FRONTLINE AIDS

RIGHTS AND REACTIONS

RESULTS AND LESSONS LEARNED FROM REACT, A COMMUNITY-LED HUMAN RIGHTS DOCUMENTATION & RESPONSE SYSTEM

CONTENTS

ABBREVIATIONS

APH	Alliance for Public Health
ART	Antiretroviral therapy
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CSO	Civil society organisation
EECA	Eastern Europe and Central Asia
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
LGBT	Lesbian, gay, bisexual and transgender
MENA	Middle East and North Africa
OST	Opioid substitution therapy
PEP	Post-exposure prophylaxis
PMTCT	Prevention of mother to child transmission
PrEP	Pre-exposure prophylaxis
PITCH	Partnership to Inspire, Transform and Connect the HIV Response
PEPFAR	President's Emergency Fund for AIDS Relief
PPE	Personal protective equipment
REAct	Rights-Evidence-Action
SDG	Sustainable Development Goal
SoS	Sustainability of Services for Key Populations Programme
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	United Nations Joint Programme on AIDS

1. SUMMARY OF FINDINGS

- Rights, Evidence ACTion (REAct) has proven itself as a **community-led human rights monitoring interventio**n that plays a critical role in diverse social contexts, legal environments and responses to HIV. This report spans eight countries – Uganda, Kenya, Mozambique, Ukraine, Kyrgyzstan, Tajikistan, Georgia and Moldova – where it is being implemented at different scales and paces. In all these contexts, it represents either the only such intervention for HIV-related human rights monitoring, or a vital addition to existing ones.

- Between December 2019 and September 2020, REAct implementers registered **1,780** clients in total. Their profile was 54% male, 39% female and 2% transgender, with the majority over 24 years old.

- Between December 2019 and September 2020, REAct recorded **1,897 cases of people experiencing human rights-related barriers to accessing HIV services.** The communities most affected by these barriers were people who use drugs, people living with HIV and sex workers. The most common types of barriers were emotional harm, denial of services and violence/physical harm. The most frequent perpetrators were the police/law enforcement and public health care workers – the very stakeholders that should be there to support and protect marginalised people.

- Each case of experiencing a human rights-related barrier can have a **major impact on the individual** concerned. For example, negative effects on: physical health; mental health; self-esteem and ability to engage in community development. The impact can be particularly harsh on community members who experience double stigma or double criminalisation, such as being a sex worker who takes drugs, or a man who has sex with men who is living with HIV.

- As of September 2020, **690 REAct cases had been resolved**, while many more were in the process of resolution. Three quarters of responses (76%) were provided directly by REAct implementers, with the remaining quarter (24%) provided through referral networks. The most common types of services provided were legal support and emotional/psychological counselling.

- REAct projects produce a wealth of **high quality and real-time data**. This is being used to shape the design and guide the implementation of human rights programmes and interventions by REAct partners and others. It also provides invaluable evidence for advocacy, such as laws, policies and institutional practices that make it difficult for marginalised communities to enjoy their rights, such as to life, health, and freedom from discrimination that need to be changed.

- **COVID-19** has placed additional strain on REAct systems. In some contexts, this has led to increases in human rights violations under the guise of measures to control the spread and impact of the virus. In all countries the pandemic has highlighted, and exacerbated, existing inequities experienced by marginalised people.

- Overall, REAct demonstrates that human rights violations against marginalised groups continue to be a **major and highly concerning reality**. They have an appalling impact on the lives of individuals. They also pose a real threat to action on HIV, for example reducing people's access to prevention, care, support and treatment. Even in countries that have invested in their response to HIV and are committed to 'leave no one behind' in the Sustainable Development Goals (SDGs), efforts will not succeed without promoting and protecting human rights.

2. INTRODUCTION

There is growing global recognition among both **state and non-state actors** that sustained, scaled-up and community-led monitoring of human rights-related barriers to accessing health services – such as REAct - are critical to ending AIDS and strengthening health systems. Government commitment is manifesting itself not only through policy change, but the integration of such interventions into national HIV plans, and funding requests – such as to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) – for human rights-based programming.

In addition to assisting partners to design and establish REAct projects, and providing training and on-going technical support, **Frontline AIDS** hosts and manages REAct on 'Wanda', the central information management system. This enables Frontline AIDS to have a global overview of REAct data across all active projects, while enabling each REAct partner to access, manage and run data analyses of their own data sets for their own purposes. This shared ownership and management provides a rich opportunity for REAct partners and Frontline AIDS to collaborate on various levels of advocacy, from community to national and global levels.

Background

REACT STATS AT A GLANCE:

8
countries: Uganda, Kenya, Mozambique, Ukraine, Kyrgyzstan, Tajikistan, Georgia and Moldova.

1,780
REAct clients reached: 54% male; 39% female; and 2% transgender.

1,897
cases of people experiencing human rights-related barriers to accessing HIV services.

690
number of cases resolved

- 2,930 instances of responses to human rights-related barriers to accessing HIV services across all countries.
- Of the responses provided, 75% were direct responses by REActors and the organisations they represent, and 25% were referrals
- Across countries with different social, cultural and legal contexts, the most common perpetrators are public health care professionals and police/law enforcement.
- The most common types of incidents are denial of health services and harassment, intimidation

There is a growing wealth of international commitments, global technical guidance and programming opportunities acknowledging that the protection of human rights and removing rights-related barriers – most prominently stigma, discrimination, violence and criminalisation – are essential to ending AIDS. Rights-based responses create an enabling environment for people most affected by HIV to enjoy their health rights, access HIV and other health and social services and enable positive health outcomes overall.

With the adoption of the SDGs, UN Member States committed to 'leave no one behind' and to end the HIV and Tuberculosis (TB) epidemics by 2030. This requires addressing stigma, discrimination and other legal, human rights, social and gender-related barriers that make people vulnerable to HIV and hinder their access to HIV prevention, treatment, care and support services.

BOX 1: UNAIDS-RECOMMENDED HUMAN RIGHTS-BASED PROGRAMMES

1. Stigma and discrimination reduction.
2. HIV-related legal services.
3. Monitoring and reforming laws, regulations and policies relating to HIV.
4. Legal literacy ('know your rights').
5. Sensitisation of lawmakers and law enforcement agents.
6. Training for healthcare providers on human rights and medical ethics related to HIV.
7. Reducing discrimination against women in the context of HIV.

International normative guidance articulates how those commitments can be put into practice. Examples include those produced by the UN Joint Programme on HIV/AIDS (UNAIDS), for example on the key programmes required to reduce stigma and discrimination and increase access to justice in national responses to HIV (*see Box 1*)[1].

In turn, such guidance is increasingly reflected in opportunities to resource human rights-based programming. An example is the Breaking Down Barriers to Access programme funded by the Global Fund and targeting 20 priority countries. This provides their governments with additional funding to incentivise increased investments in human rights programmes within national grants[2].

REAct is a community-led human rights monitoring and response programme developed by the Frontline AIDS Partnership. Through REAct, CBOs/CSOs can: document the human rights-related barriers to accessing HIV and health services experienced by marginalised communities (see definition in *Box 2*[3]); facilitate a response to those barriers, through direct service provision or a referral network of service providers; and use the real-time data to guide their own human rights programming, as well as to advocate for improved programmes, policies and laws at national, regional and global levels.

REAct was conceived – and is being implemented – as a programme that not only records human rights violations, but responds to them, where possible bringing resolution for the individual(s) involved. This is a critical value-added that makes REAct stand out from many other community-led human rights monitoring interventions.

REAct is part of a growing movement of community-led monitoring initiatives that are designed to assess – and hold stakeholders to account for – the enactment of international human rights commitments, guidance and programming within responses to HIV on the ground. Such interventions are implemented by community-based organisations (CBOs) and civil society organisations (CSOs). They aim to document, respond to, learn from and

1. *Key Programmes to Reduce Stigma and Discrimination and Increase Access to Justice in National HIV Responses,* UNAIDS, 2012.

2. Breaking Down Barriers to Access: Scaling up Programs to Remove Human Rights-Related Barriers to Health Services in 20 Countries and Beyond is providing $41 million in 2020-2022 in 20 selected countries (Benin, Botswana, Cameroon, Democratic Republic of Congo (province-level), Cote d'Ivoire, Ghana, Honduras, Indonesia (selected cities), Jamaica, Kenya, Kyrgyzstan, Nepal, Mozambique, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda and Ukraine). *Questions & Answers: Breaking Down Barriers to Access: Scaling up Programs to Remove Human Rights-Related Barriers to Health Services in 20 Countries and Beyond*, the Global Fund to Fight AIDS, Tuberculosis and Malaria, 8 June 2020.

3. *REAct User Guide,* E. Restoy, M. Ram, O. Moseki, L. Renton and M. Sigrist, Frontline AIDS, 2019. https://frontlineaids.org/resources/react-user-guide/

4. *Towards a Future Free from AIDS for Everyone, Everywhere: Global Plan of Action 2020-2025,* Frontline AIDS.

advocate for action on the real-life experiences of community members in terms of human rights-related barriers, such as to accessing HIV services. The inclusion of such interventions is now encouraged in proposals to a number of donors, such as national and regional funding requests to the Global Fund.

REAct lies at the heart of the Frontline AIDS vision for the future, as articulated in its Global Plan of Action for 2020-2025[4]. The partnership's actions for 'unlocking barriers' include a commitment to 'convene community networks to document and respond to human rights violations to hold governments and the private sector to account'. This achieves 'improved national laws and policies that respect, protect and fulfil the rights of those most marginalized' that in turn build a scenario whereby 'everyone, everywhere enjoys their human rights'.

BOX 2: DEFINITION OF MARGINALISED COMMUNITIES

'Marginalised communities' are people who are affected by HIV, and are particularly vulnerable to stigma and discrimination and other human rights violations. These communities vary according to the local context, but are usually criminalised or persecuted, for example because of their HIV status or sexual orientation. They include people living with HIV, sex workers, men who have sex with men, transgender people and people who use drugs. This definition also includes women, adolescents and girls, and sexual minorities in contexts of acute gender inequality and violence, as well as other communities affected by HIV that are at heightened risk of human rights violations.

What is the report's remit?

This report explores the experiences, results and lessons from the implementation of REAct,

This report covers data for 1 December 2019 to 30 September 2020. In this period, REAct underwent an internal re-launch, while also facing the unprecedented challenge of COVID-19.

The report's analysis focuses on data from CBOs/CSOs in eight countries where REAct was operational by September 2020: Uganda, Kenya, Mozambique, Ukraine, Georgia, Tajikistan, Moldova and Kyrgyzstan.

The first four countries were supported through the Partnership to Inspire, Transform and Connect the HIV Response (PITCH)[5], a collaboration between Frontline AIDS, Aidsfonds, the Dutch Ministry of Foreign Affairs and CBOs/CSOs. The work in Ukraine was also resourced through a national grant from the Global Fund, for which the Alliance for Public Health (APH) is a Principal Recipient. The last four countries are part of the Sustainability of Services for Key Populations in Eastern Europe and Central Asia Region Programme (SoS Programme) – a regional initiative funded by the Global Fund, for which APH is again the Principal Recipient.

