

Programme Proposal

HIV Prevention, Resilience & Well-being among Key Populations in Malawi & Uganda

2022 – 2025



 AIDS
FONDET



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ABBREVIATIONS

AF – AIDS-Fondet

AHM - Action Hope Malawi

ART - Antiretroviral therapy

CEDEP - Centre for the Development of People

CEDAW- Committee on the Elimination of Discrimination against Women

CSO – Civil society organisation

GBV - Gender-based violence

HRAPF - Human Rights Awareness and Promotion Forum

IGA - Income generating activities

KP(s) – Key Population(s)

LMEC – Lady Mermaid Empowerment Centre

LGBT - Lesbian, gay, bisexual, transgender

MSM - Men who have sex with men

PLHIV - People living with HIV

PrEP - Pre-exposure prophylaxis

PSEAH - Preventing Sexual Exploitation Abuse and Harassment

SDG – United Nations Sustainable Development Goals

SRHR - Sexual and Reproductive Health and Rights

STIs - Sexually transmitted infections

SW(s) – Sex worker(s)

ToC – Theory of Change

TG – Transgender persons

UNHRC – The United Nations Human Rights Council

UNAIDS - The Joint United Nations Programme on HIV/AIDS

UPR - Universal Periodic Review

WHO - World Health Organization

1. INTRODUCTION AND SUMMARY

AIDS-Fondet (AF) is a CISU partner with a long track record of implementing successful projects in Malawi, Uganda, Kenya, Zambia, Ukraine, Nepal and Ethiopia. AF became a CISU *programme* partner for the first time in 2019, with the programme *HIV Prevention among Key Populations¹ in Malawi and Uganda* running from 2019-21. Honouring the principles of “leaving no one behind” and “nothing about us without us,” the programme is implemented in close collaboration with local Civil Society Organisations (CSOs) led by - or close allies of - our beneficiaries: Action Hope Malawi (AHM) and Centre for the Development of People (CEDEP) in Malawi and Lady Mermaid Empowerment Centre (LMEC) and Human Rights Awareness and Promotion Forum (HRAPF) in Uganda.

Malawi and Uganda are in the unfortunate global top ten of countries with the highest HIV prevalence rates, and HIV is still a major challenge to development in both countries. The purpose of the programme is to reduce HIV incidence among sex workers (SWs) and their clients, men who have sex with men (MSM) and transgender persons (TG) in Malawi and Uganda. Together with people who inject drugs and prisoners, they are defined as key populations (KPs). KPs are disproportionately affected by HIVⁱ mainly because they are subject to discrimination, violence, and punitive legal and social environments based on their sexual orientation, gender identity and occupation, which contributes to their HIV vulnerability and prevents them from exercising their right to health.

Through an intersectional human rights-based approach to HIV prevention, which combines health promotion, capacity building and advocacy initiatives targeting right holders and duty bearers, the programme addresses these interlinked factors of stigma, marginalisation, criminalisation, inequality, deprivation of rights and KP's vulnerability to HIV, which fuel the HIV-epidemic and hamper the possibility of reaching the SDG 3.3 of ending AIDS before 2030.

Approaching the end of our first programme phase, we are happy to conclude that programme M&E data show that our Theory of Change (ToC) is valid, and that we can evidence positive impact on all programme objectives, despite the tremendous negative effects of COVID-19 on HIV prevention and human rights for KPs and CSOs. Validated data shows that the programme has:

- Empowered KPs and improved their ability to protect themselves against HIV and AIDS
- Improved access for KPs to stigma-free health services
- Removed structural social, cultural and legal barriers to effective HIV prevention and treatment
- Increased the capacity of KPs and organisations led by KPs

The external review of the current programme phase facilitated by CISU in March 2021 concludes: *“The overall conclusions of the review are very positive. The review has found difficulties in actually identifying areas for substantial recommendations. [...]. In such a situation, the **overarching recommendation is to consolidate further the solid program strategy and approach from the first phase.**”*

Aligned with the recommendation, the proposed programme 2022-25 is a direct development of the programme implemented 2019-21. It is implemented by the existing programme partnership of CSOs, all adhering to the PANT principles of a Human rights-based approach, with extensive experience in working with HIV/AIDS, SRHR, human rights and KPs in Uganda and Malawi. It continues to work directly with SWs, MSM and TG, who are our partners and represent our beneficiaries.

¹ KPs as defined by UNAIDS and WHO refers to sex workers and their clients, men who have sex with men (MSM), trans gender people, people who inject drugs, people in prisons and people living with HIV (PLHIV).

Through its intersectional, human rights-based approach, the programme aligns directly with UNAIDS' new global strategy 2021-25 *End Inequalities. End AIDS*,ⁱⁱ and contributes to a series of the UN Sustainable Development Goals (SDGs), most directly SDG 3 on good Health and Well-being, SDG 5 on Gender Equality, SDG 10 on Reduced Inequality, SDG 16 on Peace, Justice and Strong Institutions, and SDG 17 on partnerships for the Goals. It builds on the results, learnings, best practices, and increased capacity of our Global South partners achieved during the first programme phase, which function as catalysts for progression within the programme and introduction of new focus areas and innovative strategic approaches.

Proving its efficiency 2019-21, the next programme phase continues to combine the three legs of the development triangle with a weighted focus on capacity building and advocacy:

- Strategic deliveries of HIV-testing, condoms, counselling, and legal aid to beneficiaries.
- Capacity building and empowerment of CSOs and beneficiaries through peer-to-peer mobilisation, organisation, education, networking, sharing of best practices and learnings.
- Advocacy addressing structural barriers targeting key duty bearers such as health service providers, local-, traditional-, and religious leaders, police, government institutions, national politicians, international stakeholders as well as bar- and brothel owners and clients.

The Theory of Change (ToC) of the first programme phase, its pathways to change and underlying assumptions have all proven valid. However, based on results and learnings during 2019-21 and the COVID-19 pandemic's severe negative impact on HIV prevention and the rights of KPs and CSOs, the programme partnership has decided to extend the overall purpose of the programme **to reduce HIV incidences among KPs in Malawi and Uganda** to also include the purpose of **increasing the well-being and resilience among KPs and PLHIV in Malawi and Uganda**.

To reflect the proposed changes, the title of the programme will change to *HIV Prevention, Resilience & Well-being among Key Populations in Malawi & Uganda* to embrace the stronger focus on socio and economic resilience and access to basic human rights for KPs - not just as a stepping-stone to better HIV prevention, but as an objective in its own right. To align with these changes, we have updated our existing programme objectives and introduced a new:

Phase 1 - Objectives 2019-21	Phase 2 - Objectives 2022-25
1. Improve the ability of Key Populations to protect themselves against HIV and AIDS	1. Improved sexual health of Key Populations with a specific focus on their ability to protect themselves against HIV and AIDS
	2. Improved resilience and ability among KPs to take care of their immediate social and economic needs
2. Improve access for Key Populations to stigma-free health services	3. Improved access to stigma-free health services for Key Populations
3. Remove structural social, cultural and legal barriers to effective HIV prevention and treatment	4. Improved inclusion, respect and observance of rights of KPs
4. Increased capacity of KP organisations	5. Increased resilience and capacity of KP organisations and allied CSOs

This proposal presents the next phase of our programme running from 2022-25. It highlights the relevance of our programme, our implementation capacity, our strategic plans for the next programme phase, and how and why the next phase will introduce an extended focus on increasing the well-being and resilience of KPs and Global South civil society organisations (CSOs), based on results, learnings, and contextual developments during the programme phase 2019-21.

Finally, it addresses the main findings and recommendations from CISU's external programme review (March 2021) as well as the Assessment Committee note ("BU-notat") related to the assessment of AF's concept note submitted in April 2021.

2. CONTEXT

HIV represents a serious health challenge to individuals as well as a major challenge to general development in societies with heavy HIV burdens. HIV tends to increase poverty and inequity and vice versa. Those who are already poor, marginalised, and disempowered are more vulnerable to contracting HIV, and contracting HIV adds severe stigma to their already marginalised position.ⁱⁱⁱ Thus, fighting HIV goes hand in hand with empowering the most marginalised and securing their equal opportunities and human rights.

The programme focuses on Eastern and Southern Africa where HIV is most prevalent. Although HIV incidences have decreased globally within the last 10 years, Eastern and Southern Africa still counts for 20.7 of the approximately 38 million PLHIV globally, as well as half of the yearly 1.5 million new global HIV infections.^{iv} The region also sees the highest number of AIDS-related deaths amounting to 310,000 in 2020 alone.^v

2.1. HIV PREVALENCE AMONG KEY POPULATIONS IN MALAWI AND UGANDA

Situated in Eastern and Southern Africa, Malawi and Uganda are in the unfortunate global top ten of countries with the highest HIV prevalence rates.^{vi} In Malawi's 8.9% of the adult population (aged 15-49) are estimated to be living with HIV.^{vii} In Uganda, the HIV prevalence rate is 6.2%.^{viii} Both Malawi and Uganda have generalised HIV epidemics with concentrated HIV sub-epidemics among KPs – SWs and their clients, MSM, TG, people who injects drugs and people in prisons.

According to UNAIDS, KPs and their sexual partners account for 62% of new HIV infections globally, and the risk of acquiring HIV is 25 times higher among MSM, 26 times higher for SWs and 34 times higher for TG than for the general population.^{ix}

HIV prevalence rates among KPs are always subject to an amount of uncertainty in contexts such as Malawi and Uganda, where KPs are criminalised and thus reluctant to reveal their criminalised occupation (SWs), gender identity or sexuality. At the same time, data is often collected by individual projects, because government health authorities are reluctant to acknowledge, collect and provide desegregated data specifically on KPs.

In 2020, UNAIDS estimates the HIV prevalence rate in Malawi to be 49.9 % among SWs, and 12.9% among MSM.^x According to the baseline study^{xi} conducted as part of the first programme phase, 63.1% of the SWs in our target districts were HIV positive compared to 23.1% of the MSM.

In Uganda 25% of new HIV infections are among KPs and their partners. In 2020, UNAIDS estimates HIV-prevalence rates to be of 31.3% among female SWs, which was supported by our baseline study, and 13.2% among MSM.

TG are by far the most marginalised and least acknowledged gender minority in Malawi and Uganda and no official data exists on TG. Programme baseline data on TG were not collected, since the community was not initially a direct programme target group when we initiated the programme in 2019. However according to a bio-behavioural survey among groups at increased risk for HIV in Kampala, Uganda, the HIV prevalence was 20% among TG.^{xii}

About HIV...

HIV is a virus that attacks the immune system. If it is untreated, it will cause AIDS and death without exception. It most commonly transmits through sexual intercourse, from mother to child and through sharing needles. Especially anal sex and sex where one of the partners have another sexually transmitted infection carries great risk of infection. However, if HIV is treated effectively, people living with HIV cannot infect others. People living with HIV have to take medication every day. Failure to adhere can cause resistance to medication and risk of developing AIDS. However, if they adhere to treatment, people living with HIV can live as long and healthy as anyone.

2.2. HIV, WOMEN AND YOUTH

HIV does not only disproportionately affect KPs, but also women compared to men. Women account for more than half the number of PLHIV worldwide and young women (15-24 years old) are twice as likely to acquire HIV as young men the same age.

Both Uganda and Malawi are very 'young' countries, with almost half the countries' populations being aged under 15^{xiii}. Different factors contribute to this, including decreasing mortality rates combined with consistently high adolescent fertility rates, early marriages associated with early school drop-out for girls, domestic violence, traditional and cultural structures and values as well as lack of access to health services and contraception for young women and girls.^{xiv}

In sub-Saharan Africa, six in seven new HIV infections among adolescents aged 15–19 years are among girls. Young women aged 15–24 years are twice as likely to be living with HIV than men.^{xv} Approximately one-third of all new HIV infections in Malawi in 2018 occurred among young people (aged 15-24) and roughly two-thirds of these new infections were among young women.^{xvi} In Uganda 8.8% of adult women are living with HIV compared to 4.3% of men^{xvii}, and HIV prevalence is almost four times higher among young women aged 15 to 24 compared to young men of the same age.^{xviii}

High HIV prevalence among women is driven by gender inequality and discrimination, which robs women and girls of their fundamental human rights, including the right to education, health and economic opportunities.^{xix} The resulting disempowerment also denies women and girls sexual autonomy, decision-making power, dignity and safety. Gender-based violence (GBV) is among the most egregious manifestation of gender inequality: it has been shown to increase the risk of acquiring HIV infection for women and girls, and among women living with HIV, it can lead to reduced access and adherence to treatment. These impacts are most pronounced in sub-Saharan Africa, where adolescent girls and young women (aged 15 to 24 years) account for 25% of HIV infections in 2020, despite representing just 10% of the population.^{xx}

Underaged Sex Workers

During the COVID-19 pandemic our partners AHM and LMEC have identified an increasing number of under-age SWs, who are especially vulnerable to exploitation, violations, and HIV as they lack representation and knowledge of their rights. COVID-19 has increased poverty and poverty is the principal reason that young women and girls engage in sex work. Often sex work is perceived as the only feasible means of meeting their basic needs and often those of their children, siblings and/or parents. Orphanhood is another reason why children are forced into sex work at an early age. In Uganda, the majority of underaged SWs (63%) are orphans and 80% live without any connection to their families.^{xxi}

There are also clear connections between child sex work, poverty and early marriage, which in turn is associated with early withdrawal from school, risks of domestic violence, pre-mature pregnancy and denial of opportunities for economic advancement.^{xxii} The current economic crisis in Uganda and Malawi following the COVID-19 pandemic, has accelerated the rise of under-aged SWs in both countries.

The health and safety of these girls is at serious risk. They lack knowledge and authority to negotiate condom use, they are often exploited by customers who refuse to pay for the service they have received and because SWs can receive higher prices if they do not use a condom, many are at high risk of acquiring HIV and other sexually transmitted infections (STIs), as well as becoming pregnant. At the same time, underaged SWs are in high demand as many customers believe that they are "clean" from HIV and STIs.

The programme will expand the target group to include **child SWs** with a strong focus on assisting them in exiting sex work. Both Uganda and Malawi have ratified the Convention on the Rights of the Child (United Nations 1989), and the Optional Protocol on the Sale of Children, Child Prostitution, and Child Pornography (United Nations General Assembly 2000).^{xxiii} These commitments provide a basis for protecting children from abuse and exploitation, and for promoting the participation of children in decisions that affect their lives.

2.3. FACTORS FUELLING THE HIV-EPIDEMIC

High HIV prevalence rates among KPs are caused by a series of factors. On the one hand are factors such as poverty, low level of education and lack of knowledge about HIV and safe sex, lack of access to protection as well as SWs and MSM in general having a high number of sexual partners.^{xxiv} On the other hand, the high rates are fuelled by several ingrained cultural, structural and legal barriers, which hamper HIV prevention and basic human rights and prevent KPs from exercising their right to health.

Criminalisation

In Uganda, LGBT+ persons and consensual same sex relations are criminalised under Article 31 (2)(a) of the constitution that prohibits marriage between persons of the same sex and sections 145, 146 and 148 of the Penal Code Act, which criminalise consensual same sex relations. Violations of this act is punishable with up to life imprisonment.

Sex work is criminalised as ‘prostitution’ under section 139 of the Penal Code Act. According to this section, ‘any person who practices or engages in prostitution commits an offence and is liable to imprisonment for seven years. However, as these offences are difficult to prove, police officers resort to nuisance and vagrancy laws under sections 167 and 168 of the Penal Code to massively and wantonly arrest SWs and LGBT+ persons.

