

Human Rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria: How Does a Large Funder of Basic Health Services Meet the Challenge of Rights-Based Programs?

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Abstract

The Global Fund to Fight AIDS, Tuberculosis and Malaria was created to greatly expand access to basic services to address the three diseases in its name. From its beginnings, its governance embodied some human rights principles: civil society is represented on its board, and the country coordination mechanisms that oversee funding requests to the Global Fund include representatives of people affected by the diseases. The Global Fund's core strategies recognize that the health services it supports would not be effective or cost-effective without efforts to reduce human rights-related barriers to access and utilization of health services, particularly those faced by socially marginalized and criminalized persons. Basic human rights elements were written into Global Fund grant agreements, and various technical support measures encouraged the inclusion in funding requests of programs to reduce human rights-related barriers. A five-year initiative to provide intensive technical and financial support for the scaling up of programs to reduce these barriers in 20 countries is ongoing.

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Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria (hereinafter the Global Fund), which began its operations in 2002, emerged during a period in which the nexus between health and human rights had established itself as a distinct area of public health practice and an intellectual discipline. By 2002, the United Nations (UN) entities brought together to form the Joint United Nations Programme on HIV/AIDS (UNAIDS) had a strong commitment to rights-centered approaches to HIV, as seen, for instance, in UNAIDS's inclusion of nongovernmental organizations (NGOs) in its governance body and its work on discrimination and other human rights abuses related to HIV. As explained below, the Global Fund was born out of the idea that a different kind of institution might be needed to expand financing to HIV programs. As a financial institution without field staff, the Global Fund would operate very differently from a direct service provider or UN agency. But it would operate in accordance with agreed-on norms contained in HIV programs and policies, including the meaningful participation of people living with HIV, the prohibition of discrimination based on HIV status, and the inclusion of often criminalized persons—such as sex workers, people who use drugs, and LGBT persons—in HIV programs. It was also challenged to bring lessons from HIV efforts to bear on programs to address tuberculosis (TB) and malaria.

This article describes the strategies and initiatives undertaken by the Global Fund in its effort to support human rights-based programs to address HIV, TB, and malaria. It suggests that within institutional constraints specific to its foundational values and processes, the Global Fund has found progressively more active ways to assist grantees in designing, implementing, and evaluating rights-centered health programs.

Human rights and basic operation of the Global Fund

The Global Fund was created partly as a response to the reluctance of many traditional providers of development assistance in health to finance antiret-

roviral treatment, which had been available since 1996 but was seen by some donors to be unsustainable in low-income countries.¹ Donor-supported HIV interventions in the period before the United States President's Emergency Plan for AIDS Relief initiative and the "3 by 5" initiatives of the World Health Organization and UNAIDS (both dating from 2003) were largely focused on awareness-raising campaigns and health worker training.² For some years, the French government had called for a "solidarity" fund for antiretroviral treatment.³ The International AIDS Conference in Durban in 2000 brought global attention to a growing North-South movement to challenge the prices and patents of antiretroviral medicines, as well as the indifference of donor nations to the plight of Africans living with HIV.

The 2001 UN General Assembly Special Session on HIV/AIDS committed member states to providing support for "a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment."⁴ This resolution gave the Global Fund official UN member state backing that earlier large-scale public-private health initiatives such as the Vaccine Alliance (GAVI) did not have. There was great hope in many quarters that the Global Fund's existence would not only scale up antiretroviral treatment dramatically but, in so doing, also drive down the prices of HIV medicines.⁵

