Measuring the Impact of Human Rights on Health in Global Health Financing

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Abstract

In response to new scientific developments, UNAIDS, WHO, and global health financing institutions have joined together to promote a "fast-track" global scale-up of testing and treatment programs. They have set ambitious targets toward the goal of ending the three diseases by 2030. These numerical indicators, based on infectious disease modeling, can assist in measuring countries' progressive realization of the right to health. However, they only nominally reference the catastrophic impact that human rights abuses have on access to health services; they also do not measure the positive impact provided by law reform, legal aid, and other health-related human rights programs. Drawing on experience at the Global Fund to Fight AIDS, Tuberculosis and Malaria, which has incorporated expanded stakeholder consultation and human rights programming into its grants, the article argues that addressing human rights barriers to access is often an ad hoc activity occurring on the sidelines of a health grantmaking process that has focused on the scale-up of biomedical programs to meet global health indicators. To ensure that these biomedical programs have impact, UN agencies and health financing mechanisms must begin to more systematically and proactively integrate human rights policy and practice into their modeling and measurement tools.

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Introduction

In their 2012 article, "The Beginning of the End of AIDS?" in the *New England Journal of Medicine*, Diane Havlir and Chris Beyrer note a series of AIDS-related scientific breakthroughs that has brought the world to "a moment of extraordinary optimism." They call for AIDS programs and donors to respond by rapidly scaling up "access to and coverage of high-quality prevention and treatment services tailored to affected populations."[1]

In response to these new scientific developments, UNAIDS has announced ambitious new targets aimed at mobilizing financial and political resources for the AIDS response. In *Fast Track: Ending the AIDS Epidemic by 2030*, UNAIDS shows modeling of the AIDS epidemic that demonstrates that by drawing on these new advancements, increased investment in prevention and treatment programs could avert "nearly 28 million new HIV infections and 21 million AIDS-related deaths … by 2030."[2] UNAIDS calls the new targets "90-90-90": "90% of people living with HIV knowing their HIV status, 90% of people who know their status receiving treatment, and 90% of people on HIV treatment having a suppressed viral load."[3]

The United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria endorse the UNAIDS plan.[4] Though critics such as Mark Heywood call it unrealistic, "ending epidemics" has become the prevailing discourse.[5] It has been adopted by the World Health Organization (WHO) in its 2014 End TB Strategy, which includes "targets to reduce TB deaths by 95% and to cut new cases by 90% between 2015 and 2035, and to ensure that no family is burdened with catastrophic expenses due to TB."[6] And the World Health Assembly has approved an equally ambitious plan for a "world free of malaria" by 2030.[7]

By setting numerical targets based on infectious disease modeling, UNAIDS and WHO aim to scale up access to health services; the 90-90-90 numbers create a framework for the evaluation of country-level progress, on which national AIDS programs will report to UNAIDS annually. In this way, the indicators and the infectious disease modeling on which they are based contribute to the measurability of economic and social rights. These indicators, and the reporting routinely done on their progress, could be used by United Nations (UN) treaty bodies and others as an additional source of information for assessing countries' progressive realization of the right to the highest attainable standard of health.[8]

But this "epidemic-ending" vision falls short in one key area: it does not meaningfully address the significant barriers to accessing health services created by punitive laws and police abuse of marginalized populations, religious morality, toxic electoral politics, inequality of and violence against women and girls, weak civil society and media oversight, and corruption and cronyism. (UNAIDS committed to a "zero discrimination" target in 2011, but reports on progress to date—like progress itself—have been inconsistent and lacking in rigor.[9]) These concerns have been frequently reiterated by rights advocates and by representatives of key populations most affected by HIV.[10]

In addition, the testing and treatment targets mask a dark side to numerical indicators: a long and ugly history of incentivizing the detention and forced testing of marginalized populations (such as sex workers, people who inject drugs, men who have sex with men, and migrants); violations of medical confidentiality, discrimination, and violence; and other abuses against these populations.[11] In fact, at the global AIDS conference where the new UNAIDS "fast-track" targets were launched, community advocates marched to protest the roundup and mandatory testing of sex workers in Tajikistan, where the national health authority believes fewer than half of the estimated 14,000 people living with HIV have been persuaded to voluntarily use HIV testing services.[12] Sex workers' HIV status had been recorded and shared with their families, exposing them to criminal prosecution and eviction from their homes, as well as, reportedly, blackmailing, sexual abuse, and extortion by police.[13]

Anthropologists have long noted the risks that can accompany the use of quantitative data to capture and address the nuances of social realities. James C. Scott has argued that "high modernism,"

or the "sweeping, rational engineering of all aspects of social life in order to improve the human condition," when combined with the unrestrained use of power by the state and a "weakened or prostrate" civil society, can cause more harm than good in the context of development projects.[14] Similarly, James Ferguson has described how development agencies discursively create politics-free zones, reframing the poverty created by socio-economic and political inequality as a technical problem to be fixed. In the process, he argues, the politics-free discourse inadvertently justifies the expansion and intrusion of an abusive and bureaucratic state into new terrain.[15] But can international development agencies turn this dynamic on its head and do the opposite? In other words, by assessing and acknowledging the politics in development aid, can they expand the role of actors and measures to rein in state abuses? This is, in essence, what the human rights-based approach (HRBA) was designed to do: to develop a shared approach to development cooperation that "contributes to the development of the capacities of 'duty-bearers' to meet their obligations and/or of 'rights-holders' to claim their rights."[16]

In 2012, the Global Fund committed to funding human rights-related work through its health grants and required countries applying for health funding to self-identify human rights barriers to access based on consultation with communities using health services—in line with an HRBA. As the first senior human rights advisor at the Global Fund from January 2013 to May 2015, I wrestled with how best to support the agency and its national partners in operationalizing these commitments and in measuring progress toward them.