On 3 May 2021, the Parliament of Uganda approved a new sexual offences bill. The bill offers provisions designed to prevent and punish sexual violence, but at the same time it further criminalizes LGBT+ people and SWs as well as organisations representing them and fighting for their rights. It also includes provisions that discriminate based on HIV status. Our programme partner, HRAPF, has strongly advocated for the President not to assent the bill, which violates international human rights law. On 3 August 2021, President Museveni informed the Parliament that he would not assent the bill in its current form, because there are several provisions in the bill, which are already provided for in other penal codes. However, the bill in a revised form is still pending.

In Malawi, the Constitution prohibits discrimination in any form and guarantees all people equal and effective protection under the law. Nevertheless, homosexuality is illegal, and Chapter XV of Malawi’s Penal Code, on “Offences Against Morality,” contains several provisions that criminalize adult consensual same-sex conduct with section 153 providing that any person found guilty of committing an “unnatural offence /offence against the order of nature” is liable to 14 years in prison, with or without corporal punishment. Although arrests and prosecutions under this law was suspended by a moratorium issued in 2012 by the then minister of justice, and reaffirmed by the President in 2017, the lack of clarity and divergent opinions regarding the legality of the moratorium encourages private individuals to attack LGBT+ people with impunity, while health providers frequently discriminate against them on the grounds of sexual orientation.^{xxv} Our programme partner, CEDEP, is still running a case at the constitutional court for the complete removal of the Sodomy laws from the penal code. The case continues to be postponed but has not yet been dismissed.

Sex work is not illegal in Malawi, however related criminal offences are often used as a reason to target, harass, abuse and arrest SWs, since it is an offence to behave in an indecent way or perform an indecent act in public.^{xxvi} The Rogue and Vagabond Law (which has been used *de facto* to criminalise sex work and to extort sex or money from SWs) was repealed by the High Court in January 2017, after being raised by a group of CSOs led by our Malawian programme partners, CEDEP and AHM.

According to an analysis led by Georgetown University’s O’Neill Institute for National and Global Health, criminalization of KPs has a negative effect on HIV outcomes. Where same-sex sexual relationships, sex work and drug use are criminalized, levels of HIV status knowledge and viral suppression among people living with HIV (PLHIV) are significantly lower than in countries that opted not to criminalize them. Conversely, there is a positive correlation between better HIV outcomes and the adoption of laws that advance non-discrimination, the existence of human rights institutions and responses to GBV.^{xxvii}

Stigma and Discrimination

In both Uganda and Malawi, KPs face severe stigma and discrimination. SWs, MSM and TG continue to be marginalized and criminalized for their gender identities and expression, sexual orientation, lifestyles, and livelihoods—or for simply living with HIV. KPs are often accused of fuelling the HIV epidemic, which further stigmatises and marginalises them. According to a recently published UNAIDS survey, 20% of people aged 15-49 years in Malawi and 35% in Uganda reported having discriminatory attitudes towards PLHIV.²

The social stigma of KPs penetrates all layers of society and is used as moral justification for frequent violations of KP rights in different settings. Many SWs experience harassment, rape, blackmail and violation of rights from the police as well as from clients, bar owners and health staff. MSM also experience harassment, violence, forced anal examinations, outing and unlawful arrests by the police as well as discrimination in the health system. Some are denied access to health services because of their sexual orientation or gender expression.

People living with HIV and other key populations still regularly face multiple and intersecting forms of stigma and discrimination based on their HIV status and other health conditions, race, gender, sexual orientation, economic background, drug use, involvement in sex work and age that undermine their health, safety, and dignity—and impede efforts to end AIDS. Ending this stigma and discrimination is an essential component of a human rights-based response to HIV.

CONFRONTING INEQUALITIES
Lessons for pandemic responses from 40 years of AIDS,
UNAIDS 2021

Both SWs and sexual minorities frequently experience public humiliation, violent attacks, and other forms of discrimination: They are fired from jobs, excluded from families and from religious communities, beaten up and denied access to education, housing and employment. The lack of legal protection for these groups contributes to their marginalisation and vulnerability.

The severe stigmatisation, discrimination, and marginalisation of KPs causes high levels of stress, depression, and a variety of other mental health problems. This often leads to alcohol and drug use, which again affects their well-being and leads to increased risky sexual behaviour as well as reduced adherence to HIV treatment.

Influential opinion-makers often fuel and legitimize this stigmatization and play important roles in shaping norms, attitudes, and popular opinion about KPs and influencing the degree of public moral judgement, condemnation, and discrimination. Many politicians, religious and traditional leaders practice hate speech about MSM and sexual minorities and exclude KPs from religious and traditional communities. A 2017 study on MSM in Kampala city, found that 40% had experienced homophobic abuse.^{xxviii}

Like in other spheres of society, stigmatization, and discrimination of KPs also permeates the health sectors. This is reflected in different ways – both when KPs are left out of government HIV prevention programmes

² Discriminatory attitudes are measured through "No" responses to either of two questions: (1) Would you buy fresh vegetables from a shopkeeper or vendor if you knew this person had HIV?; and (2) Do you think that children living with HIV should be able to attend school with children who are HIV negative? Source: Confronting Inequalities. Lessons for pandemic responses from 40 years of AIDS, UNAIDS 2021, p.169.

and when health service providers discriminate against KPs seeking services. Even when national HIV programmes do target KPs, it is difficult to reach them, because they live in hiding because of social stigma, discrimination, and criminalisation. The lack of targeted interventions towards KPs means that levels of knowledge about HIV transmission, prevention and treatment is relatively low among KPs. Social stigma and fear of harassment and humiliation results in SWs and MSM often refraining from accessing HIV services to be tested or to access HIV treatment.

In Uganda, access to HIV services in general has also been hampered by the HIV Prevention and Control Act, which was passed in 2014. It criminalises behaviours that might result in transmission by those who know their HIV status and allows health care providers to disclose a patient's HIV status to others. Predictably, this has reduced people's inclination to be tested for HIV. Consequently, the proportion of KPs knowing their HIV status, accessing HIV services, enrolling into and adhering to treatment is still low in both Uganda and Malawi due to lack of HIV knowledge, criminalisation, stigma and discrimination^{xxix} coupled with high levels of human rights violations.^{xxx}

This said, while discrimination of KPs within the health sector is common, there is also a recognition in both countries, especially among health authorities, that KPs need to be targeted in order to solve the HIV/AIDS crisis. It is also evidenced through the programme and AF's previous interventions with partner organisations in Malawi and Uganda, that collaborations with health services providers on providing KP friendly services, is an effective way of reducing discriminations of KPs in health settings.

COVID-19 - Impact on HIV Prevention and Key Populations

The global COVID-19 pandemic has had a solid grip on all corners of the world throughout most of 2020 and 2021 and has had a huge effect on the socioeconomic and political contexts in both Malawi and Uganda. The extent of long-term effects of the COVID-19-pandemic is still to be seen. However, it is evident that COVID-19 is a new structural barrier for effective HIV prevention and for the protection of KP rights.

COVID-19 lockdowns and related restrictions badly disrupted HIV programmes and testing, and in many countries led to steep drops in HIV diagnoses, referrals to care services and HIV treatment initiations. Health facilities (including HIV-focused clinics) were repurposed to handle the influx of COVID-19 patients, face-to-face services were suspended, and many people either avoided or were unable to access health care. The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) reported that, according to data collected at 502 health facilities in 32 African and Asian countries, HIV testing declined by 41% and referrals for diagnosis and treatment declined by 37% during the first COVID-19 lockdowns in 2020, compared with the same period in 2019.^{xxxi} Thus, the pandemic has put immense pressure on already weak health systems shifting focus from HIV prevention programmes to COVID-19, which has negatively affected HIV-testing and enrolment and adherence to Antiretroviral Therapy (ART). It has also increased the inequality and marginalisation of those already left behind.^{xxxi} Fortunately, according to UNAIDS, COVID-19 disruptions in HIV services have to some extent been mitigated by community led service deliveries and telehealth measures, which was exactly what our programme partners LMEC and AHM implemented during the pandemic in Uganda and Malawi.

National COVID-19 lock downs, social distancing and other government measures to address the pandemic, have severely affected the SW industry and have increased violence, stigma, poverty and homelessness. LGBT+ persons and SWs have been forced out of housing and have been arrested for trumped up charges of spreading COVID-19 and AIDS. At the same time, SWs and LGBT+ persons have deliberately been excluded from national food distribution programmes. COVID-19 has also caused a dramatic increase in GBV and intimate partner violence, which increase the risk of HIV transmission and infections. In many places, closure of schools and community centres have disrupted access to HIV and SRHR services, putting adolescent girls and young at increased risk of GBV, unplanned pregnancy, forced marriage, HIV or other STIs.^{xxxiii} Adding to this,

an increasing body of evidence indicates that people living with untreated HIV who acquire COVID-19 infection are at heightened risk of severe COVID-19 illness and death.^{xxxiv} National lock-downs, travel restrictions and fear of COVID-19 have also negatively affected the Malawian and Ugandan economy and has forced already poor people making a living day-by-day into extreme poverty, which has also increased the number of children dropping out of school and turning to sex work. Accordingly, the COVID-19 pandemic has if anything increased the relevance of our programme focusing on HIV-prevention and human rights for the groups most at risk and “left behind”.

LGBT+ activists released after 50 days

As if COVID-19 was not a terrifying threat in its own right, authorities in Uganda have taken advantage of the extraordinary circumstances to crack down on the LGBT community - all under the guise of containing the spread of COVID-19. On March 14th, 2020, during Uganda’s national COVID-19 lockdown, police in Kampala raided a hostel run by the NGO, Children of the Sun, who assists and offers shelter space for vulnerable members of the Ugandan LGBT+ community. 20 young people were arrested and charged with a “negligent act likely to spread infection or disease” as well as “disobedience of the lawful order”. The latter clearly indicating that the arrests were primarily motivated by homophobia. COVID-19 was simply an excuse for the raid.

HRAPF’s lawyers worked night and day to ensure the swift and unconditional release of all 20, but it took 42 days before any of their lawyers could speak to the prisoners. But then, just over a week later, after 50 days under lock and key, the Director of Public Prosecutions was asked by the magistrate court to drop all charges and the 20 were finally released. AIDS-Fondet supported HRAPF by granting programme funds to the purchasing of two motorcycles, which enabled HRAPF to bypass COVID-19 imposed restrictions on transport.

AIDS-Fondet assisted HRAPF in mounting political pressure on the Ugandan authorities by flagging the case to the Danish Minister for Development, Rasmus Prehn, and the Minister engaged his political colleagues in Uganda and made it a priority for the Danish Embassy in Kampala to offer full support to HRAPF in whatever it needed to see the 20 LGBT activists released.

Restrictions on Civic Space and Civil Society

Civic space in Uganda is *repressed* according to CIVICUS’ Civic Space monitor. The Uganda NGO Act from 2016 still makes it difficult for organisations working on LGBT+ and SWs issues to register and operate as it imposes ‘special obligations’ upon organisations not to do ‘anything prejudicial’ to the ‘laws of Uganda’, ‘security of Ugandans’ and ‘interests of Ugandans’. In November 2019, more than 12,000 NGOs and charities were ordered to stop their operations, until they complied with new regulations.^{xxxv} An initiative, which political observers believe was a crackdown on groups that have been critical of the government, especially organisations campaigning for sexual minorities’ rights. During 2021, the government intensified its harassment and intimidation of CSOs. In connection with the presidential elections in January 2021, the government Financial Intelligence Authority ordered the freezing of bank accounts of several CSOs, and NGOs involved in good governance and election observation in the country.^{xxxvi} In January 2021, President Yoweri Museveni directed the immediate suspension of the activities of the Democratic Governance Facility (DGF), the largest pool of donor funding to non-governmental organisations in Uganda.^{xxxvii} In August 2021, the government closed another 54 NGOs mainly working with human rights and marginalised communities. This development of course puts additional pressure on our partners as well as on smaller KP-led organizations, who are also struggling to meet government requirements and who are especially targeted.

At the same time, the COVID-19 pandemic and government instituted measures to curb the spread of the disease has further restricted civic space in Uganda during 2020. Presidential directives have been used as a pretext to target NGOs and our beneficiaries, who have been vulnerable to rampant arbitrary arrests under the guise of “disobeying lawful orders” or “doing a negligent act likely to spread infection of disease”. During the period March to June 2020 alone, there was widespread violence against KPs. SWs reported being raped and sexually violated at will by security operatives and being subjected to extortion, ridicule, shaming, arbitrary arrests and physical violence. LGBT+ persons also suffered arbitrary arrests and the case that stood out the most was the arrest of 23 young LGBT+ persons from a shelter run by the Children of the Sun Foundation (COSF) in Kyengera and who endured torture, abuse and imprisonment for over 50 days.^{xxxviii}

Civic space in Malawi is *obstructed* according to CIVICUS’ Civic Space monitor. The 2019 presidential elections in Malawi were marred by irregularities, which led to a year of public protests and arrests of Human Rights Defenders including the Executive Director of our programme partner CEDEP, who is also chair of the Human Rights Defenders Coalition that led the case against election fraud. In February 2020, the Constitutional Court annulled the election results and a new presidential election was held in June 2020, resulting in the inauguration of the President, Lazarus McCarthy Chakwera.^{xxxix} With the new government, Malawi currently witnesses a more open space for civil society. During the electoral campaign, the current ruling party manifesto proposed a referendum on LGBT+ rights. However, no follow-up actions have so far taken place.

2.4. SUMMING-UP

In the following, we will summarize learnings from the first phase and flesh-out how the programme addresses these interlinked factors of stigma, marginalisation, criminalisation, inequality, civic space restrictions, deprivation of rights and KP’s vulnerability to HIV as part of an intersectional human rights-based approach to HIV prevention. The section will also include an introduction to our ToC and target groups.

This will be followed by an overview of the strategic relevance of our programme within a broader development context, and an introduction to how the programme works with both nexus, risk management and sustainability within fragile contexts.

Next, we will present how AF and partners hold the capacity to implement the programme, succeeded by an overview of our approach to monitoring, evaluation and documenting our results, including a summary of the programme’s comprehensive result framework and targets for the next programme phase.

Finally, we will elaborate on the cost effectiveness and efficiency of our programme and on the strategies and principles informing our programme budget.

3. KEY RESULTS AND LEARNING 2019-21 SHAPING THE NEW PHASE 2022-25

3.1 KEY RESULTS 2019-21

Monitoring of progress summarized in status reports shows that the programme has reached very good results towards improving HIV Prevention among KPs in Malawi and Uganda during the first two years. The programme has positively contributed to all expected outcomes:

The programme has **improved the ability of KPs to protect themselves against HIV and AIDS**, despite COVID-19 negatively affecting HIV-prevention. We have seen positive progress on all our indicators for HIV testing, condom use and adherence to HIV medicine among all our beneficiaries in Malawi and Uganda.

The progress was facilitated through the empowerment and education of SWs, MSM and TG to organise in support groups, provide peer-to-peer support and educate fellow peers on HIV, medication, safe sex practices, human rights, distribute condoms and lubricants and through mobile testing and referrals to KP friendly health services. The peer-to-peer model proves to be very effective in empowering marginalised beneficiaries and facilitate sustainable change. The negative effects of COVID-19 on HIV prevention were to a large extent

mitigated by our agile and innovative approaches, distributing self-testing kits, condoms and ART to SWs as well as introducing digital support and counselling.