The board of the Global Fund, which institutes funding strategies and policies and approves budgeting and funding decisions, was constituted to include representatives of governments, civil society from the Global North and South, foundations, and people affected by the three diseases; this last constituency sets it apart from GAVI and other similar entities and signals a commitment to the meaningful involvement of people affected by the diseases in all decisions about the Global Fund and its activities. The Global Fund also incorporated another distinctive element with human rights importance—a commitment to "country-driven" grant-making. The foundation document of the Global Fund said that it would "base its work on

programs that reflect national ownership and respect country-led formulation and implementation processes.⁷⁶ Country coordination mechanisms (CCMs)—meant to include representatives of government, NGOs, other private-sector entities, UN agencies in the country (often called “technical partners”), and people living with or affected by the diseases—were created to develop proposals. CCMs were entrusted to submit proposals requesting a realistic level of funding for health programs that could be absorbed and programmed readily. The Global Fund’s foundation document also pledged to “give due priority to the most affected countries and communities, and to those countries most at risk” and to “aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially ... women, children and vulnerable groups.”⁷⁷

As of February 2017, the Global Fund estimated that with total disbursements of more than US\$30 billion since 2002, it has supported antiretroviral treatment for about 10 million people, TB testing and treatment for about 16.6 million people, and the distribution of over 700 million bed nets for malaria prevention.⁸ From a human rights perspective, it is important to note that the Global Fund has also supported an unprecedented scale-up of HIV prevention activities for certain marginalized populations, including people who inject drugs. In its first nine rounds of funding, for example, approximately US\$180 million enabled the expansion of drug-related harm reduction services in 42 countries, many of which had never been able to scale up services of this kind.⁹

“Country ownership” and country-driven processes may not have worked out ideally in every case, but they represented an attempt to do business in a new way. Both the formal independent evaluation commissioned by the Global Fund after five years and the conclusions of other observers of the Global Fund’s work echoed the long-held concern of some donors that although the Global Fund had indeed put program design and implementation more squarely in the hands of recipient countries than ever before, some of those programs floundered for lack of outside technical assistance.¹⁰ The

Global Fund defended its approach, asserting that it was high time that programs for infectious diseases not be designed in Geneva or Washington.¹¹ Key actors in the field appreciated this sentiment. Médecins Sans Frontières, for example, said that entrusting countries with the responsibility to estimate resources that could be absorbed and realistic rates of scale-up of programs resulted in unprecedented progress both in the programs themselves and in strengthening health systems.¹²

As of 2004, the Global Fund had already stepped a bit over the “country ownership” line and required that CCMs include a person living with HIV among their members. And in 2008, it issued guidance “strongly encouraging” CCMs to include key populations affected by the three diseases among their members—beyond just people living with HIV—and to ensure their participation in decision making.¹³ Though the inclusion and meaningful participation of key populations—especially persons affected by the criminalization of drug use, sex work, and aspects of sexual preference and gender identity—remains a challenge in many places, in some countries CCMs became the first platform in which key population groups could sit with policy makers and program managers and participate in decision making on programs affecting them.¹⁴

While “country ownership,” with its ring of empowerment, was appealing from a human rights perspective, human rights advocates over the years noted the other side of the coin—that “ownership” of programs by countries with poor human rights records or little culture of human rights might mean that these countries would steer programs in rights-unfriendly directions and have little incentive to do otherwise.¹⁵ Some observers concluded that the Global Fund’s commitment to rights-based programs was too passive. At a Global Fund “partnership” meeting in 2006, civil society organizations presented an appeal signed by over 250 health and human rights NGOs, calling on the Global Fund to

increase funding for programs to eliminate human rights abuses against people living with and at high risk of HIV/AIDS—including sexual and gender-based violence; discrimination; and violations of

*the right to complete and accurate information about HIV/AIDS prevention, treatment and care.*¹⁶

Dr. Michel Kazatchkine, director of the Global Fund from 2007 to 2012, noted that the country ownership principle did indeed pose human rights concerns but that the Global Fund had processes to ensure that it would not fund programs that contributed to human rights violations or that did not reflect sound evidence-based approaches.¹⁷ With respect to human rights questions, the Technical Review Panel, the independent expert body that reviews Global Fund proposals and makes recommendations for funding, is asked to consider whether proposals address