Information has also been gained from some countries where REAct is being established or scaled-up, such as South Africa, Cote d'Ivoire, Lebanon, Jordan, Senegal and Zimbabwe.

This report discusses and answers the following questions about REAct and human rights-related barriers to accessing HIV services (as defined in *Box 3*) that it addresses:

AREA 1: What **number** of human rights-related barriers to accessing HIV services are CBOs/CSOs documenting through REAct?

AREA 2: **Who** is reporting human rights-related barriers to accessing HIV services through REAct, and what **types** of barriers are they experiencing?

AREA 3: What **responses** to human rights-related barriers to accessing HIV services is REAct enabling?

AREA 4: How is REAct **data** being used to inform human rights programmes and advocacy?

The report also: explores the impact of COVID-19 on the implementation of REAct; draws conclusions and outlines key messages; and highlights lessons learned. A supplementary Data Appendix is available on request, providing a more detailed breakdown of the data summarised in this publication.

5. *PITCH*, (webpage), Frontline AIDS, https://frontlineaids.org/our-work-includes/pitch/

BOX 3: KEY DEFINITIONS RELATED TO HUMAN RIGHTS[6]

'Human rights' refers to basic universal entitlements that all people have because they are human. They are based on the idea that all persons are equal and are entitled to be treated with dignity and respect, regardless of their race, sex, gender, age, disability or any other characteristic. Human rights apply to all people throughout the world at all times. They give people the freedom to choose how they live, how they express themselves, and what kind of government they want to support, among many other things. They also guarantee people their basic needs, such as food, housing, healthcare and education. By guaranteeing life, liberty and security, human rights protect people against abuse by those who are more powerful.

Generally, a **'human rights violation'** can only be committed by a state[7]. A violation can occur through the:

- **Failure to respect a right** – an instance where a state is the direct perpetrator of a violation.
- **Failure to protect a right** – an instance where a state fails to protect an individual's right when it has been violated by a civilian or private person.
- **Failure to promote and fulfil a right** – an instance where a state fails to put in place mechanisms to ensure the adequate enforcement of laws and policies that are intended to protect a right, or fails to enable individuals to access the justice system.

'Human rights-related barrier to accessing HIV services' refers to an instance where a person experiences a barrier (such as physical violence, arbitrary arrest or a breach of confidentiality) to accessing HIV services, and that barrier is related to a violation of one or more of their human rights (such as to safety, freedom or privacy). In some cases, the official responsibility of the state for the barrier is established. In other cases it may not be, but there is still a clear infringement of a person's human rights.

How is this report informed?

This report is informed by a range of sources. These include Wanda, the REAct management information platform that securely stores qualitative data and testimonies, and enables quantitative analyses for single or combinations of countries and search criteria. The sources also include: a survey among 20 representatives of REAct partners in 12 countries in April 2020, and a follow-up survey among a sample of seven representatives of partners in seven countries in November 2020[8]; interviews with representatives of REAct partners for four countries[9] and for the SoS Programme[10]; and a literature review of REAct resources. Of note, the latter included a detailed set of presentations and country profiles produced by partners implementing REAct in Ukraine and the SoS Programme[11].

6. *REAct User Guide*, Frontline AIDS, 2019.

7. This includes state institutions and representatives, such as government officials, police officers, army personnel, prison officers, civil servants, the judiciary, political authorities and medical or educational personnel in state-run facilities.

8. First survey of REAct Coordinator Organisations and Implementing Partners in: Cote D'Ivoire, Georgia, Jordan, Kenya, Kyrgyzstan, Lebanon, Moldova, Mozambique, Tajikistan, Uganda, Ukraine and Zimbabwe. Follow-up survey of REACT Coordinating Organisations in Kenya, Moldova, Mozambique, Uganda, Ukraine, Georgia and Tajikistan.

9. Kenya, Mozambique, Uganda and Ukraine.

10. Alliance for Public Health.

11. The primary source of data used in this report for Ukraine and the SoS Programme is Wanda, covering the period December 2019 – September 2020. In some instances, specific references are made to the detailed set of presentations and country profiles produced by partners implementing REAct. These cover the periods: 1.11.19 - 15.10.20 for Ukraine; and up to the beginning of December 2020 (presentation) and January – June 2020 (reports) for the SoS programme.

3. OVERVIEW OF REACT

What is REAct?

REAct started in 2013. It was conceived as a system to be implemented by CBOs/CSOs to systematically and easily support people experiencing human rights-related barriers to accessing HIV and health services, and to build an evidence base to inform programme improvements and policy and legal reforms. At this time, such groups were struggling with the reality that community members – particularly those from marginalised communities – were experiencing abuses as a result of stigma, discrimination, violence and criminalisation, making it difficult for them to access support. There was also a growing need for data that organisations could use to advocate for rights-based programmes, services, policies and laws.

REAct was designed for use by CBOs/CSOs that focus on HIV initiatives with marginalised communities. However, the intervention is adaptable. For example, it can be scaled-up to be used as a collaboration between civil society and other stakeholders, such as government; and for other areas of health, such as TB, hepatitis C, sexual and reproductive health (SRH) and harm reduction for people who use drugs.

Between 2013 and 2018, REAct was piloted and rolled-out through a range of initiatives in 22 countries[12]. In 2018, Martus, the information management system on which REAct was originally based, was phased out. This led to a re-launch in December 2019, with REAct – an initiative that is constantly innovating – benefiting from various modifications. Frontline AIDS re-launched the information management system on Wanda, a customised version of DHIS2 – a user-friendly, opensource platform commonly used by ministries of health and major donors, such as the President's Emergency Programme for AIDS Relief (PEPFAR). Using Wanda centralises REAct data 'under one roof', allowing for easy global overview and comparisons to be made. Whilst Frontline AIDS hosts this data, implementers own and manage it.

As part of the December 2019 re-launch, Frontline AIDS also took the opportunity to: standardise many of REAct's data indicators (to aid data consistency and comparability); amend the REAct case template (to enable partners to make programme-level recommendations); and articulate opportunities to transition REAct from small to large-scale (including through partnership between civil society and government).

How does REAct work?

As seen in *Box 4*, through REAct, a person's journey involves a number of steps. These start with them seeking support from a REActor (such as a peer educator or paralegal in their community) who listens and takes notes, using a template.

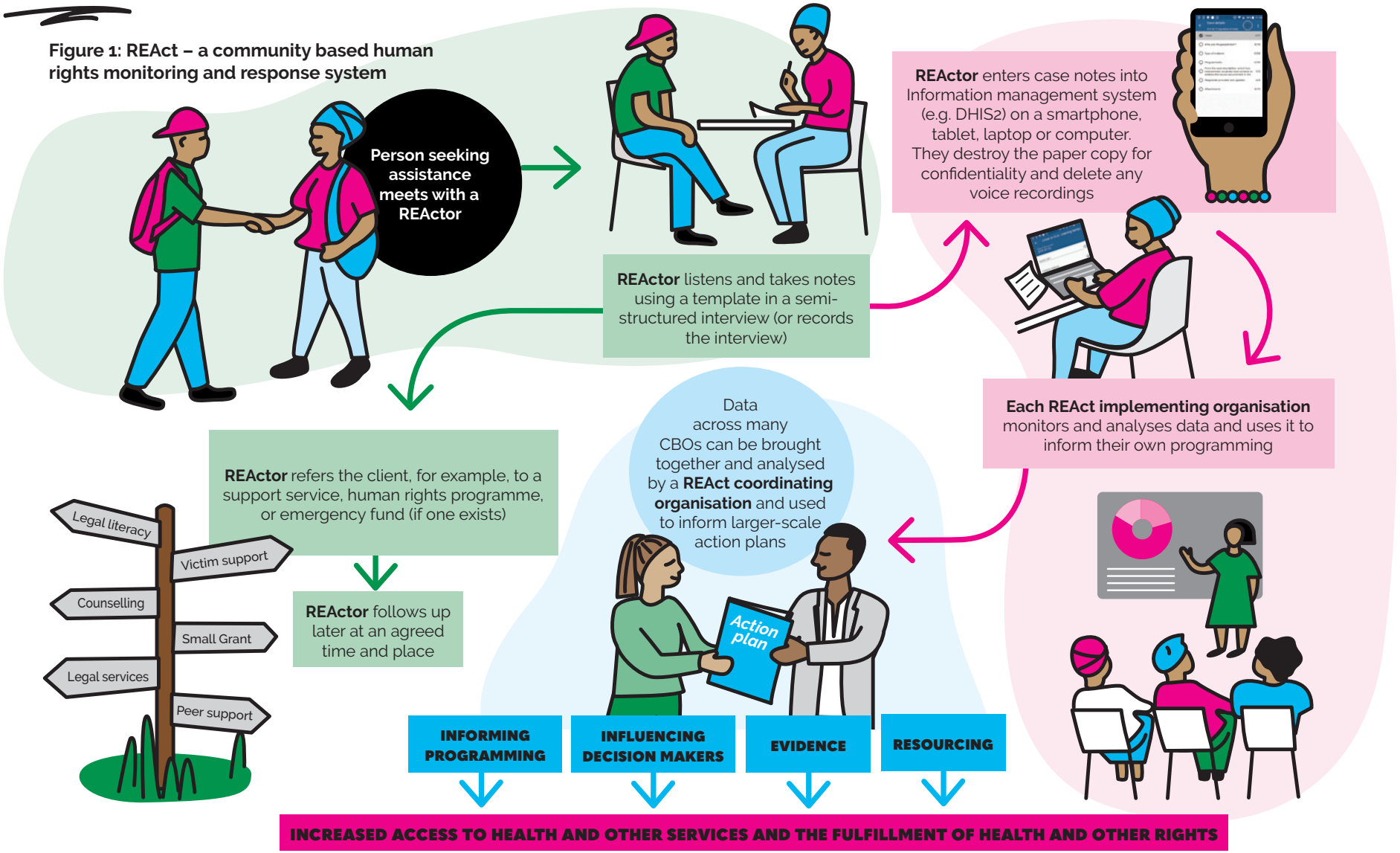
Through the completion of the REAct process, CBOs/CSOs:

- **Respond to individual crises:** REAct implementers identify and prioritise crisis situations and rapidly mobilise resources to avert or respond to individual emergencies.
- **Provide a service directly or refer clients elsewhere:** These services include: legal support; HIV treatment, care and support; psychosocial support; sexual and reproductive health and rights (SRHR) support; related health services (such as for TB or hepatitis C); medical support; food; and shelter.
- **Build a body of evidence for advocacy:** Implementers assess each case where the state may be said to have failed to fulfil its duty to respect, protect or promote an individual's right to health. This evidence is vital when engaging with state and non-state actors, holding them to account and pushing for improved human rights-based programming, policy and law.
- **Gather evidence to provide or recommend rights-based programmes to help mitigate against violations:** While rights-based programmes are increasingly incorporated into the package of recognised HIV interventions, information collected through REAct enables implementers to identify the right combination of activities and actions that are needed. These recommendations can be used by organisations to shape their own provision of human rights-based programmes and to advocate to other stakeholders to provide such programmes.