The programme has **improved access for KPs to stigma-free health services**. The change has been facilitated through outreaches and targeted advocacy towards health service providers on their duty bearers' responsibility to treat all clients without discrimination, which has led to positive change in negative views of KPs among HSP and increased access to KP friendly health services. Results are validated through pre- and post-training questionnaires and by routine visits and access of KP friendly compliance at health facilities. They are also validated by questionnaires and reports from beneficiaries, who have visited trained health service providers. Further, we have educated our beneficiaries on their right holder's right to equal and discrimination free access to health, which has empowered them to claim their rights and report abuses to health management.

The programme has also made good progress in its attempt to **remove structural barriers to HIV prevention**. Advocacy targeting duty bearers on local and district level led to positive change. Regular stakeholder meetings and advocacy targeting local leaders, police, soldiers and other relevant stakeholders such as bar and brothel owners have led to validated positive behavioural changes and reduction in discrimination and violations towards KPs. Unfortunately, COVID-19 and national elections have further limited human rights for LGBT+ persons, SWs and NGOs, especially in Uganda, which saw an increase in violations of rights and rampant arrests of KPs. HRAPF has trained KP paralegals and provided legal support to SWs and LGBT+ persons. Also, consistent documentation and verification of human rights violations against SWs and LGBT+ persons has strengthened evidence-based advocacy towards key stakeholders. Partners use the evidence to inform meetings with the relevant stakeholders and cases are published in annual reports and informs Universal Periodic Review (UPR) shadow reports to the UN HRC. Strengthening KP organisations, documenting violations of KPs' rights at national level and working to ensure that relevant authorities address the violations is an important step to remove structural barriers to HIV treatment and prevention.

Finally, the programme has managed to **empower and increase the capacity of partners and other KP organisations** by assisting them in the process of becoming democratic, transparent, lawfully registered NGOs

Asiyatu's story – Diagnosed with HIV and getting support from a peer (August 2021)

"I looked at the nurse in disbelief. I felt tears streaming down my face. I ran out of the room and out of the health facility before getting medication or any other further assistance." Those are the words of Asiyatu, a sex worker in Malawi, as she recalls the day in February 2021 where she went to the clinic and was told that she was HIV-positive. The nurse told her bluntly and Asiyatu was too shocked to stay and get information about medication. She ran home and stayed the rest of the day in her room.

In the evening, other women from the rest house where she stays, were concerned, and went to talk to her. And another sex worker, Nafe, who had received training as a peer leader, managed to get through to Asiyatu – who eventually told her why she was in such a state. With the training Nafe received as a peer leader, she could talk to Asiyatu and give her some of the information that she missed at the clinic when she ran home. In addition, Nafe could share this information with Asiyatu, not as a nurse, but as a peer – someone who knows what it means to be a sex worker.

Eventually Nafe convinced Asiyatu that with medication she could still have a normal life – and the next day they went to the clinic together. Ever since the day Asiyatu learned that she has HIV, Nafe has been dropping in regularly to check on her – and she has not missed a day of her medication.

(AHM, Malawi).

and comply with the national NGO legislation. AF has increased the capacity of programme partners and strengthened South-to-South and South-to-North connectedness by facilitating networking, collaborations, sharing of learnings and best practices across the partnership, providing trainings in M&E and knowledge management and increased financial sustainability of partners by linking to fundraising opportunities and new donors and assisting in preparation of applications. All four partners express an increase in capacity as CSOs as a direct result of the programme.

3.2. KEY LEARNINGS INFORMING THE NEXT PHASE

The overall lessons learned during the first phase is that our ToC and underlying assumptions and pathways have proved valid. Our programme strategy works and has contributed to a stronger Global South civil society and positive developmental changes for some of the world's most marginalised people. Consequently, the next phase of the programme will build on existing strategies and methods, while at the same time introducing new focus areas and changes informed by learnings from the first phase.

COVID-19, a New Structural Barrier

Even though, the programme has contributed positively to all outcomes, it is evident that the COVID-19 pandemic has negatively impacted HIV prevention, well-being and human rights of our beneficiaries and accordingly our programme results in 2020. Consequently, we have included **COVID-19 as a new structural barrier to HIV prevention and human rights for KPs**, which the programme will address. On one hand, the focus will be on advocating for the inclusion of KPs in follow-up COVID-19 health plans and on securing HIV prevention programmes. On the other hand, focus will be on documenting COVID-19 related violations of human rights, educating KP paralegals to provide legal aid, and advocating for justice.

Resilience of Key populations

COVID-19's destructive effects on our beneficiaries' livelihoods, SWs in particular, have also put a spotlight on a missing dimension in our change strategy. During the next phase, we will highlight **resilience** as a new component in our ToC and introduce income generating activities (IGA), management skills and exit strategies for SWs. During the current programme phase, AHM and LMEC have identified an increasing number of underage SWs. The programme will develop strategies to help these children to have access to HIV treatment, preventative measures and human rights protection and link them to social services to provide rehabilitation assistance to exit sex work, guided by the UN Convention on the Rights of the Child. We will also target IGA trainings at caregivers of young SWs to provide them with tools to exit immediate poverty and thereby regaining the power to care for their children. As part of the resilience focus, we will build our partner's capacity to work with IGAs by training them and linking them to other CSOs with IGA expertise.

Resilience of CSOs

A strong focus on **resilience** has consistently been part of our strategy to build the capacity of our partners and other Global South KP organisations. We will strengthen this commitment even further during the coming phase, considering the increased **clampdown on civil society** in Uganda and the window of opportunity we see in Malawi after a period with high political tension. Our resilience focus will be on **financial sustainability** and **national and international networking** to foster a stronger, independent, and more diversified civil society. We will also use the strong capacity of HRAPF as a catalyst to build the capacity of our partners and other small KP-led organisations to withstand pressure from government.

Innovative Methods and Techvelopment Solutions

The COVID-19 crisis is unprecedented in scale and scope and has had severe implications for our programme partners' ability to implement activities according to plans. However, it has also showcased our partnerships' ability to act agile and adapt to fast changing contexts and offered opportunities to innovate our approaches and accelerate implementation of new forms of collaborations with both beneficiaries, external stakeholders and within the partnership. The programme managed to mitigate and minimize many of the negative effects of COVID-19 on HIV prevention for our beneficiaries through a rapid response revising and introducing new

activities and methods to engage both beneficiaries and stakeholders. This included distributing of HIV self-testing Kits, HIV medicine and condoms to SWs during lockdowns and introducing capacity building on online means of communications for meetings and trainings and the use of digital means to accelerate ART and PrEP³ adherence and psychosocial WhatsApp support groups. The next phase will build on the experiences gained during the pandemic to develop and build on **innovative methods and techvelopment solutions** such as online training, electronic data-collection, WhatsApp support groups, HIV-self testing and others. AF will also empower partners to become trainers on HIV and on sexual health more broadly through digital training.

Catalyst - The Male Champion method

In 2018, AHM innovated and implemented The Male Champion method to fight GBV as part of a CISU-funded project implemented in collaboration with AIDS-Fondet. The method in all its simplicity engages male representatives of groups driving GBV against sex workers - bar owners, clients, community leaders, taxi drivers - to be champions of change and fight GBV. The Male Champions visit sex hot spots at night, they disseminate relevant information on HIV/AIDS to men, incite clients to respect sex workers and their rights and assist sex workers in cases of abuse and harassment and with filing charges or resolving disputes.

As part of a Programme Steering Committee meeting in Malawi in 2019, partners met with sex worker support groups and Male Champion groups, who praised the method. LMEC Empowerment Centre, who initially had expressed reservation against engaging male violators in protection of sex workers right, were inspired by the method and its results. In 2021, AHM travelled to LMEC in Uganda and trained the team in the Male Champion method, which will be implemented by LMEC as a pilot in Uganda from 2022.

In April 2021, AHM shared the method with more than 100 representatives from CSOs from all over the world at a seminar organized by AIDS-Fondet, Danner and SOS Childrens Village, focusing on gender, norms and violence and methods to combat GBV. Many CSOs were inspired by the method and engaged Action Hope Malawi for further consultation. In August 2021, the Male Champion method was officially adopted by the Malawi Ministry of Gender and other organizations in Malawi including UN agencies as a validated means to combat GBV.

Peer-to-Peer, Duty Bearer-to Duty Bearer, Partner-to-Partner

Experience from the first phase and previous projects, validates that the **peer-to-peer approach** is a cost-efficient and powerful method to promote sustainable development change, which almost instantly and directly benefits beneficiaries, empower them and improves their self-esteem. The method will be continued vis-à-vis beneficiaries but will also inspire how we work with duty bearers.

We will engage duty bearers such as police and health service providers, which we have trained in existing districts, to train and build the capacity of their peers in new programme districts. We will also continue a strong focus on facilitating sharing of methods, learnings, capacity and best practises between partners. We will put increased focus on capacity building between partners as a catalyst for change.

Linking Mental Health, Sexual Health, and Well-Being

During the first phase of the programme, we have witnessed widespread poor **mental health** and low self-esteem among beneficiaries, leading to increased drug and alcohol use, depression and suicidal behaviour, which have severe negative effects on safe sex behaviour, HIV prevention and adherence to treatment. At

³ PrEP is the term for a preventive treatment against HIV infection with antiretroviral drugs. Info available from: <https://www.sst.dk/da/Udgivelser/2019/Rationel-Farmakoterapi-10-2019/Komponenter/PrEP-et-forebyggende-tilbud-mod-HIV-infektion>

the same time, we have also seen COVID-19 being used as a pretext for clampdowns and rampant arrests of both SWs and LGBT+ persons, whose **human rights have been more challenged** than before. Both tendencies have negatively affected the lives and well-being of our beneficiaries. During the next programme phase, we will extend our impact level to include **increased well-being for KPs** and put spotlight on increasing human rights for our beneficiaries, emphasising the link between sexual and mental health. We will educate our peer educators on how to address mental health issues with their peers and support referrals to mental health treatment and counselling. We will introduce training of SWs and LGBT+ persons to be paralegals, who can document and assist KPs in cases when their rights are violated.

Advocacy

Finally, we have learned that our strategy of targeted **advocacy** towards duty bearers, who exclude and violate the rights of KPs, to promote inclusion and equal access to services and rights is efficient. We see very good results on local and district levels with changes in attitudes and behaviour among direct-targeted stakeholders. However, changes, as expected, take longer and are harder to reach when we target national duty bearers, institutions, policies and legislations, but even at national level we see good progress.

Our advocacy will continue to target all levels of society, with CEDEP and HRAPF taking lead on national and international advocacy promoting structural and legal changes, supported by AHM and LMEC. In their national advocacy work, the SDGs along with participation in CEDAW reporting and UPR shadow reports will provide a strategic platform for advocacy work and media attention on government commitments both at the national and international level. We will include advocacy against discriminatory structures in the education sector by addressing curriculums and discrimination of LGBT+ persons and PLHIV in the Malawian education sector, and by targeting state attorneys in Uganda. We will also target advocacy directly at media to promote KP-friendly reporting.

Exit Strategies - From Peer Education to Advocacy

During the first programme phase, we have worked directly with peer educators and support groups for both SW, MSM and TG. Sex worker support groups and peer education has been facilitated by AHM in Malawi and LMEC in Uganda, while CEDEP has facilitated support groups and peer education for MSM and TG in Malawi.

During the next phase, we will continue working with SWs support groups, but the programme will no longer directly work with MSM and TG peer educators and support groups in Malawi. CEDEP's focus within the programme will exclusively be on advocacy and capacity building to support LGBT+ rights in Malawi.

Together with CEDEP, we have developed exit strategies, securing that all support groups and peer educators, who are part of the programme will continue under CEDEP's health department, which implement KP health projects and programmes funded by other donors. Data from CEDEP's support groups will still inform advocacy initiatives under the programme. Our assessment is that this change supports CEDEP's organization and capacity. It also gives the programme and CEDEP an opportunity to make further use of CEDEP's strong capacity withing advocacy and take advantage of a seemingly positive momentum for pushing for LGBT+ rights in Malawi within the new political landscape.

"AF seems to strike a balance where service delivery is strategic, i.e. provision of KP-friendly health service is used as an entry point, which in addition to enhancing the rights of KPs, also feeds into advocacy for breaking structural barriers, while capacity building takes place at organizational and individual (KP) level. The on-going dialogue with CEDEP to change focus in the coming program period, from service delivery to advocacy and capacity building, in order to enhance the organizational sustainability is an example of timely and pertinent adjustment of focus".

CISU review 2021, p 10

Ride To End AIDS

In June 2021, the government of Uganda imposed a tight 42-day lockdown that included curfew and a ban on public transport in efforts to beat back COVID-19 cases. With support from AIDS-Fondet, LMEC implemented an initiative to increase access to HIV services by sex workers, their clients and partners through use of boda-boda riders to deliver HIV prevention kits.

Ms. Eve is a sex worker affected by the lockdown measures on public transport. Eve has been doing transit sex work for four years which involves moving from one site to another looking for customers. At the beginning of the lockdown, Eve had travelled to Namataba, a sub-urban town on the Eastern region transit route for work, 41 kms from the hospital, where she normally seeks her HIV services. Because of the ban on public transport, Eve had to stay in Namataba and wait for the lockdown to be lifted. This, however, didn't stop her need for HIV services. "Just a few days into the lockdown, my PrEP drugs were done, I had to go back for re-fills and also getting some STI treatment, but I had no way back to hospital," explains Eve.

Instead, Eve benefitted from LMEC's initiative where she could order a HIV prevention kit with PrEP drugs, condoms, HIV self-testing kit as well as STI drugs – all delivered by the boda-boda driver, David.

(LME, Uganda, June 2021)

4. PROGRAMME OVERVIEW 2022-25

4.1. PROGRAMME AIM AND JUSTIFICATION

The overall aim of the programme 2022-25 is to reduce HIV incidence and increase well-being and resilience among KPs, primarily sex workers (SWs), men who have sex with men (MSM) and transgender persons (TG) in Malawi and Uganda. The overall aim is justified by the fact that East and Southern Africa is the region most affected by HIV in the world, with HIV prevalence rates among KPs being much higher than the general population due to interrelated structural factors, which fuel the HIV-epidemic and hamper the possibility of reaching the SDG 3.3 of ending AIDS before 2030, cf. Chapter 2 on context analysis.

The ToC of the first programme phase, its pathways to change and underlying assumptions have all proven valid. However, based on previous listed results and learnings during 2019-21, the programme partnership has decided to extend the overall purpose of the programme from **reducing HIV incidence among KPs in Malawi and Uganda** to also including the purpose of **increasing the well-being and resilience among KPs in Malawi and Uganda**.

To reflect the proposed changes, the title of the programme will change **to HIV Prevention, Resilience & Well-being among Key Populations in Malawi & Uganda** to embrace the stronger focus on socio economic resilience and access to basic human rights for KPs - not just as a stepping-stone to better HIV prevention, but as an objective in its own right.

The programme objectives and ToC have been updated since we submitted our programme concept note, April 2021. The changes do not imply any underlying changes in activities, expected outputs and outcomes compared to the concept note. Rather, they reflect discussions and decisions taking place at a two-day workshop between all programme partners in June 2021. At the workshop, our partners from Malawi and Uganda gave strong arguments to reword specific objectives and outcomes and add a separate objective and pathway to change in our ToC and Result Framework to emphasize the programme's new focus on resilience and economic empowerment.