Drawing on that experience, this article explores some lessons learned and questions raised that may be useful to other donors, as well as for UNAIDS and global health financing institutions such as the Global Fund, PEPFAR, and bilateral donors to national health programs. In particular, I argue that the process of implementing an HRBA at the Global Fund has been challenged when countries focus on the rapid scale-up of biomedical programs, while publicly committing to—but in practice, sometimes sidelining—the work of assess-

ing and addressing the impact of human rights. The argument in this article represents my views and does not represent the position of the Global Fund.

UNAIDS and the Global Fund are currently developing new strategies and indicators for the next few years. As part of this work, UN agencies should commit to taking the lead on analyzing health policies in each country eligible for Global Fund and PEPFAR support, in addition to punitive laws and human rights abuses that fuel the spread of epidemics. They should routinely and transparently share this analysis with governments and civil society as countries develop their national strategic plans, in order to enable countries to identify human rights-related barriers that impede access to health services. To do so, however, UN agencies and health donors may need to develop a clearer and more accountable process of consultation with affected communities, and develop new modeling and costing tools that factor in human rights—an ambitious agenda. If UN agencies and donors fail to do these things, many of the millions of dollars currently spent on procuring condoms, medicines, and other goods for biomedical programs may not reach those who urgently need these goods.

Operationalizing human rights at the Global Fund

Founded in 2002, the Global Fund is the largest international health financing agency, disbursing up to four billion dollars a year to national health programs in 140 countries. In response to a strong push from civil society constituencies and others on its board, which was supported by the Global Fund leadership, in 2012, the Global Fund launched a strategy that committed to "protecting and promoting human rights in the context of the three diseases" through three actions:

1. Ensure that the Global Fund does not support programs that infringe human rights.

2. Integrate human rights considerations throughout the grant cycle.

3. Increase funding for programs that address human rights-related barriers to access.

To implement these commitments, in 2013–2014, the Global Fund created new grantmaking tools and briefing materials, provided regular briefings for staff and the independent panel that reviews funding requests, and consulted with UN agencies and civil society groups to develop guidance—entitled *Human Rights for HIV, TB, Malaria and Health Systems Strengthening Grants Information Note*—on what could be financed as part of health grants to address human rights-related barriers to access.[17] The "removing regal barriers" package of programs, which was designed based on this guidance, includes legal environment assessment and law reform; legal literacy services and legal aid; human rights training for police officers, public officials, and health care workers; community-based monitoring; and policy advocacy. The Global Fund secretariat established a Community, Rights and Gender department of technical advisors to manage this and much other work.

In 2015, the Global Fund incorporated minimum human rights standards into its grant agreements and committed to investigating complaints alleging violations of those standards by grant recipients.[18] This commitment arguably represents the boldest commitment to human rights accountability taken by any international financing mechanism to date. The board monitors performance of the human rights complaints procedure through a corporate key performance indicator: twice each year, the secretariat must report to the board on the number of human rights complaints received, the number investigated and resolved, and the number of cases successfully predicted using risk assessment tools.

Despite all this activity, though, my experience was that work to address human rights remained marginal in a high-speed, high-stakes process of getting concept notes approved and money out the door. Addressing human rights and gender in grants, while strongly encouraged, was an optional add-on activity for country applicants. The reasons for this sometimes had to do with the strong push to scale up biomedical programs without systematically addressing human rights impact on those programs.

The new funding model and the need for speed

In the past, Global Fund grants were awarded through competitive applications: a round of funding was announced, countries submitted applications, and these were approved or not by the secretariat in Geneva. This process was found to be too unpredictable—and in cases where applications were unsuccessful, it created a grave risk of treatment interruption.

In 2014, the Global Fund launched a "new funding model" intended to streamline the process of health financing, make it more flexible, and enable better alignment with country budgeting processes.[19] Country Coordinating Mechanisms (CCMs), the national committees that submit funding requests and oversee grant implementation, now receive a letter informing them of their allocation amount for all three diseases, calculated based on the country's disease burden, ability to pay, and other factors.[20]

With this allocation amount in hand, the CCM reviews the epidemiological data, national health strategic plans, and past performance of health programs; engages in "country dialogue" (discussed in more detail below); and drafts a concept note and budget for submission. To do this, the CCM uses a concept note template and a modular template, a set of drop-down menus listing packages of programs based on UN and WHO guidance (see Tables 1 and 2).