12. Bangladesh, Botswana, Burundi, Egypt, India, Kenya, Lebanon, Lesotho, Malawi, Mozambique, Myanmar, Namibia, Nigeria, Senegal, South Africa, Sudan, Eswatini, Tunisia, Uganda, Yemen, Zambia, Zimbabwe.

BOX 4: THE REACT JOURNEY

Figure 1: REAct – a community based human rights monitoring and response system



Where is REAct being implemented?

TABLE 1: REACT COORDINATING ORGANISATIONS, IMPLEMENTING PARTNERS AND IMPLEMENTATION LOCATIONS IN EIGHT FOCUS COUNTRIES

Country	REAct Coordinating Organisation	REAct Implementing Partners	REAct implementation locations
Uganda	Sexual Minorities Uganda	13 CBOs/CSOs	
Kenya	ISHTAR	4 CBOs/CSOs	Nairobi, Kisumu. National hotline and office line – all regions of Kenya
Mozambique	LAMBDA	12 CBOs/CSOs	
Ukraine	Alliance for Public Health	28 CBOs/CSOs	4 cities: Dnipro, Kryvyi Rih, Kyiv, Odesa . National OST Hotline – all regions of Ukraine.
Georgia	Georgia Harm Reduction Network*	14 CBOs/CSOs	6 cities: Batumi, Gori, Kutaisi, Ozergeti, Samtredia, Tbilisi
Kyrgyzstan	Partnership Network/Soros Foundation*	13 CBOs/CSOs	7 cities: Batken, Bishkek, Jalal-Abad, Karakol, Naryn, Osh, Talas
Moldova	Positive Initiative*	12 CBOs/CSOs	8 cities: Balti, Bender, Cahul, Chisinau, Comrat, Orhei, Rybnica, Tiraspol
Tajikistan	SPIN-Plus*	8 CBOs/CSOs	6 cities: Dushanbe, Khorugh, Khujand, Kuliab, Tursunzoda, Vahdat

* Note: The SoS programme also has a REAct Regional Coordinating Organisation (APH).

REAct projects are currently being set up or implemented in 12 countries across Africa, Eastern Europe and Central Asia (EECA) and the Middle East and North Africa (MENA)[13]. This report focuses on eight of those countries, where REAct was being actively implemented by September 2020. *Table 1* outlines the following for those countries:

- **REAct Coordinating Organisation.** The responsibilities of these organisations include: identifying funds to implement REAct; identifying staff to attend REAct training and give on-going support to implementing partners; establishing a REAct Committee consisting of at least the key REAct database system mangers in each Implementing Partner; identifying REActors within implementing organisations; and ensuring timely reporting of information by implementing partners and for Frontline AIDS and/or donors.
- **REAct implementing partners.** The responsibilities of these partners include: identifying REActors to undertake REAct training and to lead on interviewing, gathering information and evidence, and inputting data into the REAct system; documenting human rights-related barriers to accessing HIV and health services; providing expert data to be entered into the REAct system; bringing to the attention of the REAct Coordinating Organisation or Committee any challenges, discrepancies or breaches of confidentiality relating to projects.
- **REAct implementation locations.** These are the geographic areas (such as cities or districts) within which REAct is being implemented.

In each country – particularly where REAct is embedded within national plans and programmes – other stakeholders are involved in REAct. These include: National AIDS Councils and their sub-committees, such as those focused on human rights; and Country Coordinating Mechanisms (CCMs), which oversee Global Fund grants and within which multi-sectoral human rights technical working groups are often established to drive policy decisions on human rights programmes within grants.

13. Africa (Kenya, Mozambique, Uganda and Zimbabwe), Eastern Europe and Central Asia (Georgia, Kyrgyzstan, Moldova, Tajikistan and Ukraine) and the Middle East and North Africa (Egypt, Jordan and Lebanon).

4. ANALYSIS AND FINDINGS

Important note on analysis

This section presents an analysis of data from REAct projects in eight countries between December 2019 and September 2020. When considering these findings, it is important to note that conclusions can**not** be drawn by comparing data across the countries. This is due to a number of variations between programmatic and national contexts, including in relation to the:

- Scale of REAct projects, including the geographic reach;
- Duration of REAct projects;
- Number and type of marginalised communities focused on through REAct;
- Number of REAct implementing partners and REActors;
- Coordinating Organisation and implementing partners' organisational capacity;
- Coordinating Organisation and implementers' experience of working on human rights-based approaches and community-led monitoring;
- Level of resourcing for REAct;
- Legal and policy environment, in particular for marginalised groups.

Each country is operating their REAct project from a different starting point and implementing their work in a different way. As such, their work and results should be considered individually and not compared.

Area 1:

How many human rights-related barriers to accessing HIV services are CBOs/CSOs documenting through REAct?

Number of clients registered through REAct

Between December 2019 and September 2020, REAct projects across the eight countries registered 1,780 clients in total. The reach per country varied significantly reflecting – as noted – factors such as the scale of programmes, capacity of organisations, level of resources and external environment.

Among those where gender is identified, the overall profile of the REAct clients was: 54% male; 39% female; and 2% transgender. Five countries (Uganda, Kenya, Mozambique, Ukraine and Moldova) registered more males, while three registered more females. This often mirrored the project focus of implementers. For example, in Uganda and Kenya, the fact that more males were registered is partly due to the projects primarily serving men who have sex with men and gay men. Also in those two countries, a notable proportion of clients (16% in Uganda and 5% in Kenya) are transgender people – again reflecting the focus of REAct implementers, as well as the nature of human rights violations taking place.

An analysis of the age of clients registered with REAct shows that, for the majority (62%), this criterion is left blank in the template completed by REActors. However, among the clients who do record their age, a majority are aged over 24 years. According to REAct stakeholders, this partly reflects the reality that those experiencing human rights-related barriers to accessing HIV services are predominantly adults. However, it may also be due to contextual issues within countries, such as members of marginalised groups who are younger than 24 years being less aware of their human rights and/or less likely to reach out to, or by reached by, REActors.

Number of cases reported through REAct

TABLE 2: CASES OF HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES RECORDED THROUGH REACT (December 2019 – September 2020)

Country	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Total
Uganda		8	8	9	9	6	16	11	20	31	**118**
Kenya	4	31	21	8	21	15	19	19	29	14	**181**
Mozambique			2	3	2	9	10	7	6	15	**54**
Ukraine	30	73	85	91	71	76	57	83	66	82	**714**
Kyrgyzstan		31	39	39	40	43	55	45	44	55	**391**
Tajikistan		13	14	6	10	14	11	15	9	7	**99**
Georgia	19	33	19	14	7	8	13	7	5	26	**151**
Moldova		13	7	4	26	38	26	20	47	8	**189**
Total	**53**	**202**	**195**	**174**	**186**	**209**	**207**	**207**	**226**	**238**	**1,897**

Between December 2019 and September 2020, 1,897 cases of human rights-related barriers to accessing HIV services were recorded through REAct (see *Table 2*). Note that this number is higher than the number of clients, as one client can report more than one case.

Data limitations

Once more, the differences in the number of cases reported by countries reflect programmatic and national issues, rather than the likely level of need or scale of violations taking place. As an example, while REAct in Kenya is of a modest scale and has four CBO/CSO implementers, REAct in Ukraine operates at a national level, has a national hotline and benefits from 28 implementers that deploy a large number of REActors. Similarly, while REAct was new to all four countries in the SoS Programme in EECA, Kyrgyzstan's recording of 391 cases (the largest number in the four countries) partly reflects that the programme involved 13 established CBOs/CSOs and built on an existing scheme of street lawyers. Meanwhile, the lowest number of cases seen in the four countries (99) reflects that, in Tajikistan, the work took place in a particularly challenging legal environment for marginalised communities, involved seven implementers with lower technical capacity in human rights-related work, and represented a newer way of working for the country's CBOs/CSOs (in terms of directly engaging in work related human rights)[14].

As shown in *Table 2*, the monthly trends in the number of cases reported to REAct varied. For example, while REAct implementers in Ukraine documented a relatively consistent numbers of cases across various months (with an average of 71), Moldova had more distinct ups and downs, varying from 4 to 47 per month.

In some countries, the variation in the rate of REAct cases can be attributed to identified reasons. For example, the first few months of REAct implementation may be slow, and then pick up as the project is firmly established, as seen with the increase in cases from May onwards in Mozambique. Also, documentation slows down when: REActors go on annual leave (as seen with a decrease in

14. *REAct Implementation in EECA: Key Finding and Responses to Human Rights Violations*, SoS Project, APH, Frontline AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, December 2020.

cases in June in Ukraine); or there are funding interruptions, project closures or strained organisational capacity (as seen with a decrease in cases documented in September in Kenya[15]). Conversely, the number of cases speeds up when a REAct project expands to more cities (as seen with an increase in cases from the end of August in Georgia).

As described later in this report, an external issue affecting the number of cases documented through REAct was the onset of COVID-19. Across different countries and timeframes, the pandemic brought diverse impacts, including both surges in demand (contributing to increased cases) and interruptions to implementation (contributing to decreased cases).

In all countries, REAct implementers are recording a significant *number* of human rights-related barriers to accessing HIV services – serving as the only monitoring intervention of its type in the country or as a valued addition to existing ones. They often document cases that would otherwise not be recorded. However, the *proportion* of cases being documented in comparison to the real scale of incidents taking place in communities is low. Again, this reflects contextual factors and limitations, such as to the scale of REAct projects and environments in which they operate. In Mozambique, the Coordinating Organisation describes the number of cases being documented by REAct as the *"tip of the iceberg"*, with significant scale-up needed to ensure a fuller and more accurate picture[16].

15. Interview with Jeffrey Walimbwa, REAct Kenya.

16. Interview with Gabriel De Barros, REAct Mozambique.

Area 2:

Who is reporting human rights-related barriers to accessing HIV services through REAct, and what type of barriers are they experiencing?

Communities affected by human rights-related barriers

TABLE 3: MARGINALISED COMMUNITIES REPORTING HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES THROUGH REACT
(December 2019 – September 2020)

Marginalised community	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total (% of 1,897 cases)
People who use drugs	27	1	33	426	9	26	48	118	**833 (44%)**
People living with HIV	3	1	4	259	80	75	15	70	**507 (27%)**
Sex workers	15	26	1	36	139	21	86	45	**369 (19%)**
Men who have sex with men	11	114	8	106			3		**242 (13%)**
LGBT people	56		3		9	1	33	4	**106 (6%)**
Prisoners				50	2	2		4	**58 (3%)**
People living with TB				33	9	3		4	**49 (3%)**
Homeless people				20					**20 (1%)**
Roma people				8					**8 (0.4%)**

Table 3 sets out the number of cases reported to REAct by different marginalised communities in each country. It should be noted that a case can relate to a client who identifies as a member of multiple marginalised communities and, as such, the numbers add up to more than the 1,897 total. It should also be noted that not all eight countries record information about all marginalised communities. For example, the REAct project in Ukraine is the only one to record Roma people as an indicator.

