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VIRTUAL ROUNDTABLE

Rights-Based Approaches to HIV, Tuberculosis, and Malaria

Nina Sun and Joseph J. Amon

Participants

All roundtable participants contributed to the Global Fund's Breaking Down Barriers program progress assessment, which occurred in 20 countries in 2023. They are identified by their country of residence.

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Nina and Joseph: *Thank you everyone for participating in this virtual roundtable on rights-based approaches to—and their impact on—HIV, tuberculosis (TB), and malaria, drawing on results from the recent evaluation of the Global Fund's Breaking Down Barriers initiative.*

Joseph: *Let me start with a big question for Alistair and Alexandrina—why is the Global Fund providing funding for rights-based interventions? Why is this important not just to each of you as human rights advocates but for the organization as a whole?*

Alexandrina: The Global Fund recognized some years ago that in order to end HIV, TB, and malaria, we must invest in rights-based responses: scaling up comprehensive human rights programs and supporting the establishment of enabling environments—that is, environments which ensure that health care is available without discrimination, that people's rights and dignity are respected, and that policies support access to prevention and treatment. By dismantling barriers to health services and addressing the inequities that leave people behind, we are creating resilient and sustainable systems for health and empowering people to claim their rights. Putting human rights at the heart of health responses is even more critical today given the global context of conflicts, climate-related disasters, pandemics, and pushback against human rights.

Alistair: I agree with Alexandrina completely, but I'll just add that we know that human rights-related barriers significantly reduce the effectiveness and impact of national responses to HIV, TB, and malaria. They make people more vulnerable to infections, they limit access to quality health services, and they drive poorer health outcomes. These barriers are further compounded by an aggressively growing pushback against gender equality and human rights in many countries around the world, evidenced by punitive and regressive policies and actions. Evidence shows that removing human rights-related barriers can powerfully accelerate progress toward ending AIDS, TB, and malaria, and has demonstrated that inaction against structural barriers will result in an increase in people living with or affected by the three diseases. So, quite literally, we can't do our job at the Global Fund without paying attention to human rights.

Nina: *When did the Global Fund begin this work? Can you describe the kinds of human rights interventions you support? How hard has it been to implement and scale up these interventions?*

Alexandrina: The Breaking Down Barriers (BDB) initiative was launched in 2017 in 20 countries. The initiative provides countries with matching funds to amplify Global Fund investments and with technical support to drive the development and implementation of country-owned national plans and comprehensive programs to address the injustices that continue to threaten progress against the three diseases. The interventions funded by BDB cover the following program areas:

- Eliminating stigma and discrimination in all settings
- Ensuring the nondiscriminatory provision of health care
- Promoting human rights-based law enforcement practices
- Expanding legal literacy ("know your rights")
- Increasing access to legal services and justice
- Improving laws, regulations, and policies
- Reducing gender discrimination, harmful gender norms, and violence against women and girls, in all their diversity
- Mobilizing communities for human rights advocacy
- Removing barriers to TB services in prison
- Advancing equity, rights, and gender equality for malaria responses.

Alistair: Since the BDB initiative started, we have observed big jumps in the scale of human rights programs being implemented, especially related

to TB and malaria, where rights-based approaches were less common than with HIV. Programmatic funding increased from US$10.6 million in the 2014–2016 allocation period to $135 million between 2020 and 2022, leading to substantial progress in the scaling-up of programs.

Nina: *Let's turn now to some of the researchers who participated in the recent evaluation of the BDB initiative, which, full disclosure, I also participated in and which was led by my co-moderator. Let's start out with what people found most surprising or impressive. Rachel, do you want to go first?*

Rachel: I worked on the Ghana assessment and I was most surprised and impressed by the enthusiastic reception of the program, particularly the commitment shown by the Commission on Human Rights and Administrative Justice (CHRAJ) commissioner, who launched it as the first initiative of its kind in Ghana. The strong endorsement from CHRAJ, along with support from the Ghana Health Service, the Ghana AIDS Commission, and traditional and religious leaders, played a crucial role in the program's success.

