OPEN SOCIETY FOUNDATIONS

Discussion Paper

Solidarity Sidelined: Is there a future for human rights-driven development assistance for health at the Global Fund?

Prepared by:
Joanne Csete
March 2015

For:
Influencing Global Fund Policies and Practices to Advance Human Rights
A meeting of civil society experts and advocates
13-14 April 2015
Barcelona, Spain

Executive Summary

The Global Fund to Fight AIDS, Tuberculosis and Malaria in its founding principles and first decade of work challenged decades of top-down and sometimes questionably motivated practices of official development assistance (ODA) by committing itself to "country-driven" assistance. Global Fund grants responded to countries' own assessments of the level of assistance that was needed and realistically absorbable for essential health programs. This approach, while not perfect, was seen by many as an expression of solidarity with countries endeavoring to fight diseases of poverty and marginalization. It enabled unprecedented levels of support for programs that reached millions of people living with and at high risk of HIV, including people often excluded from health programs such as sex workers, people who use drugs and men who have sex with men (MSM). This approach reflected the spirit of an important global movement for HIV treatment and prevention, which challenged traditional ODA practices in which donors set the envelope for assistance and designated which countries were deserving of aid.

As the Global Fund in its fourteenth year reflects on a new strategy, it must take care to avoid measures that are inconsistent with both its stated objectives and the history of human rights activism and solidarity that helped to bring it into being. New funding processes and some institutional reflections undertaken recently by the Global Fund step back from the country-driven approach. The "new funding model" assigns funding totals to countries independent of their own estimates of program need. It uses a formula based on income and disease burden to calculate the appropriate funding envelope, a method that disadvantages middle-income countries.

The recent reflection of the Global Fund's Development Continuum Working Group (DCWG) recognizes the flaws in this method, noting that the majority of people living with HIV and TB live in middle-income countries (MIC), just as the majority of the world's poor now also live in middle-income countries. Moreover, many HIV and TB epidemics concentrated in politically unpopular "key populations"—such as people who who inject drugs—are also largely in middle-income countries. These countries, despite their designation as middle-income and the compelling epidemiologic case, have not supported programs for these populations in government health budgets. The new funding approach has already resulted in severe cuts to HIV programming in some countries, often at the same time as cuts by ministries of health to HIV programming.

The DCWG report notes that the Global Fund's contribution to overall global health expenditures has been quite small in monetary terms throughout its history. But one of the factors that made the impact of that contribution larger than might be expected from the monetary sum alone was the achievement of reaching previously unreached populations heavily affected by the three diseases. Where its support produced a scaling up of services to marginalized persons and even at times—though not often enough—a degree of empowerment of previously completely disenfranchised persons, the Global Fund truly distinguished itself from other health-sector donors.

Its work represented the hope that not all ODA in health needed to be top-down and driven by ulterior motives but that aid rather might reflect a spirit of solidarity with the often marginalized persons affected by HIV, TB and malaria and other diseases that feed on poverty and marginalization. But that vision of solidarity seems to be put in jeopardy by new funding decisions.

The DCWG reflection asserts that rising income in MIC opens possibilities for new public and private funding sources that should sustain health programs in the face of reduced Global Fund support. **But there is no evidence that any of these new funding sources are particularly amenable to focusing on politically excluded key populations or on human rights interventions,** a reality also acknowledged by the final report of the DCWG.

Both civil society groups and donor institutions have called for urgent action to ensure that there are adequate transition periods and cushioning measures where Global Fund support is significantly reduced, and that affected populations play a meaningful role in transition planning and implementation. Where significant funding reductions are foreseen, there is an urgent need for Global Fund attention to rights-centered transition processes, including the potential usefulness of non-country cordinating mechanisms (CCM), civil society-led programs especially for key populations in the transition period, as well as support for sustained advocacy with governments, other donors and the public for funding essential programs for marginalized persons.

The adoption of human rights goals by the Global Fund in 2011 was an important milestone. Meeting these goals is important for participation and protection of key populations but also for access to affordable medicines, commitment to evidence-based prevention programs, gender equity in health programs, access to justice and awareness of rights of patients and many other issues. It is commendable that the Global Fund has put in place a number of human rights oversight mechanisms, built staff capacity on human rights in the secretariat, and introduced human rights language in grant agreements.

The coming years must be a time of mobilizing significant funding to meet the strategic human rights objectives, or the steps taken so far will not come to fruition. Human rights cannot be an add-on or the poor cousin of other program investments. The Global Fund needs especially to ensure a human rights oversight presence on the ground, revisit its policy on grants to non-CCM entities, and mobilize and strategically use dedicated funding for human rights interventions and rights-based programs that are essential for fighting the three diseases and would not be funded otherwise. Indicators should be developed to measure progress against the Fund's human rights goals, and they should be able to capture unamibiguous funding totals for key population interventions and direct human rights measures. **It is crucial in the coming decade that the Global Fund embody the uncontroversial idea that respecting the rights of people affected by and at risk of HIV, TB and malaria is not just useful but essential for health services to be effective.**

At this stage in its work, the Global Fund has the stature and the strategic direction to provide leadership on human rights in global health, both by example and in the many forms its advocacy can take. In spite of irrefutable epidemiologic and programmatic

evidence, meaningful inclusion of key populations and protection of the human rights of people affected by and at risk of HIV, TB and malaria are still seen as side issues by governments and donors. The Global Fund must reclaim and act on the spirit of solidarity that characterized its origins to be a leader in making human rights central to global health programming.

> *"The success of the Global Fund is a test of global solidarity."*
>
> -Ban Ki-moon, Secretary-General of the United Nations, May 14, 2010[1]

I. The Founding Spirit of the Global Fund

Introduction

Official development assistance (ODA), as government-to-government foreign aid is known, has been criticized for as long as it has existed for being anything but an expression of solidarity with the poor. Anti-poverty assistance has often been denounced as serving the political interests of the donor more than the true needs of the beneficiary. Food assistance, a prominent form of ODA from some countries, for example, has often been judged to benefit the agriculture and shipping sectors of the donor economy more than the lives of those who receive it.[2] The stated goal of ODA may often be poverty reduction, but it has rarely been devised with only that goal in mind.

Foreign assistance—or lack thereof—in the area of HIV/AIDS at first embodied some of the most criticized elements of ODA. When it was understood—belatedly—that AIDS was killing young adults in southern Africa at a rate without precedent in modern history, there were those in the development assistance establishment in Washington, for example, who were not alarmed because Africa was, in any case, "overpopulated".[3] Progress in access to treatment for HIV in Africa was delayed and nearly completely derailed by key donor countries more inclined to protect the interests of their pharmaceutical industries than to save the lives of Africans. But eventually a remarkable global movement changed AIDS-related foreign aid and was—at least for the most part—driven by a sense of solidarity that set it apart from most aid experiences

A period of changing global health governance and a dramatically shifting geography of poverty are part of the context for this paper's consideration of the impact of changes at the Global Fund to Fight AIDS, Tuberculosis and Malaria, including the Fund's so-called New Funding Model. This paper explores the challenge of reaching people most affected by the diseases of concern to the Global Fund who live in middle-income countries but nonetheless live in poverty and are often marginalized by criminalization and systematic violations of their human rights. We also consider what Global Fund processes and policies do and should mean for addressing the human rights problems that directly affect Global Fund-supported programs. In so doing, we comment on the March 2015 report of the Global Fund's Development Continuum Working Group, which analyzes some of these issues.

Development assistance for health: Changing approaches and centers of power

A cursory look at the history of global health might indicate that HIV fortuitously appeared at a time when international solidarity in the health area was at its peak. The human immunodeficiency virus was identified in 1981. In 1979, just two years earlier, the Alma Ata Declaration on Health for All, a visionary, rights-based statement of solidarity, asserted that overcoming economic and social inequality was the key to protecting the right to health of all people and was endorsed by 134 UN member states.[4] Alma Ata embodied a politically daring theme that resonated through many UN declarations in the 1970s—the need for a "new international economic order" that would attack global inequality—which was promoted by the new UN member states freed from colonial rule.

But for many reasons, the impact of Alma Ata's "health for all" mobilization would not be lasting. Within the UN itself, a "selective primary health care" agenda adopted by UNICEF drew donor attention to a few well-defined interventions and a "results-oriented" framework rather than the solidarity-based development of primary health for all that Alma Ata sought.[5] In addition, beginning in the 1980s, the World Bank went beyond its traditional lending on infrastructure projects and became an important lender in the health sector under the rubric of "structural adjustment," which was meant in part to encourage reduced government expenditures on basic services. In the health sector, that meant privatization of services or imposition of user fees to cover costs of public services. By the end of the 1980s, the World Bank's lending in the health sector was several times the annual budget of WHO, and user fees for health services, even in the lowest-income countries, were the order of the day.[6] The "health for all" spirit of solidarity in Alma Ata gave way to policies that plainly undermined access to health services for the most marginalized.