The first three communities listed in *Table 3* – people who use drugs, people living with HIV and sex workers – were reported on by all REAct projects. In total, these communities accounted for 44%, 27% and 19% of all cases documented. However, there were notable differences between individual countries. For example, in Uganda, Mozambique, Ukraine, Kyrgyzstan and Moldova, the largest number of cases were reported for people who use drugs. Meanwhile, in Kenya and Georgia, it was sex workers, and in Tajikistan, people living with HIV.

According to interviews with programme managers in REAct Coordinating Organisations, the differences between countries with respect to which marginalised communities are reporting more or less cases is accounted for by factors such as the: HIV epidemiology of a country (and, in turn, those who are most vulnerable); legal environment (such as which communities are criminalised); and focus of the project. In relation to the latter, there is often a straightforward link – that if, for example, partners have an established and trusted reputation among people who use drugs, they are more likely to have cases reported to them by such community members.

Data about the number of cases being reported by different marginalised groups can also be used to strengthen programme approaches and focus. For example, in Ukraine, recognising that few cases were being reported by sex workers (36 compared to 426 for people who use drugs), the REAct partners made a concerted effort to involve more sex worker CBOs in implementing REAct and recruit more sex workers as REActors[17]. Similarly, REAct partners in Uganda have partnered with organisations with programmes focused on enhancing the health and rights of adolescent girls and young women and, in the future, expect to see more cases reported by such communities.

17. *Implementation of React In Ukraine: Main Results And Ways Of Responding To Problems Of Human Rights Violations: Results 2020*, Global Fund National Grant, APH, 2020.

Perpetrators of human rights-related barriers

TABLE 4: PERPETRATORS OF HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES REPORTED THROUGH REACT (December 2019 – September 2020)

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
State representatives:									
Public healthcare professional	3	7	1	367	57	32	20	65	**552**
OST site staff					6		8	27	**41**
Maternity hospital worker						5		5	**10**
Police/law enforcement*	23	23	23	138	239	23	41	43	**553**
Police					114	23		41	**178**
Military	2			1	18				**21**
Local authority	4	8		4	13	7	3	10	**49**
Prison service staff	3			31			1	2	**37**
Public educator				20			3	5	**28**
Judiciary	1	1		6	3	10	3	1	**25**
Social worker				20			1		**21**
Government official	4		1		10				**15**
State employer		1		3			1		**5**
Civil servant	1		3				1		**5**
Political representative	1								**1**

* Note: In some countries, the category for Police/law enforcement was further disaggregated into two sub-categories: Police and Military

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Individuals:									
Family	20	22	4	37	5	25	18	5	**136**
Partner	13	30	4	27	17	7	29	9	**136**
Neighbour	22	26	5	14	3	6	7	1	**84**
Friends	7	17		5	7	4	12		**52**
Client of sex worker					21	1	14	1	**37**
Other:									
Private employer		2		30	1	1		20	**54**
Hate group	2	9		12			2		**25**
Business	1	1		8	3		5	7	**25**
Private healthcare professional				10	1			1	**12**
Private educator				3				1	**4**
Non-profit organisation				3					**3**
Religious/ traditional leaders		1		1					**2**
Unknown:									
Unknown	14	11	5	29	13		26	1	**99**

Table 4 gives a breakdown of the alleged perpetrators of human rights-related barriers recorded through REAct. This identifies that – across countries with different social, cultural and legal contexts – the most common perpetrators are public health care professionals and the police/law enforcement. This confirms that such stakeholders – whose role should be to protect and support community members – continue to present a significant threat to the rights of marginalised communities. Some stakeholders report that the existing situation has become yet worse during COVID-19, such as with the police/law enforcement using the guise of mitigation measures (such as lockdowns and curfews) to escalate their abuse of marginalised people.

In some countries, there are distinct trends in relation to perpetrators. For example, in Ukraine, by far the largest proportion of violations are committed by public health care professionals who discriminate against marginalised people in the context of providing health services, such as antiretroviral therapy (ART) or harm reduction[18]. This indicates that stigma remains a major issue in the country, including within the health system. The situation is similar in two other countries in the EECA region (Moldova and Tajikistan), while, in Kyrgyzstan and Georgia, the highest proportion of perpetrators are the police/law enforcement.

Representatives of REAct Coordinating Organisations express concern about some persistent or emerging trends in relation to perpetrators, even where current numbers are relatively low. Examples include violations committed by: employers (with some people still being dismissed from their employment, such as due to living with HIV); and hate groups (which are feared to be on the rise in countries such as in Kenya and Ukraine). In some contexts, specific responses have been developed to address such patterns. For example, in one country, REActors have engaged with private or member-only social media groups of both marginalised communities and hate groups, as a way to track the activities and impact of the latter.

Another concerning trend is that domestic, intimate partner and gender-based violence – where violations are committed by a family member, partner, friend or neighbour – are increasing in many countries. These types of violation have particularly escalated during COVID-19, with people forced to spend extended periods of time locked-in with perpetrators, or with couples and families facing overwhelming socio-economic pressures, such as due to the loss of employment.

18. *Implementation of React In Ukraine: Main Results And Ways Of Responding To Problems Of Human Rights Violations: Results 2020*, Global Fund National Grant, APH, 2020.

Types of incidents of human rights-related barriers

TABLE 5: CATEGORIES OF INCIDENTS OF HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES REPORTED THROUGH REACT
(December 2019 – September 2020)

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Emotional harm	50	91	26	308	206	73	97	68	**919**
Denial of services	22	17	8	451	85	22	41	79	**725**
Violence/ physical harm	46	76	29	148	111	39	59	43	**551**
Other types of incidents	15	28	4	120	128	21	18	45	**379**
Other: please describe	15	32	6	115	72	9	10	15	**274**
COVID-19 related					32	2	2	42	**78**

TABLE 6: SPECIFIC TYPES OF INCIDENTS OF HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES REPORTED THROUGH REACT
(December 2019 – September 2020)

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Emotional harm									
Harassment, intimidation	30	60	4	87	152	29	49	17	**428**
Extortion, blackmail	3	7	2	45	91	3	19	2	**172**
Discrimination because of HIV status	4	1	2	85	10	25	13	31	**171**
Public outing, defamation	12	17	3	44	13	6	19	7	**121**
Discrimination because of sexual orientation	15	13	5	68	5	1	6		**113**
Discrimination because of drug use			7	74				11	**92**
Other breach of privacy	11	2	3	37	19	7	11	1	**91**
Disclosure of HIV status				40	4	23		7	**74**
Discrimination because of affiliation with sex workers			2	25				8	**35**
Psychological mistreatment in public health facility					5	17		6	**28**

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Emotional harm (continued)									
Discrimination because of gender/gender identity	2	3	5	2	2		11	2	**27**
Coercion to be tested for HIV				6				9	**15**
Discrimination because of TB status				9	2			1	**12**
Disclosure of private medical data				4		4		2	**10**
Discrimination in media								1	**1**
Denial of services									
Denial of health services	2	6	1	418	45	10	14	28	**524**
Refusal to provide OST				94			3	28	**125**
Denial of protection by the police	3		4	34	13	1	15		**70**
Denial of investigation by the police	9	1	3	22	7	1	10	2	**55**
Refusal to prescribe ART				40		1		2	**43**
Denial of other public services	1	3		16	5		2	7	**34**
Denial of legal services	1	2	4	10	6		2	1	**26**
Denial of social services				26					**26**
Deprivation of parental rights				9		1	1	4	**15**
Denial of education	1			4				5	**10**
Lack of pre- and post- test counselling						3		1	**4**
Refusal to apply for child material support						3			**3**
Refusal to issue a medical certificate during marriage registration						2			**2**
Denial of marriage registration						2			**2**
Refusal to issue infant food						1			**1**

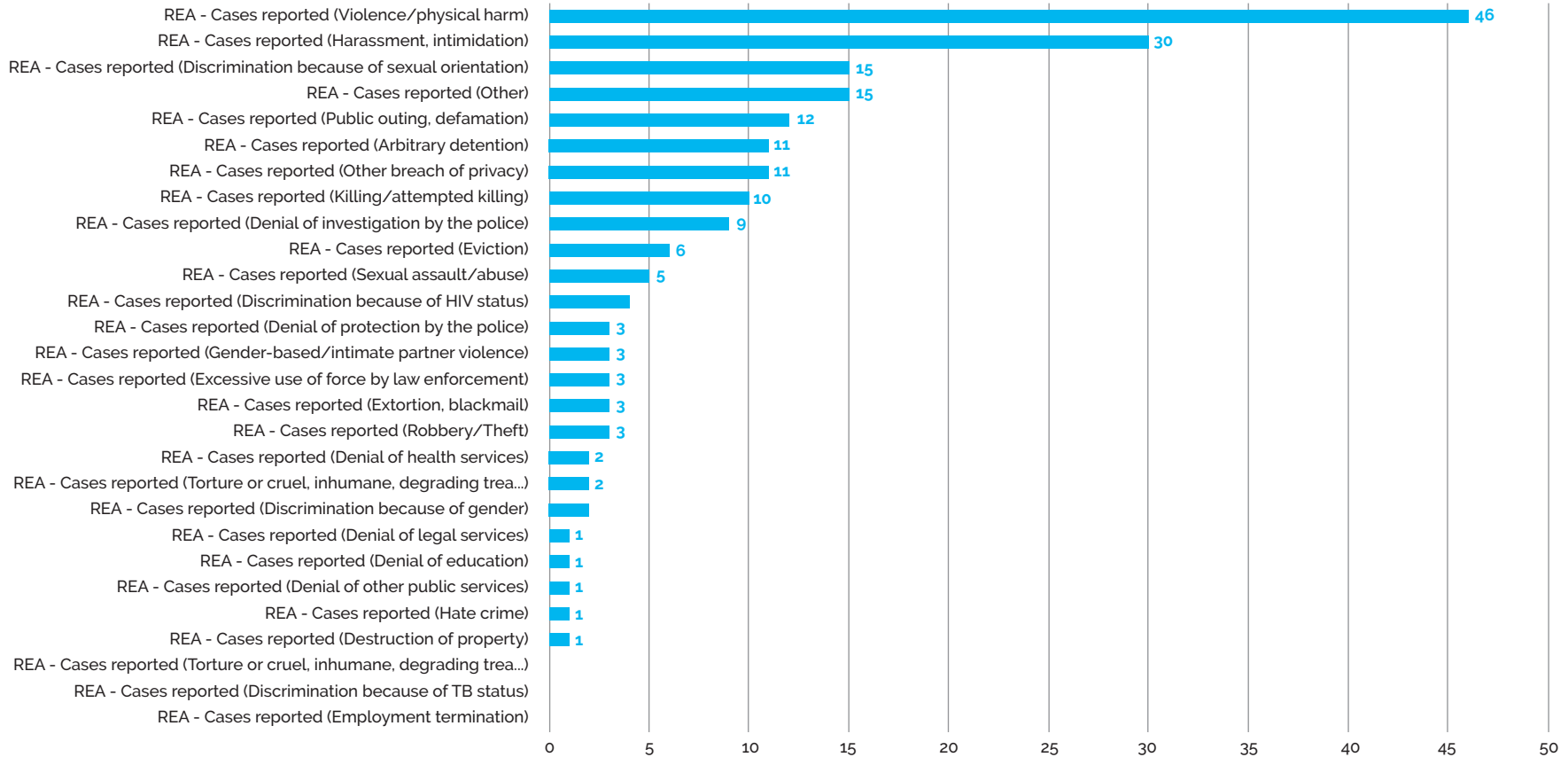
	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Violence/physical harm									
Violent assault/abuse	21	43	16	6	44	2	34	2	**168**
Excessive use of force by law enforcement	3	3	8	29	25	5	6	12	**91**
Gender-based/intimate partner violence	3	6	3	11	6	13	15	10	**67**
Sexual assault/abuse	5	12	5	8	16	1	12	3	**62**
Bodily harm/physical assault				51					**51**
Torture or cruel, inhumane, degrading treatment in police/prison custody	2		6	19	7	3	2	9	**48**
Misuse of power by law enforcement					10	17	5	15	**47**
Domestic violence/abuse				31					**31**
Killing/attempted killing	10	1	1		1	2			**15**
Planting of drugs				5	7				**12**
Hate crime	1						10		**11**
Criminalisation of HIV transmission						9			**9**
Torture or cruel, inhumane, degrading treatment in public health facility				5					**5**
Other types of incidents									
Arbitrary detention	11	2	5	54	35	14	2	23	**146**
Eviction	6	12		17	14	12	3	1	**65**
Employment termination				15	2	2	2	16	**37**
Destruction of property	1	1		11	9	2	1	2	**27**
Robbery/theft	3								**3**