Sheilla: I worked in Kenya, and what I found most surprising was that rights-based programs were able to scale up despite Kenya's challenging legal environment that had threatened to derail gains made. For example, legal literacy programs implemented by key population-led organizations were scaled up despite increased stigma and discrimination exacerbated by anti-LGBT protests and the draft Family Protection Bill, which sought to further criminalize same-sex sexual relationships. Most impressive was the sense of national ownership for reducing or removing human rights- and gender-related barriers to HIV, TB, and malaria services. This was clear from the adoption of the Kenya AIDS Strategic Framework (2020/2021–2024/2025), as well as the National Strategic Plan for Tuberculosis, Leprosy and Lung Health (2019–2023) and the Kenya Malaria Strategy (2019–2023), all of which have a strong emphasis on the removal of human rights- and gender-related barriers, such as addressing gender-based violence and providing post-violence care.

Juliette: I was particularly impressed by the work done in Côte d'Ivoire on changing the perceptions and gaining the support of police officers for men who have sex with men, transgender people, and sex workers. These populations are socially shunned in many countries, and efforts to challenge perceptions are often reduced to a narrative of "Western" values against "African" culture. The approach led by Alliance Côte d'Ivoire together with key population organizations helped create a safe space (during a three-day workshop called "Look In Look Out") where police officers and key populations could connect as human beings, share life stories and challenges, question their behaviors, and build bridges between them. Some key populations noted that this approach of sharing their life and struggles with a group of police officers had a "therapeutic" effect for them. This really blew me away; I had never seen police officers talk in the way they did about key populations and how this changed their perspectives and behaviors afterward in their interactions with sex workers, men who have sex with men, or transgender persons who would come into the police station for help.

Cécile: When conducting the assessment in Senegal, I was particularly impressed and inspired by the tireless work and dedication of peer educators. They are proud of their work because they know they save lives. Senegal put in place a strong network of mediators and peer educators throughout the country that has proved essential to improving access to care, decreasing stigma, and improving self-esteem. Another element that struck me is the importance of maintaining a culture of dialogue in Senegal. Despite what seems to be an increasingly polarized world, dialogues remain possible and, in countries like Senegal, can make a difference. Many stakeholders we met during the assessment talked about people's ability to listen and change their minds. They also described the importance of talking with local authorities and community leaders to secure HIV-related interventions, espe-

cially for key populations that face violence and discrimination within the broader community. That confirmed the importance of maintaining and supporting space and time for dialogues with multiple stakeholders, including at a very local level.

Joseph: *It's great to see both the way in which government commitment can advance programs and the way that civil society organizations can work to break down stigma and discrimination person-to-person, bringing people together to recognize that we have to see one another as people first. Let's hear from some researchers who have worked outside of Africa about some of their findings.*

Karyn: I have worked in Asia, especially Thailand, for many years, and for this project, I worked in Indonesia and Nepal. As always, I was most moved by the community advocates whom I met—whether a TB survivor, an HIV-positive transgender migrant worker, or a woman who uses drugs—and who are creatively pushing for change, locally or nationally, despite countless barriers and daily assaults on their dignity. Also, peer project workers, despite being lowest on the budgetary totem pole in terms of financial reimbursement for their work, are deeply motivated to achieve services and justice as equals in their society. This kind of brave and experience-driven leadership in challenging political and economic environments never ceases to amaze me. There is such a tremendous resistance to despair—even without resources, you can be sure these activists will persist. I was so grateful to meet them and to be profoundly inspired as an "unintended consequence" of my work on this project!

Diederik: In Ukraine, despite the challenges from Russia's full-scale invasion, we saw impressive progress over time in reducing HIV-related stigma and discrimination. Led by the organization 100% Life—formerly the Network of People Living with HIV—Ukraine is one of very few countries that has regularly conducted stigma index studies since 2010. This allowed us to examine trends over time: we found, across four stigma index studies, that most key variables show steady decreases over time. For example, exposure to gossip related to HIV status in the past 12 months dropped from 30% in 2010, to 25% in 2013, to 19% in 2016, to 8% in 2020. Fear of breaching of medical confidentiality similarly dropped steadily, from 34% in 2010 to 6% in 2020. While the stigma index studies do not allow us to identify what exact programs or developments have contributed to this trend or how, the fact that HIV-related stigma and discrimination has declined so steadily and consistently suggests that Ukraine is largely getting its response to this challenge right.

Megan: In Jamaica, the Philippines, and Indonesia, I was most impressed by the extent to which access-to-justice programs were integrated into HIV prevention, testing, and treatment services. Each country I worked in took a different approach, but the combination of legal literacy and legal assistance to clients of health facilities was truly transformative for health care outcomes. For example, in Jamaica, one of the largest community-led health care providers had a legal team operating at each of its clinics in three regions. Peer educators acted as legal "focal points," and all case managers, clinical staff, and outreach workers were trained to identify and make referrals to the legal team for clients experiencing gender-based violence, discrimination, or other legal problems. Often, these issues were causing people to struggle to stay in care or fall out of care altogether—but assistance from the para legals and lawyers allowed them to return.