The submitted concept note is reviewed first by a team of secretariat portfolio managers and technical advisors, and then by an independent panel of experts known as the Technical Review Panel (TRP). The TRP may recommend that the concept note go into grantmaking, or it may return the note to the country for revisions, which can include recommended changes in prioritization, changes in approach, or the strengthening of efforts to address human rights, gender equality, and the needs of key populations

The Grant Approvals Committee—which is made up of senior Global Fund managers, technical partners, and a representative from the Communities Delegation to the board—then reviews the recommendations of the TRP. While most concept

TABLE 1. Sample Global Fund HIV module: Prevention program for men who have sex with men (MSM) and transgender persons (TGs)

Impact indicator*	Outcome indicator**	Coverage/output indicator	Module	Intervention
HIV I-7 Modeled lives saved based on latest epidemiological data Percentage of MSM who are living with HIV	HIV O-1 Percentage of children and adults known to be on treatment 12 months after initiation of antiretroviral therapy HIV O-4a Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	KP-1a Percentage of MSM reached with HIV prevention programs —defined package of services KP-3a Percentage of MSM who have received an HIV test during the reporting period and know their results	Prevention program for MSM and TGs	Behavioral change Condoms HIV testing and counseling Diagnosis and treatment of sexually transmitted infections Diagnosis and treatment of viral hepatitis

*These are just two of the twelve pre-set impact indicators used for all HIV modules. The full set of HIV, TB, malaria, and health system strengthening modules is available online.[21]
**These are just two of the eight pre-set outcome indicators used for the module.

TABLE 2. The Global Fund's Removing Legal Barriers module[22]

Impact indicator	Outcome indicator	Module	Intervention	Sample output indicators
None	None	Removing Legal Barriers	Legal environment assessment and law reform	1. Assessment report on laws, policies, and their implementation published 2. Costed action plan finalized, based on the report's recommendations 3. Action plan implemented *Note: Since law and policy reform normally requires many years, it is usually not recommended to set the enactment of laws or policies as a milestone.*
			Legal aid services and legal literacy	1. Number of individuals trained and informed, demonstrating increased knowledge and understanding as a result 2. Number of individuals receiving legal aid services 3. Number of legal aid cases resolved 4. Proportion of people indicating satisfaction with legal services received
			Training on rights for police, officials, and health care workers	1. Number of individuals trained and informed, demonstrating increased knowledge and understanding as a result
			Community-based monitoring	1. Number of people trained in monitoring who are meeting standards in performance of monitoring as established by the project (disaggregated) 2. Measurable, time-bound research plan developed, including risk management plan and data management system 3. Monitoring plans, tools, or systems developed 4. Number of interviews/cases in research plan is met 5. Reports or submissions based on community monitoring completed and referenced 6. Number of reports or submissions based on community monitoring completed and disseminated
			Policy advocacy and social accountability	1. Costed advocacy plan completed and implemented 2. Number of individuals trained in advocacy and involved in conducting advocacy or implementing advocacy plans (disaggregated) 3. Number of advocacy activities conducted (by type of event and level) as per project plan 4. Number of advocacy products produced and disseminated (as per project plan)

notes are approved the first time they are submitted, some go through one or even multiple iterations based on review by the TRP and the Grant Approvals Committee.

Once a concept note is approved, the budget, implementers, and measurement and evaluation plan are finalized during a very rapid period of negotiations between the secretariat, the CCM, and the grant implementers, before the finished grant is reviewed a second time by the Grant Approvals Committee, and ultimately approved and signed by the board.

In fact, during the whole process, speed is critical for two reasons. First, countries have an urgent need to avoid treatment interruptions, considering that no new Global Fund grants were made between 2010 and the launch of the new funding model. Second, like many donors, the Global Fund faces its own time pressures. Its three-year financial cycle, reliant on global replenishment campaigns, leaves little time for funds to sit around. Thus, under the new funding model, even countries with poor records of cash absorption are awarded new allocations of hundreds of millions of dollars.[23]

At the secretariat, portfolio managers and their regional managers, who steer concept notes through the complex process of review and approval, are evaluated annually based on the speed with which they get grants signed and funds disbursed. A corporate key performance indicator on access to funding also requires the secretariat to report to the board semiannually on whether it has met the target of 75% of grants reaching their first disbursement in 10 months or less after final concept note approval. In 2014, 97% of grants met this target, and the 2015 target was shortened to eight months, further ratcheting up the pressure for speedy approval and disbursement of funds.[24]

Country dialogue: Implementing a rights-based approach

A process that creates competition over a limited allocation of funding by players with unequal power, and which emphasizes speed, is not a process designed to facilitate the slow and complex process of addressing human rights. Human rights scholars have debated what process should be used in resource-constrained settings to prioritize allocation of resources among programs that would enable fulfillment of economic and social rights.[25] Sofia Gruskin and Norman Daniels argue for a process based on publicly accessible data, evidence-based rationales, appeals mechanisms, and public regulation.[26] As described below, the Global Fund's approach is more flexible than that, in light of its commitment to the principle of country ownership. However, experience suggests that a more formalized and transparent process to prioritize and allocate resources may be needed.

While the country dialogue approach is not explicitly called a "human rights-based approach" in the Global Fund's publications, it is generally in line with that described in the UN Common Understanding. Described in Global Fund guidance as a "nationally-owned and led process that is not Global Fund-specific, and may be more or less formal according to the country," country dialogue is subject to certain criteria.[27] Among them, applicants are expected to ensure

> *meaningful participation of people living with HIV, TB and/or malaria and key populations in the design, implementation, and monitoring of Global Fund-supported programs including an assessment of any legal or policy barriers to service access, and designing programs to address those barriers.*[28]

The Global Fund has hired evaluators to review lists of participants and minutes of country dialogue meetings to assess their inclusivity, and has created a new requirement that CCMs include representatives of key populations.[29] Additionally, the board has financed US$15 million for civil society-led technical support to countries to help them address human rights, gender, and community needs in concept notes.