As illustrated in *Table 5* and *Table 6*, REAct records an extensive range of incidents of human rights-related barriers to accessing HIV services. Between December 2019 and September 2020, the most common categories (broad groupings classified in Wanda) were emotional harm (1,390) and denial of services (940). Meanwhile, the most commonly occurring specific types of incidents were denial of health services (with 524 incidents), harassment/intimidation (428) and violent assault/abuse (168).

Across the countries, some concerning patterns emerge. For example, there were 15 incidents of killing/attempted killing. Meanwhile, incidents of discrimination remain a daily reality for many in marginalised communities. For example, during the project timeframe, discrimination was seen that was associated with: HIV status (171 incidents); sexual orientation (113); drug use (92); sex work (35); gender (27); and TB status (12).

The range of barriers experienced – combined with the range of marginalised groups and perpetrators – reflects the complexity of the human rights scenario in each country. While some patterns emerge in some contexts, many cases are highly individual – with a person facing a specific set of circumstances and challenges that, in turn, require a tailored understanding and response.

BOX 5: TYPES OF HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES REPORTED THROUGH REACT IN UGANDA (December 2019 – September 2020)



The prominence of some specific types of violations can be seen in certain countries. For example, as shown in *Box 5*, in Uganda, by far the most common violations are violence/physical harm, followed by harassment/intimidation and discrimination due to sexual orientation. With over half of the country's cases reported to REAct relating to men who have sex with men and lesbian, gay, bisexual and transgender (LGBT) people, this provides an indication of the intense hostility faced by such community members from the authorities and public alike.

As seen in the qualitative information documented by Wanda – alongside interviews with REAct stakeholders – the impact of human rights-related barriers on members of marginalised communities can be immense. Alongside practical implications (such as loss of employment, denial of services or limitations to freedom of movement), the consequences can include harmed physical and mental health, wellbeing, and safety and security. *Box 6* gives an idea of the human face of violations documented through REAct, in terms of their impact on individuals in the EECA region.

BOX 6: EXAMPLES OF PEOPLE WHO HAVE EXPERIENCED RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES DOCUMENTED THROUGH REACT IN THE SOS PROGRAMME, EECA

- A person who uses drugs was stopped when leaving an Opioid Substitution Therapy (OST) site. They were taken to the police station and made to clean the premises. They were threatened and intimidated. They were at the station for more than four hours. They were scared to file a complaint, as they were worried about their safety.
- A pregnant woman living with HIV was put in an isolation unit at a maternity clinic due to her HIV status. She was prohibited from using the public toilet and treated with disrespect by medical personnel. When she was released, the baby's medical records contained information about the mother's HIV status.
- A woman was forced by her partner to engage in sex work for many years. He beat her and took away her money. She went to the police twice, but was denied protection.
- A man who has sex with men was at a nightclub with his friends. They were wearing extravagant clothes and earrings. The other people in the club didn't like it and beat them. The man and his friends called police, who came quickly, but did not initiate an investigation.
- A woman living with HIV had worked as a nurse for many years. After the COVID-19 lockdown was lifted, all health workers had to have an HIV test. As a result, the woman was dismissed from her job.
- A man who was going to marry his partner went through a health check-up for marriage registration. He tested HIV-positive. His family doctor refused to issue him a health certificate to register his marriage. The Ministry of Health recommended in writing that he refrain from getting married until he is cured of HIV. The man filed a legal complaint against the Ministry of Health.
- A woman living with HIV went to child protection services to register temporary custody of her granddaughter for a period when the child's parents were away. According to the law, she had to go through a medical check-up, including an HIV test. She was denied custody of the child.

State responsibility for human rights-related barriers

TABLE 7: GOVERNMENT RESPONSIBILITY FOR HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES RECORDED THROUGH REACT
(December 2019 – September 2020)

Responsibility of the state	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Failure to respect human rights	27	97	28	417	257	56	40	113	**1035**
Failure to promote human rights	55	19	16	265	54	41	87	77	**614**
Failure to protect human rights	35	54	32	89	39	9	29	20	**307**

As seen in *Table 7*, the majority of human rights violations recorded by REAct across the eight countries represented a government's 'failure to respect' the human rights of a member of a marginalised community. Examples of what such violations look like in practice include: a public health worker treating a sex worker with disdain and refusing them SRH commodities; or a police officer denying a person who uses drugs access to an OST facility. The second most common category of government responsibility was 'failure to promote'. Here, an example is of the government failing to force a workplace to respect the rights of people living with HIV and not dismiss them due to their status. The third category was 'failure to protect'. Here, an example is the police failing to take a woman who was violated by her partner seriously, as she was believed to be a sex worker.

In some cases, the situations in individual contexts contradicted the trends across the countries. For example, in Mozambique, the highest level of cases was for 'failure to protect', while, in Georgia and Uganda, they were for 'failure to promote'.

Area 3:
What responses to human rights-related barriers to accessing HIV services is REAct enabling?

Status of cases

By the end of September 2020, 690 of the 1,897 cases reported to REAct in the eight countries since December 2019 had been resolved, and 230 cases were in the process of resolution.

Alongside a number of cases that were not resolved, there were 97 instances of clients not wanting action to be taken on their case. This was for a number of reasons, such as that the individual: did not see their case as a valid human rights violation; was afraid of being 'outed' during the resolution (such as about their HIV status or sexual orientation); or feared that the resolution process would make things worse, rather than better (such as in terms of their relations with local law enforcement officials). This provides an example of where REAct's results can be beyond the control of its partners – being, for example, dependent on the preferences of individual clients and on the external environment in which the project operates.

Responses to cases

Between December 2019 and September 2020, across the countries, 2,930 instances of responses to human rights-related barriers to accessing HIV services were provided through REAct (see *Table 8*). Of those:

- 76% were provided directly by the REActor or Implementing Organisation. The most common services were: primary legal support (with 536 instances of support); emotional/psychological counselling (535); and disclosure and/or stigma support (284).
- 24% were facilitated through a referral to another organisation. The most common services were: legal support (with 128 instances of support); emotional/psychological counselling (82); and mental health support (78).

This breakdown reflects that, where possible, REActors and implementers respond to barriers directly themselves, using their existing skills, experience and resources. This is particularly the case in sensitive areas of support where, for example, person-centred approaches present a strong advantage. For example, 535 instances of support for emotional/psychosocial support were provided directly (compared to 82 indirectly) and 284 for disclosure and/or stigma support (compared to 23). Meanwhile, referrals become necessary where, for example, REAct implementers already face high demand on their services; do not work in a specific location; or cannot offer a particular technical service.

Providing services directly enables REAct partners to manage the flow and quality of support provided themselves. However, it can also bring challenges, such as where the scale of support needed is unpredictable and difficult to plan. Meanwhile, referrals can also raise issues. These include the: heavy existing burden on referral services, in particular due to COVID-19; lack of agreed standards between referring and referral organisations; and reluctance among some marginalised communities to take up referrals (to organisations that they do not know). Another issue is that, in a number of countries, a weakness has been identified in relation to the systematic follow-up of referrals (to ensure that community members actually go to the services and receive appropriate support). If follow-up is too little or too slow, it risks a case not being fully resolved.

Data from Wanda also indicates that, across the countries, a further 176 instances of services were needed for responses, but not available (to be provided either directly or indirectly). The highest levels were for: emotional/psychological counselling; legal support; and disclosure and/or stigma support. This gap between demand and supply is concerning. However, stakeholders articulate its reasons, which were often beyond the control of REAct partners. For example, there were examples of services: not being available in geographic locations; not being accessible to marginalised groups (such as with staff untrained on anti-discrimination); not being appropriate (such as requiring some form of payment); or being de-prioritised due to COVID-19.

TABLE 8: DIRECT AND REFERRED RESPONSES TO HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES RECORDED THROUGH REACT
(December 2019 – September 2020)

	Directly provided response									Referred response								
	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
HIV treatment, care and support services:																		
ART adherence counselling/support	1	1	1		22	30		4	**59**	2				1	1		1	**5**
HIV health education and treatment literacy	2	1	1		9	28	1	3	**44**	1					2		1	**4**
ART initiation	1	1			3	5		4	**14**	1		1		1	18		1	**22**
Post-exposure prophylaxis (PEP)		5				2		2	**9**	2		1		1	8		1	**13**
Viral load monitoring					5	1		2	**8**	2		1		1	25		2	**31**
Pre-exposure prophylaxis (PrEP)		1				2		1	**4**			1			8	1	1	**11**

	Directly provided response									Referred response								
	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Legal services:																		
Legal support	8	41	7	875	31	22	7	43	**1034**	19	16	12	128	28	3	15	42	**263**
Psychosocial services:																		
Emotional/psychological counselling	43	78	6	181	22	38	43	16	**427**	4	3	1	20	45	5	5	3	**86**
Disclosure and/or stigma support	45	74	1		31	38	34	26	**249**	8	2	1		5		5		**21**
Mental health support	9	65			2	1	9		**86**	31	7			2	25	8	1	**74**
Support in processing documents related to social issues		9		40	3	2	12	4	**70**		2		10		7	7	2	**28**
Rehabilitation and other similar services		2		7	4	1	3	3	**20**			1	20	3	4	5	1	**34**
SRH services:																		
Male and female condoms, and lubricant	1	1			6	11	53	23	**95**					17	1			**18**
Sexual health counselling	2	2			1	14	36	23	**78**		1				2	1	1	**5**
Sexually transmitted infection (STI) screening	1	3					28	22	**54**						8	11		**19**
Family planning methods counselling	1				1	11	10	21	**44**		1			1			2	**4**
Post violence counselling			1			4	19	9	**33**		1			1	2	3	1	**8**
Relationships and/or sexuality counselling	1	1				2	12	16	**32**	1					1			**2**
Prevention of mother to child transmission (PMTCT)						2		8	**10**	1	1				2		1	**5**
Post abortion counselling							3	2	**5**						1		2	**3**
Other services:																		
Food and shelter	1			9					**10**	1			36					**37**
Non HIV-related services (Malaria, TB, Hepatitis C)		2			1			2	**5**	2					4		3	**9**
Medical support					1				**1**					1				**1**

AN EXAMPLE OF WHAT RESPONSES TO HUMAN RIGHTS-RELATED BARRIERS CAN LOOK LIKE IN AN INDIVIDUAL COUNTRY IS PROVIDED BY UKRAINE.