Mina: I agree with Megan on the point about integration. In the Philippines, I was impressed by the Love Yourself Project, which emphasized the grassroots implementation of activities—mobilizing peer navigators, building local capacities, and serving as a testing center and treatment hub. With offices strategically located in communities, the project improved visibility and had a welcoming atmosphere to make HIV/AIDS programs an inclusive engagement at the community level. It is also thinking about sustainability, having expanded

its funding base and now receiving compensation from PhilHealth (Philippine Health Insurance Company) for services rendered to people living with HIV.

Nina: *Now let's look at some specific interventions. What did the evaluation find in relation to efforts to eliminate HIV- and TB-related stigma and discrimination? Julie, what stood out for you in your assessment in the Democratic Republic of Congo?*

Julie: In the Democratic Republic of Congo (DRC)—and really everywhere—stigma and discrimination against transgender and gender-diverse people can be severe, and deadly. In the fight against HIV, they represent one of the most invisible populations. In DRC, we met a transgender woman who started working on HIV issues as an activist with Progrès Santé Sans Prix, an organization caring for orphans, vulnerable children, and people living with HIV. A few years ago, this activist decided to launch Entre Nous Plus, an organization focused on the situation of transgender people in DRC. She has personally faced numerous arrests and abuses of all kinds, but through her organization and her participation in workshops, training sessions, and advocacy activities, she has led a change of perception in DRC toward transgender individuals. For instance, her intervention during a training session for the police ended in the police commissioner making commitments to transgender issues and even sharing his phone number in case of someone's arrest. This is just another example where you need to break down stigma and discrimination by forging new relationships. It's not quick work, though.

Mina: In the Philippines, ACHIEVE Inc. sought to address stigma and discrimination through legal and psychosocial support services to TB and HIV patients. It also developed and tested a Human Rights Score Card at the community level to measure trends in stigma and discrimination within health care services and by providers. The organization also organized a national network of TB support groups and provided them with organizational development and capacity-building.

Joanne: In Botswana, the Rainbow Identity Association, which advocates for the rights of transgender and intersex persons, took advantage of the national dialogue opened by a broad constitutional review exercise to push for greater respect for human rights. The organization arranged "town hall" sessions in communities with local chiefs and other authorities to enable people to hear directly from trans and intersex persons. There was partial success: The constitutional reform commission convened by the president wound up recommending legal protections for intersex people, but these protections were ultimately not included. The community meetings also helped reduce fear of trans people as the "unknown." To overcome the weak enforcement of anti-discrimination laws in Botswana, BONELA, which has worked on HIV and human rights for many years, recognized that better public awareness of U=U (undetectable = untransmittable) could help reduce discrimination and the labeling of people living with HIV as "vectors." They were just gearing up to go in that direction as we finished the assessment.

Kitty: In South Africa, TB HIV Care's work with communities to reduce community-level stigma and discrimination toward people who use drugs and to find solutions to address human rights issues affecting this population was exceptionally important. The organization worked with people who use drugs and multiple partners (e.g., health, social development, local government, police, private security companies, and civil society organizations) to set up community-level task teams, engaging communities to find solutions in terms of housing, access to harm reduction, employment, and psychosocial support for people who use drugs. The partnership approach has reduced community level stigma and discrimination, sensitized service providers, and helped overcome some of the structural and societal barriers to access to health care for people who use drugs. While past surveys found extremely high rates of discrimination against

people who use drugs in health settings and in the community, recent assessments have unveiled real progress.

Joseph: *What was found about the impact of HIV and TB legal literacy and legal services interventions? Mikhail, you have worked in this area for a long time—what did you find in Kyrgyzstan?*

Mikhail: One of the most impactful examples of HIV and TB legal literacy work that I found was the work of key population-led groups and peer "street lawyers" in Kyrgyzstan. What makes this work stand out is the fact that these street lawyers come from within the community—many of them are people who use drugs and have an intimate understanding of the specific challenges and needs of their peers. These individuals are quick learners, driven by a deep sense of pride in being able to help their community. Their work goes beyond the duration of any specific program or funding; they remain with the community, offering ongoing support and advocacy even after formal programs end. In Kyrgyzstan, there have been numerous instances where street lawyers from the community of people who use drugs successfully prevented unjust persecution by the police, who often attempted to extort bribes. In many cases, simply providing information about the legal threshold quantities of controlled substances was enough to fend off police harassment. This approach not only protected individuals from wrongful prosecution but also empowered the broader community, reducing their vulnerability to HIV and TB by fostering a sense of agency and resilience. The work of these peer street lawyers is a powerful example of how grassroots legal literacy initiatives can have a lasting and meaningful impact on marginalized communities.