*issues of human rights and gender equity and use human-rights based approaches to address the three diseases, including by contributing to the elimination of stigmatization of and discrimination against those infected and affected by tuberculosis and HIV/AIDS, especially populations that are marginalized or criminalized, such as injection drug users, men who have sex with men, transgender communities, sex workers and other key affected populations.*¹⁸

Indeed, efforts to ensure that marginalized and criminalized populations are reached by Global Fund-supported programs, particularly for HIV and TB, have been challenging throughout the Global Fund's history. The 2011 Political Declaration on HIV/AIDS called on countries to implement specific programs to ensure that national HIV responses were inclusive, effective, and rights based. UNAIDS identified these key programs as consisting of the following: (1) the reduction of stigma and discrimination; (2) access to HIV-related legal services; (3) the monitoring and reform of policies, regulations, and laws that undermine HIV programs; (4) legal literacy, or "know your rights," efforts; (5) the sensitization of lawmakers and law enforcement agents; (6) the training of health care providers on rights and ethics related to HIV; and (7) the reduction of discrimination against women and gender-based violence.¹⁹

The UN Development Programme led an investigation of whether these types of programs

figured in two Global Fund funding rounds (6 and 7).²⁰ The study found that successful HIV funding proposals generally included at least a few programs to address human rights barriers, but that about a quarter of these programs were dropped before they made it into work plans.²¹ In addition, it was noted that stigma and discrimination reduction was the most common of the seven programs to be included and that countries with generalized epidemics were unlikely to identify program needs for key populations. The Global Fund had developed information notes and technical briefs on human rights, gender, sexual orientation, and gender identity meant to help CCMs include, in their funding proposals, measures that would ensure access to services for marginalized persons and would promote gender equality, but clearly more needed to be done.²²

Recognizing the continuing challenge of getting funding proposals to embody human rights norms and universal access, the Global Fund, in its tenth round of funding, established a special reserve allocation for programs for "most at risk populations," which were defined as (1) men who have sex with men, transgender people, and their sexual partners; (2) female, male, and transgender sex workers and their sexual partners; and (3) people who inject drugs and their sexual partners.²³ About one-third of applicants in this round requested support from this special reserve, for a total of about US\$100 million in programs over two years; about half that amount was finally approved.²⁴ Two countries, Malaysia and Uruguay, received Global Fund support for the first time through this special reserve.²⁵

The Global Fund's support for what it calls "community systems strengthening" was also an important step in encouraging rights-based programming for the three diseases. The community systems strengthening framework, developed by the Global Fund in 2010 (and revised in 2014) in consultation with many civil society organizations, encourages funding applicants to see the "mobilization of key affected populations and community networks" as an essential element of effective programs.²⁶ It urges applicants to include

in their analyses and funding requests an emphasis on “strengthening community-based and community-led systems for prevention, treatment, care and support; advocacy; and the development of an enabling and responsive environment.”²⁷

Formalizing and addressing strategic objectives for human rights and gender

As the time came to prepare an institutional strategy for 2012–2016, the Global Fund heard from civil society organizations and technical partners on the continued need for attention to human rights issues. A consultation convened by the UN Development Programme and the Open Society Foundations in 2011, which included wide civil society representation, stressed the need for the Global Fund to have a formal commitment to human rights goals. In a paper prepared for that meeting, Daniel Wolfe of Open Society Foundations and Robert Carr of the Caribbean Vulnerable Communities Coalition urged the Global Fund to address situations in which it might unwittingly undermine rights-based approaches, including the following:

- when health programs to benefit criminalized people who use drugs, prisoners, sex workers, and LGBTI persons expose these populations to arrest, arbitrary detention, and other abuses, without adequate protections of their human rights;
- when programs are carried out in closed settings—such as prisons, remand centers, and drug detention centers—where abusive practices are prevalent and health programs may be part of the abuse; and
- in countries with poor human rights records and weak protection of marginalized persons, where health programs are carried out in ways that undermine rights, deny meaningful participation to key populations, and do not embody evidence-based health practices.²⁸

