HHR
Health and Human Rights Journal

Human Rights and the Global Fund to Fight AIDS, Tuberculosis, and Malaria

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Abstract

In recent years, multilateral and bilateral donors have begun engaging more actively in assessment and management of human rights risks that can either impact, or unintentionally result from, aid investments. In 2012, the Global Fund committed to a four-year strategy which includes protecting and promoting human rights as one of its strategic objectives. This ambitious commitment placed the Global Fund at the forefront of multilateral health donors engaging on human rights concerns. In 2013, the Global Fund began to operationalize this commitment in partnership with internal and external stakeholders and civil society, opening up a new field of debate around the obligations of multilateral health donors in the context of country ownership.

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Competing interests: None declared.

Introduction

DEVELOPMENT AID AIMS to help states fully realize their human rights commitments, in particular their commitments to respect, protect and fulfill economic and social rights. But as international aid comes under increasing scrutiny, proponents and critics alike have wrestled with the responsibility aid agencies have to integrate related human rights considerations into grant-making in order to avoid doing harm while trying to do good.[1] Development aid agencies, such as the World Bank, and UN agencies have debated these questions for decades, but health donors have largely kept out of the conversation. Beginning in 2012, the Global Fund to Fight AIDS, Tuberculosis, and Malaria (hereafter "The Global Fund") began intensive work to integrate human rights systematically and robustly across its grant-making process. The first year of this work has led the Global Fund to wrestle with some complex questions, including how to balance a variety of human rights considerations against the need to promote fulfillment of the right to highest attainable standard of health and how to negotiate "country ownership" in the context of multilateral aid. This article provides insight into some of the internal change process underway that brings external human rights experts, technical partners, Board members, implementers, and Global Fund staff together to debate and define answers to these questions.

International human rights standards are structured around the obligations of States, while the obligations of aid agencies are as yet imprecise. Unlike aid agencies, States sign onto international human rights treaties, and States have the primary responsibility to uphold them through good governance and access to remedy.[2] However, given that international aid agencies and international organizations sometimes exercise significant influence in developing countries, this paper explores how that influence might balance against the principle of State sovereignty. Furthermore, it addresses how a commitment to "country ownership" in development aid should be understood if a State's legitimacy to represent the beneficiaries of international aid is questioned by groups representing marginalized or criminalized populations.

How these questions are answered could help shape the Global Fund and global response to the three diseases. As Joanne Csete cautioned in her study of human rights at the Global Fund:

> While the programs supported by the Global Fund are derived from country-driven processes and not conceived by the Global Fund in Geneva…at many points, it has had and will continue to have the choice to proceed in rights-based or non-rights-based directions. Those choices are likely to be very important for the future of HIV and those affected by it.[3]

About the Global Fund to Fight AIDS, TB, and Malaria

The Global Fund was founded in January 2002 with the mission of directing resources to countries to support their response to the three diseases – at least in part, in response to a global campaign that demanded greater funding for AIDS and other "diseases of poverty." As of 2013, it was the main multilateral funder of health programs, investing in more than 140 countries and disbursing between two and three billion dollars a year.[4]

The institution's Board is composed of representatives from donor and implementing governments, civil society in both developed and developing countries, the private sector, private foundations, and affected communities. The Board is responsible for such typical governance tasks as establishing strategies and policies, making funding decisions and setting budgets.

Grants for programs addressing HIV, tuberculosis, malaria, and health system strengthening (HSS) are awarded to eligible countries through a Country Coordinating Mechanism (CCM). CCMs are com-

mittees made up of representatives from both the public and private sectors, including governments, multilateral or bilateral agencies, non-governmental organizations, academic institutions, private businesses, and people living with HIV, TB, and malaria.[5]

Based on priorities and needs identified in the country, the CCM is asked to develop a concept note for review by the Global Fund Secretariat, which should be based on national strategic plans and incorporate input from multiple stakeholders. Concept notes are evaluated for technical soundness by a Technical Review Panel (TRP) composed of external health experts, some of whom also have expertise on cross-cutting issues, such as gender.