I also just want to mention the work of Fond Soros Kyrgyzstan (FSK) too. FSK's advocacy work with civil society and professional lawyers resulted in amendments to the law concerning access to free legal aid that not only provided greater access to professional lawyers and civil society paralegals but also established the first training program to certify paralegals within the free legal aid system. This program enables civil society paralegals, including those who serve as peer street lawyers, to obtain certification and become an integral part of the state-guaranteed free legal aid framework.

Julie: The impact of paralegals has been remarkable in DRC. Our interviews suggested major improvements among key populations in knowledge of rights in parallel to a huge reduction of self-stigma and greater confidence, all as a result of "know your rights" activities. In addition, paralegals are closely connected to the legal clinics and the different types of services they provide (psychosocial support, legal support, and judicial support). Another element highlighted during our visit to DRC is the importance of mediation led by paralegals on the ground. This constitutes alternative and community forms of dispute resolution, which is often the method of dispute resolution preferred by key populations (as compared with litigation).

Kitty: In South Africa, the South African National AIDS Council set up a national process covering six of the nine provinces, working with communities at the district level to discuss HIV- and TB-related human rights issues affecting key and vulnerable populations and to develop district-level human rights charters. In some districts and areas which have been slow to implement stigma- and discrimination-reduction programs, the researchers noted a marked difference in levels of legal literacy about HIV, TB, law, and human rights: the process of developing the human rights charters led to strengthened legal literacy and to the development of and commitment to community-owned human rights charters (as well as provincial charters and a national charter). These charters have now laid the basis for further action-oriented community-centered human rights programming (stigma- and discrimination-reduction programs) that will be built into the new cycle of Global Fund grants.

Ria: In Indonesia, the ORBIT Foundation in Jawa Timur is exceptionally important in improving

the legal literacy of key populations and people living with HIV. It provided paralegal training to representatives of all key populations and people living with HIV in Surabaya and Sidoarjo districts. In addition, the foundation was able to raise funds locally to provide legal aid for marginalized communities. With limited funding from the Global Fund, it was also able to train representatives of all key populations in Sidoarjo and Surabaya on human rights.

Florence: The Uganda Network on Law Ethics and HIV/AIDS (UGANET) and Human Rights Awareness and Promotion Forum (HRAPF) in Uganda have been using the community paralegals model to improve access to justice, with UGANET focusing on the provision of legal services to persons living with HIV and HRAPF focusing on the provision of legal services to key populations. The model is structured in such a way that these organizations identify individuals from within the community—and in the case of key populations, the key populations themselves—and provide them with training. Community paralegals act as frontliners in advancing access to justice, identifying community members in need of legal services, providing basic legal advice, and, for individuals with needs beyond their capacity, referring these individuals to UGANET, HRAPF, or other legal services providers for further assistance. The two organizations also implement community reporting tools by which they are able to monitor, document, and profile human rights violations against people living with HIV and key populations. Information generated through these tools is critical for informing advocacy and programming for key populations.

Nina: *We've heard of the impact of police discrimination in communities, as well as efforts by paralegals and lawyers to ensure that rights are respected and that people—especially key populations—have access to HIV and TB services. But what about higher-level factors—such as laws, regulations, and policies—that can reinforce stigma and discrimination or help prevent it? What efforts are being made at that level?*

Sheilla: That's definitely an important area of work that we saw in Kenya. For example, KELIN (the Kenya Legal and Ethical Issues Network) engaged in strategic litigation related to women living with HIV who were sterilized without their knowledge or consent, and in December 2022 the Kenyan High Court delivered a landmark judgment finding that the nonconsensual tubal ligation of a woman living with HIV violated her rights to dignity, to freedom from discrimination, to the highest attainable standard of health, and to found a family, and awarded damages to the claimants. KELIN has been doing this kind of work for a long time—in 2018, it published an assessment of the TB-related legal environment, providing a critical foundation to inform advocacy to address rights-related barriers to TB services.