The global catastrophe of AIDS, however, challenged global health governance and the "business as usual" of ODA and would eventually refocus the world on universal access, at least with respect to HIV services. The creation of UNAIDS in 1996 was seen by many to be the result of a loss of confidence in WHO's capacity to lead the multilateral system in the AIDS response as well as wider concerns about mismanagement and corruption that had arisen since the late 1980s.[7] The Medicines for Malaria Venture (MMV), created in 1999, was the harbinger of a new approach to global health governance—an "alliance" of pharmaceutical companies, research institutions, private foundations and UN agencies that aimed to mobilize new funding to take advantage of technical breakthroughs.[8] The "public-private" nature of MMV foreshadowed the structure of the large "global health initiatives" (GHI) that were created in its wake.

The two most prominent of these new institutions, GAVI—originally the Global Alliance for Vaccines and Immunizations, now called the Vaccine Alliance—and the Global Fund to Fight AIDS, TB and Malaria (hereafter "Global Fund") came into being in 2000 and 2002 respectively. GAVI, like MMV before it, appealed to another important new player on the global health scene, the Bill and Melinda Gates Foundation, which enabled GAVI's start-up with a five-year $750 million grant.[9]

The Global Fund and changing global health governance

The Global Fund's creation, recounted in detail elsewhere,[10] was partly in response to the reluctance of many traditional providers of health ODA to pay for HIV treatment, which they claimed was unsustainable and inappropriate for the developing world.[11] Donor support for HIV until 2000 was largely for information and education campaigns, staff training, and infrastructure building; treatment was not high on the agenda.[12] (The U.S. President's Emergency Plan for AIDS Relief [PEPFAR] and the WHO/UNAIDS "3 by 5" initiative would both come along only in 2003.) The French government had called for a "solidarity" fund for HIV treatment since 1997.[13] A bold movement to challenge patents and pricing of anti-retroviral medicines was making UN rhetoric on the subject look feeble. At the International AIDS Conference of 2000 in Durban, WHO and UNAIDS were publicly excoriated for not providing leadership on affordable treatment.[14] Thousands of African AIDS advocates challenged the indifference of the richer nations to the reality that if they had access to treatment, they too would live.

At the first UN General Assembly Special Session on HIV/AIDS in June 2001, the unanimous declaration of member states included a commitment to "support the establishment, on an urgent basis, of a global HIV/AIDS and health fund to finance an urgent and expanded response to the epidemic based on an integrated approach to prevention, care, support and treatment…".[15] Unlike the previous GHI such as MMV and GAVI, the Global Fund thus had the unanimous endorsement of the most important member-state forum of the UN. The 2001 declaration also specified that the new fund should give "due priority to the most affected countries" and mobilize funds from public and private sources, including the pharmaceutical industry. Key players in the global movement for HIV treatment had advocated for the creation of the Global Fund and expressed the hope that it would result in a dramatic increase in the purchase of antiretroviral medicines that would drive down prices.[16]

The Global Fund also brought an important new element that would set it apart from other public-private partnerships—a commitment to "country-driven" or "demand-driven" grant-making. The Global Fund would respond to proposals from countries that, it was hoped, would be based on realistic assessments of funds that could be absorbed and activities that were feasible and readily programmable. Proposals from countries were to be submitted by "country coordinating mechanisms" or CCMs that were to include representatives of government, NGOs, other private sector entities, UN agencies present in the country and, importantly, people living with or affected by the diseases. "Country ownership" was the watchword, and long-term commitment—the Global Fund was to make five-year grants in two phases—the ethos. Reflecting the aspiration of the UN's 2001 Declaration of Commitment on HIV/AIDS, the Global Fund also pledged in its core framework document to "give due priority to the most affected countries and communities, and to those countries most at risk."[17]

The Global Fund's approach was thus a radical departure from the usual practice whereby country needs to address a problem would be calculated in Washington, Brussels, Geneva or somewhere else in the North. It was a leap of faith and of solidarity and seemed to pay off. In Lidén's view, donors found this change very persuasive:

> The way in which the Global Fund's rounds of applications provided the world with a measure of realistic fundable demand, broken down to the extent that one was able to count the bed nets that would be delivered and the number of AIDS, TB and malaria treatments administered—and thereby attached a moral imperative to funding this demand—was probably the single most significant reason behind the dramatic rise in spending on the pandemics over the past decade.[18]

Though many of its bilateral and private donors had questions early on about how the Global Fund was constituted and how it would operate—as a funding but not implementing organization, without staff in the countries receiving grants—when it made its first grants in 2002, it already had about $2 billion to disburse. By mid-2014, the Global Fund had awarded grants in the amount of almost $30 billion for the three diseases and health systems strengthening in 140 low- and middle-income countries.[19] By historical standards in development assistance for health, this sum was unprecedented to address diseases associated with poverty and marginalization, as was the span of the Fund's geographic engagement. The Global Fund was indeed global.

The first decade: Reaching the previously unreached

In the first decade of its work, the bulk of the Global Fund's grants were awarded in fixed grant "rounds" for which application processes and dates were well defined. There was about one round per year through Round 10. Prospective grantees did not face prescribed ceiling amounts below which their proposals needed to stay. While countries classified as high-income were not eligible to receive Global Fund support, those classified as low-income were always eligible. Countries in between—those ranked as upper-middle-income or lower-middle-income—were also eligible, though they had to demonstrate some level of cost-sharing by the government in question and had to make an epidemiologic case for needing support for a particular element of the disease or affected population. In exceptional cases where certain affected populations or interventions were excluded by the CCM and non-governmental organizations could make a case for their importance, or where the state was in conflict or without stable government, the Global Fund awarded non-CCM grants, but they were few and not encouraged.

While the Global Fund has tended to highlight the number of people who received HIV, TB and malaria treatment through its support as key results of its work,[20] the magnitude of Global Fund support also enabled scaling up of prevention activities for the three diseases in many countries. With respect to HIV, this included previously neglected services for traditionally marginalized "key populations" such as sex workers, people who use drugs, men who have sex with men, transgender persons, prisoners and former prisoners. Harm reduction services such as provision of sterile injection equipment (needle and syringe programs) and opiate substitution therapy had long been promoted by WHO and UNAIDS as effective, cost-effective and essential elements of HIV responses,[21] but were neglected in funding before the Global Fund came on the scene. For example, the UNAIDS global

report on HIV/AIDS in 2002, before the first Global Fund grants, documented very high levels of HIV transmission among people who inject drugs but virtually no examples of scaled up HIV services for them in the Global South or transitional countries.[22]

The Global Fund dramatically changed that picture. From 2002 to 2009 (through Round 9), for example, the Global Fund supported HIV activities for people who use drugs (PUD) in 55 countries valued at $430 million (counting the grants that terminated after 2009; $361 million counting budgeted amounts through 2009).[23] All but three of the countries included in this total were without generalized HIV epidemics—that is, they had HIV epidemics largely concentrated in key populations. In Round 10, the Global Fund gave prospective grantees the option of applying for funds specifically designated for activities meant to benefit key populations, and an additional US $150 million was granted for HIV programs for PUD.[24] While the approximately $600 million that the Global Fund allocated to HIV programs for people who use drugs before the NFM was still estimated to be a relatively small percentage of the funds needed to stem HIV transmission in this population,[25] it was historically a giant step forward, providing life-saving services for millions of people previously unreached by HIV prevention activities. In some cases, organizations of people who use drugs, sex workers and men who have sex with men (MSM) even became recipients of Global Fund support, and their representatives participated in program planning and oversight through the CCM.[26]

The language and practice of global health assistance have continued to take a number of turns in the lifetime of the Global Fund. Particularly in the UN with respect to HIV, making the "investment case" became the dominant framework for shaping assistance and advocacy.[27] In this framework, human rights became a "critical enabler" to good programs along with a number of other "enablers" such as mass media, program communication and research.[28] While it is important that human rights appears in any guise in the investment framework, the UNAIDS Reference Group on HIV and Human Rights and others have noted that the "enabler" language makes it easy to think of human rights as a facilitating factor rather than as the central strategic element of HIV programs.[29] What donors see to be "critical enablers" became perhaps only too clear during the special fiscally constrained Round 11 of the Global Fund when it was specified that "essential services" but not "critical enablers" would be eligible for funding.[30] The struggle for rights-centered approaches to HIV was not for a human rights add-on element that can be cut when money is tight.

II. The Middle-Income Country Challenge for the Global Fund

The New Funding Model and Related Changes

Following Round 10 in 2010, a time of fiscal challenge for many donor countries, an important funding shortfall led the Global Fund to postpone Round 11. At the same time, management practices at the Global Fund and the Fund's oversight of in-country management of grants came under scrutiny, eventually leading to a change in a number of basic procedures of the institution as well as a change in leadership. A "new funding model" (NFM) was approved by the Global Fund Board in late 2011 as part of a new 2012-2016 strategy.