To align with the changes, we have updated the four main programme objectives for the coming phase and added a new objective:

Phase 1 - Objectives 2019-21	Phase 2 - Objectives 2022-25
1. Improve the ability of Key Populations to protect themselves against HIV and AIDS	1. Improved sexual health of Key Populations with a specific focus on their ability to protect themselves against HIV and AIDS. 2. Improved resilience and ability among KPs to take care of their immediate social and economic needs
2. Improve access for Key Populations to stigma-free health services	3. Improved access to stigma-free health services for Key Populations
3. Remove structural social, cultural and legal barriers to effective HIV prevention and treatment	4. Improved inclusion, respect and observance of human rights of KPs
4. Increase the capacity of KP organisations	5. Increased resilience and capacity of KP organisations and allied CSOs

4.2. THEORY OF CHANGE AND PROGRAMME SYNERGY

A ToC is essentially a comprehensive description and illustration of how and why a desired **change** is expected to happen in a particular context. To align with the new extended focus of the programme, we have added pathways and short- and mid-term outcomes to our ToC for the next programme phase, which put extra weight on increasing the **well-being** and **resilience** of KPs.

The structural barriers to HIV prevention, causing unequal access to health, form the context and starting point of our TOC, as illustrated in Figure 1. At the heart of our ToC is building the capacity of KP CSOs and partners as strong civil society actors and especially within their abilities to address the pathways affecting HIV incidence, wellbeing and resilience among KPs in Uganda and Malawi. According to our ToC:

- ⚡ We build the capacity of KP CSOs and partners to be resilient and able to advocate for KP rights and HIV prevention
- ⚡ We empower right holders to organise, know and claim their equal rights to health and protect themselves from HIV and STIs
- ⚡ We empower SWs with new income generating skills and refer underage SWs to social services increasing their resilience providing tools to exit sex work and seek new employment opportunities
- ⚡ We build the capacity of health staff to know KPs' needs and rights and to live up to their obligations as duty bearers to provide non-discriminatory health services
- ⚡ We advocate for KP rights and inclusion in local, national, and international fora, legislation and policies and engage relevant duty bearers and stakeholders motivating them to observe KP rights

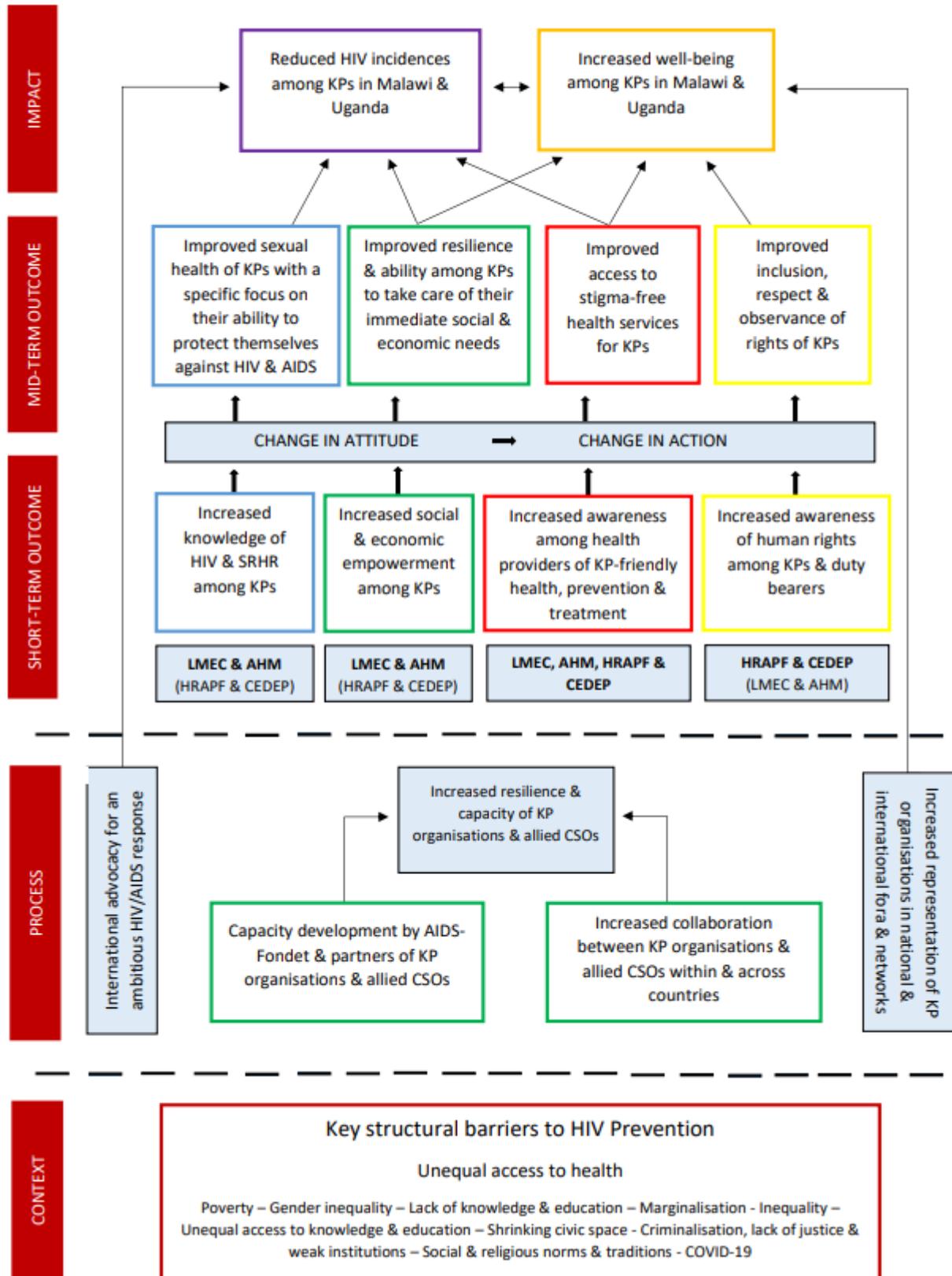
By this multifaceted approach, we pave the way for increased HIV prevention, well-being and resilience among KPs in Malawi and Uganda. We base our ToC on the following assumptions:

We assume that our capacity building and support of CSOs and their increased interlinkage to national and international fora and network will enable them to become strong, sustainable CSOs with the ability to empower KPs and effectively advocate for their rights. It will also empower them to be catalysts of change contributing to a stronger civil society within their countries.

When we mobilise KPs into support groups, educate them on HIV and safe sex and refer them to KP friendly health services for testing and treatment, we assume that it will increase their safe sex and HIV-testing behaviour and their enrolment into treatment and thereby reduce HIV incidences among KPs.

Figur 1

PROGRAMME THEORY OF CHANGE



When we teach KPs about their human rights and provide them with legal support and protection, we assume that it will increase their resilience and self-esteem and empower them to claim their rights to equal access to health and justice. We assume this will increase the well-being of KPs and increase their ability to protect themselves against HIV and reduce HIV incidences among KPs.

When we use HIV as a lever for human rights, advocate for the rights of KPs to equal access to health, justice, and inclusion in society among duty bearers and train them on their obligations as duty bearers, we assume that they will change attitudes and behaviour against KPs. We assume this will lead to duty bearers providing KP friendly services and promote inclusion of KPs in society. We assume that this will lead to KPs increasingly seeking services, leading to reduced HIV incidences and increased well-being among KPs.

When we provide evidence-based documentation of violations against KPs to courts, national authorities and the The United Nations Human Rights Council (UNHRC), and advocate for the removal of criminalising and discriminatory legislation, we assume that it will increase access to human rights for KPs, and in a long-term perspective contribute to the removal of discriminatory legislation, policies and practices, which assumably will lead to reduced HIV incidences and increased well-being among KPs.

When we educate KPs in loans, savings, and business management skills, we assume that it will increase their resilience and their ability to exit immediate poverty. We assume that this will lead to increased self-esteem and well-being among KPs, increase their ability to protect themselves against HIV, adhere to treatment and reduce HIV incidences among KPs.

Aligned with the overall ToC, all partners have developed individual ToC, informing their specific interventions. We will continuously revisit whether the ToC and underlying assumptions and pathways of change are valid.

4.3. TARGET GROUPS

The direct programme beneficiaries are MSM, TG and SWs with a particular focus on young representatives and underage SWs. The programme primary and secondary target groups are comprised of both rights-holders, duty-bearer and stakeholders. In the following, we will elaborate on the programme's reach of each group. **Please refer to section 2 for a comprehensive presentation of the main development challenges of KPs, youth, woman and girls in Malawi and Uganda.**

[Rights-holders: MSM, Transgender persons, Sex workers and their Organisations](#)

Uganda is estimated to have a population of 22,663 MSM and 130,359 female SWs.^{xi} In Malawi, records from UNAIDS estimate a population of 42.600 MSM, 36.400 female SWs and 400 TG.^{xii} The programme will benefit all these groups, either from direct inclusion in activities or through planned advocacy aimed at securing their rights and strengthening their representation at the national level, as well as from campaigns and communication interventions, nationally and internationally.

In Malawi, AHM's intervention will benefit 9000 SWs and directly target 1596 SWs, out of which 846 are underaged. The SWs will be reached in three districts: Zomba, Machinga and Blantyre. The districts have been chosen based on several parameters. All three districts are in the highest HIV prevalent zone of Malawi.^{xiii} In Zomba and Blantyre, the HIV-prevalence is as high as 17%, which is almost twice the HIV prevalence of the country.^{xiiii} The districts have also been chosen based on the scope of sex work (urban areas, border towns farming hubs, etc. have higher levels of commercial sex work), the geographical proximity to AHM, that is located in Zomba, and because CEDEP is active there, which facilitate collaboration. AHM will target 60 hotspots, including 10 new sex worker hotspots in each of the three target districts. Due to a high level of sex worker mobility to new hot spots many of the targeted SWs will be new to the programme. AHM will

furthermore reach **30 KP-led CSOs** directly with training on leadership and governance skills and well as the democratic structures of organizations.

In Malawi, CEDEP's political advocacy at national level will indirectly benefit Malawi's population of 42.600 MSM, 36.400 female SWs and 400 TG and directly engage and benefit 100 MSM and 50 TG through programme activities. CEDEP's intervention will also directly benefit the 7 KP-led CSOs that make up the Diversity Forum. CEDEP's intervention has been reoriented to focus on advocacy at national level in order to influence discriminatory policies and increase awareness raising on the rights of sexual minorities.

In Uganda, LMEC will directly target 3951 SWs, out of which 1831 are aged between 14 and 19. Through LMEC's advocacy efforts, their intervention will further benefit an additional number of 9210 SWs. The SWs will be reached in the capital city Kampala, in the fishing landing sites of Wakiso district and in the two newly established cities, Jinja and Mbale in the eastern transit route where Uganda boarder with Kenya. Both in Kampala and in the hard-to-reach fishing landing sites of Wakiso, there is a high demand for the sex work related services. Both districts are densely populated and have the country's highest HIV-prevalence. Jinja and Mbale have the main import/export route via the Maraba boarder with a large number of truck drivers coming through creating a high demand for sex work services. Female SWs in Jinja and Mbale are faced with high sexual violence, very low HIV knowledge and inadequate access to HIV services^{xiv} and commodities as most HIV service organisations are concentrated in the Central regions. LMEC will scale up HIV/AIDS and prevention of sexual violence among unserved female SWs and their clients and partners in the new programme target areas of Jinja, Mbale and the fishing landing sites of Wakiso while sustaining prevention and treatment achievements in Kampala City.

In Uganda, HRAPF will directly reach another 600 MSM, 200 TG, 840 SWs and 65 KP-led CSOs through their national level intervention. HRAPF's national level advocacy efforts will indirectly benefit Uganda's population of 22,663 MSM and 130,359 female SWs. They will reach the beneficiaries with legal counselling, legal literacy training and support to form community-based organisations, as well as paralegals training. HRAPF will not reach the primary target groups with information about HIV prevention and treatment or referrals to health services, since they are not an HIV or health specific organisation but a human rights organisation. However, they will indirectly support the primary target groups in improving access to health services, by training service providers, collecting data on gaps in access to health for KPs and engage in advocacy to hold authorities accountable.

The programme activities will also directly benefit clients and partners of SWs⁴, and indirectly benefit family members of beneficiaries, network alliances and the general public.

In Malawi, the programme will benefit:

- 3510 clients of SWs
- 1935 partners of SWs
- 3750 family members of beneficiaries
- 1.150.000 members of the general public (through community radio programs etc.)
- 64 CSOs/ network alliances

In Uganda, the programme will benefit:

- 1008 clients of SWs
- 144 partners of SWs
- 7744 family members of beneficiaries
- 15780 members of the general public (through online magazines, SoMe etc.)

⁴ The target groups are calculated in a way that we do not double count. E.g., a sex worker client or a bar manager might also be trained as a Male Champion. To avoid double counting, those trained as Male Champions are only counted as such.

- 617 CSOs/ network alliances

Duty-bearers and stakeholders

Beside the programme beneficiaries, the programme primary target also includes a large number of stakeholders and duty bearers, who have a great impact on the access to health and justice for KPs.

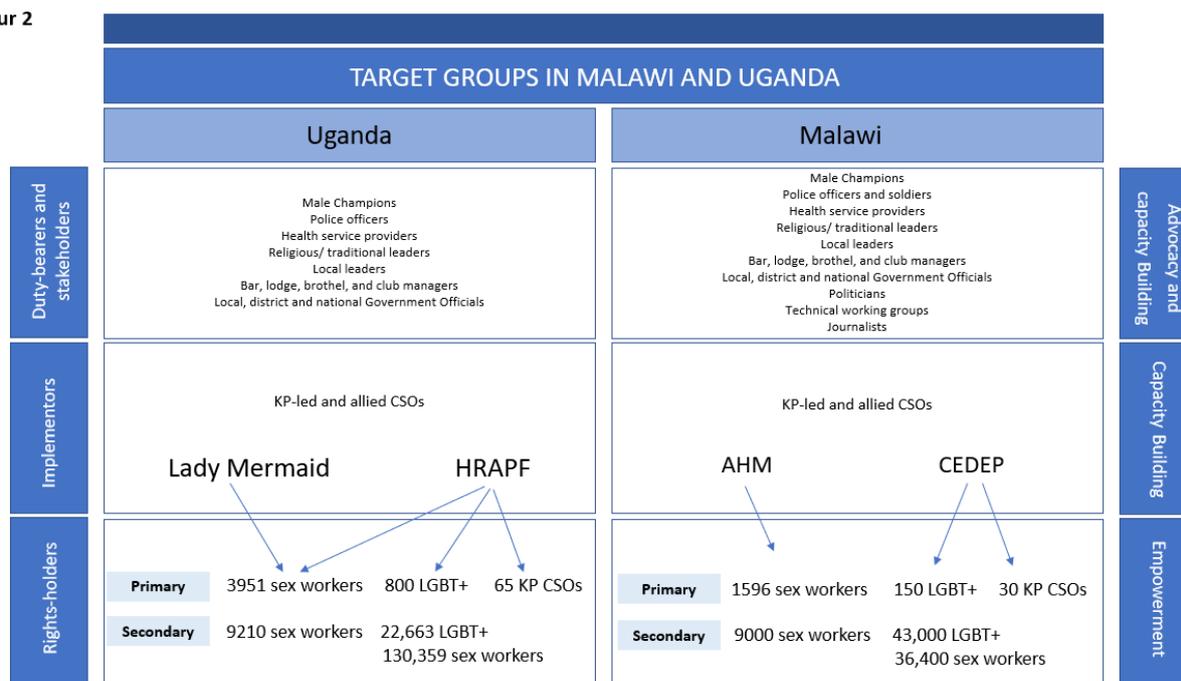
In Malawi, the programme will directly target:

- 450 Male Champions
- 230 Police officers
- 265 Health service providers
- 135 Religious/ traditional leaders
- 115 Local leaders
- 60 Bar, lodge, brothel, and club managers
- 30 Local, district and national Government Officials
- 45 Soldiers
- 80 Politicians
- 3 Technical working groups
- 25 journalists

In Uganda, the programme will directly target:

- 15 Male Champions
- 108 Police officers
- 840 Health service providers
- 108 Religious/ traditional leaders
- 428 Local leaders
- 140 Bar, lodge, brothel, and club managers
- 208 Local, district and national Government Officials

Figur 2



Beside the duty-bearers who are directly targeted by programme activities, we estimate that a number of their colleagues will indirectly benefit from the interventions through the transfer of information and knowledge. In Malawi we estimate that 1065 colleagues of directly targeted duty-bearers will benefit. In Uganda, we estimate that 2280 will indirectly benefit from the interventions.