Grants are administered in each country by one or more Principal Recipients (sometimes a government agency, a non-governmental organization, or a UN agency) selected by the CCM. The Principal Recipient sub-contracts to smaller organizations to fulfill the grant agreement. As the Global Fund is a partnership organization with no staff based in-country, the donor also contracts a Local Fund Agent (often, an accounting firm) to monitor grant implementation.

After concerns were raised about corruption in countries that received Global Fund support, the institution suspended new commitments in 2011.[6] Based on a year-long process of consultation, in 2012 the institution announced the launch of a "new funding model," designed to enable the Global Fund to "invest more strategically, to make the most of its resources and maximize the impact of its grants."[7] In this system, instead of responding to requests for proposals, implementers are informed of the allocation they have up-front, are able to set their own application dates in consultation with the Secretariat, and are encouraged to express full demand.

Other key elements of the new funding model include an iterative process of grant making, in which the Global Fund Secretariat and TRP may recommend changes to ensure greater impact as well as a multi-stakeholder "country dialogue" (discussed in more detail below). The CCM convenes meetings with multiple stakeholders which result in the creation of a "concept note" analyzing the country context, the proposed response, the available funding, the programmatic gap, and proposed implementation arrangements. This concept note is reviewed by the TRP and can be refined and revised in an iterative process before it is submitted to an internal Grant Approvals Committee composed of senior Secretariat managers who recommend to the Global Fund Board whether to approve the grant.

In 2013, three "early applicants" went through an accelerated new funding model process, resulting in grants signed to support the response to HIV, tuberculosis and malaria in El Salvador, Zimbabwe, and Myanmar. In 2014, an estimated 130 concept notes will be submitted. Meanwhile, grant-making tools continued to be refined based on early experiences.

In 2012-13, while developing the new funding model, the Global Fund also underwent internal restructuring and personnel changes, including a change of leadership. Under an interim manager, the Global Fund streamlined operations. Staff in the Global Fund's civil society team and its gender advisor left the organization, raising some concerns at the time about the strength of the institution's focus on human rights.[8]

Developing a human rights strategy

With a unique governance model that brings together diverse public and private constituencies, from its inception, the Global Fund demonstrated a commitment to human rights as part of its internal management principles, which were identified as key to good governance: transparency, accountability and participation by communities "infected with and directly affected by the three diseases."[9] This community role in the institution's leadership was and is critical to the Global Fund's development and implementation of its human rights strategic objective.

In 2008, in response to continual demands from communities living with and affected by HIV and by Board members, the Global Fund approved a *Gender Equality Strategy*. In 2009, it approved a *Sexual Orientations and Gender Identities (SOGI) Strategy*.

However, subsequent independent assessments

found that the strategies were not reflected in actual Global Fund grants. A 2011 review by Pangaea found that the Global Fund "has not as consistently prioritized [the strategies'] implementation, as would be demanded by such critical issues."[10] Similarly, a review of the grant portfolio by United Nations Development Program in 2010 found:

> the majority of key human rights programs identified in successful proposals were included in work plans with budgets, but 23 percent did not make it into work plans… Generally weak demand from Global Fund applicants for key human rights programs highlights the need for increased support for the inclusion of these programs in proposals and national HIV responses.[11]

In part in response to the perceived failure to operationalize these strategies, human rights advocates and members of communities living with and affected by HIV and TB joined together to advocate for more robust and meaningful attention to human rights concerns. They helped to coordinate and support two consultations on the role of human rights in the Global Fund's work. This transition largely took place due to the concerted and intense advocacy by the Communities Delegation to the Global Fund Board, but was also strongly endorsed by other Board constituencies, the Executive Director, and other Secretariat staff.