These points partly reflected concerns about the particular case of compulsory detention of people

who use drugs, ostensibly to treat their dependence on drugs. Human Rights Watch, among others, had for some time investigated compulsory drug “treatment” centers in East and Southeast Asia, finding that these facilities provided virtually no scientifically sound health care but rather were scenes of forced labor and physical and psychological abuse of “patients.”²⁹ In 2012, a joint statement by 12 UN bodies called for the closure of these centers.³⁰ Dr. Kazatchkine, as the Global Fund’s executive director, also called for the centers to be shut down but noted that while they operate, the Global Fund should seek out ways to provide basic care, including HIV treatment, for detainees “in an ethical manner and respectful of their rights and dignity.”³¹ The Global Fund would eventually adopt a policy of generally not funding “treatment” programs where there is detention without due process, where “treatment” is not scientifically sound, and where there is torture or cruel, inhuman, or degrading practices.³² This case is another example of the challenge of remaining true to country ownership while also seeking to ensure maximum impact of health services through rights-based programming.³³

With many explicit and implicit efforts to address these and other human rights concerns in place but not formalized, the Global Fund’s board made the decision to adopt strategic objectives on human rights and gender equality as part of the entity’s 2012–2016 strategy. That strategy, unlike its predecessor, included the strategic objective of “promot[ing] and protect[ing] human rights.”³⁴ With this strategic objective came three “strategic actions”: (1) ensure that the Global Fund does not support programs that infringe human rights; (2) increase investments in programs that address human rights-related barriers to access; and (3) integrate human rights considerations throughout the grant cycle.³⁵

The strategy noted that these objectives and actions reflected a “broad consensus” that the Global Fund could do more to address “poor and inequitable targeting of interventions, discriminatory social and legal environments, unsupportive policy settings, and sometimes severe and persistent human rights violations” that undermine

programs in many countries.³⁶ It also recognized that the Technical Review Panel, in its review of round 10 funding proposals, expressed its concern about “the limited inclusion in proposals of existing human rights instruments and measures to address stigma and discrimination” and other barriers to services for HIV and TB. At the same time, the strategy made it clear that the Global Fund as an institution needed to balance many factors in choosing strategic priorities and actions, including “additionality, sustainability, country ownership, multi-sectoral engagement, partnership, pursuing a balanced and integrated approach in dealing with the three diseases, human rights, performance-based funding, value for money, transparency and accountability.”³⁷

Meeting implementation challenges

Shortly after the new strategy was approved, the Global Fund unveiled what it called a “new funding model” in which, among other things, ceiling amounts of Global Fund grants would be determined by the Global Fund secretariat based on policies adopted by the board rather than by applicants, an important change in one of the pillars of “country ownership.” In addition, the new model featured a commitment to focus “on those countries with the highest needs and least ability to pay, while remaining global, and supporting the highest-impact interventions.”³⁸ According to the Global Fund, the new funding model is a means “to re-balance and give strategic direction to the organization’s portfolio of investments” and to ensure greater predictability of funding for grantees.³⁹ The model’s country-level process includes a “country dialogue” envisioned not as a single event but as a continuing process by which key affected populations and others “involved in the response to the diseases,” including persons not well represented in the CCM, can take part in identifying needs, developing strategies, and identifying program priorities.⁴⁰

A number of civil society organizations raised concerns about the new funding model. Médecins Sans Frontières, for example, charged that in the

name of funding predictability, the model would disempower countries and deflate the constructive capacity and ambitions that had resulted in scaled-up programs and unprecedented progress on infectious disease responses.⁴¹ Some NGOs expressed the concern that upper middle-income countries with concentrated epidemics, which were likely to be phased out or receive much less funding under the model, were home to millions of people who use drugs and other key populations and that the programs for these politically unpopular persons were unlikely to be funded by governments if the Global Fund withdrew.⁴² The NGO Eurasian Harm Reduction Network has documented re-surgent HIV epidemics among people who inject drugs in Romania, Bosnia and Herzegovina, and other Balkan countries, criticizing both the governments in question and the Global Fund for having inadequate transition plans to prevent the collapse of services.⁴³

In time, the Global Fund developed a policy on “sustainability, transition and co-financing” that allocated resources to support transition planning and allow for several years of funding after the period of a country’s formal eligibility.⁴⁴ Under this policy, upper middle-income countries in particular can apply for transitional funding for programs for key populations. In practice, it will remain very challenging for the Global Fund (and other donors) to ensure that much-needed programs to reduce human rights-related barriers to services and programs for key populations will continue once countries are no longer eligible to receive funding or other donors withdraw.