4.4. PARTNERS ROLES AND RESPONSIBILITIES

The coming programme phase engages the existing programme partners. In **Malawi**, AF works with the community-based organisation, **Action Hope Malawi** (AHM) in the districts of Zomba, Machinga and Blantyre and on a national level with the LGBT+-led human rights organisation, **Centre for the Development of People** (CEDEP). AF's partnership with AHM was initiated in 2016 and the partnership with CEDEP goes back to 2008. In **Uganda**, we work in Kampala, Wakiso district and the newly established cities of Jinja and Mbale alongside the sex worker-led **Lady Mermaid Empowerment Centre** (LMEC), and on a national level alongside the human rights organisation, **Human Rights Awareness and Promotion Forum** (HRAPF). AF's collaboration with LMEC and HRAPF was initiated in 2018 under the current programme.

Roles and Responsibilities Related to Objective 1, 2 and 3

AHM in Malawi and LMEC in Uganda will be main responsible for implementing activities contributing to objective 1, 2 and 3.

Objective 1 – Improved sexual health of Key Populations with a specific focus on their ability to protect themselves against HIV and AIDS.

In both Malawi and Uganda, AHM and LMEC will implement activities to improve sexual health of KPs and their ability to protect themselves against HIV and AIDS. The progress will be facilitated through the empowerment and education of SWs to provide peer-to-peer support and educate fellow peers on HIV, medication, safe sex practices, human rights, distribute condoms and lubricants and referrals to KP friendly health services through mobile testing. The peer-to-peer model proves to be very effective in empowering marginalised beneficiaries and facilitate sustainable change.

In Malawi, AHM in collaboration with health service providers will conduct outreaches to sex hotspots to promote testing and adherence to treatment.

In Uganda, LMEC will scale up their existing interventions to the new districts continuing best practices from the first programme phase, such as providing testing and dispense ART and PrEP from their own sex worker health clinic, peer-led referral to KP friendly health facilities, outreaches to sex worker hotspots. LMEC also include new innovations such as a HIV self-testing results disclosure app, the establishment of HIV Prevention walls⁵ and PrEP campaigns.

As a new component, both AHM and LMEC will track the mental health of their beneficiaries and refer to services.

Objective 2 – Improved resilience and ability among KPs to take care of their immediate social and economic needs.

In both Malawi and Uganda, AHM and LMEC will continue to organize SWs in support groups to enhance their social support system.

⁵ A HIV Prevention wall is a tailor-made 24/7 HIV knowledge hub within sex workers' brothel hotspots, bars and clubs targeting sex workers and their clients.

In Malawi, AHM will reach under-aged SWs in collaboration with social services, Male Champions and the police, focusing on getting the young girls out of sex work and back to school. They will introduce economic empowerment of adult SWs and the caregivers of underaged SWs, training them to take up IGA, collective savings and loans, and develop strategies to exit sex work.

In Uganda, LMEC will address the challenge of an increasing number of under-aged SWs, focusing on exit strategies. Additionally, the intervention will implement strategies to address COVID-19 related financial issues that affect SWs' capacity to protect themselves against HIV through economic empowerment. In the first programme phase, LMEC developed "Women Up" a SW-led economic empowerment model to promote financial recovery. The new programme will hence pilot this innovation among selected SWs - both adult and underaged.

Objective 3 – Improved access to stigma-free health services for Key Populations.

To increase access to health services, both AHM in Malawi and LMEC in Uganda will work directly with their respective target groups. Through dialogue meetings with health management, trainings of health service providers and efficient referral systems, they will work to increase uptake of HIV services among the target groups and assess the quality of these services as delivered by duty bearers. The two organisations will collect information on perceived discrimination in the health system on their respective target groups. HRAPF will support the objective with additional rights training of health service providers.

Roles and Responsibilities Related to Objective 4

CEDEP in Malawi and HRAPF in Uganda will be the main responsible for implementing activities contributing to the programme objective 4 with supporting activities by AHM and LMEC.

Objective 4 – Improved inclusion, respect and observance of human rights of KPs

In Malawi, CEDEP will increase focus on conducting political advocacy, taking advantage of their great expertise and influence at local and national level. CEDEP's intervention will foster increased awareness and support for sexual minorities' rights through sensitization and engagement with relevant stakeholders. CEDEP will document human rights violations among the LGBT+ community and use the documentation to influence policy change and removal of structural barriers for accessing health services and justice for KPs. CEDEP will also engage with different media platforms to increase awareness at national level to seek, understand and incorporate LGBT+ knowledge, concerns and rights in policy discourse and decision-making processes. Through CEDEP's initiative, a media forum for the LGBT+ community has been established. The LGBT+ Media Forum operates as a network of media journalists supporting reporters and editors to cover Sexual Orientation and Gender Identity and Expression (SOGIE) related issues to enable the general public to get a better understanding of human sexuality and gender expression. Finally, the Diversity Forum will have a prominent role coordinating and uniting the voices of the LGBT+ community in Malawi and conducting joint advocacy for inclusive health care support.

In Uganda, HRAPF will continue to conduct outreach sessions with KPs to increase their awareness of human rights, laws and policies affecting them and encourage them to seek legal redress in case of violations, and they will provide legal aid services for LGBT+ persons and SWs who have been victims of human rights violations. They will train health workers on KP issues and human rights and conduct dialogues with other duty bearers and stakeholders, including state prosecutors on issues affecting access to HIV services for KPs. Finally, HRAPF shall also continue to train paralegals from LGBT+ and sex worker organisations. The trained

paralegals play a key role in educating communities on human rights, identifying and handling cases of violations.

In Malawi, AHM will form additional groups of Male Champions and train them in legal literacy. They will carry out refresher training of soldiers in leadership skills and knowledge on HIV/AIDS. They will train local police officers to handle cases of GBV, and they will carry out interface meetings with duty bearers in promoting the rights of SWs. Finally, AHM will introduce a new component, training SWs as paralegals in all three target districts to assist their peers in cases of human rights violations.

In Uganda, LMEC will assess the level of stigma and discrimination in health facilities in the targeted districts through a participatory approach. The results of the assessments will be used for advocacy purposes. LMEC will also train community peer leaders in correct data collection, reporting and documentation. As a pilot, LMEC will identify and train 15 Male Champions to help fight and address violations of sex workers.

Roles and Responsibilities Related to Objective 5

HRAPF in Uganda and AHM in Malawi will be the main responsible for implementing activities contributing to the programme objective 5 within the two countries.

AF is main responsible for promoting increased resilience and capacity within partner organisations

Objective 5: Increased resilience and capacity of KP organisations and allied CSOs.

AHM will reach 30 KP-led CSOs directly with training on leadership and governance skills and well as the democratic structures of organizations to strengthen their resilience and capacity.

Over the years, HRAPF has built capacity in NGO management. Many KP CSOs lack capacity build to maintain sustainable organisations, yet this is key to their organising and advocacy for access to services. HRAPF will conduct training of 65 organisations on NGO legal framework, corporate governance and financial management for NGOs. HRAPF shall also assist interested organisations to file annual returns as well as resolutions during the programme period.

AIDS-Fondet's Role and Added Value

While our highly professional and dedicated partners in Malawi and Uganda are responsible for the direct programme implementation on the ground, AF has the overall responsibility for managing the programme, building the capacity of partners, for monitoring progress and learning and for documenting and communicating results to CISU and the Danish public.

AF has strong capacity - technically, context knowledge, program and financial management. Staff is competent and dedicated with sound work routines and systems for partnership management in place. AF has a long track record in popular engagement and information work in Denmark.

CISU review 2021, p.22

AF's added value to the programme and partnership springs from lessons learned from our Danish experiences of contributing to the developing of a strong and independent civil society, and a continuous process driven by learning and reflection among a highly skilled staff, who strive to improve our interventions for the benefit of our partners and the most vulnerable communities. We also build on AF's extensive knowledge within sexual and mental health and rights and our experience in reaching most at risk target groups in Denmark. We see our role in development work as a catalyst and facilitator helping to build the capacity of partners, introduce partners to new networks, disseminate knowledge, facilitate sharing of learning and best practices between partners,

facilitate processes and new innovative approaches and rapidly respond to our partners' needs on the basis of professionalism. AF also adds value through our advocacy and popular engagement in Denmark, which enable us to put pressure on politicians to push our common agenda of equal rights to health. Through our global strategic partnerships and networks, we are able to raise local agendas and issues on an international and global stage and link partners to international stakeholders. For elaboration, see section 7.6. and 7.7.

AF's capacity building efforts are coordinated with partners based on identified needs. During the first phase, capacity building has focused on organisational development, networking, sharing of learnings and best practices, financial sustainability, HIV and sexual health trainings, developing innovative methods to mitigate COVID-19 challenges as well as M&E with a focus on knowledge management and measuring results on outcome level. In order to sustain a joint strategic focus and facilitate cross-country sharing of learnings, results and best practices within the programme, a Steering Committee has been established with key representatives from all partner organisations, who meet every 4 months.⁶ According to statements from our partners and CISU's review 2021, AF's catalyst strategy has resulted in increased capacity among our partners and facilitated a stronger civil society:

“Organizational capacity has been strengthened in the areas of human resource management (e.g. staff performance reviews and time registration), implementation and monitoring, donor diversification and governance structure. There were several examples of partner organizations stressing the successful leverage effect of the AF support in terms of enhanced visibility and credibility vis-à-vis other funders (CEDEP, AHM, LMEC). The overarching focus on learning, not only through structured training, but through interactive mentoring and coaching, through engagement of peers in exchange of experience and joint lessons drawing from discussion of progress reports at the Steering Group meetings were all highlighted by partners as important elements of South-South learning. This has resulted in stronger and more visible partner organizations” [CISU external programme review 2021, p. 13].

During the next programme phase, capacity building will continue to focus on interlinking our partners to national and international networks and stakeholders and increase financial sustainability in order to promote resilience and stronger civil society actors. This will contribute directly to the programme objective 5: *Increased resilience and capacity of KP organisations and allied CSOs*. In addition, we will also focus on:

- Mapping and increasing sustainability of all programme components and developing exit strategies
- Follow-up on M&E capacity building 2019-21
- Communication of results and interlinking partners and AF's media channels
- Strengthening advocacy and connecting local, national and international advocacy
- Capacity building, partner to partner, on evidence-based documentation, paralegals & advocacy
- Strategies and methods for economic empowerment of KPs
- Empower partners to be trainers on HIV and sexual health
- TechVeloPMENT, digital solutions and digital security

5. STRATEGIC FRAMEWORK, APPROACHES AND PROGRAMME RELEVANCE

Although HIV is a health problem relating to the structural barrier of unequal access to health, it is also a general development problem, underlining the programme's relevance within a larger development context. Thus, HIV/AIDS is both a cause and a consequence of poverty, creating a complex cycle that demands multi-sectoral emergency and long-term strategies. HIV/AIDS' impacts on human and institutional capacity are affecting economies, the labour force, formal and informal social safety nets, health systems, education, and food security from the national level right down to the household and individual level. Consequently, the

⁶ The Steering Committee meets twice a year online and once a year (if possible to meet physically) for a physical three days' workshop, which include a field visit to partner projects, beneficiaries and stakeholders.

epidemic is driven by a series of structural barriers such as poverty, marginalisation, (gender) inequality, lack of knowledge and education, discriminatory laws, lack of justice and weak institutions, cultural and religious norms, making the causes driving the HIV epidemic and the solutions to enhance prevention intersectional.

5.1. WHO AND UNAIDS GUIDELINES ON HIV PREVENTION FOR KEY POPULATIONS

The programme's focus on KPs and its approach to HIV prevention directly aligns with UNAIDS's global strategy 2021-26, and its inequality lens on how to close the gaps that are preventing progress towards ending AIDS, reflected in its three strategic priorities, which are to: (1) maximize equitable and equal access to comprehensive people-centered HIV services; (2) break down legal and societal barriers to achieving HIV outcomes; and (3) fully resource and sustain HIV responses and integrate them into systems for health, social protection and humanitarian settings.

The programme is also in alignment with WHO's *Guidelines on HIV prevention, diagnosis, treatment and care for Key populations*, which are consolidated by UNAIDS, and its recommendations on promoting condoms and condom-compatible lubricants, PrEP, PEP, community-based HIV testing and counselling for KPs linked to prevention, care and treatment services, access to antiretroviral therapy (ART), routine screening and management of mental health disorders (depression and psychosocial stress), screening, diagnosis and treatment of sexually transmitted infections and cervical cancer screening.^{xiv}

The programme also directly promotes all critical enablers for HIV Prevention for KPs identified by WHO in its guidelines:

1. Laws, policies and practices should be reviewed, engaging stakeholders from KPs to scale-up of health-care services for KPs.
2. Countries should enforce antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination, and violence against KPs.
3. Health services should be made available to KPs, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health
4. Programmes should enhance community empowerment among KPs.
5. Violence against KPs should be prevented, addressed, monitored and reported.

5.2. THE SUSTAINABLE DEVELOPMENT GOALS

As previously addressed, the programme honours the overall commitment guiding the SDGs to "leave no-one behind" by working directly for and with KPs, who are among Uganda and Malawi's most marginalised communities and the most severely affected by HIV and inequality. Through an intersectional approach to HIV prevention, the programme works towards several SDGs that are key for ending the HIV epidemic:

SDG 1: Ending poverty

SDG 3: Ensuring health and well-being

SDG 4: Ensuring inclusive and equitable quality education and life-long learning

SDG 5: Promoting gender equality and empowered women & girls

SDG 8: Promoting economic growth, employment, and decent work

SDG 10: Ending inequality

SDG 11: Making cities inclusive, safe, and resilient

SDG 16: Creating access to justice for all and building effective, accountable institutions

SDG 17: Creating partnerships for the goals

The programme contributes directly to the achievement of **SDG 3** on health and well-being, more specifically 3.3 - ending AIDS by 2030. **SDG 10** on reducing inequality cuts across the programme objectives and guides our interventions, as does **SDG 5** on gender equality and empowerment of women, including ending discrimination and violence against women and improving sexual health.

The intervention is also designed to pursue **SDG 16** on justice and accountable institutions, as the programme places empowered KPs at the centre increasing their ability to protect themselves against HIV and to know and claim their rights, but also by promoting an inclusive society with accountable and effective duty bearers and institutions that are responsive to all citizens' needs.

The programme educates KPs on HIV, sexual health, human rights, and paralegal training and educate SWs in IGA, skills, loans, and savings contributing to **SDG 1** on ending poverty, but also **SDG 8** of promoting economic growth, employment and decent work and **SDG 4** on ensuring inclusive and equitable quality education and life-long learning.

Finally, the programme at its core is designed to create a strong, independent, interconnected civil society contributing to **SDG 17** on creating partnerships for the goals. It builds on strong partnerships between programme partners, coupled with capacity development and building of networks, alliances and collaborations between NGOs, human rights organisations, governments, multilateral institutions as well as international funds and alliances to build up network, knowledge, influence, global connectedness, and a strong, vibrant civil society. For elaborations on the programme's contribution to the SDGs, see Annex 3.4.