In the new model, the richest of the middle-income countries, according to the World Bank "Atlas" classification,[31] are not eligible for Global Fund grants. Eligible countries were divided into four "bands," defined with respect to (1) income level (by the "Atlas" method) and (2) disease burden, based on data provided to the Global Fund by WHO and UNAIDS.[32] Some elements of the NFM compared to the previous model are as follows:

- Pre-defined allocation and eligibility: Maximum allocations are assigned for each eligible country. According to the Global Fund, the maximum allocations are calculated based on disease burden, income level of the country as determined by the World Bank "Atlas" method,[33] external financing and a "minimum required level", which reflects past grants and the need for transition to the new NFM funding level.[34] Allocations are determined before the country dialogue but can be adjusted as the country dialogue process yields information on the diseases, absorptive capacity and risk factors.

- Counterpart financing: CCMs are required to demonstrate that funding in addition to the Global Fund grant will be avaiable, presumably mostly from the government, according to the following formula: low-income countries, 5 percent of the value of the Global Fund grant; "lower lower-middle-income" countries, 20 percent; "upper lower-middle-income" countries, 40 percent; upper middle-income countries, 60 percent.

- Three-year grants: Most grants under the NFM are envisioned to be for three years, as opposed to the five years possible under the previous funding model.

- "Incentive" stream: In addition to the pre-defined allocation for the country, countries in the first three bands can apply for limited "incentive" funds that will be granted based on the case made for activities with "quantifiable impact" or linked to "robust national strategic plans or a full expression of prioritized demand for strategic interventions, based on a program review."[35]

- No funding rounds: There are no fixed funding rounds in the NFM. Rather, countries are expected to submit proposals within their allocated amount "when it suits them best, according to their own national planning cycles."[36]

The early reaction to the new funding model from civil society organizations included many very critical views, particularly regarding the pre-determined caps on funding. Health GAP called the NFM a "radical and regressive shift from the Fund's founding principles," noting that an "arbitrary amount determined by what donors have managed to pay" was no substitute for "country requests…based on what they actually need to halt and reverse the diseases."[37] Médecins Sans Frontières (MSF) predicted dire consequences for HIV, TB and malaria programs from the cutbacks embodied in the predetermined allocations for sub-Saharan African countries.[38] According to MSF, the ability of these countries under the old funding model to estimate and work toward a maximum absorbable amount yielded unprecedented progress in the response to the three diseases and in strengthening weak health systems. "Is country demand being curtailed for the sake of funding predictability?" MSF asked.[39]

Services for key populations: A public health imperative

Advocates for marginalized "key populations" have been especially concerned that the changed funding practices will eliminate Global Fund support that has enabled traditionally excluded persons to receive life-saving services.[40] Pre-determined ceiling amounts of grants are likely in some countries to undermine funding for programs destined for key populations. Faced with a pre-determined grant ceiling, probably less than expected or hoped for in many cases, CCMs may find it politically easier to prioritize treatment or other established mainstream services over programs for criminalized persons or human rights interventions.

The concern for sustaining programs for key populations is also related to the Global Fund's reliance on an income classification that seems not to correspond to epidemiologic realities or to recognized definitions of poverty. According to the World Bank's "Atlas" method of estimating gross national income, which is relied on by the Global Fund, numerous countries have gone from lower-income to middle-income status in the last ten years (see Table 1). In at least some cases, the reclassification was related to profits in extractive industries and export revenues that did not have a commensurate impact on domestic poverty.[41] Other indicators of poverty have not shown the same pattern as the "Atlas" criteria.[42] Based on assessments of people's actual purchasing power, Sumner and others estimate that about 70 percent of the world's poorest people—over a billion—live in countries classified as middle-income by the Atlas method.[43]

Table 1: Number of low-income countries (LIC) and middle-income countries (MIC) as defined by the "Atlas" method

World Bank Fiscal Year (data from calendar year)	FY02 (2000)	FY05 (2003)	FY10 (2008)	FY11 (2009)	FY12 (2010)
LICs	63	61	43	40	35
MICs	92	93	101	104	109

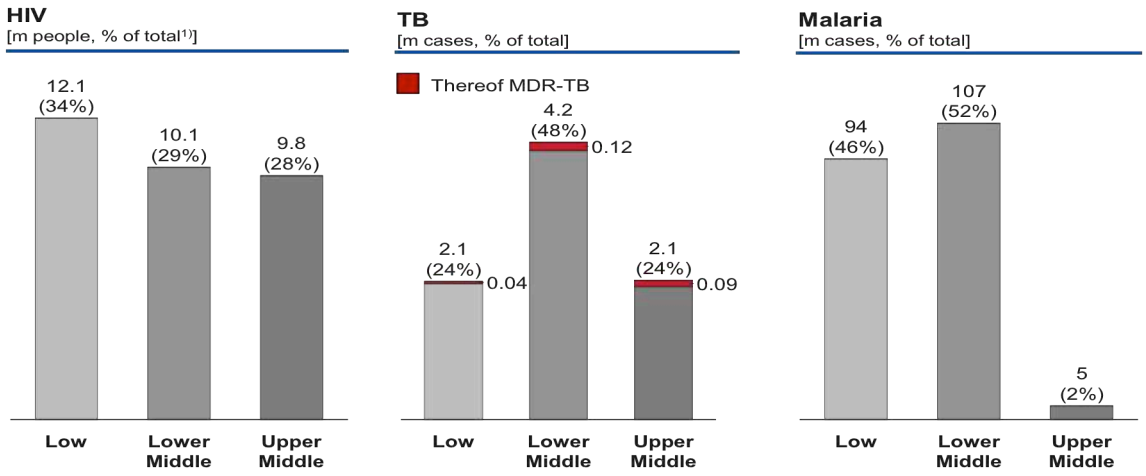
Source: Sumner (2012).[44]

The Global Fund's Development Continuum Working Group was convened in 2014 to consider funding allocation criteria as part of the development of the Global Fund's next multi-year strategy. The DCWG report notes that the Atlas classification is problematic partly because of the preponderance of people living with HIV or TB and malaria cases in middle-income countries (see Fig. 1 below), just as it is clear that the majority of people living in poverty in the world are also in middle-income countries.

The situation is even more stark for certain populations at high risk of HIV and TB. In numerous middle-income countries, HIV and to some degree TB are heavily concentrated among politically unpopular and socially marginalized persons such as people who use drugs, sex workers, men who have sex with men (MSM), transgender persons, migrants, prisoners/detainees, and former prisoners—referred to by the Global Fund as "key populations." As noted above, in many countries, including many now classified as middle-income, Global Fund grants represented basic HIV and TB services for these persons at a

meaningful scale for the first time—in some cases the only expression of solidarity in health service provision ever known to these persons.

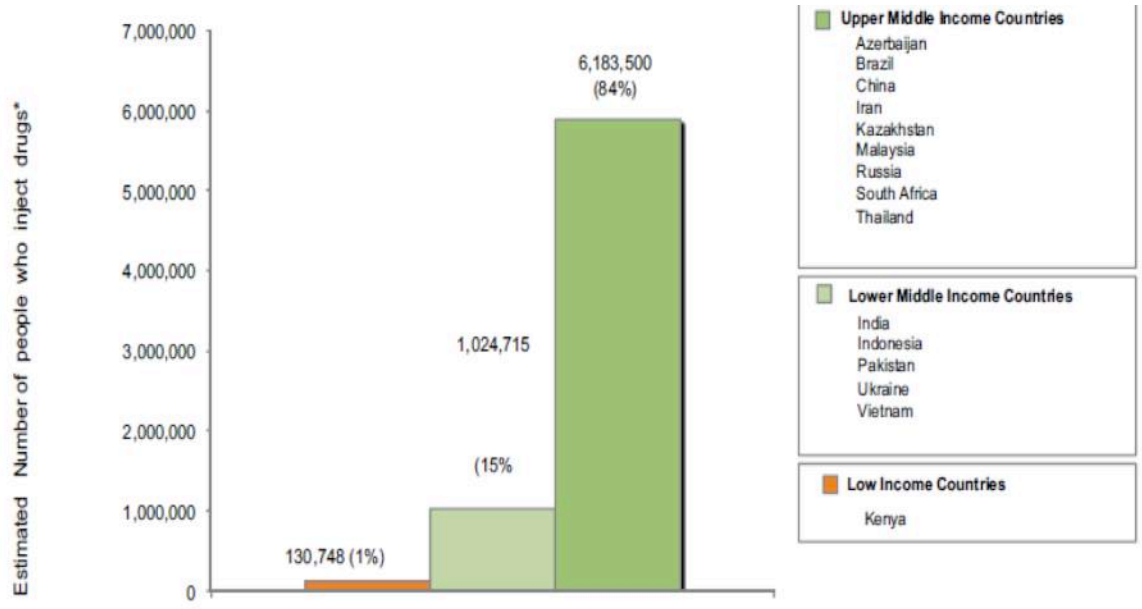
Figure 1: Proportion of people living with HIV and TB and cases of malaria in low- and middle-income countries, 2012



Source: Development Continuum Working Group report

HIV services for people who use drugs are a case in point. One estimate suggests that of people living in the 15 countries identified by UNAIDS in its 2011-2015 strategy as highest-priority for programs to address HIV and injection drug use, only one percent lived in a low-income country (see Fig. 2). Restrictions on support for middle-income countries could be catastrophic for programs for people who use drugs, to take one example. The situation of some countries illustrates that this catastrophe is already playing out.[45] For instance:

Figure 2: Estimated numbers of people who inject drugs by country income in UNAIDS priority countries for HIV and drug use, 2010



† List of countries from UNAIDS (2010). 'Getting to Zero: 2011-2015 Strategy,' p.23.
* Estimates of PWIDs : Mathers, B. et al. (2008) 'Global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,' *The Lancet* 372(9651): 1733-1745.