Held in New York in March 2011, the first consultation brought together over 40 participants from UNAIDS, UNDP, Gates Foundation, Human Rights Watch, Ford Foundation, Open Society Foundations, as well as leading health and human rights advocates and Global Fund Board members. The meeting generated a list of 10 recommendations on such areas as risk management, programming, capacity building, and measurement and evaluation, among others.[12] A second consultation, in Johannesburg in May 2012, generated a similar list of recommendations.[13]

At the same time, the Global Fund Board approved a strategy for 2012-16 with five strategic objectives, one of which was to "protect and promote human rights" through three strategic actions:

- Strategic Action 4.1: Ensure that the Global Fund does not support programs that infringe human rights
- Strategic Action 4.2: Integrate human rights considerations throughout the grant cycle
- Strategic Action 4.3: Increase investment in programs that address rights-related barriers to access (including those relating to gender inequality)

In the following months, participants in the Johannesburg meeting gave a presentation to the Strategy committee of the Global Fund Board, and other participants submitted more detailed recommendations on specific areas to the Secretariat.

The recommendations from the two consultations are available on the Global Fund's website, and highlight the urgent concerns raised by leadership of populations living with and directly affected by the three diseases, including sex workers, people who inject drugs, men who have sex with men, transgender people, and advocates of the rights of migrants, ethnic minorities, and prisoners. Those concerns, which tend to fall into the area of civil and political rights, are discussed more below.

Grounded in a human rights commitment

The Global Fund's mandate – to direct resources to support the fight against HIV, TB, and malaria – is grounded in a human rights commitment: It supports governments in their obligation under the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Universal Declaration of Human Rights (UDHR) to progressively realize the right to the highest attainable standard of health.[14] Through this public/private partnership, Hammond et al. argue that international donors may also meet a "complementary obligation" to assist and support states with limited resources.[15] The right to the highest attainable standard of health is premised on availability, accessibility, acceptability, and quality of health services provided by the State, and all four elements of the right to health can be addressed through the combination of funding and technical support provided through the Global

Fund and its technical partnerships.

However, a growing body of literature, especially focused on populations living with and vulnerable to HIV, shows that violations of intersecting human rights impede fulfilment of the right to health.[16] These rights violations can range from lack of access to adequate housing (also a violation of the ICESCR) to lack of health literacy or discrimination. In their pivotal 2011 article describing the "strategic investment framework" now endorsed by UNAIDS, Schwartlander et al. called interventions aimed at addressing these human rights concerns "critical enablers" and said they are "crucial to the success of HIV/AIDS programs."[17]

Schwartlander et al.'s recommendations are consistent with the concerns repeatedly raised with the Global Fund by community representatives and human rights advocates, for instance in the consultations referenced above. Some examples have been well documented by civil society organizations: discrimination by health providers, forced sterilization of women living with HIV, and criminalization of sex work.[18] While the Global Fund may support a state to procure condoms by the thousands, if police use condoms as evidence of sex work, then sex workers are less likely to carry and use them. Global Fund Board member and sex worker advocate Andrew Hunter put it more forcefully when he said, "If you don't address the rights abuses against sex workers, every other dollar spent on prevention is wasted."[19]

Similarly, some violations of the right to health can discourage those who need health services from returning to use them again. When health service providers engage in discrimination on the basis of HIV or other status, individuals vulnerable to HIV are often discouraged from seeking those services.[20] When women-led networks and human rights organizations in Namibia found that women living with HIV were sterilized, one advocate noted, "People should have peace of mind that if you have HIV, you can still go to the hospital and be treated with dignity and equality. If we are scared we might be sterilized, we will not use the hospital services as much."[21]

In the context of reaching people who are most vulnerable to HIV, TB, and malaria, the intersectional nature of human rights is not simply theoretical: rights violations become a tangible barrier. That said, while HIV advocates have tended to prioritize issues relating to criminalization and discrimination, the emerging discussion around human rights in the context of TB and malaria has raised questions about whether other economic and social rights should be prioritized. These and similar discussions about intersecting rights and how best to address them became lively at the Global Fund during the early phase of operationalizing the strategic objective on human rights.

Putting strategy into practice

In early 2013, the Global Fund appointed a new executive director, Mark Dybul. Formerly head of the Presidential Emergency Plan for AIDS Relief (PEPFAR), Dybul took the helm with a strong commitment to addressing human rights in order to reach the key populations most affected by HIV, tuberculosis and malaria. In a June 2013 blog post, he observed,

> The people most vulnerable to disease often don't have access to health programs due to lack of information, discrimination, and the fear of arrest. To reach the most vulnerable people…greater engagement is needed by partners in civil society including community- and faith-based groups that meet people where they are.