In my experience at the Global Fund, in countries where civil society was strong and well organized, or where the secretariat country team and UN country offices made significant efforts to reach deep into constituencies that had not previously been consulted, this country dialogue approach

did seem to create space for groundbreaking and meaningful engagement (for instance, in Cambodia, South Sudan, Uganda, and Vietnam). In a few countries, a safe space was created—even by flying community representatives to other countries—to enable their consultation. The executive director of the Global Fund, Mark Dybul, speaks often in public about the importance of addressing human rights and the needs of key populations, women, and girls, and he has made a point of meeting with representatives of key populations in countries.[30]

But despite these efforts, Global Fund senior managers and advisors could not be in 140 countries at all times in the process. In some countries, the stakeholder consultation process came after national strategic plans and resource allocation decisions had already been finalized. Some domestic advocates complained that they had not fully understood the complex and technical process or had not understood that they could request funds to address human rights barriers to accessing health services. Others raised concerns that recommendations resulting from their arduous consultation process had been cut from the final concept note and budget, with the full allocation going to biomedical programs and the procurement of drugs to meet new WHO guidelines mandating treatment scale-up.

The budgets for the first year of concept notes under the new funding model reflect both these successes and the challenges to implementing an HRBA. The 119 concept notes submitted to the Global Fund in 2014 for HIV, TB, and malaria programs totaled US$8.3 billion; the amount requested to address human rights barriers to health services was just over US$8 million, a significant increase over the past, but still less than 1% of the total.[31] While 72% of concept notes identified human rights barriers to access in the narrative section, some lacked specific programs in the budget to address them. Most of the concept notes that did were those requesting funding for HIV, joint HIV/TB, and health system strengthening funds. Sixty-five percent of TB and 50% of malaria concept notes reviewed in 2014 identified human rights barriers to access in the concept note, but not one included

human rights interventions in the budget.[32] (The amount requested for human rights programs may increase in 2015, thanks in part to regional grants in development.)

The TRP noted progress in addressing human rights barriers to accessing health services and raised concerns about countries' failure to include clear and funded plans to address human rights in these grants. In its periodic overview of concept notes reviewed, the TRP noted

> that many concept notes lack meaningful and effective interventions to address human rights barriers. Some concept notes lack prevention and advocacy activities focused on key population, despite evidence of concentrated epidemics among key populations. Others fail to present epidemiological data for key populations. ... In a number of concept notes, the TRP noted that human rights issues were articulated in the background section, but that applicants did not follow through with activities designed to address the specific issues raised … [suggesting] that, in some cases, human rights issues were not adequately discussed in the process of concept note development and that key populations were not adequately represented.[33]

The Global Fund's commitment to country dialogue is an important step toward increasing transparency and accountability of health financing, and toward implementing HRBAs; it is arguably the boldest commitment to human rights taken by any health financing agency. But as an approach to addressing human rights consistently and systematically across all 140 eligible countries, the approach in the new funding model leaves gaps that still need to be addressed. In essence, the current approach shifts a disproportionate amount of the burden of addressing human rights policy from UN and national human rights agencies to national advocates who may or may not be adequately resourced to play that role. In some cases, these advocates may not even be able to speak freely: many of the countries receiving international health financing are those with the poorest rankings on international human rights and transparency indices.[34]

If UN agencies and bilateral aid programs had established an institution to receive and disburse

billions on treatment for lung cancer, they would begin by briefing countries on the anticipated impact of national laws on smoking. Addressing human rights, the community response, and corruption in the HIV, TB, and malaria response should be a routine part of planning, targeting, and funding work—and not an optional add-on.

How, then, can UN agencies and donors promote more effective action to address human rights barriers to accessing health services?

Given growing resistance to aid conditionality, a heavy-handed approach compelling governments to finance and implement human rights programs would almost certainly backfire. Among other things, human rights aid conditionality would counter the Paris Declaration on Aid Effectiveness, which commits donors to principles of country ownership and alignment with national strategies.[35] It would also counter the expressed wishes of domestic human rights advocates, such as the group of 53 African organizations that spoke out against making aid conditional on the decriminalization of same-sex sexual behavior:

> Donor sanctions are by their nature coercive and reinforce the disproportionate power dynamics between donor countries and recipients …. They disregard the agency of African civil society movements and political leadership. They also tend, as has been evidenced in Malawi, to exacerbate the environment of intolerance in which political leadership scapegoat LGBTI people for donor sanctions in an attempt to retain and reinforce national state sovereignty.[36]

However, given their human rights mandate, UN agencies could instead work with domestic advocates to systematically assess relevant laws and policies—including universal health care, laws on the registration of civil society organizations, and the criminalization of key population behaviors—and their implementation in each country eligible for international health aid, as well as assessing the likely impact of those laws and practices on health outcomes. With sufficient resources, a UN agency with a human rights mandate and relevant expertise could produce human rights and gender country profiles for health donors, or could subcontract them to an independent research organization.

When they prepare to write new national strategic plans and concept notes, health planners usually receive information from the UN and aid agencies on epidemiological data, infectious disease modeling, grant performance, and the cost of various health interventions. At that time, they could also be provided with both a qualitative assessment of how the country's current policy environment factors into the picture, and a quantitative assessment of how that environment will influence the country's ability to reach its targets for HIV, TB, and malaria prevention, treatment, and care.