Ukraine:[46]

Before the Global Fund existed, Ukraine's HIV epidemic, driven by injection drug use, was out of control. Thanks to Global Fund support, Ukraine is one of the few countries in eastern Europe that has scaled up HIV prevention services for people who inject drugs, and lower HIV incidence is the result. WHO has recognized as "best practice" Ukraine's harm reduction efforts, which include several approaches to providing clean injection equipment as well as a wide range of counselling services and interventions for both opiate and stimulant use. The country is classified as "lower middle income" by the World Bank, and it is expected that Global Fund support will decline over the next few years. In 2014, Ukraine was informed that, rather than the increased funding it had anticipated, it should expect a 50 percent cut in Global Fund support in 2015. At the same time, national government spending on health also significantly declined. The principal recipients were able to stave off a significant drop off of Global Fund support by negotiating a higher budget and reprogramming a portion of the 2014 budget. But these funds are largely covering the anti-retroviral therapy program, while interventions for key populations, especially reaching people who use drugs, have sharply decreased. [47] Even without the political crisis that the country is undergoing, there would be doubts that the government would take up the funding shortfall to ensure the continuation of these services at the needed scale.

Vietnam:

Vietnam, classified as a lower-middle-income country (LMIC), is estimated to have over 250,000 people who inject drugs, mostly opiates, of whom the government estimates that up to 40 percent are living with HIV.[48] For a number of years, the World Bank, PEPFAR, the UK Department for International Development (DFID) and the Global Fund funded harm reduction services that averted an estimated 31,000 cases of HIV and many deaths. With Vietnam classified as LMIC, World Bank and DFID support ended in 2012, and practitioners on the ground fear neither the government nor other donors will take up this work.[49] Under the NFM, Global Fund support for this work will go from about US $30 million a year to about $9 million a year beginning in 2016, a reduction of about 70 percent. Between 2013 and 2014, the government budget for HIV programs was cut by 65 percent.[50] Expansion of a methadone program that has been seen as a model for Asia and has helped thousands to protect themselves from HIV and stabilize their lives is in jeopardy.

Serbia:

Global Fund support enabled Serbia, clasisfied as an upper middle-income country, to bring to significant scale for the first time needle exchange, opiate substitution therapy and outreach activities in 2006-2014, both in the community and in prisons.[51] The government has a harm reduction strategy and pledged to take up these services when the Global Fund grant was over, but as of March 2015 it had not done so. The NGOs providing the services are endeavoring to sustain them with volunteer workers and reduced space to save on heating and rent, but they fear having to close soon. NGOs in the country are appealing to other donors and to government for urgent support to avert spikes in HIV and hepatitis C transmission and seek the help of all advocates to persuade the government to make good on its pledge to take over these essential services.

Romania:
The Global Fund classified Romania as too high-income for support of its HIV programs before the NFM was in place, but the country's experience is relevant to the discussion of its impact on middle-income countries. The number of new HIV cases among people who use drugs in the country was not above 5 in 2007-09, but increased to 12 in 2010, 129 in 2011 and 120 in the first half of 2012.[52] According to figures submitted to UNAIDS, in 2012, about 30 percent of new HIV cases in 2013 were linked to injection drug use vs. 3 percent in 2010.[53]

Global Fund support for large-scale harm reduction activities ended in 2010, after which time some services continued but, according to the government, not on an effective scale or with the quality of services that was possible with Global Fund support.[54] Some observers see Romania as the first of many spikes in HIV epidemics likely to follow with Global Fund withdrawal from other eastern European countries.[55]

Development Continuum Working Group: Positive trends and proposed solutions

The Development Continuum Working Group (DCWG) notes that there are a number of trends in middle-income countries that may cushion the blow of reduction in Global Fund support to programs in these countries. These include:

- A pattern of greater government expenditure generally in the health sector in MICs, to some degree linked to increasing tax revenues.
- A wider range of private sector partners interested in health programs in MICs.
- Greater "internal" philanthropy resulting from the emergence of "high net worth" individuals, including in sub-Saharan Africa.
- Increased program implementation capacity in MICs.

There is, however, little evidence that any of these factors are systematically or even sporadically related to greater commitment to scaled-up programs for key populations or to gender equity in health programming, as the DCWG also acknowledges. Other things equal, greater revenue coming into government coffers is not in itself an engine of political support for rights-based, evidence-based programs. There is no evidence to suggest that the "new" private sector players in health in MIC, including newly rich individuals, are drawn to programs for marginalized persons. And the lack of funding for programs for key populations has rarely been mainly a problem of insufficient program implementation capacity or expertise. **Rather, obstacles to these programs are related especially to deep and intransigent stigma and moral judgments, which in turn facilitate the inappropriate use of criminal law.**

"Responsible transition" away from Global Fund support is also considered by the DCWG. The report recommends that at the concept note stage countries develop a transition plan to be submitted along with grant applications. It recommends that the Global Fund establish an operational definition of sustainability that will enable it to monitor the

success of transitions in preserving programs. It also notes the importance of a transition process that ensures that "countries are given advance notice and sufficient time to plan and implement the transition process with the full involvement of all key country stakeholders at all stages.[56] In this respect, the DCWG is responding to concerns expressed by both NGOs and donor institutions that appropriate transition planning and cushioning measures were not in place before significant reductions in support were announced.[57] With respect to the countries cited above as having lost support for harm reduction programs, civil society organizations have lamented the lack of consultation with affected populations about transitions and how the cuts are experienced by them.

The DCWG report goes on to consider a number of strategies that the Global Fund could adopt to address the MIC challenge and the general challenge of transition to lower levels of support in some countries, including the following:

- Rather than a "one size fits all" approach to classifying countries, develop differentiated criteria for countries in different situations, including varied co-financing models (i.e. the Global Fund could have a longer commitment to items that are harder to work into government budgets).

- Support the CCM to mobilize new funding sources, including "local philanthropy which could potentially fund programs targeting key populations…or social enterprise mechanisms focused on investing for impact."

- Focus on investments in strengthening health systems and community systems.

- Develop differentiated approaches to transition planning, including identifying "triggers" and "enablers" that indicate a country's ability to take up a greater share of program funding.

- To learn from program sustainability successes of GAVI, PEPFAR and the Gates Foundation-funded Avahan project in India (see DCWG report appendix).

- Greater use of human rights "leverage" (to be discussed in part III below).

It is commendable that the DCWG group recognizes the inadequacy of the Atlas income classification and the need for a more nuanced consideration of countries' situations. However, it would be useful for it or the Global Fund to share examples of what DCWG cites as "local philanthropy" players interested in funding programs for key populations as these have not been evident in many MIC situations. Moreover, the "triggers" and "enablers" suggested in the DCWG report—undoubtedly a first stab at these lists—do not include factors that explicitly address the level of criminalization and social exclusion of key populations, other impediments to participation of key populations in program and policy decision-making, or the capacity or track record of civil society or human rights institutions in the country in advocating for the rights of key populations.

In addition, GAVI and PEPFAR may offer some lessons on program sustainability, but GAVI does not have the key population challenges of the Global Fund, and PEPFAR is far

from a good example when it comes to programming for sex workers or people who use drugs. It seems clear from the experience of many countries that general health system strengthening and generally better transition planning will not be effective in reducing impediments to funding of programs for key populations without specific targeted interventions to address these barriers—that is, explicit measures to show solidarity with those left behind in health programs and more broadly.