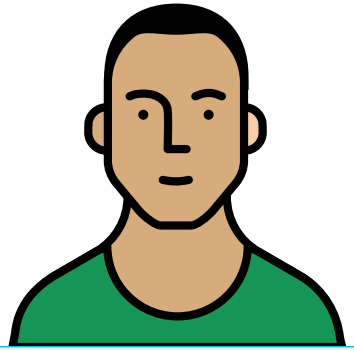
In a sample of cases, 1,112 instances of support were provided directly, with the largest numbers addressing: representation of marginalised community interest in health facilities; legal counselling; and psychological support. Meanwhile, a much lower number of instances (214) were provided through referral, with the largest numbers addressing: legal counselling; secondary legal aid; and food and shelter. Overall, this process led to the vast majority of cases being resolved or being in the process of resolution, with low numbers of instances of losing contact with clients, clients refusing support or a case being unresolved. This status partly reflects the large scale of REAct in Ukraine. However, it also reflects how the programme has worked hard to find the right type and number of partners that can respond to the needs of the country's marginalised communities.

In some other contexts, the social and legal environment presents an obstacle to REAct's provision of responses, whether direct or through referral. In Kyrgyzstan, for example, police/law enforcement officials are the most frequent perpetrators of human rights-related barriers, being responsible for six times as many as the next type of perpetrator (health care professionals). The complexity of dealing with such officials – whose actions can be perceived as being endorsed by the state – contributes to a large proportion of all cases being unresolved[19].

In all countries, responses by REAct have been supported through on-going relationship-building between Coordinating Organisations, REAct implementers and other key stakeholders. One of many examples is Mozambique, where they have formed a partnership with the Mozambique Bar Association (to support referrals for legal support), and have worked with the police. The latter has included conducting meetings with police commanders, who were presented with evidence of human rights violations – such as harassment at OST sites and denial of health services – and discouraged from targeting individuals who are in possession of small amounts of drugs. The meetings also provided an opportunity to raise awareness about Naloxone, with the police expressing an interest in having access to the overdose prevention medication so that they can help community members who are in urgent need.

Overall, REAct's experiences between December 2019 and September 2020 show that responses to human rights-related barriers to accessing HIV services are possible and effective. This is the case even in challenging contexts, whether national (such as where there is legislation again marginalised groups) or global (such as with the emergence of COVID-19). The inclusion of responses is a vital aspect of REAct interventions– as it provides hope and justice to countless individuals. It is also critical in terms of the message it sends to other stakeholders – that human rights violations against marginalised communities are unacceptable, are being documented and will be actioned.

19. *REAct Implementation in EECA: Key Finding and Responses to Human Rights Violations*, SoS Project, APH, Frontline AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, December 2020.



BOX 7:
REACTOR STORIES FROM GEORGIA

A client living with HIV worked on a construction site and rented an apartment with workmates. One of them found out about his HIV status and demanded that he move out. The client was desperate and called a REActor. The latter arrived and talked to the man who was driving the client out. He told him about HIV, that the client was on ART and that it was safe to live with him. The man understood everything, apologised to the client and allowed him to stay in the apartment.

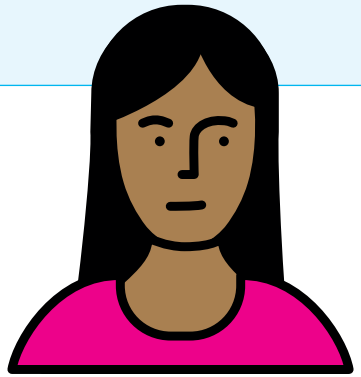
A person living with HIV worked in a restaurant. He disclosed his status to a friend, and the friend told other people in the workplace. The client was fired. He is solely responsible for his sick mother, and his money ran out. The client became depressed and attempted suicide. He survived and was given psychological support by a REActor.

A sex worker was forced by another sex worker to change the location where she worked. The client asked for help from the police, but they were unhelpful and took the perpetrator's side. The client thinks that the sex worker is a police informant and chooses not to file a complaint because she is afraid of revenge.

A woman was forced to engage in sex work for many years. Her partner would beat her and take the money. She asked for help from the police twice, but was refused. Then she received support from a lawyer – to draw up a complaint and apply to the appropriate authorities. An injunction was granted, but her partner violated it. Finally he was brought to justice, supported by the REAct Implementing Partner's social workers communicating with this family.

A client was the subject of hate speech while working in a shop. He called the police and filed a complaint. The client received support from a local CSO lawyer. The perpetrator was punished under the applicable law and justice was served.

A female sex worker was harassed, verbally abused and threatened with disclosure of her sex work by an acquaintance of one of her clients. The client demanded sex. Following the legal intervention of a REAct partner, an immediate restraining order was issued.



Area 4:
How is REAct data being used to inform human rights programmes and advocacy?

Human rights programming

TABLE 9: TYPES OF PROGRAMMATIC RECOMMENDATIONS MADE TO REDUCE HUMAN RIGHTS-RELATED BARRIERS TO HIV SERVICES IDENTIFIED THROUGH REACT
(December 2019 – September 2020)

	Uga.	Ken.	Moz.	Ukr.	Kyr.	Taj.	Geo.	Mol.	Total
Stigma and discrimination reduction	75	122	19	324	129	50	50	33	**802**
HIV-related legal services	57	71	20	239	97	47	40	78	**649**
Legal literacy ('know your rights')	32	37	7	170	117	6	72	17	**458**
Training for healthcare providers on human rights and medical ethics related to HIV	5	2		217	19	7	13	39	**302**
Monitoring and reforming laws, regulations and policies related to HIV	6	28	2	104	5	1	21	32	**199**
Sensitisation of lawmakers and law enforcement agents	14	29	28	62	26	1	17	14	**191**
Reducing discrimination against women in the context of HIV	7			30	16	27	15	9	**104**

An important part of the design of REAct is to connect incidents of/responses to human rights-related barriers with programmes – as recommended by UNAIDS (see *Box 1*) – that can promote and protect people's human rights. REAct's data is used to inform the selection and design of human rights programmes that are implemented by REAct partners, as well as to advocate for such programmes to be provided by other stakeholders. As seen in *Table 9*, across the eight countries, the types of programmes identified to be the most relevant were: stigma and discrimination reduction; HIV-related legal services; and legal literacy ('know your rights').

This aspect of REAct's work is important as it goes beyond the immediate situation and enables a longer-term response to human rights violations – in terms of designing and implementing programmes that are central to the on-going work of CBOs/CSOs, whatever their national and legal context. In time, this might lessen the number of emergency incidents and violations, such as those recorded and addressed through REAct.

Advocacy

BOX 8: USING REACT DATA TO ADVOCATE FOR CITY AND NATIONAL-LEVEL CHANGES, MOLDOVA[20]

In Moldova, legislation related to marginalised groups remains repressive and discriminatory. For example, criminal laws explicitly prohibit HIV transmission and exposure to HIV infection, while sex work and drug use are under strict administrative prohibitions. Here, the evidence generated through REAct has been used to advocate for change at different levels.

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 OST. Using this evidence, negotiations were launched with the Ministry of Health about the opening of an OST site in Orhei. The Ministry issued an order for such a service to start, and advocacy is on-going for it to be implemented.

At the national level, cases collected through REAct have served as evidence to build a dialogue with the government on legislative changes. For example, despite national laws prohibiting all forms of discrimination in employment, 20 cases were collected about such practices against people living with HIV. One of these was selected for strategic litigation, with the client represented by a lawyer from Positive Initiative, the REAct Coordinating Organisation. The case was won and the client was reinstated in their workplace, with compensation for material and moral damages. The case received widespread media attention, including on mainstream TV channels.

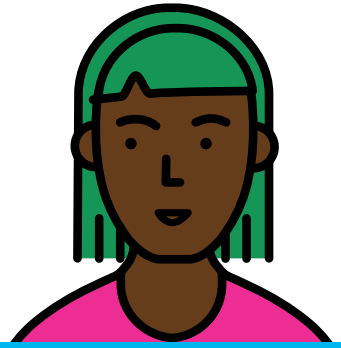
A further aim of REAct is to fill national gaps in evidence of human rights violations against marginalised communities. This provides accurate and robust information that can be used in advocacy, such as to authorities and governments to change harmful policies and laws.

Box 8 gives an example of how REAct data has been used to advocate for change at the city and national levels in Moldova. Such work is especially important since the country – along with the other three in the SoS Programme in EECA – has a legal environment in which marginalised communities are penalised and/or unprotected by specific anti-stigma and discrimination legislation. In such contexts, real-time and high quality data is essential for arguing why punitive laws prevent marginalised groups from accessing their rights (such as to health, life and freedom of expression) and why changes should be made.

Other countries provide examples of where evidence from REAct is being used to begin to achieve change within individual sectors, areas of policy or aspects of legislation. In Kenya, for example, during efforts in 2019 to repeal Sections 162 and 165 of the Penal Code – that legislate against same-sex relationships[21] – CBOs/CSOs were told by the judge that they had inadequate evidence for their advocacy asks. Now, with many cases documented in REAct, there is enough data to produce policy papers and, potentially, re-open dialogue with the judiciary about changing the law. The data collected will help in the repeal case and other policy discussions. Similarly, in Uganda – a country that has experienced significant social tension and legal turmoil over issues of sexual orientation – it is hoped that REAct will provide a strong enough evidence base to take a case to court against the criminalisation of LGBT people, as well as sex workers and people who use drugs.

20. *REAct Implementation in EECA: Key Finding and Responses to Human Rights Violations*, SoS Project, APH, Frontline AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, December 2020.

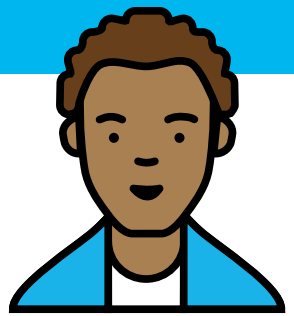
21. Sections 162 (a) and (c) say that any person who has 'carnal knowledge against the order of nature' or permits a person to have 'carnal knowledge against the order of nature' against them has committed a crime. Section 165 states that any person who commits an act of 'gross indecency with another 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.



BOX 9: OPINIONS ABOUT REACT AND ADVOCACY

"LAMBDA has a seat in different coordination platforms at the provincial and national levels. Having this [REAct] 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."
Programme Officer, LAMBDA, Mozambique

"REAct gives us the opportunity to have a conversation with national stakeholders like the Ministry of Health – because we have a databank of information for evidence-informed advocacy. They can't ignore the facts. It opens the door, such as to conversations about the decriminalization of LGBT people, sex workers and people who use drugs."
Richard Lusimbo, SMUG, Uganda



Sustainability

Finally, data generated through REAct intrinsically reinforces the crucial contribution that community-led human rights monitoring make to the HV response, and is therefore useful data to support greater and more sustainable resourcing for its continuation and scale up.

