other marginalized groups (such as people with disabilities, who are not identified as a most at risk population). Nonetheless, this is a more direct connection between human rights and the health sector than most agreements contain. And potentially, the policy and guidelines that the Kenyan government will disseminate would include policies protecting the rights of MARPs in health settings and providing for redress where their rights are violated. Community mobilization could – again, potentially – including educating MARPs on their rights.

While the relevant expected contributions from partners are insufficient, this item does include scope for addressing health worker discrimination, as it is clearly related to the objective. Also and more generally, health sector discrimination falls within the ambit of the overall principle contained in the framework agreement about a human rights-based approach to discrimination. Furthermore, addressing stigma and discrimination in the health sector will contribute to successfully providing interventions to MARPs as well as to reducing vertical transmission – as will creating protective legal and regulatory frameworks for MARPs and women.

Malawi

(Final, May 2009, <http://www.pepfar.gov/documents/organization/124286.pdf>)

Discriminatory laws and policies

The partnership framework agreement

NAF Objective 1.4 (page 10): *Build capacity of professional and lay counsellors and organizations in public sector and civil society implementing the NAF (GOM: GOM to build capacity of leaders and communities to speak against harmful practices and norms)*

Analysis

The framework agreement lacks objectives and actions related to reviewing, identifying, and changing discriminatory laws and practices and developing protective legal and regulatory frameworks. Support for civil society efforts to address issues of stigma and discrimination, at least as included in the agreement, is directed at building the capacity of communities to speak out against harmful practices and norms. This is a critical component of a strategy to address stigma, discrimination, and gender inequalities, but does not address possibly necessary changes in law or policy, and is not necessarily directed at all relevant populations.

Of interest, the agreement does address the need for legislation in another area. As part of an objective related to care for orphans and vulnerable children, Malawi's Office of the President and Cabinet and the country's Ministry of Welfare and Child Development and commit to "advocate for passage of the child protection and justice bill in parliament" (page 12).

Health sector stigma

The partnership framework agreement

NAF Objective 1.2 (page 10): *Reduce mother-to-child transmission*

Analysis

The agreement is silent on addressing health sector stigma. The above item on speaking out against harmful norms and practices may create some space (i.e., harmful practices in the health sector), though this would not appear to be the intent of this objective. The goal of reducing vertical transmission also provides some room for addressing the treatment of and respect for the rights of women in the health sector, as lack of respect for women and their rights may impede uptake of services to reduce vertical transmission.

Swaziland

(Final, June 2009, <http://www.pepfar.gov/documents/organization/124969.pdf>)

Discriminatory laws and policies

The partnership framework agreement

Principle (page 3): *Addressing gender norms and stigma: The Framework should promote and support approaches that: ensure both men and women have equal access to prevention, care,*

treatment and support; address social and cultural norms that have been identified to fuel HIV transmission and prevent full implementation of national policies; and, improve the status and rights of women, people living with HIV and AIDS (PLWHA) and other vulnerable groups in Swaziland.

Objective (page 8): *Improve the human and institutional capacity of the MOH and NGOs to respond to the HIV epidemic (USG: Provide capacity development support to local NGOs working on the HIV response)*

Analysis

The principle on addressing gender norms and stigma is comprehensive and provides considerable and scope for improving laws and regulations from discriminatory to protective frameworks, and covers PLHWA, women, and other marginalized populations. It also includes scope for building the capacity of civil society organizations to advocate for such change and otherwise address stigma and discrimination.

Missing from the agreement are objectives and specific commitment related to developing and enforcing laws that protect the rights of women, PLHWA, and other marginalized populations.

The most important objective towards fulfilling this principle provides for PEPFAR support for local NGOs working on the HIV response, potentially encompassing capacity building for NGOs working to secure the rights of women, PLHWA, and other marginalized groups. It is critical that the U.S. government interpret this provision as such. This is, however, a broad action and objective, and it is unclear the extent to which issues of stigma and discrimination, and rights more generally, are considered to be part of it. Also, in principle capacity development should not be limited to organizations involved in the AIDS response, but also others working to secure the rights of women and marginalized populations. However, particularly in a country with as high HIV prevalence as Swaziland has, an NGO working with marginalized populations or women would very likely also be working on the HIV response, so in practice the absence of a commitment to support other NGOs may make little difference.

Health sector stigma

The partnership framework agreement

[Nothing]

Analysis

The agreement is silent on health sector stigma and discrimination. Potential for action remains, though, under the broad principle referenced above about improving the status and rights of various populations.

Swaziland is the only agreement analyzed here that lacks specific objectives on prevention in marginalized populations or on reducing vertical transmission, both of which would have created

additional avenues for creating protective legal environments and for addressing health sector stigma.