III. Human Rights and Global Fund Strategies, Processes, and Practices

Progress on human rights at the Global Fund

It is beyond the scope of this paper to summarize the human rights challenges that face the Global Fund, particularly in countries where democratic processes are not open to civil society, health services themselves may be delivered in ways that abuse or undermine human rights, and persons most affected by the three diseases are marginalized by stigma, discrimination and criminalization.[58] Another central human rights challenge in the Global Fund's work is equitable access to affordable medicines to which structural barriers remain profoundly difficult to overcome. The Global Fund's promotion of human rights-centered programming may appear to be inconsistent with "country ownership", but, as noted by Wolfe and Carr, that inconsistency exists "in theory but not in practice."[59] That is, consistency with human rights norms is essential for program effectiveness, which is in the interest of all parties, and clarity and accountability in minimizing factors that undermine human rights is indisputably central to both the reputation and the strategic goals of the Global Fund.

It is thus helpful that the DCWG recognizes a "push for stronger policy and human rights leverage and impact" as one avenue for the Global Fund's efforts to deal with changes in global health and development. Indeed the challenge of sustaining programs for key populations in middle-income countries is at least partly a fundamental human rights problem, though it is also more than that. And the human rights challenges faced by the Global Fund also go beyond the problems of key populations to encompass many kinds of health program impediments related to stigma, discrimination, marginalization, gender-related subordination, barriers to participation and others.

The DCWG report section on human rights focuses on civil society participation in health programs as a key element of rights-centered programs and concludes that the Global Fund should make it a priority to ensure that country dialogues are inclusive. It also stresses advocacy to raise domestic funding of health programs, though it is not clear how this result would strengthen the human rights orientation of programs.

Since explicit human rights goals were approved in the Global Fund 2012-2016 strategy, important steps have been taken to strengthen the human rights focus of the Global Fund's work. The very existence of the three human rights goals in the strategy is an achievement; those goals are:

- Integrate human rights considerations throughout the grant cycle
- Increase investments in programs that address human rights-related barriers to access
- Ensure that the Global Fund does not support programs that infringe human rights.

A senior human rights advisor position was created and filled, now sitting in the Community, Rights and Gender Department of the secretariat. An advisory Human Rights Reference Group of outside experts was created and has commented on numerous Global Fund policies and processes. Guidelines have been developed for rights-based programming with respect to the three diseases of concern to the Global Fund, along with key population and gender guidelines, which also emphasize human rights themes. Human rights has been added to the "operational risk framework" of the Global Fund, the guide to 19 categories of risk that helps staff assess factors that may impede a grant's success.[60] Human rights training has been conducted for secretariat staff, including the Office of the Inspector General. A May 2014 consultation with outside human rights experts drew the active participation of Global Fund staff from many departments.[61] The Global Fund in 2014 adopted a policy whereby it will generally not fund compulsory treatment in detention facilities for people who use drugs and sex workers.[62]

Significantly, in 2014 formal human rights provisions were incorporated into the standard grant agreement language. Grant agreements specify that Global Fund-supported programs should fulfill the following criteria:

1. Grant non-discriminatory access to services for all, including people in detention;
2. Employ only scientifically sound and approved medicines or medical practices;
3. Not employ methods that constitute torture or that are cruel, inhuman or degrading;
4. Respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered; and
5. Avoid medical detention and involuntary isolation, which, consistent with the relevant guidance published by the World Health Organization, are to be used only as a last resort.

It is too early to know the effect of this language or the way in which countries are reacting to it.

In 2014, $15 million was set aside for technical assistance in the area the Global Fund calls Community, Rights and Gender for early stages of the grant proposal planning process (pre-concept note). As of December 2014, about $4 million of that sum was disbursed, of which about 40 percent went to sub-Saharan Africa.[63] Human rights, gender and key population organizations were competitively awarded contracts to provide this technical assistance.

In addition, the instructions for the existing procedure for reporting fraud linked to Global Fund-supported grants were expanded to include the possibility of reporting human rights abuses.[64] A special system for reporting human rights violations, particularly related to the five points in the grant agreement noted above, is the subject of a brochure that the Global Fund began distributing in March 2015.[65] Interested parties will be able to make a complaint using an online form, by telephone or by e-mail, as they currently can through the more general complaints mechanism.

The Global Fund undertook an internal review in 2014 of progress against the human rights goals in its grant-making in 2010-2012. The human rights goals were new in 2012, so this was in a sense a baseline evaluation. Five elements of human rights actions, derived from a Global Fund information note,[66] were the focus of this evaluation: (1) legal assessment and reform; (2) legal aid services and legal literacy; (3) training on rights for state officials and health workers; (4) community-level monitoring; and (5) policy advocacy and social accountability. The evaluation noted firstly the difficulty of tracking human rights-related activities in proposals. By the best estimation of this evaluation, with respect to HIV and TB grants only, there was about US $4.3 million budgeted for human rights-related programs, and about US $3.2 million actually spent of the multi-billion dollar grant totals in the 2010-2012 period.[67] There is clearly a long way to go from this point. It is worth noting, however, that though these sums are modest, there is so little funding for health-related human rights efforts in some countries that the funds here still represent an important contribution.

Under the New Funding Model, a number of CCMs have used the "incentive funding" stream to propose "critical enabler"-type activities such as community systems strengthening and human rights programs, while core treatment activities are proposed in the main pre-allocated envelope. This may be one more way to marginalize human rights funding, particularly if the incentive funding proposals are rejected. In its report on the early windows of the NFM, the Technical Review Panel (TRP) of the Global Fund noted that many of the incentive funding proposals are not funded, and CCMs need to write all of the central elements of their activities into the proposal for the main funding envelope.[68] The TRP also recommended a revisiting of the whole idea of the incentive stream, concluding that it is burdening applicants and not fulfilling its intended purpose.[69]

Access to medicines

The Global Fund since its inception has naturally been concerned about access to medicines and affordability of medicines purchased with its support, but access to medicines has not generally been framed by the Global Fund as a human rights issue. The DCWG report notes that access to medicines is an important issue in transition away from Global Fund support and raises the possibility that countries in a transition period or already "graduated" might be able to benefit from Global Fund prices for a certain time.[70] It notes that the Global Fund should consider technical support to build "robust procurement systems" that would help countries no longer receiving Global Fund grants.

The Global Fund has co-convened with UN agencies, GAVI and UNITAID an "Equitable Access Initiative" (EAI) in which a high-level expert group is charged with making recommendations to deal especially with ensuring access to essential goods and services

for impoverished people who live in countries classified as middle-income, including medical "technologies" and medicines.[71] Access to essential medicines should be seen as a human rights issue by the Global Fund.

Lessons from the Global Fund's human rights efforts

In the progress made so far, the Global Fund has responded to a number of critiques and calls for action from civil society and other external experts.[72] In the period of the new Global Fund strategy and the years beyond, it will be time to test the new human rights processes and get much more clarity than there is now on what the Global Fund realistically can and cannot achieve in this area. In the progress made so far on human rights in the Global Fund and related activities, there may be some lessons to inform thinking for the next decade. Among these we would note:

Need for sustained support and mobilization of in-country human rights and legal expertise: Unless it changes radically as an institution, the Global Fund will need the assistance of other organizations to have the capacity to conduct the advocacy, oversight and programmatic action needed to advance in its human rights objectives. There is unlikely to be a "one size fits all" way to do this, and it will require dedicated resources to identify and engage the right assistance and to work out the limits of what is feasible in a given country. In many countries the groups representing the interests of those most likely to face human rights abuse are unlikely to be able to participate to the degree that is necessary for effective programs unless there is sustained local pressure for that to happen. Continuing and strong partnerships with human rights organizations at country and regional level and at the secretariat are likely to be needed to ensure ready access to the expertise needed to meet the Global Fund's human rights objectives.

Need for earmarked funds: The experience of the Global Fund's Round 10 that earmarked grant funds for programs for "most at risk" populations showed that relatively unpopular programs will nonetheless make their way into proposals prepared by CCMs if there is dedicated funding and guidance and encouragement to go with it. Human rights efforts may need a similar boost. (See Box 1 below for one idea of how dedicated funding might be operationalized).

Need for non-CCM funding arrangements: In certain countries, CCMs are unlikely ever to incorporate adequate human rights protections and program actions in their proposals. There should be continued efforts to ensure that CCMs represent all parties who should be present, especially representatives of populations affected by the diseases, but success is not likely in all countries. At least for some time, there needs to be the flexibility to enable non-CCM entities to receive support to undertake human rights interventions within health programs or to ensure oversight and reporting of violations. Non-CCM grant processes should be designed to enable and support civil society groups to achieve the goals of the grants. They should not be so heavy as to undermine the important advocacy and other work of organizations already likely to be overburdened in difficult environments.

Need for stronger human rights capacity in the secretariat: Staff capacity on human rights in the secretariat has made advances, but continued efforts are needed. It may be useful to investigate, for example, whether new portfolio managers, or some proportion of them,

should have prior human rights experience. A strong human rights unit in the secretariat should help to identify areas in which institutional policy statements—such as the one on drug detention centers—are needed, and should assist in the development of those policies. Continued assistance is needed to ensure that the human rights complaint mechanism gets a good test and is reviewed and improved over time.