Ensuring those groups have the right to register as organizations, to exchange health information freely, and to share opinions that can help countries to improve health policy, is equally important. In other words, a strong health system must reach past the clinic into the community.[22]

In early 2013, Marijke Wijnroks joined the Global Fund as chief of staff, with a mandate to address gender equality and human rights. Kate Thomson was recruited from UNAIDS to head a new Community, Rights and Gender Department, with a team to specifically focus on these areas. While developing plans to operationalize the human rights

strategic goals, the department also worked with external partners to develop new implementation plans for both the Gender Equality and SOGI Strategies, broadening the SOGI Strategy to incorporate needs of all key populations affected by HIV, tuberculosis, and malaria.[23]

The process of developing an implementation plan to put the Global Fund's human rights commitments into practice has drawn on formal consultations, informal discussions, and the establishment of a reference group, as well as an internal staff task force. While these consultations can take time, they have also helped to open up a conversation more broadly, build agreement among diverse institutions and networks, and ensure broader buy-in to the human rights commitment. To promote open debate, the Global Fund Secretariat also held a series of brown-bag lunches on human rights for Secretariat staff, bringing in experts from Human Rights Watch, Open Society Foundations, UNAIDS, the Global Commission on HIV and the Law, World Vision International, and other agencies for presentations that led to dynamic debates.

In order to ensure more regular input by human rights experts, in early 2013, the Global Fund issued a call for applications to a new Human Rights Reference Group, beginning monthly calls with the group in May.[24] UNAIDS and WHO are permanent observers of the Human Rights Reference Group. Other members were selected through an open application process. They include leading experts on health and human rights from UNDP, Open Society Foundations, AIDS Alliance, networks of key populations, and local and regional human rights groups. Their expertise spans Africa, the Middle East, Asia, and Latin America.

A Staff Human Rights Task Force brings together 14-20 staff from across the Secretariat as internal champions, including 15-20 focal points from each regional team within the Grants Management Division. In 2013 and early 2014, the Secretariat provided training and mentoring for these regional focal points on human rights, gender equality, Community System Strengthening (CSS), and key populations concerns.[25] These focal points have begun to act as peer mentors for other grant management colleagues working in the same geographic regions. The Human Rights Reference Group helped to push the process forward as external experts and advocates, with the Staff Human Rights Task Force making more detailed recommendations aimed at integrating that advice into grant-making practices and procedures.

Based on all these discussions and consultations, in July 2013 the Board's strategy committee approved an 18-month process to put the strategy into practice.[26] This included a two-phase process: first, developing guidance and grant-making tools to ensure that programs addressing human rights barriers to access were addressed in grants in the new funding model (during late 2013); and second, reviewing policies and procedures to better manage risk of rights violations by Global Fund-supported programs (in 2014).

Phase 1: Increasing investment in human rights programs

In August through December 2013, the Secretariat engaged with technical partners and the Human Rights Reference Group to develop recommendations on the kinds of programs that could be included in grants. For early applicants to the new funding model, two information notes were published in February 2013, *HIV and Human Rights* and *TB and Human Rights.* In reviewing these information notes, the Staff Task Force found that they were too general to be easily applicable in grants, and requested a package of interventions to address human rights barriers to access, as well as specific examples of actual programs.

In addition, human rights experts working in the field of tuberculosis expressed a strong interest in meeting to review and discuss the tuberculosis guidance. With support from members of the Human Rights Reference Group, the Global Fund invited a group of experts on tuberculosis and human rights to discuss and draft language for the guidance in September 2013.[27] At the same time, finding almost no guidance available on human rights issues in the context of malaria, the Secretariat worked with a consultant to conduct research and draft rec-

ommendations.