The rapid pace set by the new funding model, exacerbated by pressure to ensure the continuity of services in many countries, has meant that country dialogues have focused largely on developing a Global Fund funding request. Ideally, an inclusive country dialogue would be embedded in the routine work of developing a national strategic plan, with funding requests to international aid agencies just one output of that process. The prioritization of health allocations and the development of a plan of action to address human rights barriers in country dialogues should follow a clearer, more rational, and more transparent process. Communications with the Global Fund during the writing of this article suggest, encouragingly, that work along these lines is planned as part of joint efforts with UN partners that would develop a comprehensive approach to addressing human rights barriers to accessing health services.

Measuring human rights impact on health

To ensure that human rights is addressed in this planning process, we will need new tools and analysis; this should include integrating evidence of the impact of human rights on health, including gender equality, into the quantitative frameworks and indicators currently used by UNAIDS, the Global Fund, PEPFAR, and national health programs.

The methodology developed over the past 60 years by human rights practitioners—derived from law, social science, and journalism—has focused on first-person testimony. As a result, the rich specific-

ity of the lived experience of survivors has helped shine light on hidden crimes and has provided essential data for litigation and advocacy. But as Daniel Tarantola et al. observe, policymakers (and we may add, advocates) need a variety of types of information "of varying precision and complexity, and for different purposes."[37] Tarantola et al. recommend a diversity of methodological approaches to assess the impact of human rights on health. Indeed, expanding the human rights methodological toolkit is essential for advocates of the right to health—for, otherwise, the systems routinely used by national health programs, donors, and UN agencies to target, report on, and evaluate progress will continue to exclude important realities. As discussed below, a small number of epidemiologists have begun to explore this new direction.[38]

Qualitative evaluation

For most Global Fund interventions, the monitoring and evaluation (M&E) framework is based on a short list of preapproved indicators set by UN agencies, which are relatively easily applied to the grant budget. Based on successful periodic performance against these indicators, implementers receive their tranches of funding (also known as "performance-based funding"). The biomedical modules are linked to output, outcome, and impact indicators, such as "HIV incidence among 15–49 age group," "percentage of transgender persons living with HIV," and "AIDS-related mortality per 100,000 population" (see Table 1).

As the Global Fund began to increase financing of human rights programs as part of health grants, it was faced with the challenge of how to integrate M&E for those programs into this system. The programs are small-scale in the context of a given grant (perhaps US$100,000 in a grant of tens of millions). It would not be plausible, for example, to use a national-level coverage indicator on HIV incidence to measure a program that provides access to community paralegals to people living with HIV in a few districts.

The same problem arises if an impact or coverage indicator were to be added on human rights. Work done to develop numerous human rights im-

pact indicators by the Office of the United Nations High Commissioner for Human Rights created more options than could be applied systematically for HIV, TB, and malaria. Another option is to use a global impact indicator to measure discrimination against people living with HIV in countries receiving aid. However, this would create new problems. First, the US$100,000 legal aid program in our example would be too small to make a measurable impact on national discrimination. Second, in most countries there is no mechanism in place to track medical discrimination against people living with HIV, so that would have to be funded and established as well. (UN treaty bodies, which do monitor discrimination in the right to health, are not in the business of measuring and evaluating small legal aid programs.) Writing about the Millennium Development Goals, Inga Winkler et al. observe:

> Given the intense focus on producing the necessary data for the MDG indicators and showing progress toward meeting the MDGs, there has been little incentive to measure what is not in the goals and to put in place policies and programs to make progress on other areas of development. The downside of delivering on what is measured is that there are fewer incentives to go beyond what is required and to work on the areas that are not monitored at the global level.[39]

Sally Engle Merry has noted the obvious challenges involved in governments self-reporting on human rights indicators.[40]

As a folklorist and human rights researcher, I argued internally for using qualitative assessment for human rights programs. Thus, currently the Global Fund uses a qualitative approach for the measurement of human rights. It requires implementers to use "work-plan tracking measures" (output indicators) to track whether the program is actually being implemented, complemented by periodic qualitative evaluations (see Table 2).[41]

However, developing a set of output indicators and an evaluation plan for a small portion of a grant is a burdensome task for national health programs, caught up in the rush to turn approved concept notes into signed grants within the weeks allotted them, and with many tasks on their plate.

In a real-world setting where decision making and planning happens on a short timeline and based on quantitative data, a purely qualitative approach to evaluation, like that currently used to measure Global Fund human rights programs, actually risks impeding the scale-up, financing, and evaluation of human rights programs.

Quantitative indicators, like those used in the UNAIDS fast-track approach, are a critical part of health governance. Countries base their national strategic plans on numerical targets, which are in turn based on disease impact models. National AIDS programs report annually on progress against the targets to UNAIDS, reports that are published on the UNAIDS website. The same data is used to report on progress to Global Fund grant managers. As countries meet their targets, they are able to access new tranches of Global Fund funding.

Health donors such as the Global Fund are developing new approaches to the M&E of programs such as health system strengthening, human rights, and community systems strengthening. As Merry and others have noted, quantitative indicators used in global governance may sometimes leave out critical factors.[42] Using statistical models and epidemiological data, disease impact models aim to measure and predict how many people will contract a virus, how quickly they will contract it, and how various interventions may "bend the curve" or control the epidemic. But they do not currently factor in analysis of real-world factors—such as human rights abuses, gender inequality, and corruption.

Qualitative analysis and the voices of people living with and affected by HIV, TB, and malaria are essential to understanding how health programs work, or fail to, in practice. The following section suggests avenues that may be worth exploring in the future to integrate human rights analyses into disease impact modeling in order to make those models, and the targets set by UN and other global health agencies, more reflective of reality.