Demand creation: There is a need to equip local groups to know the resources and help they can demand from the secretariat—that is, for example, requesting Fund Portflio Manager (FPM)-specific site meetings with key popluations groups outside of the formal CCM structure, as well as documenting and filing complaints of human rights abuses; requesting technical assistance in concept note and budget development, for example, from local human rights providers supported by the Community, Rights and Gender Department of the Global Fund.

The Global Fund's assessments of its own success always feature the number of persons being treated for the three diseases, and rightly so. The Global Fund's human rights challenge includes finding ways to use its institutional clout and resources to help ensure access to affordable medicines as well as to encourage balanced programs that do not let a focus on treatment marginalize prevention, particularly in concentrated epidemics. The Equitable Access Initiative, is charged with taking on the country classification challenge described in the DCWG report but with a particular focus on ensuring access to affordable medicines in countries all along the "development continuum".[73] The solidarity that characterized the Global Fund's founding and early work will need to be much in evidence for this effort to succeed.

IV. Conclusions and Recommendations

The DCWG report notes that the Global Fund's contribution to overall global health expenditures has been quite small in monetary terms throughout its history.[74] The report does not seem to appreciate that one of the factors that made the impact of that contribution larger than might be expected from the monetary sum alone was the achievement of reaching previously unreached populations heavily affected by the three diseases in a spirit of solidarity with countries struggling to fight disease. Where Global Fund support produced a scaling up of services to marginalized persons and even at times—though not often enough—a degree of empowerment of previously completely disenfranchised persons, the Global Fund truly distinguished itself from other health-sector donors. Enabling countries to determine themselves what level of resources they needed and could absorb was ground-breaking. The Global Fund represented the hope that not all ODA in health needed to be top-down and driven by ulterior motives but that aid rather might reflect a spirit of solidarity with the often marginalized persons affected by HIV, TB and malaria and other diseases that feed on poverty and marginalization.

The DCWG report and some aspects of the Global Fund's new funding procedures seem not to recognize or honor this contribution. For example, the Global Fund is currently wrestling with whether to support programs to address hepatitis C among people who use drugs, even though that is not one of its three focus diseases.[75] Rights-based, meaningful consultation with people who use drugs would undoubtedly point to treatment of hepatitis C as central to a successful HIV response, and one hopes the continuing deliberation on

this subject will reflect that centrality. Further, the relatively small contribution the Global Fund has made to hepatitis treatments in the past allowed activists and governments to sucessfully negotiate price reductions, demonstrating the political clout the Fund can wield to promote access to medicines and other human rights issues.

"Investment frameworks" are the order of the day among global health funders, and it is right to think about maximizing the impact of investments in programs. But the Global Fund is not true to its founding unless human rights and solidarity with people affected by HIV, TB and malaria are central to its way of operating and its public presentation of its ideas. **It is especially crucial in the coming decade that the Global Fund embody the uncontroversial idea that respecting the rights of people affected by and at risk of HIV, TB and malaria is not just useful but essential for health services to be effective—an idea that can get lost in an investment-framework approach but is front and center in solidarity-based programming.**

HIV is only part of the Global Fund's mandate, but it is a crucial part—without which the Global Fund would probably not exist. Global movements to promote essential HIV services and the rights of people living with and at risk of HIV set a standard of global solidarity with socially excluded and criminalized persons that has contributed to shaping global health debates and health ODA in the 21st century. The Global Fund should take care not to center its work on processes and strategies that are inconsistent with both its stated objectives and the history of human rights activism and solidarity that helped to bring it into being.

It is commendable that through the reflections of the DCWG and in other ways, the Global Fund is grappling with how to make the most of its limited resources in the face of a changing geography of poverty. This challenge should not be underestimated. The readiness of the Global Fund to abandon the "Atlas" method of income classification is very welcome. It is disappointing, however, that DCWG's analysis is not imbued with the idea that the Global Fund's "investment" is best protected by doing everything possible to protect the rights of and include in decision-making and programs those affected by and at risk of the three diseases, especially those most socially and politically marginalized. Ensuring sustainability and fair transition processes for middle-income countries must include having sharp strategies for identifying and doing everything possible to address the health needs and rights of those most excluded, especially where those needs and rights are ignored or dismissed by CCMs.

The Global Fund cannot be held responsible for all of the human rights difficulties of people who are excluded from health services because of complex factors such as criminalization and social exclusion. It also should not be alone in finding equitable and rights-based ways to deal with billions of people living in poverty but also living in middle-income countries. But it has assumed a mantle of leadership in finding new ways of thinking about development assistance, and it should not stop now. The Global Fund should take the lead in demonstrating that "business as usual" in the aid world has failed and will continue to fail in fighting diseases of poverty and marginalization. Productive and just "investment" in fighting these diseases must mean putting money behind efforts that are explicitly focused on protecting and promoting human rights of people at risk and affected by the diseases.

In particular, we offer the following recommendations:

Essential information for classifying countries and determining eligibility:
The Global Fund's decision-making on country eligibility should be informed by the factors noted in the DCWG report but also, crucially, by other information, including (1) the degree to which the exclusion of marginalized and/or criminalized key populations or other human rights abuses are undermining programs, (2) the potential to rectify this exclusion and other abuses through the CCM, (3) the possibility of mounting better programs through non-CCM arrangements (i.e. the capacity of in-country organizations excluded from CCM processes in program design, implementation and evaluation), and (4) the potential of other donors to support rights-oriented and key population programs over time. **The Global Fund should make memoranda of understanding with in-country organizations or institutions to ensure that it can get this information. It should consider making it an obligatory step in the grant proposal process to have an assessment that covers these points. (See Box below.)**

Non-CCM grants:
Where the information noted in the previous point indicates that there may be organizations not part of CCM processes that could undertake programs that would address human rights abuses or exclusion of affected or at-risk persons, a number of actions might be indicated. One of them is likely to be a non-CCM grant for an NGO, international agency or regional body. The Global Fund has discouraged non-CCM grants—sometimes justifiably—but it should see these grants as a central tool at least for the coming period when it will be working expressly to build in-country capacity in human rights-based programming and to cement its leadership toward that end. Non-CCM grants will not be the answer in all cases, but they are likely to be essential to addressing human rights and middle-income countries issues in many cases. Non-CCM grants may also be needed during periods of transition from Global Fund-led support to alternative financing.

Invest needed resources in human rights strategies:
The progress that the Global Fund has made in instituting mechanisms and processes to advance human rights analysis and action in its work is laudable. But these first efforts will not come to fruition without an explicit and significant investment of resources in rights-centered work. The Global Fund human rights goals merit more investment than the institution is currently making. Human rights cannot be the poor cousin of other priorities at the Global Fund if the institution is to be successful in supporting effective programs to control epidemics. There should be greater capacity in the secretariat and the TRP focused on human rights, including to interact with NGO and UN representatives in places where marginalized and criminalized persons are excluded from health programs.

The human rights unit in the secretariat should be strengthened and should be ensured a central place in policy decision-making. **And there is a crucial need in the coming years for strategies and actions leading to increased and measurable funding for human rights interventions as part of HIV, TB and malaria programs**—that is, the interventions suggested in Global Fund guidelines and compliance with the new grant agreement language on human rights. Indicators to measure the realization of the human rights goals of the Global Fund should be developed in consultation with human rights

experts and representatives of affected populations and should be designed to capture funding support to human rights interventions and key population programs on the ground. There is also a need for attention to new funding processes and their particular impact on human rights funding, including oversight to prevent human rights and key population activities from being lost in unfunded proposals for incentive funds.

Urgently monitor the impact of new funding decisions:
As noted in this report, decisions made in the New Funding Model have already resulted in cuts to crucial programs for key populations in countries where other support for these programs is not evident. In concentrated epidemics, uncushioned cuts in programs for key populations inevitably undermine the national response to the diseases. Having evidence of unexpected rises in infection rates or other consequences of funding reductions is essential for advocacy with the Global Fund's donors or other funders to mobilize resources and help avert sustained damage. The Global Fund should consider convening the donor community to discuss the risks to key populations posed by the funding cuts and establish emergency funds to help prevent the excess mortality and morbidity.

Transition processes that respect human rights:
There is an urgent need for the development of transition processes that are long enough to permit planning with meaningful participation of persons most affected by the programs in question as well as implementation cushioning measures and the complete exploration of alternative funding sources. The voice of key affected populations in identifying funding priorities in a transition period is indispensable. Their participation and that of civil society more broadly is also key to what may be lengthy processes of developing public awareness and political will for governments to take up the funding of essential programs.