As the new funding model was put into place, the Global Fund began implementation of the human rights objectives and actions in the 2012–2016 strategy. In 2013, the entity established a Community, Rights and Gender Department, whose staff included a senior human rights advisor (later expanded to include another human rights expert) and advisors on gender, key populations, and community systems strengthening.⁴⁵ This department organized training sessions on human rights and gender equality for grants management and legal staff at the secretariat, as well as the Office of the

Inspector General (an independent office) and the Technical Review Panel. A Community, Rights and Gender Advisory Group of external—mostly NGO—experts helped steer the work and comment on priorities, as did a Human Rights Reference Group and a Harm Reduction Working Group established at about the same time.

In addition, a number of key human rights provisions were added to the language of Global Fund grant contracts. These points were meant to articulate some fundamental elements of rights-based programs that would be relevant to the three diseases in all countries. The provisions were that Global Fund-supported programs would provide non-discriminatory services to all, including people in state custody; would be based on scientifically sound and approved medicines or medical practices; would not employ methods that constitute torture or that are cruel, inhuman, or degrading; are expected to respect and protect informed consent, confidentiality, and the right to privacy concerning medical testing, treatment, or health services rendered; and would avoid the use of medical detention and involuntary isolation, except as measures of last resort.⁴⁶ These provisions were reviewed extensively by the Global Fund secretariat, the Human Rights Reference Group, and human rights experts.⁴⁷ In 2014, the Global Fund also joined UNAIDS and its cosponsor agencies in publishing guidelines for responding to HIV-related human rights crises.⁴⁸

In 2015, the Global Fund announced the establishment of a mechanism for reporting human rights concerns linked to Global Fund-supported programs. A telephone hotline and email address were allocated to receive complaints, which could be anonymous and could come from anyone who experienced or witnessed a human rights violation linked to a Global Fund-supported program.⁴⁹ Information disseminated about this procedure explained what kinds of violations might be reported, especially with respect to the five points in the grant contracts noted above. The Office of the Inspector General was charged with responding to complaints. This office was founded in 2005 as an entity independent of the Global Fund secretar-

iat and staff, and it reports directly to the Global Fund's board of directors. It was pledged that the Office of the Inspector General would respond to all complaints within 48 hours and would determine promptly whether to conduct a full investigation.⁵⁰ As of early 2017, nearly two years into the mechanism's operation, only a few complaints considered eligible for resolution by the Office of the Inspector General had been received, and an independent assessment was underway to determine why there has been such low uptake of the mechanism.⁵¹

Another initiative was a US\$15 million allocation to offer technical assistance to NGOs aimed at improving their participation in Global Fund processes in their countries and supporting their longer-term capacity to develop and provide leadership in human rights programs.⁵² By early 2016, there were over 100 requests for technical assistance through this initiative and 34 expert providers of assistance responding to them.⁵³ The initiative also supported six regional "platforms" for communication with and the coordination of civil society organizations. The regional platforms are meant to improve awareness of and participation in Global Fund processes and related national decision-making opportunities and to help organizations receive technical support for human rights programs. Alliances with Roll Back Malaria and the Stop TB Partnership were also formalized to provide assistance for the development of programs and situation analyses that would reflect human rights and gender equality concerns.⁵⁴