In a number of countries – from Kyrgyzstan to Uganda – REAct has proven its value and quality and, in turn, been successfully incorporated into proposals to the Global Fund. This required REAct stakeholders to demonstrate that the intervention can meet the rigorous demands of reporting required for the financing mechanism. It is a vital step – both for the longer-term resourcing of REAct, and for ensuring that the work is integrated into a country's wider strategies for HIV, frameworks for human rights and systems for monitoring.

5. REACT AND COVID-19

When REAct was re-launched in late 2019, its partners could not have foreseen the significant additional challenges that would be faced in 2020, in the form of COVID-19.

The degree of the pandemic's impact on REAct has varied from country to country. Ukraine cites that, in the period addressed in this report, COVID-19 did not make a significant difference to the number of cases reported each month. However, Georgia cites an initial **decrease** (with levels returning to normal after adaptations), as does Tajikistan (where many REActors are, themselves, members of vulnerable groups and needed to self-isolate). Meanwhile, in the early months of the pandemic, Mozambique saw an **increase** in approaches to REAct, for example, due to a rise in police harassment of people who use drugs under the guise of mitigation measures.

BOX 10: REACT AND COVID-19

"During the COVID-19 pandemic, there was a decline in registered [REAct] cases over several months. Then, the organisations and the REActors themselves managed to adapt to the current situation, creating new mechanisms and methods to find cases. Consequently, the COVID-19 pandemic initially hampered the process of finding and working with cases. However, we were then able to adapt."
Gvantsa Chagunava, Georgia Harm Reduction Network, Georgia

Such differences between countries reflect various factors. These include the: level of COVID-19 infection; stage of REAct development; capacity of REAct partners to adapt; and existing legal and human rights context, in particular for marginalised communities. It also reflects the scale and nature of governments' mitigation measures for COVID-19, for example in terms of lockdowns, curfews, travel restrictions, border controls, sanitisation regulations and social distancing.

As experienced through REAct projects, such measures have often had a disproportionately large and negative effect on marginalised communities (see *Box 11*). An example is sex workers who, across many of the REAct countries, have faced: bans on working on the streets, in bars or in brothels; increased risk-taking (such as due to working in clients' homes); reduced income; food shortages; relocation from urban to rural areas; reduced access to HIV, SRH and other health services; exclusion from government aid schemes; and increased harassment, discrimination and even blame for COVID-19.

In all eight countries, within the implementation of REAct, COVID-19 raised a number of fundamental questions about the nature of human right violations in a pandemic. These included: *What rights are still protected? What restrictions are justified? Which new laws, practices or policies are excessive? Which government or government bodies are using COVID-19 as an excuse to repress their own people?*[22] Guidance by Frontline AIDS[23] helped REAct partners build a common understanding of how rights violations can be understood and categorised within a public health crisis (see *Box 11*).

Alongside community members, COVID-19 has also had a significant impact on REActors and their organisations. For example, such stakeholders have experienced: fear of COVID-19 infection; poor access to personal protective equipment (PPE); restricted movement; reduced or no face-to-face contact with clients; inability to complete REAct processes (such as securing signed consent); closure of, or limits to, referral services; changes in demands from community members (such as for food and housing); and challenges with building rapport with clients (due to not being able to work face-to-face). Some REActors have, themselves, faced human rights violations while trying to continue their work during the pandemic.

In response, many implementers have had to move beyond 'business as usual' and make changes to how they work. Across the eight countries, examples include: stopping or scaling-back REAct work; changing how they meet with community members (for example, now going to medical facilities or convening virtually, rather than meeting at community centres); working on phones or tablets, rather than in hard copy; and working remotely, away from offices or

22. *Transforming the HIV Response: How Communities Innovate to Respond to COVID-19*, Frontline AIDS, 2020.

23. *Operationalising REAct in the Context of COVID-19*, Frontline AIDS, 2020.

BOX 11: HUMAN RIGHTS-RELATED BARRIERS TO ACCESSING HIV SERVICES REPORTED THROUGH REACT IN THE CONTEXT OF COVID-19

Within the context of COVID-19, human rights violations can be understood to refer to four areas:

1. **State-sponsored repression using COVID-19 regulations.** This recognises that COVID-19 mitigation is being used by some governments as an opportunity to further repress marginalised groups.

   Within REAct programmes, reports have been received of marginalised communities being: prevented from travelling to health services; forbidden from gathering in their community; the subject of unlawful arrest or detention; denied travel permits; mishandled by law enforcement officials during curfews; and the subject of raids, such as on drug dens. For example, in Uganda, REAct documented a raid on an LGBT centre, committed by the police in the name of imposing a Presidential Decree on COVID-19. This led to the arrest of 40 young LGBT people, without full access to legal support or medical services.

2. **Increased stigma and discrimination.** This recognises that, in some places, marginalised communities affected by HIV are blamed for the spread of COVID-19.

   Within REAct programmes, reports have been received of marginalised groups being: the subject of hate speech linking their communities to COVID-19; blamed for the introduction and spread of COVID-19; and 'outed' and discriminated against at busy or unfamiliar health services responding to COVID-19. For example, in Tajikistan, REAct documented a situation whereby people living with HIV were being blamed by community members for the presence of COVID-19 in the local area.

3. **Increased gender-based violence and domestic violence** against individuals from marginalised communities stranded in households that reject them or in situations they cannot escape from due to lockdowns.

   Within REAct programmes, reports have been received of marginalised communities experiencing: intimate partner violence between couples; domestic violence, such as by parents or other relatives, at places of residence; and gender-based assault, such as in communities. For example, in Kenya, REAct received an increased number of reports of gender-based violence, family attacks and forced conversion therapy for LGBT people – reflecting the heightened pressures within relationships and households during COVID-19 lockdown.

4. **Increased pre-existing vulnerabilities** due to lack of access to HIV/TB or related services, as these are deprioritised, limited or not adapted to new operating guidelines.

   Within REAct programmes, reports have been received of marginalised communities being: isolated from outreach staff and peer educators (such as due to hotspots being closed); unable to travel to health services; denied access to health services (such as due to them being closed); unable to work (resulting in increased poverty and food shortages); and excluded from government aid and welfare schemes for COVID-19. For example, in Mozambique, REAct received reports of people who use drugs experiencing a complete loss of income due to COVID-19, while also struggling to access essential harm reduction support, as services were closed or reduced. This contributed to women who use drugs engaging in high-risk behaviour, such as sex work, as a means of survival – increasing their already high levels of vulnerability.

In combination, these four areas of COVID-19-related violations serve to exacerbate the existing inequalities faced by marginalised groups. As reported through REAct, they have severe consequences for individuals. Examples include: poor mental health; decreased adherence to treatment, such as ART; decreased uptake of harm reduction; poor nutrition; and increased risk taking (for example, with people who use drugs sharing injection equipment as they cannot access clean commodities). Meanwhile, people are not able to access their usual social and clinical support services, such as OST for people who use drugs or peer support for people living with HIV.

hotspots. They also include: moving support services, such as counselling, online; developing information materials on COVID-19 and human rights; training community members on COVID-19; providing hotlines for COVID-19 and HIV information; and adapting referral systems (such as by referring people to geographically nearer services than before).

In some cases, implementers have had to take on new roles, such as, in Mozambique, being negotiators with the police to allow people who use drugs to take supplies of needles and OST medicines home with them without risk of arrest.

REAct Coordinating Organisations have faced many similar challenges. In addition, some have struggled to: deliver planned programmes on time; maintain the security of data (with changes taking place to information management systems); and link REAct to the national response to COVID-19. Again, changes have been necessary, for example: moving REAct administrative systems online; having staff work from home, as part of virtual teams; making changes to budgets (such as to buy REActors phones and data); providing REAct training online; and investing in new confidential and reliable information and communication systems.

BOX 12: ADAPTING THE SOS REGIONAL PROGRAMME TO COVID-19, EECA[24]

When COVID-19 struck, APH and the four Coordinating Organisations of the SoS Programme found that their usual channels of communication failed and they risked losing contact with their partners on the ground.

In response, APH moved swiftly to ensure that all of the programme's outreach workers, street lawyers and community activists had mobile phones and internet access, so that they could maintain contact with their clients and hold on-line meetings. Hotlines were set up in some of the countries to give information and support to target audiences. Also, business cards were printed with phone numbers for people to call if their rights were violated or they needed support. In some cases, innovative outreach strategies were used – such as in Georgia, where REActors used the dating app Tinder to find potential clients from the LGBT community and offer them HIV services and legal support.

The SoS Programme faced a number of challenges in its adaptation to COVID-19. As Victoria Kalyniuk, APH, explains: **"Neither clients nor staff could identify new types of human rights violations. They were unsure what rights and rights violations are in emergencies, what police and governments should do and what they should not."** APH held training sessions for its partners and issued briefing papers to provide them with up-to-date information, explain which rights should still be protected during emergencies and indicate which violations to look out for.

APH also prioritised the wellbeing of its own staff and volunteers, including providing PPE to outreach workers and street lawyers. As Victoria further explains: **"They are on the frontline of both viruses and they need to continue their work in this turbulent time."**

24. *Transforming the HIV Response: How Communities Innovate to Respond to COVID-19*, Frontline AIDS, 2020.

6. CONCLUSIONS AND KEY MESSAGES

Based on the findings presented in this Data Analysis and Review Report, the conclusions and key messages are that:

- Rights, Evidence ACTion (REAct) has proven itself as a **community-led human rights monitoring interventio**n that plays a critical role in diverse social contexts, legal environments and responses to HIV. This report spans eight countries – Uganda, Kenya, Mozambique, Ukraine, Kyrgyzstan, Tajikistan, Georgia and Moldova – where it is being implemented at different scales and paces. In all these contexts, it represents either the only such intervention for HIV-related human rights monitoring, or a vital addition to existing ones.
- Between December 2019 and September 2020, REAct implementers registered **1,780** clients in total. Their profile was 54% male, 39% female and 2% transgender, with the majority over 24 years old.
- Between December 2019 and September 2020, REAct recorded **1,897 cases of people experiencing human rights-related barriers to accessing HIV services.** The communities most affected by these barriers were people who use drugs, people living with HIV and sex workers. The most common types of barriers were emotional harm, denial of services and violence/physical harm. The most frequent perpetrators were the police/law enforcement and public health care workers – the very stakeholders that should be there to support and protect marginalised people.
- Each case of experiencing a human rights-related barrier can have a **major impact on the individual** concerned. For example, negative effects on: physical health; mental health; self-esteem and ability to engage in community development. The impact can be particularly harsh on community members who experience double stigma or double criminalisation, such as being a sex worker who takes drugs, or a man who has sex with men who is living with HIV.
- As of September 2020, **690 REAct cases had been resolved**, while many more were in the process of resolution. Three quarters of responses (76%) were provided directly by REAct implementers, with the remaining quarter (24%) provided through referral networks. The most common types of services provided were legal support and emotional/psychological counselling.
- REAct projects produce a wealth of **high quality and real-time data**. This is being used to shape the design and guide the implementation of human rights programmes and interventions by REAct partners and others. It also provides invaluable evidence for advocacy, such as laws, policies and institutional practices that make it difficult for marginalised communities to enjoy their rights, such as to life, health, and freedom from discrimination that need to be changed.
- **COVID-19** has placed additional strain on REAct systems. In some contexts, this has led to increases in human rights violations under the guise of measures to control the spread and impact of the virus. In all countries the pandemic has highlighted, and exacerbated, existing inequities experienced by marginalised people.
- Overall, REAct demonstrates that human rights violations against marginalised groups continue to be a **major and highly concerning reality**. They have an appalling impact on the lives of individuals. They also pose a real threat to action on HIV, for example reducing people's access to prevention, care, support and treatment. Even in countries that have invested in their response to HIV and are committed to 'leave no one behind' in the Sustainable Development Goals (SDGs), efforts will not succeed without promoting and protecting human rights.