Incorporating "the negative case" into disease impact modeling

One avenue is to integrate quantitative research documenting the negative impact that human rights abuses have on health services into disease impact modeling.

For instance, it has been well documented that police use of condoms as evidence of prostitution discourages thousands, if not millions, of sex workers from carrying and using them.[43] How many condoms procured with international health financing are sitting on shelves unused as a result of these policies, and what are these policies costing the global AIDS response? How many more lives would be saved if the laws and policies on condoms as evidence were changed?

These are questions with quantitative answers. Sheree Schwartz et al.'s work quantifying the real-time effect that Nigeria's same-sex prohibition law has on HIV prevention and treatment services among a cohort of men who have sex with men and Robert E. Booth et al.'s quantification of the impact of abusive law enforcement practices on HIV infection among people who inject drugs show ways to answer them. These approaches to quantifying the impact of human rights could be replicated for other Global Fund-financed commodities and services.[44]

In a *Lancet* special issue on sex workers, Kate Shannon et al. go a step further to model the impact of police abuse, criminalization, and other rights abuses on access to HIV services. The study found that the decriminalization of sex work could have a significant effect on HIV, "averting 33–46% of incident infections in the next decade."[45] The article lists other structural factors and associated negative or positive link to HIV infection and condom use.[46] Drawing on the studies by Schwartz, Booth, Shannon, and others, it should be possible—and indeed, the Global Fund is now exploring this possibility—to similarly model the impact of human rights laws and policies on health interventions (such as condom distribution, the provision of antiretroviral treatment, and HIV testing). When countries set out to write their national strategic plans or hold a country dialogue, they could then consider two scenarios: the impact on the epidemic they hope to have given their current laws, and the impact they could have if these laws were changed.

Monitoring and measuring "the positive case"

In many countries, law reform is not feasible because of the current political climate; or the laws are less of a problem than the ways they are implemented in practice. In those cases, the challenge is to measure the risk mitigation offered by other human rights interventions, such as legal aid services, legal literacy, and human rights training for police and health care workers. As Flavia Bustreo et al. note, programs that are shaped by and aligned with human rights standards can have positive impacts on health.[47]

Consultation and qualitative research done in partnership with affected communities is beginning to identify which human rights programs might have a positive impact on specific global health indicators. For instance, access to legal literacy training may positively correlate with the percentage of men who have sex with men who take an HIV test and return to get their results; access to legal aid as part of palliative care may be linked to improved adherence to antiretroviral treatment.

Along these lines, some scholars are beginning to conduct research to set more quantitative measures on health-related human rights programs, which in turn could eventually enable modeling of the impact of human rights programs on health services for specific subpopulations who use them. Based on this, countries entering the national planning process could consider a third scenario: the impact on disease outcomes if legal aid, legal literacy, or other human rights programs are funded.

This research could eventually facilitate analysis of the cost-effectiveness of human rights programs in the health response. For example, STAR (socio-technical allocation of resources) is an approach that facilitates resource allocation for health by bringing "individuals or groups, faced with a set of options, to systematically rank their preferences using a range of different criteria," including evidence of impact, cost of the programs, number of people reached, and other qualitative priorities agreed on and weighted by the group. Mara Airoldi notes that this approach can be used to facilitate a collective decision to allocate more funding to community-based health interventions.[48] While STAR does not currently include human rights analysis, approaches like this could help put country-level stakeholder consultations that lead to developing national strategic plans, resource allocation, and funding requests on a more structured, transparent, and accountable footing.[49]

As Ferguson notes, technical solutions like these may not work to solve problems that are fundamentally located in political, economic, and social inequalities.[50] But they could help create a more rational foundation for prioritization and evidence-based decision making in stakeholder consultations. These consultations, aligned with an HRBA, should be a standard part of planning for development aid at all international financing institutions, as they now are at the Global Fund.

Conclusion

The UNAIDS and WHO global targets for "ending epidemics" offer visions that can mobilize global resources for urgently needed biomedical programs. However, they fail to take account of real-world obstacles, including laws and abuses that impede access to those services.

In the future, a systematic country-by-country analysis of punitive laws and other human rights abuses that will affect the performance of health services may be developed by UN agencies for countries that receive international health aid. A quantitative analysis of human rights risks should be integrated into national and global modeling and target-setting for the health response. Developing these technical tools would not solve all the human rights problems that impede access to HIV, TB, and malaria programs, and it should not serve as a substitute for consultation with stakeholders; but it could provide a more rational starting point for the consultation and prioritization of limited resources. The rollout of the new UNAIDS strategy for 2016–2021 offers an opportunity to put this work into action.

Acknowledgments

References

1. D. Havlir and C. Beyrer, "The beginning of the end of AIDS?" *New England Journal of Medicine* 367 (2012), pp. 685–687.

2. UNAIDS, "UNAIDS reports that reaching fast-track targets will avert nearly 28 million new HIV infections and end the AIDS epidemic as a global health threat by 2030," press release (November 18, 2014). Available at http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2014/november/20141118_PR_WAD2014report.

3. UNAIDS, *Fast track: Ending the AIDS epidemic by 2030* (Geneva: UNAIDS, 2014), p. 10.

4. UNAIDS, "UNAIDS welcomes bold new HIV prevention and treatment targets from PEPFAR," press release (September 26, 2015). Available at http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/september/20150926_PS_PEPFAR_targets; Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), "Global Fund backs plan to end AIDS by 2030," press release (December 1, 2014). Available at http://www.theglobalfund.org/en/mediacenter/newsreleases/2014-12-01_Global_Fund_Backs_Plan_to_End_AIDS_by_2030.