These materials were shared with UNDP, which took the lead on drafting new human rights guidance for grants to all three diseases and HSS. The new draft human rights information note was edited by internal and external stakeholders, including the Human Rights Reference Group, experts on children's rights, and other agencies.

The new human rights information note, published in January 2014, makes two recommendations. First, it strongly recommends that all disease programs supported by the Global Fund take a human rights-based approach and are designed in consultation with the communities and tailored to meet specific needs.[28] In discussing how to address intersecting economic and social rights (right to housing, right to safe drinking water, and others), some participants in the TB and human rights meeting called for use of a human rights-based approach to design national health programs as "a paradigm shift" that moves the focus away from top-down national TB programs and "puts communities at the center" of the planning and delivery of services.

As requested by the Staff Task Force, the human rights information note also recommends a package of interventions, "Removing Legal Barriers to Access," which includes:

- Legal environment assessment and law reform
- Legal aid and legal literacy
- Human rights training for police, health workers, officials
- Community-based monitoring, and
- Policy advocacy[29]

These interventions, which draw on the UNAIDS-recommended "Seven Key Programs" to address human rights, can be included in any request for support for HIV, TB, malaria or Health System Strengthening to the Global Fund.[30] The human rights information note includes examples of programs that carry out these activities and interventions, as well as recommended process indicators for those programs. Combined with the human rights-based approach to health service design and delivery, this package of interventions was seen by those consulted as an effective way to combine government and community-level activities to make measurable progress on one or more specific priorities on human rights.

Secretariat staff and CCMs, as well as the TRP, will use the information note in grant-making and grant approvals processes. In 2014, the Global Fund has begun to support domestic and regional organizations that have experience with implementing these human rights programs, so that they can provide technical support to applicants and help communities to mobilize and engage in country dialogue consultations. In early 2014, six domestic or regional civil society organizations and key populations networks were selected through open tender to provide technical assistance on human rights, gender, and CSS to eight countries applying for support through the new funding model. In May 2014, a larger roster of providers was selected, again through open applications, to do the same for any countries eligible to apply to the Global Fund during 2014-16. This assistance will be provided where relevant support from other sources is not available. In addition, the Global Fund plans to support civil society-led regional platforms to enhance coordination of "Community, Rights and Gender"-related technical assistance; to provide funding for global and regional networks that support longer term capacity development of key population and other community groups at country level; and to help achieve better engagement with Global Fund processes. The Global Fund Board has approved a total of $15 million for this initiative.

All these processes and capacity-building programs have created a space for open debate and discussion. This has helped to address anxieties concerning human rights, mitigate fears of what might happen to Global Fund grants in countries where rights violations occurred, and to begin to develop internal consensus on the way forward.

Phase 2: Addressing rights violations in Global Fund-supported programs

In 2014, the Secretariat is beginning the second

phase of the 18-month timeline, reviewing policies and procedures to unpack what may be the most challenging part of the strategic objective: how to ensure that the Global Fund does not support programs that infringe human rights.

As part of the 2011 consultation on human rights for the Global Fund in New York, Daniel Wolfe and Robert Carr wrote a paper analyzing the human rights risks to Global Fund grants, and grouped these in three key areas:

> The first occurs when the Global Fund supports programs in **closed societies with a record of systematic human rights abuses** [for instance, in countries that prohibit registration of independent civil society organizations, or that jail AIDS advocates]. In these countries, the Global Fund has limited ability to act against spending of funds in a manner that works against the commitments to evidence-based programming and civil society engagement that the Global Fund regards as central.
>
> Second, **support for interventions to benefit criminalized populations** without attention to rights protections may, irrespective of the country context, expose these populations to police harassment, detention, incarceration, and deprivation of services.
>
> Third, **funding in institutional settings where abuses are routine**, including in penal institutions, detention centers, drug rehabilitation centers and some health clinics, can create ethical and human rights dilemmas for the Global Fund.[31]

While not published in an academic journal, the Wolfe and Carr article cited above, is available in Open Society Foundations' report on one of the consultations held to advise the Global Fund on human rights. It synthesizes numerous human rights reports and should be essential reading for those interested in understanding the kinds of human rights risks that could affect Global Fund grants.