5.3. CONTRIBUTION TO NATIONAL STRATEGIES

The programme not only contributes to multilateral strategies and goals, but also to national strategies within partner countries. It contributes to Malawi's 2017-2022 *Malawi Growth and Development Strategy III*, in which HIV/AIDS is a key priority, and Malawi's *National Strategic Plan for HIV/AIDS 2020-25*, which is committed to ensure that all necessary HIV and AIDS control measures are implemented so that Malawi reduces the impact of HIV and AIDS and eliminates HIV as a public health threat by 2030. The National Strategic Plan has eight thematic focus areas, of which the programme most directly contributes to number 5 on Reducing Human Rights and Gender-Related Barriers.⁷

The programme also contributes to Uganda's *National HIV AIDS strategic Plan 2020/21–2024/25*^{xlvi}, which commits to the SDGs with a goal to scale up targeted HIV prevention programmes for KPs, and to Uganda's *National Plan for Achieving Equity in Access to HIV, TB and Malaria Services in Uganda (2020-2024)*,^{xlvii} which is intended to contribute to achieving an HIV, TB and malaria free Uganda through improved health equity and increased respect for, protection and promotion of human rights and gender equality for all Ugandans, in all their diversity.

Finally, the programme is in line with Denmark's new political strategy for Development Cooperation, *The World We Share* and its focus on promoting democratic values, human rights, gender equality and strong and independent civil societies with a specific focus on assisting the most vulnerable groups and the rights of women and girls and promote global connectedness through a partnership approach.^{xlviii}

All mentioned national strategies acknowledge and contribute to the UN SDGs. Even though, national laws and norms in Uganda and Malawi criminalise and discriminate against KPs, it is evident that HIV can be used as a lever to promote human rights for KPs and inclusion in national policies and plans. This is a direct result of CSOs', including our programme partners', long-term advocacy efforts, which has secured that KPs increasingly are included in national working groups and policies related to HIV/AIDS.

⁷ The eight thematic focus areas are: i) Combination Prevention; (ii) Differentiated HIV Testing Services; (iii) Treatment, Care and Support for HIV/AIDS and Related Diseases; (iv) TB/HIV; (v) Vulnerable Children; (vi) Reducing Human Rights and Gender-Related Barriers; (vii) Social and Behaviour Change Communication; and (viii) Resilient and Sustainable Systems for Health.

5.4. HUMAN RIGHTS BASED APPROACH

The DNA of our programme and partnership is a human rights-based approach (HRBA). Accordingly, we take our point of departure in international human rights conventions, norms and instruments, which guide our development interventions, partnerships and political dialogue.

Based on the HRBA, we identify KPs – MSM, TG and SWs in Malawi and Uganda respectively - as rights-holders with entitlement to proper services and fulfilment of basic human rights such as non-discrimination and equal access to health and justice. We identify duty-bearers as politicians, officials, judiciary, police, public opinion makers and health service providers and their obligations to ensure that KPs are treated equally to other groups in society and have equal access to relevant health care and other services.

We direct our development interventions towards empowering KPs to know and claim their rights by enlightening KPs about HIV prevention, treatment, and universal human rights. We initiate dialogues with duty-bearers to raise their attention on how to meet their obligations to provide KPs with health and other services without discrimination.

The HRBA offers both ends and means to our development interventions in the sense that human rights standards define the desirable outcomes of our efforts and human rights principles ensure the legitimacy of the process, as elaborated on below. The human rights principles guiding our interventions are the PANT-principles: Participation, accountability, non-discrimination, and transparency.

The principle of **participation** within our programme translates into promoting approaches, systems and procedures that ensure that KPs can access relevant information and develop their capacity to be key actors in their own development e.g., by influencing government decisions and implementation of government strategies affecting them.

Accountability is about ensuring that relevant duty bearers are held accountable for their actions. For instance, that discrimination and harassment of KPs by police and health care providers are reported and followed up upon. Accountability is also about working to ensure that CSOs, working as intermediaries are accountable to KPs needs and that KPs are empowered with knowledge about HIV and human rights as well as with information about opportunities to obtain their rights.

Non-discrimination is at the core of our programme. As addressed, MSM, TG and SWs continue to see much higher HIV prevalence rates than the general population, due to several ingrained structural barriers hampering HIV prevention and hindering KPs from exercising their right to health. Combatting discrimination requires a strong and independent civil society with the ability to fight for – and give voice to – the most discriminated groups, in this case KPs. The programme partners are either formed by KPs themselves (CEDEP, LMEC) or representing KPs (AHM, HRAPF) with the purpose of empowering SWs, MSM and TG in Uganda and Malawi to fight for non-discrimination, recognition of rights and access to relevant health care and justice.

Transparency is about ensuring the legitimacy of the processes and interventions – providing legitimate frameworks of entitlements and obligations to address development needs, harassment, and violence. For AF and our partners, it is also about being transparent about practices, approaches, and interventions and by making adequate use of relevant human rights conventions and instruments, cf. Annex 3.6.

6. NEXUS, RISK MANAGEMENT AND SUSTAINABILITY

The review found that AF and partners have reacted promptly and with flexibility and secured momentum during the COVID-19 situation. Thinking on strategic coping mechanisms for working in a COVID-19 environment in the next program phase has already begun and has been addressed upfront by AF”

CISU review 2021, p.22

AF characterizes ‘risk’ as ‘the effect of uncertainty on the programme objectives’. Potential risks come and go, or evolve, as the programme’s internal dynamics change, and as the external environment in which it operates changes. Fragile states like Uganda and Malawi^{xlix} by their very nature involve a high degree of uncertainty. When these uncertainties are added to those already present in stable contexts, it is especially important to have an effective risk management strategy in place.

6.1. NEXUS – OPERATING IN FRAGILE CONTEXTS

The programme works within fragile contexts, with Uganda scoring higher on the fragile state index (95.3 points out of 120) compared to Malawi (83.3 points out of 120).^l Thus, out of 179 states, Uganda ranks 24 on the index and Malawi 46. As mentioned, COVID-19 and Presidential and Parliamentary elections have added fuel to already fragile contexts for our partners and beneficiaries.

Working in fragile countries requires that implementing partners have a high level of capacity with expertise knowledge on the fragile context they operate in and are able to act with due diligence, quickly and innovative and adjust plans when changes occur to mitigate risks and take advantage of new opportunities.

AF and partners in Malawi and Uganda have extensive experience working in fragile contexts, representing the most vulnerable and marginalised citizens using a HRBA. Our ability to assess and mitigate risks and take advantage of new opportunities is at the core of our programme approach. This is evidenced most recently during the COVID-19 pandemic, where all partners with the support of AF successfully managed to rethink and adjust implementation plans to mitigate negative effects of COVID-19 on our programme.

During the coming phase, the programme will more actively work within a nexus approach for context analysis and interlink humanitarian, development, and reconciliation approaches to strengthen the sustainable development of local civil societies and protect and secure human rights for the most vulnerable within fragile contexts. Weight will be on the development axis focusing on empowerment and securing human rights, and the reconciliation axis, reconciling beneficiaries and key stakeholders. This said, COVID-19 has also increased the need for introducing humanitarian, need-based, emergency components in the programme to reduce increased vulnerability among our beneficiaries, when they are suddenly confronted with new life-threatening unmet needs during crisis and pandemics. Please refer to Annex 3.7 for an elaboration of how the programme will address the nexus fragility dimensions.

6.2. RISK MANAGEMENT

AF’s and partners’ risk management aims firstly at anticipating risks. Then it aims at preventing them from happening or at minimizing their impact if they do happen. Since responding to risk is intended to help us achieve our objectives, risk management is integral to all aspects of our programme management including strategic planning, decision-making, operational planning and resource allocation. AF’s risk management system encompasses three key elements: risk management principles, a risk management framework, and a risk management process. Please refer to Annex 7.4. for an elaborated strategy for risk management.

The programme framework for managing risks is structured around our Risk Management Matrix, please refer to Annex 7.5. The Risk Management Matrix is designed to enable the best possible evaluation and

treatment of the identified risks. The risk matrix has been developed in close collaboration with programme partners and is a living document and tool that will be used actively throughout the implementation of the programme. The programme risk management process is the whole set of activities we carry out to identify, assess, manage and monitor any risks to which the programme may be exposed. This includes context analysis; identification of all the risks the programme may be exposed to or that our activity may pose to others; an analysis of the identified risks, establishing the level of probability and impact for each risk; an evaluation of possible mitigation measures, should the risk occur; and finally, continuous monitoring and review of the risk management matrix. Identified risks during the coming programme period mainly relates to fragile states and civic space restrictions, which increase pressure on our partners and beneficiaries.

6.3. SUSTAINABILITY

According to CISU's definition, sustainable development means that changes set in motion must secure a good life for all, including for succeeding generations.ⁱⁱ The axis of sustainability cross between social justice on one hand and responsibility towards nature and the planet on the other.ⁱⁱⁱ When it comes to the direct purpose of our programme, the sustainability focus is on social justice and addressing inequality. This said, the marginalised and poor are often the ones, who are affected first by the effects of climate change and loss of biodiversity, and poor people can be forced to make decisions, which harm biodiversity and the environment. By empowering the poorest and most marginalised, the programme also supports the axis of responsible climate & environmental conduct indirectly.

The programme operates with a diversified approach to sustainability. This includes organisational and financial sustainability supported by fundraising initiatives and capacity building of partners, a volunteer and peer-to-peer approach where KP peer educators are trained on HIV prevention and human rights and a focus on economic empowerment of our beneficiaries. Also, the programme builds on existing structures, collaborations, and mechanisms, which support the sustainability of activities and results.

When interventions are planned to be phased out, we develop exit strategies in close collaboration with the relevant partner. Together with CEDEP, we have e.g. developed exit strategies, so that the support groups and peer educators, who will not be part of the programme phase 2022-2025, will continue under CEDEP's health department after 2021. Data from CEDEP's support groups will still inform advocacy initiatives under the programme.

The sustainability of the programme approach is highlighted in the 2021 CISU external review of the programme (p. 20): *"The review found that AF and partners have a diversified perception of sustainability, which include organizational and financial sustainability supported in terms of fundraising initiatives, and individual sustainability among KPs engaged with the program in terms of skills, knowledge on rights and (future) focus on economic empowerment"*.

The review found that AF has in-depth contextual understanding and strong analytical capacity built on long standing experience and technical capacity within the key areas of operation. This - combined with a close collaboration with partner organizations - provide a solid background for operating in changing political contexts"

CISU review 2021, p.5

The programme considers its climate and environmental impact when it comes to e.g., international flights and physical partner meetings. During COVID-19, monitoring visits and capacity trainings of partners have been conducted online, which has reduced climate impact. The learnings from - and increased capacity within - online trainings and remote monitoring will be carried over to the next phase. However, when travel restrictions are lifted, on site monitoring and regular physical partner meetings will be reintroduced, since it is assessed that the positive gains in joining forces to

promote social justice and strong civil societies outweighs the negative climate impacts of travels and physical meetings.

7. PARTNERSHIP CAPACITY AND PROGRAMME MANAGEMENT STRUCTURE

The principle of “**Nothing about us without us**” guides AF’s partnership approach. In our experience, sustainable development is best achieved when the target groups themselves are empowered to drive change and join forces with local movements, human rights organisations and institutions and form local, national, regional and international alliances with joint advocacy, sharing of knowledge, and a readiness to take joint action.

The coming programme phase engages the existing programme partners, which directly reflects our “nothing about us without us” approach to local partnership engagements. During the programme phase from 2019 to 2021, we have built a strong partnership, where the partners complement each other and taken together, represent rights holders and beneficiaries, as well as strong human rights advocates. They possess the required technical and administrative capacity, have a broad network of collaborative local and national partners and have the capacity to disseminate experiences and learning within the partnership and conduct effective political advocacy at local, national and international level.

By working with the same partners for a number of years, we have gained a deep understanding of each other’s strengths and weaknesses as organisations, and we utilize this knowledge to support and complement each other in the best possible way, fostering stronger and more valuable and efficient relationships and better results. By working in both Malawi and Uganda for years, we have gained an in-depth knowledge about the socio-economic realities on ground, enabling us to better play the role as catalysts. This means that we are able to engage in more meaningful and relevant dialogues within the partnership, ultimately achieving better results for our beneficiaries.

The programme directly aligns with partners’ missions and priorities as well as with AF’s overarching strategy and vision of a world without HIV and AIDS where PLHIV are able to live worthy and healthy lives free of stigma and discrimination, receiving the best HIV treatment available.

7.2. LADY MERMAID EMPOWERMENT CENTER (LMEC)

LMEC Empowerment Centre was founded in 2002 as the first Sex Worker-led organisation in East Africa. Their mission is to create a strong voice for SWs, to bring to light the harassment and abuse faced by SWs, and to educate and empower them. By challenging inequalities, LMEC tackles the conditions that allow ongoing violations of SWs’ rights. The organisation advocates for universal access to health services, engages local leaders and police in addressing violence, opposes human rights abuses, and challenges stigma and discrimination against SWs. LMEC uses different approaches to reach SWs with information on safe sex, condom use and the advantage of being tested for HIV and STIs. Some of these approaches are peer education, community outreaches at SW hotspots, as well as the establishment of support groups for the SWs. LMEC collaborates with health service providers, with the government health units and other CSOs and community-based organisations. In 2019, LMEC opened the first SWs’ health clinic and drop-in-centre in Uganda. LMEC has challenged discriminatory laws such as the Anti-Pornography Act and the HIV Prevention and Control Act through a combination of public demonstrations, court actions and petitions. The organisation contributes to the advancement of SWs’ civic rights through advocacy, operating the first SW-led blog, the [Neeko’s Diary](#) and the SW-led magazine, The Neeko.

LMEC is also involved in various research and documentation projects about SWs with the aim of informing and influencing e.g. health policy makers. LMEC is a member of several key national and international networks, among others, the Uganda Network of Sex Worker serving organisations (UNESO), the Uganda Key Population Consortium (UKPC), the Uganda Network of AIDS Serving Organisations (UNASO) and the African

Sex Worker Alliance (ASWA) and the Global Network of Sex Worker Projects (NSWP). Furthermore, LMEC represents SWs in different advocacy and capacity development forums, such as the Global Fund Country Coordinating Mechanism of Uganda.

7.3. HUMAN RIGHTS AWARENESS AND PROMOTION FORUM (HRAPF)

HRAPF is a human rights organisation. Although not KP-led, **HRAPF** operates through grassroots organisations founded and led by LGBT+ persons and SWs throughout the country. HRAPF's mission is 'to promote respect and protection of human rights of marginalised persons and KPs through enhanced access to justice, research and advocacy, legal and human rights awareness, capacity enhancement and strategic partnerships.

HRAPF established the very first legal aid clinic providing legal aid services to KPs in Uganda in 2010. Since then, they have established several regional legal aid centres to effectively reach KPs throughout Uganda. Over the past 12 years, HRAPF has filed and supported 12 strategic litigation cases on rights of LGBT+ persons, including the case that led to the annulment of the Anti-Homosexuality Act of 2014. HRAPF is responsible for the training of more than 150 paralegals from different KP groups to work as first level references in their respective communities in providing legal aid services and has supported over 75 community KP groups to register and operate as organisations.