Use the Global Fund's stature for global advocacy and leadership on human rights:
The Global Fund leadership may state that it is not an advocacy organization, but in its fourteenth year its stature in global health gives its actions and statements an inherent advocacy cachet. There is an urgent need for leadership and courage to enable global health donors and other institutions to be seized by the centrality of human rights in fighting HIV, TB and malaria, including addressing epidemics concentrated in persons who are inappropriately made criminals under the law. The Global Fund has expertise from lessons learned from the wide range of programs it has supported for these populations and should be an important voice in mobilizing further support at national and international levels. Carrying forward human rights advocacy is consistent with the spirit of solidarity that defined the origins of the Global Fund and is part of what sets the Global Fund apart from technical institutions such as GAVI.

Box 1: A Global Fund human rights funding scenario (or too much flight of fancy)?

The Global Fund can respond to human rights challenges in many ways with the various tools at its disposal. The scenario described – imagined – below is only one idea.

Background facts:

- The Global Fund does not have field staff outside Geneva. It pays about US $60 million per year to Local Fund Agents (LFA) to be its "eyes and ears" locally to "verify, oversee and report on grant performance." LFA do not generally have expertise in human rights.
- The UN Development Programme is present in every country. (UNDP has been a Principal Recipient (PR) in 48 countries, especially those "facing significant capacity constraints, complex emergencies, or other difficult circumstances"; in 22 of those UNDP has handed off the PR role to another entity.[1]) UNDP has a human rights mandate in the context of development.
- About 150 of the UN's 196 member states have national human rights institutions of some kind, with varying levels of power of legal redress.[1]

The Global Fund decides to undertake a bold program to address human rights barriers to effective health programs (defined broadly), including efforts to ensure participation of key populations in programs. It puts aside $25 million annually (less than half the sum devoted to LFAs) in a Human Rights Incentive Fund for this effort. A significant percentage of this sum is readily raised from bilateral donors and foundations concerned about human rights impediments to health programs. The program is designed to operate in this way:

- Every country applying to the Global Fund submits a brief "human rights situation analysis" (HRSA) with respect to the disease(s) for which it is seeking support, according to guidelines developed by the Global Fund in consultation with human rights experts. (For HIV, the HRSA can rely heavily on data already reported to UNAIDS.) Preparation of the HRSA will include (demonstrable) meaningful participation of human rights NGOs, UN agencies and the national human rights commission or ombudsperson (if any). It should include both an analysis of the main groups in the country capable of health-related human rights interventions and a summary of legal and policy barriers to reaching affected and at-risk populations. It would include description of punitive laws that impede health programs, pricing and other barriers to access to medicines, health-systems barriers to rights-centered programs, etc. (And, yes, adding any more documentation requirements to GF processes should be undertaken with caution.)
- The HRSA will be prepared before the country dialogue, and issues it raises should be on the agenda of the country dialogue. The concept note must make reference to the key issues identified in the HRSA.
- CCMs will be encouraged as much as possible to integrate funding to address human rights barriers into the main budgets of their proposals.
- The TRP will be strengthened to include at least three experts in health and human rights, and all TRP members will be offered periodic human rights training.
- Where the HRSA indicates clear barriers to effective programs but the proposal from the CCM does not address them, civil society, national human rights commissions, UN agencies or other entities present in the country can apply for Human Rights Incentive Funding if they can make the case that there is capacity in-country to address human rights barriers with financial support. Under the terms of a human rights MOU with the Global Fund, UNDP can, if necessary, provide a commentary on which organizations or institutions have the best track record for the tasks at hand.

The Human Rights Incentive Fund would be only one element of a comprehensive effort to improve the human rights performance of Global Fund grants, including periodic human rights refresher training for GF staff and the TRP, continued monitoring and improvement of the human rights complaint mechanism for country-level actors, and a strengthened human rights unit in the secretariat that is meaningfully involved in policy decisions.

Annex: Key messages for Global Fund advocacy for the new multi-year strategy and beyond

1) The Global Fund may be the only or the most important feasible source of funding in some countries for essential programs for key populations (MSM, people who use drugs, sex workers, prisoners and former prisoners), including in concentrated epidemics in middle-income countries where neglecting key populations is sure to undermine successful responses. The Global Fund cannot abandon support for these programs without some cushioning of the blow. Rights-based transition processes are urgently needed, including support for meaningful participation of affected populations in identifying priorities for transition programming, support for non-CCM grants in the transition period if needed, possible dedicated human rights transition funding, and advocacy to urge governments and other donors to step in.

2) The DCWG has noted the inappropriateness of the income classification specified in the New Funding Model to determine funding eligibility and the probable need for something other than a "one size fits all" classification. Any new classification system must take into account the degree of marginalization and criminalization of key populations, the capacity of groups on the ground to address this marginalization (including groups excluded by the CCM), and the prospects for other donors to assist in this area.

3) The Global Fund is unlikely to have the information it needs to find ways to ensure essential programs for key populations and to strengthen human rights without having formal arrangements with in-country institutions to assess capacities on the ground. It should conclude MOUs and mobilize the resources needed for this function, which should not be limited to the concept note stage but rather should be concerned with long-term sustainability of human rights interventions, key population programs, and measures to ensure access to medicines.

4) Some mechanisms and staff capacity have been bolstered to strengthen human rights approaches in Global Fund-supported programs. These measures will not come to fruition without additional sharply conceived and well-funded action in the next few years. This includes the possibility of non-CCM grants when needed, dedicated human rights funding, and more human rights capacity in the secretariat and TRP.

5) Human rights are still too often seen as an "add-on" rather than a key to program effectiveness. The Global Fund must use its stature in the global health field to help governments and other donors see the centrality of human rights to program effectiveness in fighting diseases of poverty and marginalization.

Endnotes

[1] Global Fund to Fight AIDS, TB and Malaria, "Ban Ki-moon, Carla Bruni-Sarkozy, Bill Gates, Kofi Annan and Bono come together to voice support for the Global Fund" (press statement), May 14, 2010, at: http://www.theglobalfund.org/en/mediacenter/newsreleases/2010-05-14_Ban_Ki-moon_Carla_Bruni-Sarkozy_Bill_Gates_Kofi_Annan_and_Bono_come_together_to_voice_support_for_Global_Fund/
[2] CB Barrett, D Maxwell. *Food aid after fifty years: recasting its role.* New York: Routledge, 2005.
[3] B Gelman. "Death watch: the global response to AIDS in Africa," *Washington Post,* 5 July 2000. At: http://www.washingtonpost.com/wp-dyn/content/article/2006/06/09/AR2006060901326.html
[4] Primary health care comes full circle: an interview with Halfdan Mahler. *Bulletin of the World Health Organization* 86(10): 737-816, 2008.
[5] C Taylor, R Jolly. The straw men of primary health care. *Social Science and Medicine* 26(9):971-977, 1988.
[6] C Clift. The role of the world Health Organization in the international system. London: Chatham House, 2013. At: http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0213_who.pdf
[7] Ibid. See also TM Brown, M Cueto, E Fee. The World Health Organization and the transition from international to global public health. *American Journal of Public Health* 96(1):62-72.
[8] J Lidén. The grand decade for global health: 1998-2008. London: Center for Global Health Working Paper Series, Chatham House, 2013. At: http://www.chathamhouse.org/sites/files/chathamhouse/public/Research/Global%20Health/0413_who.pdf
[9] "GAVI's mission" on GAVI web site. See http://www.gavi.org/about/mission/
[10] Lidén, op.cit.
[11] The then director of the US Agency for International Development (USAID), Andrew Natsios, was famous quoted as saying that "many Africans have never seen a clock or a watch" and would be unable to adhere to treatment that entailed taking medicines at certain times during the day. See B Herbert, "In America refusing to save Africans," *New York Times*, 11 June 2001. At: http://www.nytimes.com/2001/06/11/opinion/in-america-refusing-to-save-africans.html
[12] E t'Hoen, J Berger, A Calmy, S Moon. Driving a decade of change: HIV/AIDS, patents and access to medicines for all. *Journal of the International AIDS Society* 14:15, 2011 (open access).
[13] Lidén, op.cit., p 31.
[14] Ibid., pp 31-32.
[15] UN General Assembly, Declaration of commitment on HIV/AIDS, UN doc. A/RES/S-26/2, 2 August 2001, para 90.
[16] t'Hoen et al., op.cit.
[17] Global Fund to Fight AIDS, Tuberculosis and Malaria. *The framework document* (2001, revised 2012). Geneva, 2012, p 92. At: http://www.theglobalfund.org/en/documents/governance/
[18] Lidén, op.cit., p 39.
[19] Global Fund to Fight AIDS, Tuberculosis and Malaria. "Funding and spending," online report. At: http://www.theglobalfund.org/en/about/fundingspending/
[20] Global Fund to Fight AIDS, Tuberculosis and Malaria, "Results" at http://www.theglobalfund.org/en/about/results/
[21] WHO, UNODC, UNAIDS. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users.* Geneva, 2009. At: http://www.unicef.org/aids/files/idu_target_setting_guide.pdf
[22] Joint United Nations Programme on HIV/AIDS (UNAIDS). *Report on the global HIV/AIDS epidemic 2002*. Geneva, 2002. At: http://data.unaids.org/pub/report/2002/brglobal_aids_report_en_pdf_red_en.pdf
[23] J Bridge, BM Hunter, R Atun, JV Lazarus. Global Fund investments in harm reduction 2002 to 2009. *International Journal of Drug Policy* 23(4):279-285.
[24] Ibid.
[25] O Avdeeva, JV Lazarus, MA Aziz, R Atun. The Global Fund's resource allocation decisions for HIV programmes: addressing those in need. *Journal of the International AIDS Society* 14:51, 2011 (open access).