Florence: In Uganda, HRAPF has also worked for a long time to improve laws, regulations, and policies, engaging with policy makers and pursuing strategic litigation. For example, in 2021–2022, when the Sexual Offences Bill was passed, HRAPF and others successfully lobbied the president of Uganda to return the bill to Parliament for reconsideration. No further action was taken on the bill, which remains seated in Parliament. But this work is difficult, and not every battle is won. This same approach was applied when the Anti-Homosexuality Act of 2023 was passed. Soon after enactment, HRAPF and others used strategic litigation to petition the Constitutional Court to challenge the constitutionality of the act. The Constitutional Court panel of five judges unanimously declined to annul the act, holding that it complies with the Constitution. However, the court also nullified sections 3(2)(c), 9, 11(2)(d), and 14 of the act for contravening the Constitution. For example, section 14 mandated health workers to report persons involved in same-sex relations to police, and section 9 made it an offense punishable by seven years to rent or lease property to a person engaged in same-sex relations. HRAPF and other petitioners filed an appeal against the Constitutional Court ruling, and this appeal is currently awaiting a decision by the Supreme Court, so it's possible we'll see more success.

Joanne: In Botswana, we also saw mixed results from efforts to improve the legal environment. After an amazingly thoughtful statement by the High Court decriminalizing same-sex relations, the Evangelical Fellowship of Botswana organized considerable pushback. With allies in Parliament, it promoted the idea that the High Court decision couldn't be final until Parliament passed a law explicitly protecting people in same-sex relationships. We consulted with constitutional lawyers, who said unanimously that this interpretation was incorrect—that the court's decision made anti-discrimination protections the law of the land. An unfortunate part of this story is that when we asked the police if rank-and-file officers were being trained about the court decision, they said that they wouldn't train their personnel until there was a parliamentary decision. But nongovernmental organizations, including LEGABIBO, the main LGBTQ rights organization in the country, are taking up this fight.

Joseph: *Strategic litigation and advocacy on legislation often needs to be complemented by community mobilization. How has funding from the Breaking Down Barriers project supported those efforts?*

Karyn: In Indonesia, we saw really strong community mobilization activities among TB survivor groups and civil society networks around removing rights- and gender-related barriers faced by TB survivors. A significant body of related research, supported in part by the Global Fund, had recently been completed, including a TB stigma assessment and the launch of an online platform where communities can access TB- and rights-related information and report incidents of stigma and discrimination. But there is also an enormous need for ramped-up training, advocacy, and mobilization activities to get more organizations involved. One of the targets of community mobilization and advocacy right now is related to local budgeting for TB and the need to increase domestic funding for programs that promote TB-related human rights.

Diederik: In Côte d'Ivoire, organizations of people who use drugs and Médecins du Monde engaged in a multi-year effort to build support for changes to the country's drug law to shift it from a law enforcement to a public health approach. Over the course of several years, Médecins du Monde supported nascent community organizations, helping them build organizational strength to both provide effective services and build advocacy capacity. Community organizations then engaged in outreach to convince law makers and other key stakeholders of the importance of the legal changes they advocated, resulting in the adoption of important legal changes in May 2022 in Côte d'Ivoire's Senate. While the implementation of these legal changes—and practical changes in policing—remains a significant challenge, this work has shown the potential for legal change regarding a challenging and politically sensitive topic through an integrated approach to service provision, community mobilization, and advocacy.

Nina: *We haven't yet spoken about human rights-related barriers around malaria, which was a part of the assessment in Kenya and Uganda. What are some examples of this work from those countries? What kinds of successes and challenges are being seen?*

Sheilla: Many organizations working on malaria are not familiar with rights-based approaches, so there is a fair amount of work just getting organizations up to speed and aware of how rights-related barriers can also impede access to malaria prevention and treatment. Toward this aim, the Kenya NGOs Alliance Against Malaria (KeNAAM) carried out a rapid mapping of malaria civil society organizations in 2021 to inform the Malaria Matchbox Assessment. KeNAAM also conducted training to build the capacity of those organizations to meaningfully engage in the assessment. An introductory training curriculum for civil society organizations was developed that included content on human rights, vulnerable populations, nondiscriminatory health care, gender as a determinant of health, and gender roles in the context of malaria. KeNAAM conducted four virtual training sessions for 36 civil society organization representatives. It also supported capacity-building interventions for civil

society organizations working in the malaria sector to enhance their capacity to participate in policy design and monitoring. In addition, community health promoters were trained to provide access to medicine and diagnostics for vulnerable groups, such as the fishing community and seasonal migrant workers.