After the first few years of the new funding model, civil society organizations reported experiences of inclusion in the model's processes but also continued challenges. A 2015 survey conducted by the regional NGO African Men for Sexual Health and Rights, for example, found that representatives of key populations largely understood the new funding model and participated in many aspects of the country dialogue.⁵⁵ But many respondents said that they faced serious barriers to participating, especially in later stages of the process, including the selection of principal respondents; these barriers included the criminalization of some key populations, the fact that some key population

organizations were not officially registered or did not have good technical capacity to deal with CCM processes, and discrimination.⁵⁶

The new funding model included a revision of the instructions for funding applications, which would be submitted in the form of concept notes that were designed to be simpler than the previous application forms.⁵⁷ The concept note guidance suggested that they be organized according to topical “modules.” Reflecting the place of human rights in the new strategy, a module entitled “removing legal barriers” was added to the concept note templates. As part of this module, applicants could include actions in the areas of assessment of the legal environment; “know your rights” awareness raising; human rights training for law enforcement officers or health care providers; community-based monitoring of human rights issues; and policy advocacy.⁵⁸ These areas of activity overlap significantly with UNAIDS’s seven program areas noted above for reducing human rights barriers to HIV services. (The “removing legal barriers” module was later revised to correspond more exactly to UNAIDS’s seven categories for HIV; see below.)

One goal of the 2012–2016 strategy was for the Global Fund to reflect on its work in “challenging operating environments”—meaning countries experiencing acute emergencies and those in chronic crisis with chronically weak state institutions. In these situations, the normal succession of Global Fund processes—country dialogues, regular CCM meetings, and reliance on the health sector for a certain standard of functioning and care—may be compromised. The rule of law and justice systems may also be undermined. An initial consultation with representatives of humanitarian assistance organizations led to the identification of a number of human rights and gender-related issues, which were followed up in more detail at a second consultation. These consultations led to the development of general guidelines for “challenging operating environments,” as well as guidance for human rights-based and gender-responsive programming in such environments.⁵⁹ The latter emphasized that the seven categories of programs to address HIV-related human rights barriers and the analo-

gous actions for TB and malaria are essential for the uptake, effectiveness, and sustainability of health programs, whether in “challenging operating environments” or not. The guidance recognizes, however, that special efforts may be needed to reach marginalized people when the work of community-based groups and traditional means of access to justice are disrupted.

In 2015 and early 2016, the Community, Rights and Gender Department conducted an in-depth analysis of challenges that had arisen in the Global Fund’s human rights work, as well as opportunities moving forward. The department concluded that while much progress had been made in realizing two of the strategic actions under the human rights objective (ensuring that the Global Fund does not support programs that infringe human rights and integrating human rights considerations throughout the grant cycle), investments in programs that address human rights-related barriers to access had not increased sufficiently.

The department’s analysis of the “removing legal barriers” programs in the new funding model concluded that there was strong recognition in many countries that addressing human rights barriers was important for successful health service outcomes, and that NGOs were leading many small-scale programs to remove human rights barriers but that scaled-up versions of these programs remained scarce as budgeted items in Global Fund grants. According to the department’s analysis, in the five “windows” of the new funding model (in 2014–2015), about US\$33 million was allocated to interventions to remove legal barriers in country grants, and about US\$15 million was allocated to regional advocacy efforts to address harmful policies, which represents a tiny fraction of the total allocations.⁶⁰ In Latin America, about 2.2% of Global Fund support went to “removing legal barriers” programs, but the percentages were considerably lower in other regions. Of the 119 concept notes received in the first five “windows,” 72% identified human rights barriers to programs, especially HIV services, but only 10% sought funding specifically for removing legal barriers.⁶¹ The special initiative to provide technical assistance for including the

reduction of human rights barriers in funding applications was still getting under way during this period and perhaps could not be expected to yield results so quickly. While that initiative continued to grow, there was a determination to find additional means—including more direct means—for scaling up the removal of human rights barriers.