Lesotho

(Final, August 2009, <http://www.pepfar.gov/documents/organization/128718.pdf>)

Discriminatory laws and policies

The partnership framework agreement

The 5-year strategic overview (page 6) recognizes: *Cross-cutting issues include reducing stigma and discrimination; increasing gender equity in HIV services and activities; reducing gender violence and coercion; and addressing male norms and behaviors.*

Prevention activities (page 8) include: *stimulating introspection and discussion about masculinity and femininity, Basotho gender norms, and the cultural aspects putting Basotho, especially married couples, at risk of contracting HIV.*

Objective 4.3 (page 21): *The organizational capacity of civil society organizations (CSOs) is strengthened to improve the provision of quality HIV and AIDS services (USG: Assist CSOs to develop advocacy skills to lobby for quality, wide-spread, un-biased services for people infected and affected by HIV and AIDS) (GOL: NAC continues to facilitate support for civil society organizations on capacity building issues)*

Analysis

The agreement does not directly address the need for legal and policy change to secure the rights of women, PLHWA, and other marginalized populations. There are, though, several possible inroads to such changes. One is the agreement's overview and section on cross-cutting prevention activities, both of which recognize the need to address stigma and discrimination and gender inequalities. The overview may be more useful in this respect, as the activities are focused on norms, not laws and policies (even as laws and policies can influence norms, just as norms can impede effective implementation of laws and policies).

The second possibility is the objective related to support CSOs with advocacy skills to lobby for un-biased services for people infected and affected by HIV/AIDS. Securing such services may entail lobbying for legal and policy changes. However, this is a U.S. government commitment to support advocacy, which is quite distinct from a Government of Lesotho commitment to review and change its laws and policies. And the laws and policies that may contribute to the spread and impact of AIDS – such as property and inheritance laws biased against women – reach beyond issues of un-biased access to HIV services. Also, it is not altogether clear whether this commitment includes CSOs lobbying for un-biased services covers all populations at risk of discrimination, including women and marginalized populations, though the use of the phrase “affected by HIV and AIDS” may be intended to cover these populations.

Health sector stigma

The partnership framework agreement

Objective 1.2 (page 14): *80 percent of most at risk populations are reached with HIV prevention programs*

Objective 1.3 (page 15): *The percentage of HIV+ children born to HIV+ mothers is reduced by at least 40 percent (USG: Improve quality and reach of PMTCT services in 100 percent of hospitals and health clinics delivering services)*

Objective 3.2 (page 19): *An increased proportion of HIV and AIDS service providers are trained in relevant technical skills*

Objective 4.3 (page 21): *The organizational capacity of civil society organizations (CSOs) is strengthened to improve the provision of quality HIV and AIDS services (USG: Assist CSOs to develop advocacy skills to lobby for quality, wide-spread, un-biased services for people infected and affected by HIV and AIDS) (GOL: NAC continues to facilitate support for civil society organizations on capacity building issues)*

Analysis

The objective on support CSOs to advocate for un-biased access to HIV services could well include supporting their lobbying to advance policies and activities (such as health worker training and education patients on their rights) required to reduce discrimination in the health sector. The agreement does not include, however, any commitments from the United States or Lesotho to actually support these policies and activities.

The agreement addresses curricula reform, but only in context of training on “relevant technical skills.” Training related to understanding and respecting patients’ rights, and sensitization to issues of stigma and discrimination, might not be considered “technical skills.” And there is, as noted, no specific commitment to training on these issues.

Lesotho’s agreement is the only one analyzed to include a numerical target for reaching most at risk populations with prevention interventions. It also includes a target on reducing vertical transmission. Due to the connections between achieving these objectives and creating a respective, safe environment for most at risk populations and for women, they create additional justification for addressing the legal and regulatory framework as it relates to marginalized populations and women, as well as for addressing stigma and respect for the rights of all patients within the health sector.

People with disabilities

The partnership framework agreement

Objective 1.2 (page 14): *80 percent of most at risk populations are reached with HIV prevention programs (GOL: Develop strategic messages and services for high-risk groups (e.g. members*

men/boys, married and stable couples, single people, migrants, women and girls, sex workers, miners, cross-border/transients, government and private sector employees, sexual assault survivors, adolescent mothers, mentally disabled, alcohol/drug abusers)

Analysis

Lesotho is the only country analyzed to include people with disabilities in a list of high-risk groups (or to otherwise address people with disabilities), recognizing the need for strategic messaging and services for this group (and for other high-risk groups). This is commendable, even as it does come with a listing that encompasses a remarkable range of groups. The list includes people with mental disabilities, as well as people with a particular type of mental illness, namely addiction, through its inclusion of drug and alcohol abusers. The listing of people with disabilities is limited in referring only to mental disabilities, even as targeted messages and services will also be needed for people with physical disabilities as well.

