Managing the risk of **human rights** violations in Global Fund-supported programs

MEETING REPORT

Geneva, 22-23 May 2014

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Meeting Report

The two-day workshop was hosted jointly by the Geneva Academy of International Humanitarian and Human Rights Law and the Global Fund to Fight AIDS, Tuberculosis and Malaria. It brought together over 60 participants, including leading experts in health and human rights, technical partners, representatives of networks of key populations and people living with HIV, donors, grant recipients, civil society organizations, scholars, Global Fund Board Members and Global Fund staff.

Investing for Impact, the Global Fund Strategy 2012-2016 includes five strategic objectives. Strategic Objective 4 is to "protect and promote human rights in the context of the three diseases" through three strategic actions:

4.1 Integrate human rights considerations throughout the grant cycle;

4.2 Increase investment in programs that address human rights barriers to accessing health services; and

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

THE OBJECTIVES OF THE WORKSHOP WERE TO:

- Provide an update and seek input into ongoing work at the Global Fund to operationalize the strategic objective on human rights;
- Discuss research invited for this meeting on challenging operating environments for donors, and to draw on it to develop recommendations for the Global Fund;
- Identify partnerships and resources that can support the Global Fund to implement its strategic objective on human rights; and
- Determine the need and a process for any further consultations on the Global Fund's emerging approaches to human rights.

Recommendations for the Global Fund that emerged from the meeting appear at the end of this report. The agenda for the meeting appears as an annex to the report, along with two research papers commissioned with Global Fund support.

The meeting took place under Chatham House rules, which specify that participants are free to use the information received, but neither the identity nor the affiliation of speakers or participants may be revealed. For the purposes of this report, only the co-hosts of the meeting who made opening remarks, and the authors and presenters of research papers, are identified.

"The Global Fund's mandate to promote access to health services is fundamentally a mandate to promote the right to health".

Dr. Marijke Wijnroks, Chief of Staff,
The Global Fund to Fight AIDS, Tuberculosis and Malaria

"During this workshop to identify and manage risk violations, we don't have to use what is already established. We can work towards something that is more protective, broad and creative".

Prof. Andrew Clapham,
Director, Geneva Academy,
Director of the Geneva Academy of International Humanitarian Law and Human Rights

Day 1:

Welcoming remarks

In her opening remarks, Dr. Marijke Wijnroks welcomed participants on behalf of the Global Fund. She noted that there had been a significant debate in 2011 over inclusion of a human rights component in the Global Fund Strategy 2012-2016, and that a number of significant achievements had since been made. These include the inclusion of standard human rights language in Global Fund grant agreements, and the Office of the Global Fund Inspector General's commitment to investigating human rights complaints for the first time. Following this "good start", participants in this workshop were invited to help advance the strategic objective further and "to make it more concrete".

Prof. Andrew Clapham welcomed participants on behalf of the Geneva Academy. He noted that many public and private institutions that seek to address human rights issues do so in reaction to a failure in their own systems to prevent human rights violations, such as when the United Nations (UN) failed to prevent atrocities in Rwanda and Sri Lanka, and when Shell Oil was forced to respond to bombings that affected its work in Nigeria. He praised the Global Fund for its proactive approach to ensuring that programs it supports protect and promote human rights.

Panel 1:

Update on Global Fund Secretariat workstreams and timelines

The Global Fund Secretariat provided a number of background presentations to brief participants on the Global Fund's new approach to integrating human rights considerations throughout the grant cycle.

NEW FUNDING MODEL

The new funding model is the key mechanism for bringing the Global Fund's corporate goal of "investing for impact" to life. Its objectives include enabling more flexible timing of applications and more predictable funding, rewarding ambitious vision, and a more streamlined process. The Global Fund anticipates reviewing around 160 funding requests, or "concept notes", in 2014. All applicants are required to identify human rights and gender-related barriers to accessing health services in their concept notes. The participatory country dialogue process, which is part of the concept note development process, was emphasized as an important early entry point for key populations and affected communities, and an opportunity for dialogue on human rights.