Post-2016: Efforts to scale up programs to remove human rights barriers

In addition to a much greater, explicit focus on gender equality and programs to support women and girls, the Global Fund strategy for 2017–2022, as well as policies and funding allocation decisions adopted to support the new strategy, includes a greater commitment to scaling up programs that remove human rights barriers to accessing HIV, TB, and malaria services. Under a core objective to “promote and protect human rights and gender equality,” the 2017–2022 strategy includes a commitment to the following “operational objectives”:

1. Scale up programs to support women and girls, including programs to advance sexual and reproductive health and rights.
2. Invest to reduce health inequities, including gender- and age-related disparities.
3. Introduce and scale up programs that remove human rights barriers to accessing HIV, TB, and malaria services.
4. Integrate human rights considerations throughout the grant cycle and in policies and policymaking processes.
5. Support the meaningful engagement of key and vulnerable populations and networks in Global Fund-related processes.⁶²

Along with these ambitious objectives, the Global Fund’s board approved a revised sustainability, transition, and co-financing policy that requires all funding proposals to include an “appropriate focus on interventions that respond to key and vulnerable populations, human rights and gender-related barriers and vulnerabilities in all countries, regardless

of income level.”⁶³ Importantly, the objective is also supported by key performance indicators that will measure, among other things, “the extent to which programs to remove human rights barriers to services are implemented in 15-20 countries that will be selected for an intensive effort”; and the percentage of the country allocation invested in programs to reduce human rights-related barriers and programs targeting key populations, with a target to increase this percentage more than fourfold.

Finally, the Global Fund launched an intensive five-year effort to scale up programs that address human rights barriers in selected countries, accompanied by US\$40 million in dedicated funds that countries can access only if they match the funding provided by the Global Fund. In brief, the 20-country effort consists of the following elements:

- A review of evidence from peer-reviewed publications and other credible evaluations of the effectiveness and cost-effectiveness of programs to reduce human rights barriers to services for the three diseases across the world.
- Extensive consultation with civil society, health and human rights experts, and Global Fund staff on strategic options for building more and bigger programs to address human rights barriers as part of Global Fund-supported activities. An extensive consultation also informed the selection of the countries in this initiative.
- At the time of writing, teams of independent researchers are in the process of conducting baseline assessments of human rights barriers to HIV, TB, and malaria services in a first set of the selected countries and are rapidly assessing existing programs to address these barriers, including an analysis of why small-scale programs have remained that way.
- Informed by these baseline assessments, CCM members and other key actors at the country level, supported by Global Fund staff, will make national five-year plans to scale up programs to reduce human rights barriers (including removing policy and legal impediments). The cost of some of these new or improved programs will

be covered as part of Global Fund grants, both from within the country allocation and from supplemental “matching funds” that have been made available to countries under the condition that they use them to scale up such programs. However, it will be important to ensure that countries themselves and other donors join in this effort and work together toward the goal of having comprehensive programs to reduce human rights-related barriers to services.

- The programs introduced and scaled up to address human rights barriers and the state of the barriers themselves will be assessed twice by researchers in each country, at about 2.5 and 4.5 years after the national plan is agreed on. Detailed assessments will be made of the effectiveness, cost, and cost-effectiveness of the measures, with particular attention to how key affected populations experience the impact of these programs.
- The evidence from these assessments and lessons learned from the experiences in these selected countries will be disseminated and added to the existing evidence base on the importance of programs to reduce human rights barriers. In addition, the detailed information on scaled-up programs will be the basis for mathematical modeling and other means of estimating the impact of reducing human rights barriers on HIV, TB, and malaria services and their outcomes.⁶⁴

This is an enormously challenging initiative, but it is also much needed, for three reasons. First, there is an urgent need to achieve impact in the form of increasing access to services for people living with and experiencing enhanced risk and vulnerability to HIV, TB, and malaria. Second, intensive efforts appear necessary to overcome the long-standing impasse on insufficient inclusion and scale-up of the programs. Finally, there will be much to learn from intensive efforts undertaken in a number of countries in different regions, resulting in knowledge and experience that can inform ongoing and future efforts in other countries and settings.