Angola

(Final, August 2009, <http://www.pepfar.gov/documents/organization/128595.pdf>)

Discriminatory laws and policies

The partnership framework agreement

Principle (page 5): Addressing gender norms and stigma: This Framework should promote and support approaches that ensure both men and women have equal access to prevention, care, treatment, and support; address social and cultural norms that fuel HIV transmission and promote the adoption and full implementation of national policies to address the drivers of these epidemic; and improve the rights and status of people living with HIV/AIDS (PLHWA) and other groups vulnerable to HIV/AIDS in Angola. Policy reform should focus on gender equity, stigma, and discrimination that impact access of most at risk populations to HIV prevention, care and treatment services.

Key intervention areas: Civil Society Strengthening (page 12): the USG should help to build the capacity of civil society organizations that seek to lead the community-based response to HIV in Angola....The USG should also continue to support organizations of people living with HIV/AIDS that advocate increased access to care and treatment and the right to live free of stigma and discrimination.

Key intervention areas (page 13): The choice of combinations [of prevention methods] depends on the target group or region. For example, a basic package for CSW would include VCT and STI services...complemented by reform targeting discrimination and gender-based violence. Reducing the vulnerability of women and addressing gender inequality are also components of the national strategic plan for prevention....

Objective: Civil Society (page 20): Strengthen civil society leadership, governance, and partnership mechanisms; (1) to monitor HIV/AIDS policy; (2) to implement care and support activities; (3) to reduce vulnerability and gender inequality (USG: Support capacity building of

local NGOs to manage action in the fight against AIDS, enable fundraising capacity, improve M&E and financial management) (USG: Promote stigma reduction interventions for hidden populations (e.g., MSM)) (GOA: Improve civil society and PLHWA partnership mechanisms) (GOA: Reduce stigma and discrimination as well as women and girls' vulnerability and gender inequalities, based on a multi-sectoral approach)

Objective: Stigma and discrimination (page 22): *Reduce HIV and AIDS related stigma and discrimination (USG: Reduce women and girls' vulnerability and gender inequalities; reduce stigma and discrimination based on a multi-sectoral approach) (GOA: Develop policies to reduce women and girls' inequality, stigma and discrimination)*

Analysis

More than other partnership framework agreements, Angola's highlights the importance of reducing stigma and discrimination as well as gender inequalities. One of the framework agreement's principles recognizes the need for policy reform both with respect to gender and most at risk populations. The most relevant objectives is that on stigma and discrimination, under which the Government of Angola commits to develop policies and reduce women and girls' inequality and stigma and discrimination. This does create scope for wide-ranging legal and policy change, but only through the provision's vagueness, as it is not clear how far-reaching the intent was. For example, it is unclear whether Angola intended this commitment to address policy related to most at risk populations other than women and girls, or whether it contemplated legislative reform, if needed. Similarly, it is unclear how "HIV and AIDS related stigma and discrimination" would be interpreted, as certain stigmas that significantly impact HIV prevention are not HIV and AIDS related per se. For example, discrimination against MSM or IDUs reduces the ability to provide HIV/AIDS interventions to these populations even if the stigma and discrimination these groups face is related to their behaviors, independent of HIV/AIDS.

Provisions under civil society strengthening also potentially include the possibility of legal and policy reform, though again, whether such reforms were intended to be part of these objectives is less certain. The U.S. commitment to promote stigma reduction interventions for hidden populations – an important commitment that should be more explicit in other agreements given the largely universal need for this – could including promote legal and policy interventions and reform. However, it could also be more limited to, for example, public sensitization and education, and support to NGOs working to reduce discrimination against these populations – also critical actions, yet depending on the laws and policies in Angola, not necessarily the full scope of what is required. Angola's commitment in this civil society objective is similarly welcome but vague. Does a multi-sectoral approach include cross-sectoral legal reform? Does this commitment to reduce stigma and discrimination and gender inequalities contemplate legal and policy reform?