With a team of over 15 lawyers and paralegals as part of its staff, HRAPF conducts awareness sessions and dialogues on human rights for KPs, develops and implements advocacy campaigns to promote their rights at national, regional and international levels and documents human rights violations. HRAPF works with several government ministries, departments and agencies, including the Ministry of Health, the Ministry of Internal Affairs, the Uganda Human Rights Commission, the Uganda Police Force and the Equal Opportunities Commission to create synergies for the promotion of rights of marginalised persons and KPs. HRAPF's legal and policy advocacy is linked to regional and international levels through advocacy at the African Commission on Human and Peoples' Rights (ACHPR) where HRAPF has observer status, the UN Human Rights Council and through promoting the achievement of the UN SDG 3 on good health and wellbeing, Goal 10 on reducing inequalities and Goal 16 on access to justice for all. HRAPF has also applied for consultative status with the Economic and Cultural Council of the UN.

All partner organizations have stressed their satisfaction with the open and transparent collaboration with AF, reflecting a genuine partnership and commitment to learning: "AF is not just a donor, they also help us learn and grow", as expressed by LMEC in Uganda"

CISU review 2021, p. 9

7.4. ACTION HOPE MALAWI (AHM)

AHM implements projects within HIV prevention, access to health services and education for KPs. The organisation has four strategic priorities, which are youth development, HIV/AIDS, women and gender and human rights and justice. The organisation was founded as a community-based organisation in the Zomba district by local community members - some of whom were living with HIV - in response to the massive health education problems in the district. AHM works through a grassroots-based approach with interventions improving access to health care for SWs. AHM has strengthened the capacity of the SWs themselves as well as Male Champions to take centre stage in reducing GBV, human rights violations and improve access to health care services for the SWs.

AHM has prior experience with the implementation of IGAs and holds extensive experience working with underaged women and girls,

through a former project implemented together with Save the Children International.

Besides having SWs in the Board, AHM is not led by SWs. However, AHM staff has worked with approximately 6,500 SWs in the organisation's target districts. These SWs are directly involved in AHM'S interventions and are visited on a regular basis. AHM works closely together with public HIV/AIDS units and health service

Male Champions – James comes to the rescue as client turns violent (June 2021)

James was jerked away from his Bao board game when sex workers came running to the bar alerting the group of men that a fellow sex worker, Aida, was being attacked in one of the rooms around the back. The men quickly ran to the room, and found Aida tied to the bed, badly beaten, bleeding from injuries gained trying to fight off the client who had attacked her. Her arm was broken. James and his friends subdued the violent client and took him to the police station. Aida was helped by her friends and could attend to her injuries.

James Piyasi is a 'Male Champion' leader – and the group of men who helped Aida are all so-called 'Male Champions'. Male champions are men who have their daily routine in or around the hotspots where sex workers also ply their trade. James and his friends were all identified as potential sex worker allies by AHM and after agreeing to help protect and support sex workers, they have received training on legal as well as rights issues to help them assist the sex workers.

The Male Champions tracked and documented the case of the violent client up to the point where they were satisfied that justice was served. The perpetrator was convicted and sentenced to serve six years in prison with hard labour.

providers at district level and is an active member of several networks including the Malawi National Sex Workers Alliance, the Global Network of Sex Work Projects, the Malawi Network of AIDS Service Organisation, and the National Association of People Living with HIV/AIDS.

7.5. CENTRE FOR THE DEVELOPMENT OF PEOPLE (CEDEP)

CEDEP is a LGBT-led human rights organisation that operates in 15 out of the 28 districts in Malawi through their head office in Lilongwe and eight local offices in Mangochi, Mzuzu, Chikwawa, Mwanza, Mzimba and Blantyre districts. The organisation's core functions are to address the needs and challenges of minority groups, primarily LGBT+ persons, through advocacy and lobbying; capacity building, networking, and research; and provide support services for the improvement of the welfare of minority groups in accordance with their rights and needs. With employees throughout Malawi and more than 560 volunteer LGBT+ peer educators, CEDEP plays a crucial role in giving a voice to LGBT+ minority groups and securing them an equal access to health.

CEDEP has strong skills within political advocacy. During the programme phase from 2019-2021, CEDEP facilitated the establishment of the Diversity Forum, which is a consortium comprised of the CSOs making up the LGBT+ sector in Malawi. The Forum was established to ensure that all CSOs working for and by LGBT+ communities in Malawi are speaking with one voice, co-ordinating and networking as well as setting unified agendas nationally. Since its establishment, the Diversity Forum has not only gained visibility on LGBT+ matters alone, but also on HIV related issues. As such the Diversity Forum is member of the Civil Society Advocacy Forum— a loose network of CSOs working on HIV and other related issues in Malawi. It has also been embraced by the Malawi Network of AIDS Service Organisations (MANASO) as the voice and face of LGBT+ issues in Malawi. The Forum has also been fully recognised by government agencies like Department of HIV and AIDS and National AIDS Commission (NAC).

7.6. AIDS-FONDET'S CAPACITY

AF is born out of the activism that surrounded HIV and AIDS in the 1980's. The culture of activism and grassroots movement is still a core value in all aspects of our work. From the 1980's where the HIV epidemic struck

Denmark and up until today, AF has fought to end the HIV epidemic with a special focus on the most vulnerable and marginalised groups – in Denmark as well as abroad.

AF is a foundation with a board of directors who are democratically elected for two years at a time. Various members of the Board possess expert knowledge on HIV and treatment, including Board Chairperson Gitte Kronborg, who is chief physician and an expert within medical treatment of HIV. AF has approximately 35 full-time professional staff who possess a broad combination of competence within HIV/AIDS, stigma, sexuality, sexual orientation and gender identity, counselling, and therapy. Further, AF's international team in particular possess expertise within human rights, IGAs, research, campaigning, fundraising, communication, and advocacy as well as strategic planning, project management and financial management.

The organization is comprised of three departments: A political-economic secretariat, a national department and an international department. In **Denmark**, we offer testing of HIV and other STIs and counselling services, as well as distribution of PrEP. Further, we develop campaigns and events focusing on fighting stigma and discrimination of PLHIV. **Internationally**, AF's work rests on two legs. **(1)** We are engaged in partnership-based programmes and projects, where we work directly with the groups most at risk of acquiring HIV. **(2)** We engage in dialogue with policy makers, foundations, private sector, civil society, human rights institutions, media and the general public etc. to ensure a professionally solid and ambitious response to HIV.

AF's management is composed of a CEO, who reports to the Board and a Head of each of the three departments. This set-up makes for relatively horizontal and dynamic management with a high degree of flexibility in planning, implementation and monitoring. This enables prompt adjustment, timely learning and synergy between results in different areas. Please refer to Annex 7.7. for organisational chart.

AF's experience of working with local partner organisations in the Global South - led by or working for and with - KPs, especially SWs and MSM, spans back to 2008. We have collaborated with partners in Malawi since 2008 and partners in Uganda since 2012, and we have developed thorough insight into the political, socio-economic and cultural contexts in the two countries. AF has experience in implementing HIV prevention and human rights projects directed at highly stigmatized and marginalised groups in Malawi, Kenya, Uganda, Zambia, Ethiopia, Ukraine and Nepal. Through these partnerships, we have gained a deep understanding of issues related to KPs and HIV in various political and socio-economic contexts. AF also works closely with ethnic minorities in Denmark applying insights and learnings from our international work and vice versa.

"AF has strong capacity - technically, context knowledge, program and financial management. Staff is competent and dedicated with sound work routines and systems for partnership management in place. AF has a long track record in popular engagement and information work in Denmark".

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In our advocacy interventions, we speak up for the inclusion of those still left behind in HIV prevention and treatment. We cooperate closely with various global partnerships, including The International Partnership for Microbicides (IPM), The International AIDS Vaccine Initiative (IAVI), and The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in order to improve availability of the most effective treatment and prevention methods and ensure ambitious Danish and Nordic response to HIV through ODA. AF is a strong advocate in national, international and multilateral forums. We participate in national, regional and global civil society networks such as The Global Fund Advocacy Network (GFAN), International AIDS Society, International Association of Providers of AIDS Care, The Nordic Network for GFATM (facilitated by AF), The Danish civil society network on global health (facilitated by AF), The Danish civil society network on the SDGs, Global Focus' working groups on human rights and civic space, on Health, on advocacy towards the UNHRC, the Danish

LGBT+ network for Danish CSOs working with LGBT+ groups in the Global South and a Danish CSO Gender network.

On various occasions, AF's capacity has been assessed by external parties. The latest of these were the CISU-commissioned CapApp in 2018 and the Review in February-April 2021.

The review found that the financial management of the HIV Prevention project is handled professionally by AF, as confirmed by the CISU supervision in February 2021. Budgets are detailed and according to the prescribed formats, which do not give reason to further comments. Partners found the AF financial management easy to operate and AF's response flexible and agile.

CISU review 2021, p. 18

In the 2018 CapApp, the consultant gave AF the highest score of 5 and concluded, "*AIDS-Fondet demonstrates effective and comprehensive organisation capacity, including human resources, to enhance development effectiveness of the organisation by maintaining satisfactory professional competency and technical capacity. AIDS-Fondet shows a record of involving relevant groups and stakeholders in the Danish society to broaden and sustain popular engagement with development cooperation*".

This positive assessment was supported by CISU's 2021 review (p. 9), which found that: "*...the AF organizational structure is strong and agile to under-*

take the implementation of the HIV Prevention program. Well-qualified staff is in place and management systems are professional and subject to constant strengthening".

AF's track record and the numerous status reports submitted to CISU and other donors as well as external assessments, reviews and evaluations express a positive view of AF's and partners' ability to reach set targets and deliver results on the ground.

During the first programme phase, AF made a comprehensive job of streamlining our processes to ensure a focus on results and learning, create clear and transparent documentation and ensure that we are a relevant, reliable and professional partner. All procedures and formats are compiled in a comprehensive set of Management Guidelines. We have introduced new reporting formats and have established a solid structure around the reporting process, which has been communicated and discussed with the partners. We have prepared new budget follow-up formats and procedures. The aim has been to simplify the formats and strengthen control and transparency and a focus on delivering and documenting results and learning. Financial reports from partners are reviewed and controlled by both the Programme Officer and Head of Programme/Head of Department before they are approved by the CFO and transfers to partners are made by the Senior Administrator. The various changes have professionalized our procedures and given us better overview and control. The formats and processes are continuously adjusted and optimized, not least based on feedback from the partners, who are all very positive about the new structures. Please see Annex 5.3. Management Guidelines.

During 2020, we have focused on strengthening M&E systems and tools across the programme. We have developed a joint data-reporting framework and has strengthened the documentation of results at outcome level to ensure documentation of progress, learning and alignment between partners. Both AF and our local partners have guidelines and procedures in place for anti-corruption, safety and security for staff, volunteers, procurement and financial management. Active measures to implement policies within Preventing Sexual Exploitation Abuse and Harassment (PSHEA) with the programme partners, including capacity building and introduction of protection mechanisms, will be developed.

7.7. AIDS-FONDET'S POPULAR ENGAGEMENT AND DEVELOPMENT EDUCATION

The aim of AF's programme specific popular engagement activities is to target the Danish public, policy makers, academia, students, youth organisations, civil society, etc. with relevant and *engaging* communication on the international AIDS and human rights agenda exemplified through our programme interventions, achievements and challenges experienced on ground.

We aim to continue linking our overall communication, and especially communication around structural inequality, to our partners and beneficiaries. However, we want to further improve our capacity to identify and respectfully carve stories based on the lives of our beneficiaries and the political and social reality they operate in, anchoring global advocacy to local experience. For visual representation, we aim to build a cohort of local photographers to ensure visual communication seen through a local lens. This can challenge an ethnocentric view of the world, a western bias, and ensure a greater variety and steadier stream of photos available for communication. Handing over control of the narrative to those living it.

We will also continue using photo journals to better capture the lived realities on ground, and we will apply these approaches to more engaging communication in our various activities focused on raising *awareness*, foster *mobilization* and build *alliances* with the aim of nurturing existing "followers" and not least engaging new target groups.

Awareness raising: Besides development education targeting the Danish public at large through a wide range of events, public media debates, campaigns, an informative website, and active social media presence, AF will continue to raise awareness and educate both the Danish public and policy makers on progress and challenges experienced on ground in the Global South by sharing stories from our partners and beneficiaries, report human rights violations directly to Danish policy makers as part of our joint advocacy efforts, and when possible, invite our partners and beneficiaries to speak directly with policy makers and the Danish public at events, meetings, and seminars.

Mobilisation: The number of followers on our social media channels is steadily increasing. AF currently has 15.864 followers on Facebook, 1746 followers on Instagram, 1188 followers on Twitter and 1288 followers on LinkedIn. Our quarterly newsletter was sent to 2073 subscribers in 2020. A survey conducted among AF's existing followers in 2021 showed that more than 60 % are interested in engaging in the global fight against HIV/AIDS. This is a solid foundation for implementing a new and ambitious engagement strategy. In the coming programme period, we will develop new ways of working with our partners in order to bring compelling stories respectfully capturing the lives, dilemmas and the successes of the people whose lives we work to impact and change for the better. To reach this end, we will develop a newsletter focusing on our international work and the global fight against HIV/AIDS in the spirit of "Nothing about is without us".

Alliance building: AF wants to re-think our approach to voluntary engagement. Instead of only engaging volunteers inhouse, we want to explore a more partner-based approach to voluntarism. Through increased collaboration with volunteer-based grassroots and youth organisations in Denmark, we aim to reach new audiences and build new alliances. In the first phase of the period, we will focus on raising awareness and building trust and relations through collaborating on events with our Malawian and Ugandan partners as the experts. The second phase will take advantage of the relations built with Danish youth organisation and co-develop engaging campaigns with AFs' Southern partners, allowing people to act and interact with our southern partners and beneficiaries. This strategy is ambitious and requires more funds in order to succeed. A strategy for this is being developed.

AF is currently present in the four major cities in Denmark and have embarked upon developing community ambassador programmes connected to all Checkpoint clinics, building up capacity among voluntarily engaged

ambassadors within HIV and mental wellbeing, including capacity on fighting stigma and discrimination. The community ambassadors are all part of our Danish target groups, including MSM, TG, ethnic minorities, PLHIV and youth in general. AF aims to involve the community ambassadors in development education, linking them to our partners and beneficiaries in Uganda and Malawi with the aim of building new alliances and reaching new target groups in Denmark. Additionally, AF is partnering with a range of established influencers to assist us in improving our outreach and engaging with a larger audience, especially youth.

AF also joins forces with international allies when it comes to popular engagement. For instance, AF is currently working on a campaign in collaboration with the Global Fund, highlighting the necessary steps to reach the last mile in the global AIDS response, targeting both the Danish and Nordic public and policy makers.

8. PROGRAMME M&E SYSTEM

8.1. RESULTS FRAMEWORK

AF and partners have evaluated and adjusted the existing comprehensive results framework to align it with the ToC and objectives for 2022-25. The ambition is to measure results at impact, outcome and output levels across countries and partners. The framework was developed through a participatory approach including both management and implementing staff from all local partners. We held two online workshops in connection with Steering Committee meetings, the first one in March 2021, where we discussed the new programme ToC and defined the envisioned change and identified focus areas. The second workshop was held in June 2021, where we qualified the ToC and worked intensely with the comprehensive results framework. All participants engaged on equal grounds and contributed with their knowledge and experience within their field of expertise.

The results framework is divided into four programme objectives at outcome level and a fifth process objective, measuring capacity development among local partners and the synergies achieved through cross-country and cross-partner interventions and through international connectedness. The process objective of increased resilience and capacity of KP organizations is at the heart of our ToC with the aim of contributing to improved impact of our efforts and to form part of a resilient, dedicated and diverse civil society. Please find the summarized results framework in Annex 4.1.