5. M. Heywood, "Not the end of AIDS: Moving from quantity to quality in order to sustain the results of global AIDS activism" (speech transcript, 2012). Available at http://ahp.org.za/news-detail/425/not-the-end-of-aids-mark-heywood.

6. World Health Organization (WHO), *WHO end TB strategy: Global strategy and targets for tuberculosis prevention, care and control after 2015*. Available at http://www.who.int/tb/post2015_strategy/en.

7. WHO, *Background brief on the proposed targets and estimated costs of implementation of the draft global technical strategy for malaria (2016–2030)* (December 19, 2014). Available at http://www.who.int/malaria/areas/global_technical_strategy/WHO_HTM_GMP_2014.11_eng.pdf?ua=1.

8. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), Art. 12; Universal Declaration of Human Rights, G.A. Res. 217 A (III) (1948), Art. 25.

9. S. Davis, "UNAIDS: Bold human rights targets need better monitoring," *OpenDemocracy* (July 2015). Available at https://www.opendemocracy.net/openglobalrights/meg-davis/unaids-bold-human-rights-targets-need-better-monitoring.

10. Heywood (see note 5); Health Gap, "Uganda: World AIDS Day civil society press statement," press release (December 3, 2014). Available at http://www.healthgap.org/uganda_world_aids_day_press_statement; *The Robert Carr doctrine: Principles for a meaningful response to HIV among the world's key affected populations* (July 2012). Available at http://www.msmgf.org/files/msmgf//documents/RobertCarrDoctrine.pdf.

11. For a few examples, see C. Overs and B. Loff, "The tide cannot be turned without us: Sex workers and the global response to HIV," *Journal of the International AIDS Society* 16 (2013), p. 18459; C. Obermeyer, S. Bott, R. Bayer, et al., "HIV testing and care in Burkina Faso, Kenya, Malawi and Uganda: Ethics on the ground," *BMC International Health and Human Rights* 13/6 (2013). Available at http://www.biomedcentral.com/1472-698X/13/6; K. Wickramage, R. Premaratne, S. Peiris, and D. Mosca, "High attack rate for malaria through irregular migration routes to a country on verge of elimination," *Malaria Journal* 12/276 (2013). Available at http://www.malariajournal.com/content/12/1/276; Human Rights Watch, *Torture in the name of treatment: Human rights abuses in Vietnam, China, Cambodia, and Lao PDR* (New York: Human Rights Watch, 2012); Southern Africa Litigation Centre, *Case study: Mandatory HIV testing in Malawi*. Available at http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2015/05/Mwanza-fact-sheet.pdf; CARAM-Asia, "Human rights, HIV, and the migrant workers," *Asia-Pacific Human Rights Information Center FOCUS* 29 (September 2002). Available at http://www.hurights.or.jp/archives/focus/section2/2002/09/human-rights-hiv-and-the-migrant-workers.html.

12. Global Network of Sex Work Projects, *SWAN stands in solidarity with sex workers in Tajikistan at AIDS 2014 conference* (August 13, 2014). Available at http://www.nswp.org/news-story/swan-stands-solidarity-sex-workers-tajikistan-aids-2014-conference.

13. T. Esfendiar, "Tajikistan's prostitution crackdown worries activists," *Eurasianet Weekly Digest* (July 8, 2014). Available at http://www.eurasianet.org/node/68921; Sex Workers' Rights Advocacy Network, *AIDS 2014 participants express solidarity with Tajik sex workers facing police crackdown* (July 24, 2014). Available at http://swannet.org/en/content/aids-2014-participants-express-solidarity-ta-

jik-sex-workers-facing-police-crackdown.

14. J. Scott, *Seeing like a state: How certain schemes to improve the human condition have failed* (New Haven and London: Yale University Press, 1998), pp. 88–89.

15. J. Ferguson, *The Anti-politics machine: "Development," depoliticization, and bureaucratic power in Lesotho* (Minneapolis and London: University of Minnesota Press, 1994), p. 260.

16. United Nations Development Group, *The human rights based approach to development cooperation: Towards a common understanding among UN agencies* (NY: UNDG, 2003).

17. This work is described in more detail in S. Davis, "Human rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria," *Health and Human Rights Journal* 1/16 (2014), pp. 134–147; Global Fund, *Thirty-third board meeting: Community, rights and gender report*, GF/B33/09 (March 31–April 1, 2014).

18. Global Fund, "Global Fund launches human rights complaints procedure," press release (April 27, 2015). Available at http://www.theglobalfund.org/en/mediacenter/newsreleases/2015-04-27_Global_Fund_Launches_Human_Rights_Complaints_Procedure.

19. Global Fund, *Funding model*. Available at http://www.theglobalfund.org/en/fundingmodel.

20. Global Fund, *Allocations process*. Available at http://www.theglobalfund.org/en/fundingmodel/allocationprocess.

21. Global Fund, *The modular template*. Available at http://www.theglobalfund.org/en/me/documents/modulartemplate.

22. Global Fund, *Human rights for HIV, TB, malaria and HSS grants: Information note*. Available at http://www.globalfundadvocatesnetwork.org/wp-content/uploads/2014/10/Core_HumanRights_InfoNote_en.pdf.