In internal discussions and consultations with the Human Rights Reference Group around how to practically operationalize human rights risk mitigation, the Secretariat built on the Wolfe and Carr analysis to develop two slightly different categories of risk:

1. **Contextual human rights risk**: This includes risk of rights violations that exist in the broader environment, including arenas over which a health donor has no direct influence. It can range from restrictions on political and civil rights that make it impossible for advocates to engage openly in discussions about sensitive human rights concerns to gender-based violence (especially in conflict areas); and criminalization of key populations that the Global Fund wants to reach with health services.

The Global Fund can take steps to address environmental risk, such as:

- fund programs to address these risks, such as advocacy or legal aid services;
- require grant recipients to identify and take steps to manage the risks;
- exercise political influence to raise these human rights risks with governments and to share concerns about how specific human rights concerns may create barriers to health services.

All these actions may help to address human rights barriers to accessing health services. However, the Global Fund cannot hold health ministries or NGOs, its usual grant recipients, directly responsible for ending these rights violations.

2. Programmatic human rights risk – This includes risk of rights violations that may be perpetrated by direct recipients of Global Fund grants, including health ministries and NGOs. It can include risk of discrimination based on gender, health or other status; and risk of violations of confidentiality and informed consent. These programmatic risks can be managed by:

- establishing minimum expectations through contractual relationships between the donor and recipients;
- ensuring there are procedures in place to ef-

> fectively address any allegations of violations by grant recipients.

However, managing these programmatic human rights risks poses real challenges, even if the Global Fund mandates that all grant recipients uphold standards of non-discrimination on the basis of HIV status. Many Global Fund Principal Recipients are ministries of health, which may be subject to employment policies set by other government agencies. Revising these policies could be a lengthy process that requires the exercise of significant political leverage in more than one government agency – and in practice, ministries of health are rarely the strongest agency in any given government.

Even where good laws and policies on such issues as discrimination or confidentiality exist, they are often poorly enforced. In quite a few countries where the Global Fund invests, there is weak or no independent rule of law, so that even good laws and policies are unenforceable.

Taking these practical challenges into account, the Global Fund will begin in 2014 to use a grant agreement which includes minimum human rights expectations for programs it supports. Principal Recipients will be required to notify the Secretariat if these programs are like to, or have actually, violated the standards. The standards include non-discrimination in provision of health services, respect for informed consent and medical confidentiality in testing and treatment services, avoidance of medical detention except as a last resort, use of only scientifically proven methods and treatment, and not engaging in torture or cruel, inhuman or degrading treatment in health facilities. The Secretariat will then work with the recipients on a work plan to manage that risk, or may allocate funds to different activities or recipients.

While acknowledging that Principal Recipients cannot always control the circumstances of a rights violation, it places responsibility for identifying and developing an approach to address the violation on the grant recipient. The new grant agreement provides a clear basis for engaging with countries on health and human rights issues. However, putting it into practice will obviously raise complex questions, as is illustrated by the Global Fund's experience in addressing concerns around drug detention centers.

The case of the drug detention centers

Concerns around drug detention centers were first publicly raised in 2010, in reference to support by several international donors for HIV interventions in such facilities in Asia. Human Rights Watch and Open Society Foundations published reports as early as 2003 documenting rights abuses ranging from torture to forced labor in China, Cambodia, Thailand, and in Vietnam's compulsory drug treatment centers.[32]

In response, Michel Kazatchkine, then the Global Fund's executive director, publicly called for the closure of all drug detention centers.[33] However, he also raised ethical questions about the obligations of a health donor to support provision of medical treatment for detainees:

> All compulsory drug detention centres should be closed and replaced by drug treatment facilities that work and that conform to ethical standards and human rights norms. At the same time, as long as such centres exist, I strongly believe that detainees should at least be provided with access to effective HIV prevention and treatment, provided in an ethical manner and respectful of their rights and dignity.[34]