8.2. SUMMARY OF KEY OUTCOMES

Key outcomes from our results framework are summarised below, cf. the Summary Results Framework and related key assumptions in Annex 4.1. See also Chapter 4 for elaborations on main assumptions and Annex 7.4. and 7.5. on related risk mitigation.

Development objective/ Impact: *Reduced HIV incidences and increased well-being among KPs in Malawi and Uganda*

1. Improved sexual health of KPs with a specific focus on their ability to protect themselves against HIV and AIDS

- Outcome 1.1: Increased safe sex behaviour among KPs (incl. HIV test, STI test, condom use, PrEP)
- Outcome 1.2: Increased adherence among KPs
- Outcome 1.3: Improved mental health among KPs

2. Improved resilience and ability among KPs to take care of their immediate social and economic needs

- Outcome 2.1: Implementation of financial and business management skills among sex workers and the caregivers of underaged sex workers
- Outcome 2.2: Strengthened social support system among sex workers
- Outcome 2.3: Reduced number of underage girls in sex work

3. Improved access to stigma-free health services for KPs

- Outcome 3.1: Reduced avoidance of health care
- Outcome 3.2: Reduced experienced discrimination in health care

4. Improved inclusion, respect and observance of rights of KPs

- Outcome 4.1: Advocacy recommendations on the respect of human rights of KPs are addressed by relevant authorities and media
- Outcome 4.2: Increased access to justice for KPs in cases of discrimination and violations
- Outcome 4.3: KPs increasingly report cases when they experience violations and discrimination

5. Increased resilience and capacity of KP organisations and allied CSOs

- Outcome 5.1: Increased implementing capacity of programme partners
- Outcome 5.2: Increased financial sustainability of programme partners
- Outcome 5.3: Increased interlinking to relevant national, regional and global networks and stakeholders of programme partners
- Outcome 5.4: Increased accountability by KP organisations

8.3. MONITORING, EVALUATION AND LEARNING

AF's M&E system has the dual purpose of demonstrating progress and results through monitoring and improving efforts through evaluation and learning. AF considers knowledge management and organisational learning crucial to achieve the best possible impact, and it takes place continuously at several levels and between various stakeholders, including internally within our department, between departments and not least through exchanges with partners and external stakeholders. To improve knowledge management, we have developed a learning database where we register all positive and negative learning through our monitoring, reviews and evaluations to inform our interventions and guide adjustments.

Monitoring Tools – Quantitative and Qualitative Indicators

AF uses two overall approaches to programme monitoring:

- Monitoring of quantitative indicators, assessing outcome and output indicators
- Monitoring of qualitative indicators based on techniques such as Most Significant Change and Outcome Harvesting

The quantitative indicators have been identified and developed in close collaboration with local partners and target groups to ensure local ownership and data quality. When possible, we use official indicators validated and recommended by UNAIDS^{liii} and WHO. Using official indicators makes it easier to align monitoring systems and tools between countries and partners, to share our data and put it to use in our advocacy work. Since governments use these indicators in their national monitoring and reporting we can more easily compare our results with the official data and either support official reporting, demonstrate a more efficient strategy, or question the official numbers by producing valid shadow reports.

Indicators are developed at outcome level whenever possible to measure the specific change we want to achieve. For example, we do not measure the numbers of condoms distributed but whether our target groups actually use them. Further, we measure and consider e.g., increased safe sex behaviour, increased

The review found a strong focus on learning characterizing the entire modus operandi of AF in the HIV Prevention program. This is applied in horizontal exchange of experience, vertical compilation of lessons learned, frequent fora for peer reflection, and a systematic registration of lessons learned for institutional memory,

CISU review, p.7

HIV testing and increased adherence to medication among KPs as key outcomes, because they lead directly to reduced HIV incidence. However, the comprehensive results framework also measures direct outputs as it allows us to actively monitor our assumptions. For example, we can use output indicators to assess our assumptions - e.g., that increased HIV knowledge leads to increased safe sex behaviour, cf. Annex 4.1.

Qualitative indicators are used to capture issues, achievements, challenges, correlations and learnings which are not easily captured with the use of quantitative data, and we also use qualitative data to validate and inform our analysis and assessment of quantitative data. We make use of systematic and participatory techniques such as Most Significant Change, which we put to use throughout the programme cycle, including as part of evaluations.

The programme targets and indicators are based on the established monitoring systems as well as the organisational, technical and financial capacity of the local partners. Gaps in monitoring capacity have been identified during the 2019-21 programme phase, and steps to fill these gaps have been taken through M&E trainings and capacity building. As the programme is operating in a sensitive field, working with KPs, issues of security, anonymity and privacy has been and will continuously be considered when monitoring the programme.

Programme Monitoring and Evaluation Matrix

A comprehensive M&E Matrix based on individual partner matrices will be developed, clarifying *what* will be monitored, *by whom*, *where* data is documented, *when*, *how and how often* data is collected, *how* data is stored for analysis, and *how* the data collected will be used. It also defines means of verification. An important feature of the M&E Matrix is that it states how often data should be reviewed and by whom. This ensures that data is not just collected but also evaluated, disseminated and used for learning and innovation. The M&E matrices are flexible and adjustable to contextual changes and new insights. Please see Annex 4.2. Programme M&E Plan.

Monitoring, Quality control and Evaluation

AF conducts annual monitoring visits, including interviews with beneficiaries, peer educators, programme staff, local authorities and other external stakeholders as well as financial and administrative check of data quality. Further, AF monitors progress on the basis of narrative and financial reporting from partners every four months, which are followed up with written feedback based on checklists and online meetings, where we discuss feedback, programme progress, risk assessment, changes in context and learning. Besides the narrative reports, all partner organizations fill in a **data reporting tool**, which merges all programme data to give AF and partners a clear overview of progress on each indicator and facilitate comparison and learning between partners. We also monitor progress at Steering Committee Meetings every four months, where the Programme Board, consisting of the Executive Directors, program coordinators, and when relevant, an M&E officer from each organization, as well as representatives from AF meet to review the programme and to share experiences, lessons learned, and future strategies. The Steering Committee Meetings are facilitated so that they focus on learning.

“**Organizational learning** is the pivot of the interactive and dialogue-based collaboration between AF and partner organizations. All progress reports from periodic activity reports and annual reports from partners to AF’s Status reports to CISU have learning as an inbuilt element in the format, which encourages reflection and allows for compilation of learning across the program. The strong focus on learning is also reflected e.g. in the support and feedback from AF on partners’ periodic and annual progress and financial reports, which is highly appreciated by partners”

CISU review, 2021 p. 6

Additionally, we have developed a **learning database** for knowledge management, where we register all positive and negative lessons learned through our monitoring, reviews and evaluations to inform our interventions and guide adjustments. This enables us to build on lessons learned not only from the programme but across our project- and programme portfolio.

Evaluation takes part throughout the programme cycle. The key functions of evaluation are to continuously improve our efforts, document results, be accountable to target groups, local communities, donors, relevant stakeholders and the general public; and to enhance organisational learning. In addition to our continuous efforts, we also have specific procedures for systematic review and quality control of data, filing, and of intervention pathways and impact, including by the following measures:

- **Partner organisations conduct continuous quality control** with the peer educators, generally through monthly meetings. They provide input and advice and ensure that data collection is conducted properly and that all learning is documented and applied.
- **Consultation meetings** with community representatives, local authorities and target groups. AF has annual consultations with beneficiaries, local community representatives and other stakeholders to ensure that the interventions are in line with programme intentions and aligned with local needs in order to strengthen legitimacy and local ownership.
- **Continuous collection and review of Most Significant Change** stories contributes to evaluation because it provides data on impact and outcomes that can be used to help assess the performance of the programme as a whole.
- **A mid-term review** will be conducted with an in-depth analysis of programme progress using an external consultant.
- **A final programme evaluation** will be conducted as part of CISU's final programme review to document results and learning.

Please also refer to Annex 4.2. Programme M&E Plan and Annex 4.7. AF's Principles and Guidelines on M&E.

9. BUDGET, STRATEGIC FINANCING AND COST EFFECTIVENESS

During the first programme phase, a slightly higher percentage of funds were strategically allocated to the Malawi partners. The reasoning was that AF had existing project partnerships with AHM and CEDEP and already knew the partners. Programme funds were used to amplify the results and learning from existing projects and through the programme, operations were expanded to new districts.

During the next programme phase more funding will be allocated to the Ugandan partners, who have delivered impressive results during 2019-21. HIV prevention, KP rights, Civic space and Civil society is currently under more stress in Uganda than Malawi. Both HRAPF and LMEC has shown a remarkable ability to counter the negative changes and create positive development changes for our beneficiaries, even under these harsh conditions. On top of this, LMEC through hard work and support from the programme has strengthened its financial and administrative capacity and procedures significantly and has increased its donor base.

Working in fragile contexts with KP-led CSOs vulnerable to government restrictions and harassment, targeting Malawi and Uganda's most vulnerable and marginalised populations requires a high level of expertise, an ability to act agile and innovative and a willingness to take risks. It also is time-consuming and requires manpower and investment of resources into capacity building, support and coordination.

AF place great efforts in detailed time registering. We register time allocated to tasks on any given project or programme, not only to live up to donor requirements, but as a means to facilitate cost efficiency, organisational learning, realistic budgeting and sharing of best-practices, work procedures and processes between colleagues. During the first programme phase time allocated to programme monitoring, technical support, capacity building and partner visits in the budget was highly underestimated compared to number of hours actually spent on the programme. This gap was partly mitigated by the 80% overhead on salaries.

During the coming phase, overhead on salaries is no longer permitted. AF welcomes this transparency in budgeting, where actual time spent on various outcomes is transparently allocated. AF's salary expenses allocated to outcomes and outputs in the budget 2022-25 are based on analysis of time registration during 2019-21, which provide an actual overview of working hours invested on specific assignments such as monitoring of progress reporting, partner meetings, capacity building, status reporting, partner visits, technical support to partners.

9.1. STRATEGIC FINANCING – PROGRAMME PARTNERSHIP AS CATALYST

AF's programme team is continuously focused on identifying best practices and learnings and facilitate sharing of these between countries and partners and on identifying areas for capacity building in order to promote a strong civil society and south-to-south collaborations and networking. The positive results of this approach during the first programme phase have been apparent.

To encourage direct collaborations between partners, AF reserves unallocated funds for joint activities between programme partners. Partners are encouraged to jointly develop strategies, activity plans and budgets for joint initiatives, which are submitted to AF for review. In 2020, HRAPF worked directly with LMEC to conduct paralegal trainings of SWs in the provision of legal aid services to SWs. CEDEP and AHM held a joint meeting with relevant members of Parliament in order to lobby for an inclusive approach in budgeting and policy changes for KPs in order to remove structural barriers for access to health and education services. In 2021, funds were allocated to a cross country visit with staff from AHM visiting LMEC in Uganda to share best practices and learnings and train LMEC in the male champion method developed by AHM.

Thus, the programme has managed to establish a strong partnership and has functioned as a catalyst for increased collaborations and sharing of learning within and across countries and between partners, but also between partners and other CSOs and key stakeholders nationally, regionally and internationally.

In Malawi, the programme has enabled CEDEP to establish the Diversity Forum, which has already been acknowledged as a key player by national task forces and working groups and has impacted international advocacy by submitting a joint shadow report on sexual minority rights to the UNHRC during Malawi's UPR. LMEC, CEDEP and AHM have all set up regular fora where they share programme data and learnings with likeminded CSOs as well as with key stakeholders such as district health teams and police. These networks will be further developed and utilized through the next phase.

HRAPF trains paralegals from LGBT+ and sex worker organisations to have a key role in educating communities on human rights and identifying and handling cases of violations. HRAPF paralegal training is customised to empower marginalised groups to stand up and fight for their rights using available means of access to justice. In addition, HRAPF works as a catalyst, supporting community KP groups to register and operate as organisations. During the next phase, the program will continue to strategically promote global connectedness and South-to-South collaborations by interlinking local KP-led CSOs and strong local human rights organisations within the Global South and connecting them with CSOs and networks in the Global North.

9.2. BUDGET COST ALLOCATION

All costs have been allocated to objectives and outcomes in a fair and transparent manner according to the programme guidelines. Expenses within local administration, salaries and investments are not outcome specific and have been allocated to outcomes based on that specific outcomes' share of the total costs.

"The review found that South-South learning is addressed consistently within the program, both among partners and by supporting networking with other CSOs and KP organizations within partner organizations' national and local context".

CISU review 2021, p. 21

Overall, AIDS-Fondet's expenses primarily promotes objective 5, *increased capacity of KP organizations and allied CSO*, with a focus on building capacity and facilitate networking, sharing of learning and best practices between partners, as well as advocacy support to the programme. Consequently, AF's TA expenses which are not outcome specific have primarily been allocated to objective 5 with 60%, and 10% added to each of the other objectives.

Compared to the concept note budget, AF has reduced its TA expenses with almost 300,000 DKK. Direct supporting functions of AF's CFO and Senior Administrator are no longer covered by CSF funds but are contributed through AF's liquid funds, as are direct administration expenses. Also, to reduce TA expenses and minimize climate impact, one annual training and partner visit has been converted to online training.

9.3 COST-EFFECTIVENESS AND EFFICIENCY

The programme's general level of cost-efficiency and effectiveness is high. The programme builds on a methodology of volunteerism and a Peer-to-Peer approach where KPs educate and support each other to secure better HIV prevention and rights and KP paralegals provide legal services, which is a sustainable and cost-efficient way to obtain results.

COVID-19 has affected the cost-efficiency of our programme in different ways and forced us to change procedures, many of which will be carried over to the next phase. The travel restrictions have meant that all Steering Committee meetings have been held online. AF's monitoring of partners has also positively been carried out online as remote monitoring and AF's HIV training of partners, peer-educators and health care personnel has been carried out by a former AF employee, living in Uganda at the time. Partners have also used online means of communications for meetings and trainings and digital means to accelerate ART and PrEP adherence meetings.

These changes have of course lowered travel costs and has forced AF and partners to innovate new effective ways to reach beneficiaries and insure sharing of cross-country learning. Thus, COVID-19 has built our expertise in online communication and innovation. It has taught us digital solutions carry the opportunity to reach more beneficiaries and include more of AF's staff in activities and monitoring and carry out in-depth monitoring more often. Our full day remote monitoring programmes with each of our partners included sessions with our CFO and the Head of International Department. In the future, we have decided to link up digitally with our CFO and other staff even when we implement on-site monitoring visits.

We will carry the learnings from the pandemic into the future and use them to qualify the programme. Partners' digital innovations to reach beneficiaries, e.g., using toll-free lines, WhatsApp support groups and HIV self-testing kits will be continued.

All this said, COVID-19 and travel restrictions has also reminded us of the importance of on-site visits and meeting partners, beneficiaries, and duty bearers on the ground and in person. The added value of partners meeting in person and visiting partners projects, beneficiaries and duty bearers exceeds the negative effects of extra costs and climate impact and is essential if we want to promote a strong civil society and south to south networking across borders.

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- ^{iv} Global HIV & AIDS statistics — 2020 fact sheet | UNAIDS, CONFRONTING INEQUALITIES Lessons for pandemic responses from 40 years of AIDS, UNAIDS 2021.
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- ^{vi} [Countries With the Highest Rates of HIV/AIDs - WorldAtlas, Hiv Rates By Country 2021 \(worldpopulationreview.com\)](#)
- ^{vii} [Global HIV & AIDS statistics — 2020 fact sheet | UNAIDS.](#)
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- ^{ix} [Global HIV & AIDS statistics — 2020 fact sheet | UNAIDS](#)
- ^x [Focus on: Malawi | UNAIDS](#)
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