23. Global Fund, *2014 Financial performance: End of year results*, GF/B33/02 (March 31, 2015).

24. Global Fund, *Thirty-third board meeting: Corporate KPI results 2014*, GF/B33/04B (March 31–April 1, 2015).

25. A. Neier, "Social and economic rights: A critique," *Human Rights Brief* 13/2 (2006), pp. 1–3.

26. S. Gruskin and N. Daniels, "Process is the point: Justice and human rights: Priority setting and fair deliberative process," *American Journal of Public Health* 98/9 (2008), pp. 1573–1577.

27. Global Fund, *Resource book for applicants* (Geneva: Global Fund, 2015), p. 6.

28. Ibid.

29. Global Fund, *CCM eligibility and performance assessment*. Available at http://www.theglobalfund.org/en/ccm/guidelines/eligibilityperformance.

30. M. Dybul, "Better health, better human rights," *Huffington Post* (June 12, 2013). Available at http://www.theglobalfund.org/en/blog/2013-06-12_Better_Health_Better_Human_Rights.

31. Global Fund, *Thirty-third board meeting: Community, rights and gender report* (see note 17), p. 26.

32. Ibid.

33. Global Fund, *Report of the Technical Review Panel on the concept notes submitted in the third and fourth windows of the funding model* (Geneva: Global Fund, 2015).

34. For example, compare the list of countries eligible for Global Fund financing (http://www.theglobalfund.org/en/fundingmodel/updates/2015-02-27_2015_Eligibility_list_for_2015_released) with Transparency International's annual corruption index (http://www.transparency.org/cpi2014/results).

35. C. Alemany, *Conditionalities undermine the right to development: An analysis based on a women's and human rights perspective* (Cape Town: Association for Women's Rights in Development, 2008), p. 8.

36. *Statement of African social justice activists on the threats of the British government to "cut aid" to African countries that violate the rights of LGBTI people in Africa* (October 31, 2011). Available at http://paper-bird.net/2011/10/31/african-activists-on-human-rights-and-aid.

37. D. Tarantola, M. Unnithan, L. McGoey, et al., "Emerging themes: The features of an enabling environment and the scarcity of research and evaluation," in F. Bustreo, P. Hunt, S. Gruskin, et al., *Women's and children's health: Evidence of impact of human rights* (Geneva: World Health Organization, 2013), p. 86.

38. See, for example, S. Schwartz, R. Nowak, I. Orazulike, et al., "The immediate effect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: Analysis of prospective data from the TRUST cohort," *Lancet HIV* 2/7 (2015), pp. e299–e306;. Available at http://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(15)00078-8/abstract; S. M. Peitzmeier, A. Grosso, A. Bowes, et al., "Associations of stigma with negative health outcomes for people living with HIV in the Gambia: Implications for key populations," *Journal of Acquired Immune Deficiency Syndrome* 68/Suppl 2 (2015), pp. S146–S153.

39. I. Winkler, M. Satterthwaite, and C. de Albuquerque, *Measuring what we treasure and treasuring what we measure: Post-2015 monitoring for the promotion of equality in the water, sanitation, and hygiene sector*, New York University School of Law Public Law and Theory Research Paper Series, Working Paper No. 14-48 (September 2014).

40. Office of the United Nations High Commissioner for Human Rights, *Human rights indicators: A guide to measurement and implementation* (Geneva: OHCHR, 2012); S. Merry, "Measuring the world: Indicators, human rights

and global governance," *Current Anthropology* 52/3 (2011), S83–S95.

41. Global Fund, *M&E framework for the Global Fund grants with insufficient coverage indicators for performance-based funding* (July 31, 2014). Available at http://www.theglobalfund.org/en/me/documents/meframework.

42. S. E. Merry, K. E. Davis and B. Kingsburgy (eds), *The quiet power of indicators: Measuring governance, corruption and rule of law* (Cambridge: Cambridge University Press, 2015).

43. Open Society Foundations, *Criminalizing condoms: How policing practices put sex workers and HIV services at risk in Kenya, Namibia, Russia, South Africa, the United States, and Zimbabwe* (New York: Open Society Foundations, 2012); Human Rights Watch, *Sex workers at risk: Condoms as evidence of prostitution in four US cities* (New York: Human Rights Watch, 2012).

44. Schwartz et al. (see note 38); R. Booth, S. Dvoryak, M. Sung-Joon, et al., "Law enforcement practices associated with HIV infection among injection drug users in Odessa, Ukraine," *AIDS Behavior* 17/8 (2013), pp. 2604–2614.

45. K. Shannon, S. Strathdee, S. Goldenberg, et al., "Global epidemiology of HIV among female sex workers: Influence of structural determinants," *Lancet* 385/9962 (2015), pp. 55–71.

46. Ibid., p. 59.

47. F. Bustreo, P. Hunt, S. Gruskin, et al., *Women's and children's health: Evidence of impact of human rights* (Geneva: World Health Organization, 2013), p. 7.

48. M. Airoldi, "Disinvestments in practice: Overcoming resistance to change through a sociotechnical approach with local stakeholders," *Journal of Health Politics Policy and Law* 38/6 (2013), pp. 1–21.

49. Health Foundation and London School of Economics, Department of Management, *STAR Socio-technical allocation of resources: Guidance document.* Available at http://www.health.org.uk/sites/default/files/Star%20guidance%20document.pdf.

50. Ferguson (see note 15).