Following on these remarks, in 2010-11, the Secretariat took steps to review its portfolio and reprogram funds from drug detention centers in many countries to other health interventions. However, in 2013, a grant to address HIV/AIDS in Vietnam, while including support for HIV testing and treatment for 944 patients in drug detention centers, made the funding conditional on the government identifying an international, independent non-governmental organization to monitor conditions in the facilities.[35]

In January 2014, the Global Fund announced that it could not approve the monitoring program proposed by Vietnam, and stated that it would ter-

minate funding for HIV services in drug detention centers by June 2014, while "also seeking a commitment from the government that it will fund the treatment of patients inside the centers."[36] This solution ensures that the Global Fund is not directing resources into settings where rights violations are widespread.

The government of Vietnam has committed to reducing the numbers of people who inject drugs that are held in drug detention centers. Earlier this year the government issued a new regulation to require a court hearing before a formal sentence is passed on injecting drug users, a measure which may over time help to bring down numbers of drug users held in detention centers. The Global Fund continues to call for the closure of all drug detention centers and their replacement with voluntary treatment facilities, and to support networks of key populations who advocate for these changes within the country.

The case of the drug detention centers illustrates the ethical complexities involved in providing health services to people whose behavior is criminalized, and in providing these services in prisons and other closed settings. It also highlights the challenges in advocating for human rights faced by aid agencies.

The country ownership principle

The Global Fund and other bilateral and multilateral donors are wrestling with these questions in the context of a "country ownership" approach, which the Global Fund defines as

> …mean[ing] that countries determine their own solutions to fighting these three diseases, and take full responsibility for ensuring the implementation of these solutions. In this way, each country can tailor their response to their own political, cultural and epidemiological context.[37]

Yet, as has been often raised in discussions around the development of the Global Fund's human rights strategy, addressing human rights involves raising politically sensitive issues which could put grant-making relationships to the test with potential consequences for those dependent on Global Fund-supported treatment.[38]

When a state ratifies a human rights treaty or other international instrument, it is clear that the state has obligations under that law or standard. Addressing the rights violation and providing remedy are ultimately the concern of the government that is bound by international law, and while the role and expectations of businesses have been developed in the *Guiding Principles on Business and Human Rights,* the requirements of multilateral donors are still a matter of debate. For instance, in the Democratic Republic of Korea, a recent Commission of Inquiry published detailed recommendations for the UN Security Council but had little specific to say to donors such as the World Food Program and the Global Fund.[39]

The Global Fund's commitment to "country dialogue" has the potential to create a greater space for such contest and debate. But given that the ultimate responsibility for organizing the consultation lies with a CCM, supported by UN agencies and relevant government ministries, there is also a risk that some interested parties might be excluded, even inadvertently. Any attempt to consult with all the relevant and diverse stakeholders across three diseases, including populations who may not have established or functional representation (for instance refugees, migrants, minority groups, youth, and populations whose behavior is criminalized) will have to be built on a foundation forged through long-term outreach, community mobilization and new partnerships.

Countries can be supported by the donor and UN partners to make meaningful progress toward achieving the ideal of inclusivity. The Global Fund has provided training to staff, CCMs and a small but growing group of civil society groups on inclusive country dialogue, and is encouraging civil society advocates to raise concerns as they happen with Secretariat staff. CCMs will submit documentation of country dialogue consultations to the Grant Approvals Committee. Initial assessment of early applicants to the new funding model by Open Society Foundations has been generally positive.[40]

The World Bank defines country ownership as meaning that "a government can mobilize and sustain sufficient political support to adopt and implement the desired programs and policies even in the presence of some opposition."[41] Supposing, though, that the political support is strong because opposition is suppressed – as in the case of many countries that receive foreign aid? As Foresti, Booth and O'Neill note in their paper for the OECD,

> A technically 'capable' state can be developmental but non-accountable, bringing into question the institutional checks and, ultimately, the sustainability, equity and quality of development processes.[42]