[26] R Atun, M Kazatchkine. The Global Fund's leadership on harm reduction, 2002-2009. *International Journal of Drug Policy* 21:103-106, 2010.
[27] B Schwartländer, J Stover, T Hallett et al. Towards an improved investment approach for an effective response to HIV/AIDS. *Lancet* 377(9782):2031-2041, 2011. See also UNAIDS. A new investment framework for the global HIV response. Geneva, 2011.
[28] Ibid.
[29] UNAIDS Reference Group on HIV and Human Rights. See also M Heywood. The unravelling of the human rights response to HIV and AIDS and why it happened: an activist's perspective. In International HIV/AIDS Alliance. *AIDS today: tell no lies, claim no easy victories.* Brighton, UK, 2014. At: http://www.aidsalliance.org/resources/450-aids-today-2014-edition
[30] UNAIDS Reference Group, ibid. The Reference Group also noted that in HIV "investment framework" presentations, the "critical enabler" of human rights tends to be depicted as the equivalent of the seven interventions identified by UNAIDS as supporting human rights, but human rights are not limited to those specific activities.
[31] World Bank, "What is the World Bank Atlas method?", https://datahelpdesk.worldbank.org/knowledgebase/articles/378832-what-is-the-world-bank-atlas-method
[32] Global Fund to Fight AIDS, Tuberculosis and Malaria. Eligibility list 2014. Available at: http://www.theglobalfund.org/en/fundingmodel/updates/2014-02-04_Eligibility_List_for_2014_now_available/
[33] See World Bank, "What is the World Bank Atlas method?", online at https://datahelpdesk.worldbank.org/knowledgebase/articles/378832-what-is-the-world-bank-atlas-method
[34] Global Fund to Fight AIDS, Tuberculosis and Malaria, Frequently asked questions on the New Funding Model, July 2014, p 2. At: http://www.theglobalfund.org/en/fundingmodel/
[35] Ibid., p 3.
[36] Ibid., p 1.
[37] A Russell, "Stop Global Fund 'caps': fight for a demand-driven Global Fund to help end the pandemics," Health GAP Alert, 20 August 2013. At: https://lists.mayfirst.org/pipermail/healthgap/2012-August/003770.html
[38] Médecins Sans Frontières. Pushing the envelope: Does the Global Fund's new funding model foster country ambitions? (Issue Brief), Aug. 2014. At: http://www.msf.org/sites/msf.org/files/msf_brief_aug_2014_pushingtheenvelope.pdf
[39] Ibid.
[40] See, e.g., C Cook, J Bridge, S MacLean, M Phelan, D Barrett. The funding crisis for harm reduction: donor retreat, government neglect and the way forward. London: Harm Reduction International, International HIV/AIDS Alliance and International Drug Policy Consortium, 2014.
[41] See, e.g., UN Development Programme. *Human development report 2005 – International cooperation at a crossroads: aid, trade and security in an unequal world*. New York, 2005, pp 114-115.
[42] A Sumner. Where do the poor live? *World Development* 40(5):865-877, 2012; see also A Glassman, D Duran, A Sumner. Global health and the new bottom billion: What do shifts in global poverty and the global disease burden mean for GAVI and the Global Fund? (Working Paper no. 270). Washington, Center for Global Development, 2011,
[43] Ibid.
[44] A Sumner. "Where do the world's poor live? A new update," Institute of Development Studies Working Paper no. 393. Brighton, UK, June 2012. At: http://www.ids.ac.uk/files/dmfile/Wp393.pdf
[45] See, esp., Open Society Foundations, "Undermining the global fight: The disconnect between the Global Fund's Strategy and the real-life implications of the New Funding Model," New York, 2014. At: http://www.opensocietyfoundations.org/reports/undermining-global-fight
[46] See Cook et al., op cit., and International HIV/AIDS Alliance, International Network of People Who Use Drugs, et al. "Delegation briefing – The Global Fund New Funding Model and KP services in MICs: The case of harm reduction" (on file with author).
[47] A. Klepikov, International HIV/AIDS Alliance in Ukraine presentation, *Influencing Global Fund Policies and Practices to Advance Human Rights: An Open Society Foundations Meeting,* Barcelona, 13 April 2015
[48] Socialist Republic of Vietnam. *Vietnam AIDS response and progress report*. Ha Noi, March 2014. At: http://www.unaids.org/sites/default/files/country/documents//VNM_narrative_report_2014.pdf

[49] Cook et al., op. cit., p 19.
[50] Socialist Republic of Vietnam, op.cit., p 35.
[51] This case is based largely on European Harm Reduction Network, "Alert announcement: Serbia is losing harm reduction!", Vilnius, March 2015.
[52] A Botescu, A Abagiu, M Mardarescu, M Ursan. HIV/AIDS among injecting drug users in Romania: Report of a recent outbreak and initial response policies. Lisbon: European Monitoring Centre for Drugs and Drug Abuse, 2012, http://www.emcdda.europa.eu/publications/ad-hoc/2012/romania-hiv-update
[53] Government of Romania. Country progress report on AIDS, January-December 2013. Bucharest, 2014. At: http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/ROU_narrative_report_2014.pdf
[54] Ibid.
[55] See M Kazatchkine, "24 hours in Bucharest," *Huffington Post* (UK edition), 15 November 2013, http://www.huffingtonpost.co.uk/michel-kazatchkine/bucharest-hiv-aids_b_4095619.html.
[56] Development Continuum Working Group report, p 27.
[57] Cook et al., op. cit., p 19.
[58] For a good summary of these factors, see D Wolfe and R Carr, "Strengthening Global Fund protections against human rights abuses." In Ford Foundation, Open Society Foundations, UNAIDS and UNDP. *Human rights and the Global Fund to Fight AIDS, TB and Malaria* (report of a March 2011 meeting). New York, 2011, pp 48-57. At: http://www.opensocietyfoundations.org/sites/default/files/global-fund-human-rights-20110901.pdf
[59] Ibid., p 49.
[60] Global Fund. The risk management policy. The Global Fund 32nd Board meeting, doc. no. GF/B32/13, Nov. 2014.
[61] Global Fund. Managing the risk of human rights violations in Global Fund-supported programs. Meeting report, Geneva, May 22-23, 2014.
[62] Global Fund. Global Fund calls for end to compulsory treatment (press statement), Geneva, 26 November 2014. At: http://www.theglobalfund.org/en/mediacenter/announcements/2014-11-26_Global_Fund_Calls_for_End_to_Compulsory_Treatment/
[63] Global Fund. Progress update on the funding model: January-Feruary 2015. Geneva, 2015.
[64] See Global Fund, "Report fraud and abuse" (online), at: http://www.theglobalfund.org/en/oig/reportfraudabuse/
[65] Global Fund. Human rights complaints procedure: responding to community concerns. Geneval, March 2015. Link to download available at http://www.theglobalfund.org/en/about/humanrights/
[66] Global Fund. Human rights for HIV, TB, malaria and HSS grants: information note. Geneva, February 2014.
[67] Global Fund. Investing in human rights portfolio review, 2010-2012. Geneva, March 2014.
[68] Global Fund. Report of the Technical Review Panel on the concept notes submitted in the first and second windows of the New Funding Model. Geneva, October 2014.
[69] Ibid., p 23.
[70] Development Continuum Working Group report, p 28.
[71] See EAI documents and terms of reference on the web site of the Global Fund: http://www.theglobalfund.org/en/equitableaccessinitiative/
[72] See, e.g., Wolfe and Carr, Clayton and Cohen, and other contributions in Ford Foundation et al., op. cit.
[73] Global Fund, GAVI, UNAIDS, World Health Organization, World Bank, UNFPA, UNICEF, UNDP, UNITAID. Terms of reference for the Equitable Access Initiative. Geneva, 2015.
[74] DCWG report, Figure 12, p 17.
[75] See Global Fund, "Global Fund and hepatitis C treatment," 32nd Board meeting, doc. GF/B32/22, 2014.

Acknowledgements

This report was produced by Joanne Csete. For comments on an earlier draft, we are indebted to Krista Lauer, Julia Greenberg, Daniel Wolfe, and Ralf Jürgens.