The 20 selected countries include some where

CCMs have already identified and, to some degree, tried to address human rights barriers to health programs and where community-based organizations are present to ensure that key affected populations participate meaningfully in program design, implementation, and evaluation. But the potential obstacles are many and will require sustained efforts to address them. Legal and policy environments, as well as political unpopularity, may undermine the scale-up of efforts to include criminalized populations, for example. There may be a lack of technical capacity to build and sustain programs to reduce human rights barriers and disagreements on priorities and strategies. More broadly, even if evidence is generated to show that investing in the reduction of human rights barriers through scaled-up programs has direct benefits—including overall medium-term cost reductions linked to prevention and control of infectious disease—that evidence may still not be convincing to some policy makers. But an effort such as this has not been tried on this scale and is needed to move from rhetoric to real action on removing human rights barriers to services.

Another important element of implementing the Global Fund’s human rights objectives is improved collaboration with UN agencies and other technical partners in efforts to remove human rights barriers. With respect to HIV, in 2016 the Global Fund realigned the elements of its “removing legal barriers” module to correspond to the seven human rights program categories identified by UNAIDS and noted above. This realignment enables more effective Global Fund-UNAIDS coordination in promoting and monitoring these programs. Similarly, with respect to TB, the Global Fund has formalized collaboration with the Stop TB Partnership, including joint efforts to reduce human rights barriers in Global Fund-supported TB programs. Guided in part by the Stop TB Partnership’s publications on key populations affected by TB, a TB working group convened by the Global Fund developed a technical brief on TB, gender, and human rights that is meant to guide CCMs and others seeking to design rights-based TB programs.⁶⁵ The TB technical brief is more detailed

and program oriented than previous information notes on the subject. In addition to concerns about key populations—including migrant workers, prisoners, and people who use drugs—it discusses the need for a legal framework and standard practices that reflect the World Health Organization’s recommendation that involuntary isolation for the purpose of TB treatment must be used only as a measure of last resort.⁶⁶ A group of experts also helped develop a technical brief on malaria and human rights, an area that had not previously been well developed.⁶⁷

Conclusion

The Global Fund’s commitment to human rights-centered health programs is a testament to the international understanding established before its founding that HIV cannot be effectively addressed without reducing rights-related barriers to health services, including for the most marginalized people affected by HIV. The continuing challenge of encouraging CCMs to prioritize addressing human rights barriers as part of health programs is evidence of the depth of political and social disfavor of those affected by HIV (and to some degree TB and malaria). It may also be the result of the virtual absence of large-scale (as opposed to small, piecemeal) human rights programs that should be a pillar of the evidence base for rights-centered health services.

Some human rights advocates have criticized UNAIDS’s focus on “investment frameworks,” arguing that this focus encourages a perspective whereby removing human rights barriers is important because they impede a good return on investment in HIV programs rather than because it is the right thing to do.⁶⁸ From the Global Fund’s perspective, building programs to reduce human rights barriers on a scale not previously achieved is both a way to demonstrate the disease impact—and cost-effectiveness—of these programs and a tangible commitment to the human rights of affected populations. It is a way to address the persistent and deep underfunding of human rights-based efforts in HIV responses. In addition, the inclusion of TB

and malaria in the Global Fund’s efforts to reduce human rights barriers to services is pioneering and can help concretize the impact of rights-centered approaches in health more broadly.

The Global Fund’s initiative to build, scale up, sustain, and evaluate programs addressing human rights barriers represents a shift to an active programmatic approach to this challenge—beyond public espousal of the principles of rights-based approaches. Devoting considerable resources explicitly to removing human rights barriers, based on a rigorous analysis of where and why these barriers occur, may not succeed everywhere, but it has the potential to be a major step forward in the scaling up of efforts to ensure rights-based HIV services, which have been too small and weak in too many countries. As the principal international funder for TB and malaria programs and one of the largest HIV funders, the Global Fund is uniquely placed to be an example of how to make rights-based health programs a reality.

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