Florence: In Uganda, the Program for Accessible Health, Communication, and Education (PACE) implemented community dialogues to explore gender roles and gender-related barriers as a model for engaging men as decision-makers and gatekeepers for household and community action regarding malaria prevention and control. As part of this effort, PACE developed an organization-wide Gender Action Plan for all its interventions and updated its monitoring tools to collect more comprehensive gender- and age-disaggregated data on its activities in communities. These were informing programming in terms of identifying and resolving emerging gender-related barriers, as well as documenting best practices. The challenge and opportunity in terms of working on rights-related barriers to malaria prevention and control in Uganda is that, previously, malaria stakeholders did not see malaria as a human rights issue. However, that perception is changing. To boost work in this area, we need groundbreaking studies such as legal environment assessments for malaria, followed by clear advocacy priorities and action plans to take this work forward.

Joseph: *Looking forward, what is the biggest remaining challenge to ensuring universal access to prevention and treatment for HIV, TB, and malaria? How could rights-based interventions overcome that challenge? Alistair and Alexandrina, why don't we start with you?*

Alistair: Three major challenges to ensuring universal access to prevention and treatment come to my mind. First is discrimination in the community—including in education and justice settings. Second are harmful laws and policies, including criminalization. Third is an implementation environment with limited resources. To address these issues, we need to continue to fund community and civil society organizations to do advocacy and engage with the judiciary and law enforcement to assure legal protection, the right to fair procedure, and redress. Governments need to increase domestic funding for community groups and for addressing these societal enabler interventions. In general, TB and malaria responses are under-funded, are mainly biomedical, and do not address key gender- and human rights-related barriers that negatively impact programmatic outcomes. These trends are compounded by wider economic challenges constraining the domestic fiscal space available for health in the medium run. With less money for health, investment in interventions to address structural barriers to HIV, TB, and malaria services is expected to be further deprioritized, while other social sector investments will also be reduced, with further deterioration in the socioeconomic conditions of vulnerable populations.

Alexandrina: In my opinion, the biggest challenge hampering universal access to health services is complacency in the face of the multiple and concurrent crises. The world has believed it is on the cusp of ending HIV and TB as public health threats, and eliminating malaria, and it set ambitious health, equity, and justice targets under the Sustainable Development Goals. It then proceeded to move its attention elsewhere. However, we have seen how malaria rebounds given climate change and related disasters, how TB preys on those displaced and residing in cramped shelters in contexts of wars, and how the trajectory of HIV cases is on the rise in some middle-income countries that failed to allocate domestic resources or to provide evidence-informed services to marginalized and criminalized populations. In the current global pushback on human rights and gender, human rights programs are more important than ever. The othering and scapegoating of communities amplifies stigma and discrimination, driving key and vulnerable populations further underground. The

shrinking space and voice of civil society unravels effective community-led health responses. Only rights will fix these wrongs.

Joseph: *I think there's going to be a lot of agreement in this group that these challenges—discrimination, punitive laws, lack of funding amid multiple and concurrent crises—are seen across all 20 countries in the assessment—and really everywhere.*

Mikhail: I agree. The first challenge that came to my mind in terms of ensuring universal access to HIV and TB prevention and treatment is the existence of discriminatory laws and practices aimed at key populations. But we need to look at what is driving these laws. In Kyrgyzstan, conservative trends have dominated the political agenda over the last five years. This shift has led to the enactment or stricter enforcement of laws that are particularly harmful to key populations. These include anti-gay propaganda laws, increased policing that targets sex workers, and legislation that discriminates against civil society organizations receiving foreign funding. Despite ongoing advocacy efforts by civil society organizations to implement mitigation mechanisms, these conservative trends continue to pose significant barriers. Rights-based interventions have a critical role to play in overcoming this challenge by advocating for the repeal or reform of discriminatory laws, promoting inclusive policies, and ensuring that key populations have legal protections that support their access to prevention and treatment services. Such interventions would help create an environment where universal access to essential HIV and TB services is truly achievable.