Health sector stigma

The partnership framework agreement

Objective: Civil Society (page 20): *Strengthen civil society leadership, governance, and partnership mechanisms; (1) to monitor HIV/AIDS policy; (2) to implement care and support activities; (3) to reduce vulnerability and gender inequality (USG: Support capacity building of local NGOs to manage action in the fight against AIDS, enable fundraising capacity, improve M&E and financial management) (USG: Promote stigma reduction interventions for hidden populations (e.g., MSM)) (GOA: Improve civil society and PLHWA partnership mechanisms) (GOA: Reduce stigma and discrimination as well as women and girls' vulnerability and gender inequalities, based on a multi-sectoral approach)*

Objective: Most at Risk Populations MARPs (page 21): *Scale up access to health promotion and STI/HIV prevention among most at risk populations, focusing on professional sex workers, truck drivers and MSM, within 11 priority provinces*

Objective: Stigma and discrimination (page 22): *Reduce HIV and AIDS related stigma and discrimination (USG: Reduce women and girls' vulnerability and gender inequalities; reduce stigma and discrimination based on a multi-sectoral approach) (GOA: Develop policies to reduce women and girls' inequality, stigma and discrimination)*

Objective: Prevention Mother to Child Transmission (page 23): *Scale up prevention of mother-to-child transmission, including early infant diagnosis (USG: Expand PMTCT services in high prevalence provinces; improve M&E of PMTCT; promote task-shifting; support civil society initiatives to identify pregnant women in the community; promote their ANC and CT, increase adherence for HIV+ pregnant women to prophylaxis) (GOA: Develop policies for task-shifting and lay-counseling; expand PMTCT to 100% coverage of pregnant women)*

Analysis

Health sector stigma and discrimination is not specifically addressed. The framework agreement does include scope for action through provisions related to stigma and discrimination more generally, as discussed above. Both the U.S. government and Government of Angola committed to a multi-sectoral approach to reducing stigma and discrimination. The health sector is one sector where action to reduce stigma and discrimination could take place, and where policies to reduce women and girls' inequality could be developed and implemented.

Achieving the objectives related to scaling up prevention activities for most at risk populations and for reducing vertical transmission will be facilitated by developing and implementing protective legal frameworks for these populations and for women, as well as by reducing health sector stigma. This also creates additional justification, therefore, for addressing health sector stigma, as well as needed legal and regulatory reform, under the framework agreement.

Appendix II: PEPFAR Partnership Framework Guidance excerpts

This appendix includes excerpts of the most relevant pieces of PEPFAR’s guidance on partnership framework agreements.

Countries are required to undertake an HIV/AIDS policy reform situation analysis, covering all seven policy areas in an annex to the guidance. The guidance recognizes: “There may be differences of opinion between the USG and the government on certain policies. In such cases, the Partnership Framework may work toward a reform agenda around that policy and/or focus on other policy reform areas where consensus exists.”¹⁹

One policy area in the annex to the PEPFAR guidance is “Address gender issues.” This includes the following specific areas for consideration:

- *Addressing policy and legal reforms needed to increase gender equity in land and property inheritance rights. The following are strategies to increase women’s legal rights generally, and property and inheritance rights specifically:*
 - *Legal and policy interventions to safeguard the inheritance rights of women, particularly women in African countries, due to exponential growth in the number of young widows, orphaned girls, and grandmothers becoming heads of households.*
 - *Institutional capacity-building of government ministries, universities, NGOs, and civil society to improve women’s legal rights and indigenous women’s access to justice.*
 - *Legal and policy interventions that inform lawyers, prosecutors, law enforcement, and service providers on the legal rights of women, and encourage these groups to enforce these rights through the judicial and legal process.*
 - *Working with governments and civil society to eliminate gender inequalities in the civil and criminal code.*
- *Addressing policy and legal reforms related to Gender-based Violence (GBV). The following are relevant to addressing GBV:*
 - *Existence of National Anti-GBV/Sexual Violence Laws.*
 - *Attention to GBV within National HIV/AIDS Policies.*
 - *Policies related to provision of comprehensive health care services for victims/survivors of sexual violence, including post-exposure prophylaxis (PEP).*
 - *Capacity-building of government ministries, institutions (education, health, legal, etc.), NGOs and civil society to prevent and respond to GBV.*
 - *Policies and laws that address norms that perpetuate GBV.*²⁰

Another of the seven policy areas included in the annex to the PEPFAR guidance document is “stigma and discrimination”:

¹⁹ Office of the Global AIDS Coordinator, *Guidance for PEPFAR Partnership Frameworks and Partnership Framework Implementation Plans*, Version 2.0, Sept. 14, 2009, at 15. Available at: <http://www.pepfar.gov/documents/organization/120510.pdf>.

²⁰ *Id.* at 32.

Partnership Frameworks should describe plans to encourage leadership from governments to create non-discriminatory policies and to publicly support PLWA and their inclusion in development of policy, community interventions, and program evaluation. Policies should address causes and consequences of HIV-related stigma, and may support programmatic approaches such as: incorporating Prevention with Positives programs into the training of healthcare workers and lay counselors; utilizing PLWA as lay counselors and peer educators; and employing effective measurement and documentation of stigma in program plans.²¹

²¹ *Id.* at 33.