- There is growing global recognition among both **state and non-state actors** that sustained, scaled-up and community-led monitoring of human rights-related barriers to accessing health services – such as REAct - are critical to ending AIDS and strengthening health systems. Government commitment is manifesting itself not only through policy change, but the integration of such interventions into national HIV plans, and funding requests – such as to the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) – for human rights-based programming.

- In addition to assisting partners to design and establish REAct projects, and providing training and on-going technical support, **Frontline AIDS** hosts and manages REAct on 'Wanda', the central information management system. This enables Frontline AIDS to have a global overview of REAct data across all active projects, while enabling each REAct partner to access, manage and run data analyses of their own data sets for their own purposes. This shared ownership and management provides a rich opportunity for REAct partners and Frontline AIDS to collaborate on various levels of advocacy, from community to national and global levels.

7. LESSONS LEARNED FROM REACT

The following lessons address how to set-up, implement, sustain and scale-up REAct. They are taken from predominantly qualitative information sources, in particular interviews and surveys conducted with REAct partners. They aim to complement the data analysis provided in this report.

Lessons about setting-up REAct:

- **Context:** From the start, REAct should be informed by a thorough understanding of the context in which the project will be operated, for example in terms of the cultural norms related to human rights and the legal environment for marginalised groups.
- **Ownership:** REAct needs the buy-in of all relevant stakeholders. This includes at the level of REActors and members of marginalised communities – where ownership is vital for ensuring that people feel safe enough to report their experiences of rights-related barriers. It also includes at the level of REAct Coordinating Organisations – where ownership is crucial for organisations to take-over the lead of REAct from Frontline AIDS and to ensure strong, national projects rather than something from 'outside'.
- **Integration:** While they should remain independent, REAct projects benefit from being embedded into – or, at least, strongly connected to – other national monitoring systems for human rights. As seen in countries such as South Africa, this is particularly important for a programme's: potential scale; credibility among key stakeholders; and influence, such as with data being used to inform national planning processes.[25]
- **Marginalised communities:** Members of marginalised communities should be meaningfully engaged in all aspects of REAct programmes, from the design stage to planning for sustainability. It is especially important that such community members are represented among REActors – as this is vital for building the acceptance and efficacy of a programme. It is also important that networks and movements beyond those directly involved in implementing REAct are involved, for example with reports shared widely and joint, evidence-based advocacy initiatives developed.
- **The basics:** While implementing and scaling-up REAct, on-going attention is needed to the basics of what the programme is about. For example, materials and refresher training may be required on human rights (such as what type of incidents are – or are not – violations) to ensure a clear and common understanding among partners and to maximise the time spent on recording violations, rather than debating their validity.
- **Keep it simple:** While rolling out and scaling-up REAct, it is vital to keep things simple – from the language used in materials to instructions of how to use Wanda. The use of technical jargon or provision of complex explanations can easily dissuade people who could be invaluable members of REAct teams.
- **Hard to reach:** Within REAct, it cannot be assumed that, if the system is accepted by one marginalised group, it will be accepted by all. Instead, it may be necessary to develop specific strategies to engage those groups that are hardest-to-reach, such as through dialogue and training of local community groups that support them.
- **Referral:** When developing a referral system for REAct, it is important to: balance availability and accessibility of services (recognising that the closest ones may not be the ones most friendly to marginalised communities); consider the nature and quality of services being offered (ensuring they are genuinely appropriate for marginalised communities and have high operating standards); map out the services available (so that all local organisations are aware of each other); and conduct follow-up to referrals (to ensure that clients actually access and benefit from referral services).
- **REActors:** The role of REActors should be respected and supported to the full, in particular when they are themselves from marginalised groups. This includes through them: having a job description, outlining expected roles, responsibilities and targets; undergoing initial and on-going training; benefitting from supportive supervision; receiving appropriate financial compensation (rather than being expected to 'work for free'); engaging in the wider REAct programme (such as advocacy work); and, where needed,

25. *Integrating Human Rights Monitoring in to the National HIV Response: Experiences of Setting Up REAct*, Frontline AIDS, 2020.

having access to psycho-social support. In exchange, REActors should be held to account for their work, for example with action taken on incidents of under-reporting or lack of follow-up of referrals.

- **'Do no harm':** It is vital that a REAct programme, itself, sets a good example and respects, protects and promotes people's human rights. For example, this might include taking measures to ensure that: people's personal data is managed ethically and privately; community members' wishes are respected (for example, if they do not wish a violation to be responded to); and all staff and volunteers have access to PPE during COVID-19.

Lessons about implementing REAct:

- **Cultural adaption:** Within the implementation of REAct, it is important to achieve a balance between respecting the cultural specificities of a country and upholding universal standards for human rights. For example, in a country without a tradition of written consent, it may be appropriate to respect people's refusal, but to also seek alternative methods (such as audio or video consent).
- **Team work:** Operating a successful REAct project requires team work – with all partners at all levels actively engaged, and with understanding of each other's specific roles and responsibilities. It should not be presumed that organisations know each other well and, as such, mapping exercises and team building activities may be needed.
- **Emerging needs:** While implementing REAct, it is essential to be aware of new or increasing needs being experienced and expressed by community members. For example, in many contexts – in particular during COVID-19, but also more generally within responses to HIV – there have been increased demands in relation to mental health and psycho-social support. Action to address such demands requires attention to areas such as: the training of REActors; the allocation of budgets; and the categorisation of human rights-related barriers and responses.
- **Evidence-informed advocacy:** It is important that the results of REAct are used for 'smart' advocacy that addresses the priority human rights-related barriers and targets the priority perpetrators. For example, if REAct data indicates that the police are the most common perpetrators – such as committing violence against marginalised groups – then advocacy can target them as an institution and guide investment in relevant actions, with follow-up work to assess if interventions have impacted on the number and type of violations reported.
- **Adaptability:** REAct benefits from being an inherently adaptable system. For example, it can be modified to be: managed in collaboration with different stakeholders; implemented at different levels; and funded by different donors. It can also be modified to respond to crises such as COVID-19, including addressing growing needs for specific types of support, such as to address increased levels of gender-based violence.
- **Wanda/DHIS2 system:** DHIS2 – hosted by Frontline AIDS – provides an appropriate and reliable platform for the REAct programme. This is particularly the case as it: is already used by many Ministries of Health; provides real-time data; and has in-built systems to ensure the safety of data. However, it is not obligatory for countries to use Wanda. Also, once scale-up begins, partners may need to host the programme on a server of their own (rather than that of Frontline AIDS) and establish an equivalent information management system.
- **Data security:** The privacy and safety of data is essential to a human rights monitoring system such as REAct. Data checks and security measures should be in-built to every step in the design and implementation of such programmes. They should also be a priority in scenarios – such as COVID-19 – when REAct projects have to respond urgently to crisis situations.

Lessons about sustaining and scaling-up REAct:

- **Sustainability:** Discussions about sustainability should be initiated from the very start of designing a REAct project. This includes attention to issues such as how to: secure sustainable funding; operate at a minimum (but realistic) cost; integrate REAct into an organisation's on-going HIV programmes; ensure adequate human resources; integrate REAct into a national monitoring system for human rights; and secure the buy-in of all relevant stakeholders at all levels.
- **Scaling-up. In many contexts,** there is a clear rationale for scaling-up REAct (see *Box 13*[26] and South Africa example in *Box 14*). However, such action requires time and careful planning, with consideration of questions such as[27]:

1. **Have you piloted REAct?**
2. **Are marginalised groups, and the CBOs/CSOs serving them, at the centre of this work?**
3. **Do you have an in-depth understanding of the rights situation on the ground?**
4. **Do you have inclusive and meaningful networks and partnerships with the right stakeholders, underpinned by a common vision, shared commitment and distributed leadership?**
5. **Do sustainable resources and institutional policy recognition for scaled-up implementation exist?**
6. **Can you 'go solo' on your server and data management system?**
7. **Have you considered all the risks involved, including 'do no harm'?**

BOX 13: RATIONALE FOR SCALING-UP REACT

Scaling-up REAct:

- Ensures that rights are promoted and protected, especially for marginalised people who are particularly affected by HIV.
- Helps to maximise the reach and impact of HIV programmes by improving access to, and uptake of, HIV prevention, testing, treatment, care, and support services.
- Addresses potential human rights challenges, and prevents abuses that may occur in the context of HIV and health.
- Helps to engage, empower and mobilise marginalised people in protecting and realising their rights.
- Creates an opportunity for state and non-state actors to cooperate, and to connect the data that is generated with efforts to improve the overall quality of health systems.

26. *Integrating Human Rights Monitoring in to the National HIV Response: Experiences of Setting Up REAct*, Frontline AIDS, 2020.

27. For full questions, see: *Integrating Human Rights Monitoring into the National HIV Response: Experiences of Setting Up REAct*, Frontline AIDS, 2020.

BOX 14: SCALING-UP REACT THROUGH COLLABORATION WITH GOVERNMENT, SOUTH AFRICA

In South Africa, HIV-related human rights violations were being documented through a range of systems, some of them paper-based. Here, REAct was piloted as a means to introduce a web-based platform that, in addition to documentation, also provides a response to violations. It will now be scaled-up within a Global Fund grant for which the AIDS Foundation of South Africa is a Principal Recipient. The aim is to set up a national monitoring system that is used by, and standardised among, both civil society and state institutions. The Foundation and the South African National AIDS Council are expanding REAct incrementally, to build buy-in from relevant stakeholders. CBOs/CSOs are being actively consulted, for example on how to adapt the wording and content of the REAct questionnaire to the South African context, and how to reach marginalised and criminalised communities.

Fezile Kanju, AIDS Foundation of South Africa, says: **"REAct allows for us to get a true picture of what is happening in South Africa with regard to human rights violations at a national scale, rather than giving an anecdotal picture only. It has provided us with a tool to document human rights violations nationally, with a standardised questionnaire for all stakeholders. The data collected through this will inform our human rights policies and programming, to ensure that the rights of all people are promoted and protected."** The goal is to establish a robust system by the end of the Global Fund grant that can be sustainable within the country.

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