Rachel: I agree too. The biggest remaining challenge to ensuring universal access to prevention and treatment, particularly in Ghana, is persistent stigma and discrimination. This challenge manifests in several ways, including the reluctance of key populations to seek testing and treatment, and the enactment of laws that criminalize certain behaviors or identities associated with higher HIV and TB risk. Rights-based interventions that could overcome this challenge include legal reform and advocacy; decriminalization; anti-discrimination laws; community empowerment and education; public awareness campaigns; and empowering key populations. But we also need to strengthen health care systems by integrating human rights into health care delivery and strengthen accountability mechanisms.

Cécile: From my perspective, recurrent homophobic attacks and the politization of HIV- and human rights-related issues are significant barriers to the HIV response. They subject marginalized and key populations to violence and discrimination and encourage silence and fear. Multidisciplinary approaches and efforts to ensure country ownership are essential to human rights programs' integration within the HIV response.

Sheilla: A key challenge in Kenya, and in many countries, is not only punitive laws but also weak and inconsistent implementation and enforcement of good laws, such as anti-discrimination laws, and limited access to legal services when those laws are violated. More broadly, we need everywhere to increase scrutiny of the law through legal environment assessments that examine laws, policies, and practices that impact access to HIV, TB, and malaria services at both the national and county level. We also need to strengthen the capacity of community-led organizations and networks to effectively undertake community monitoring of and engagement in legislative processes and developments that impact communities affected by HIV, TB, and malaria.

Ria: I'd just like to highlight one challenge to universal access to prevention and treatment which hasn't been discussed much yet but is a part of the BDB initiative—and that is ensuring access to HIV and TB services among prisoners. In Indonesia, and everywhere, access to treatment for prisoners is very limited. Most prisons in Indonesia have only a small clinic with one doctor to serve all prisoners. And hospital care for prisoners is available in only a few areas. Funding for prisoner health is also very limited.

Florence: In Uganda, the evolving legal environment remains a challenge for ensuring universal access to prevention and treatment—and what we have seen, over and over, with laws such as the Penal Code, the HIV Prevention and Control Act, the Narcotics and Psychotropic Substances Control Act, and the Anti-Homosexuality Act is that these laws, even after being rejected by the courts, are just reintroduced.

Karyn: No matter what country, it's hard to imagine meaningful or sustainable progress without the crucial element of strong political leadership to achieve global and national HIV, TB, and human rights and gender goals. Without visionary, top-level political support (with strong civil society input and oversight) to institutionalize effective programming, unleash adequate resources, and ensure a legislatively and socially enabling environment, people are at a severe disadvantage in terms of the full realization of their human rights.

Diederik: I would go back to Alistair's point: stigma, discrimination, and criminalization all remain formidable obstacles to universal access to testing, prevention, and treatment. While human rights programs have shown clear potential for reducing and eventually removing these obstacles, these will not be quick wins. To make a real dent in these barriers, human rights programming will need to be implemented consistently and at scale. At present, however, in many countries, programming is still too ad hoc and small scale, lacks integration with services, and is not implemented consistently. We will need continued and consistent funding from the Global Fund, PEPFAR, and other donors, and we need to really focus on integrating human rights programs into HIV and TB services.

Julie: Building off Diederik's point about the need for continued and consistent funding, I think sustainability is still a critical concern. There's a need for more capacity-building of community organizations and collaboration between civil society organizations.

Joanne: I agree with everyone—funding, stigma and discrimination, and the need for capacity-building and involvement of key population-led organizations at the center of the response is critical. One thing I'd add is that at present, the evaluation of rights-oriented programs is often inadequate, leaving advocates without empirical grounding for program expansion.

Megan: I want to add a positive note here. I agree wholeheartedly that the persistent, and worsening, criminalization of the people most impacted by the HIV epidemic is a huge barrier and challenge to achieving "an end of AIDS." The recent wave of anti-LGBTQI laws and policies in Indonesia, Iraq, Uganda, Ghana, Kenya, and many US states not only undermines the HIV response but is part of a broader and very dangerous erosion of human rights around the globe. But we saw in the progress assessments how communities are fighting back in innovative and strategic ways, and those efforts are inspiring. It's more urgent than ever that donors such as the Global Fund continue to support this work with flexibility and commitment to what is going to be a long, difficult struggle.

Joseph and Nina: *Thank you everyone for the lively discussion! Further information on individual country assessments and an overall summary across all 20 countries can be found on the Global Fund's "Community, Rights and Gender" web page: https://www.theglobalfund.org/en/throughout-the-cycle/community-rights-gender/.*