For a multilateral health donor, the ability to implement a human rights-based approach based on consultation in design and delivery of health services will be inherently dependent on other human rights, including right to freedom of association, non-discrimination, and right to freedom of expression – all of which can affect advocates' ability to register organizations, speak openly in consultations, and participate in Global Fund governance mechanisms. In some countries, CCMs have been the first mechanism to bring together civil society and government in joint planning processes, though civil society representatives to CCMs have often been characterized as "weak" in comparison with government and other members who carry more weight.[43] By committing to a process in the new funding model that requires a "country dialogue" to develop the request for Global Fund support, the Global Fund has potentially made a bolder commitment to free expression and free association. By not prescribing who should be in the country dialogue, the institution has created an entry point for civil society advocacy at the domestic, regional and global levels. Funding of technical assistance provision by domestic and regional civil society organizations supports sustainability and gives marginalized and criminalized populations a potentially stronger voice and influence at the negotiating table when funding requests – and their budgets – are designed

That said, these discussions will happen in the real world, in the context of time pressures to move quickly to finalize requests to ensure continuity of services, and of reduced funding for health in nearly every country eligible for Global Fund support. As Kapilashrami and Hanefeld note, these pressures could militate against increasing investment in programs that address human rights barriers to access.[44]

These debates, between civil society, communities, countries, donors, UN agencies, and rights advocates are likely to continue to evolve as the consultative process aimed at strengthening integration of human rights at the Global Fund proceeds. Most of the process and discussion will happen far from the Global Fund's offices in Geneva, and will feed back into the institution's evolution and development. For instance, some questions are still not effectively resolved, such as the needs of communities affected by malaria and the human rights barriers to accessing health services faced by those who lack civil society representation either nationally or globally.

Ultimately, the discussion around the roles of donors and states in implementing human rights commitments is not a debate for one institution, but part of an ongoing debate about global governance, foreign assistance, and human rights. Founded in part by a civil society movement, the Global Fund's commitment to human rights responds to and closely aligns the institution with the priorities of that movement. It asserts that the multiple voices and diverse populations affected by HIV, TB, and malaria must play a central role in planning, managing and directing how development aid works.

Acknowledgments

The author is grateful to Kate Thomson, Andrew Hurst, Seth Faison, Olivier Cavey and Hyeyoung Lim, and two anonymous reviewers for valuable input, as well as to Daniel Wolfe, Joanne Csete, and colleagues at the Global Fund, members of the Communities Delegation to the Global Fund Board, and on the Global Fund Human Rights Reference Group for discussions that contributed to this paper.

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23. According to the *Global Fund Key Populations Action Plan*, finalized in March 2014, "A group is considered to be a key population if all three of the following factors apply:

- Epidemiologically, the population faces increased risk, vulnerability and/or burden of at least one of the three diseases – due to a combination of biological, socio-economic and structural factors;
- Access to relevant services is significantly lower than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility;
- The population faces frequent human rights violations, systematic disenfranchisement, social and economic marginalization and criminalization – which increases vulnerability and risk as well as reducing access to essential services."

See The Global Fund to Fight AIDS, Tuberculosis and Malaria, *Key Populations Action Plan* Draft document (Geneva, March 2014), page 7.

24. The Global Fund Human Rights Reference Group includes UNAIDS Human Rights and Law Department and WHO's Global TB Program as permanent observers. The members are a group of individuals selected for their human rights expertise, including Alberto Colorado (a TB activist); Michaela Clayton (AIDS and Rights Association of Southern Africa), Joanne Csete (Open Society Foundations), Mandeep Dhaliwal (UNDP), Walter Flores (Center for the Study of Equity and Governance in Health Systems), Mikhail Golichenko (Canadian HIV/AIDS Legal Network), Rick Lines (Harm Reduction International), Muriel Mac-Seing (Handicap International), Sian Maseko (Center for Sexual Rights), Charmain Mohamed (Asia Catalyst), Solome Nakaweesi-Kimbugwe (Nnabagereka Development Foundation), Joel Gustave Nana (African Men for Sexual Health and Rights), Enrique Restoy (International HIV/AIDS Alliance), Meg Satterthwaite (Center for Human Rights and Global Justice, NYU School of Law), and Christian Tshimbalanga (consultant).

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