RISK FRAMEWORK

An overview of the Global Fund risk assessment and management framework was presented, with an emphasis on the human rights and equity component in Section 3.4 of the Qualitative Risk Assessment Tool (QUART), the Global Fund's operational risk assessment tool. The QUART tool identifies human rights as one of 19 risks to grant implementation, and it is being piloted in around 180 (or 70 percent) of Global Fund grants. Workshop participants were invited to consider proposing potential improvements to the QUART framework from a human rights perspective.

GRANT MANAGEMENT AND IMPLEMENTATION

Senior Global Fund staff with oversight of grants noted that there is wide commitment in the Grant Management division to addressing human rights, gender equality, and engagement of key populations, and quite strong engagement in these discussions, with 24 staff members in the division serving as focal points on community, rights, and gender issues. However, making adequate time to focus on these issues is a challenge for many grant management staff members. It was noted that significant progress had been made over the years in some areas, such as working with the International Commission of the Red Cross (ICRC) in Afghanistan and Tajikistan, addressing tuberculosis and multidrug-resistant TB in prisons, and implementation of opioid substitution therapy and harm reduction in some countries in Eastern Europe. As of 1 July 2014, the Global Fund will not be funding any services in drug detention centers in Viet Nam. Community systems strengthening, key populations, human rights and gender issues are addressed in internal country profiles produced by the Global Fund to brief grant management staff.

HUMAN RIGHTS WORKSTREAM

An overview of the Global Fund's human rights workstream was presented. In order to operationalize the human rights pillar of the Global Fund strategy, the Global Fund began to implement an eighteen-month workplan in July 2013. Highlights of the work are shown in Table 1 (next page).

The new provision on Respect for Human Rights, which will be included in the new Global Fund grant regulations, was emphasized as an example of strong collaboration across the Secretariat to address human rights considerations in grants. This provision sets out minimum expectations with respect to human rights standards in Global Fund-supported programs, including specifically addressing non-discriminatory access to services; respecting and protecting informed consent, confidentiality and the right to privacy in testing and treatment; the use of only scientifically sound and approved medicines and medical practices; not employing methods that constitute torture or cruel, inhuman or degrading treatment; and the use of medical detention only as a last resort. Under this provision, Global Fund grant recipients will be required to notify the Global Fund if there is actual or potential non-compliance with these standards, and to work with the Global Fund to address the issue through an agreed workplan or other actions.

STRATEGIC ACTIVITY	STEPS TAKEN	
Integrate human rights throughout grant cycle	• Brown-bag lunches for Secretariat staff • Train 24 Grant Management focal points • Begin issuing statements on human rights developments on case-by-case basis; develop a communications/ human rights plan • Establish Human Rights Reference Group • Include human rights questions in concept notes • 130 country profiles • Training, briefing for Technical Review Panel	• Integrate human rights goals and actions in new Gender Equality Strategy Action Plan and Key Populations Action Plan
Increase investment in programs that address barriers to access	• Portfolio review – identify amount of investment in human rights programs 2010-2012 • TB and human rights consultation • Research on malaria and human rights presented to Roll Back Malaria • Develop Human Rights Information Note and indicators • Removing Legal Barriers module	**Strategic initiative: US$15 million** • Human rights groups to be technical support providers • Core funding for key populations networks • Regional coordination platforms
Ensure Global Fund does not fund programs that **violate rights**	• Grant regulations language • Risk assessment tool updates • Research on key areas of human rights risk in Global Fund-supported programs (prisons, conflict settings)	
Transparency, accountability	• Timeline and process posted online • Staff participate through human rights task force • Wider consultations	

Table 1:
Global Fund human rights workstream, July 2013-December

Philippines © The Global Fund / John Rae

Key points raised in the discussion

- It is important to recognize that some governments see human rights differently, and feel that by including marginalized groups in service delivery they are holistically addressing human rights. There remains inadequate attention to nurturing rights advocates in countries, and to strengthening their links to international advocacy efforts.
- Greater effort will need to be made by technical partners at the country level to bring civil society, the health sector and governments together on human rights issues. The Global Fund and the United Nations Programme on HIV/AIDS (UNAIDS) sometimes work in silos when it comes to these issues, and much of the good work accomplished is dependent on individual personalities.
- There remains a significant amount of tokenism when it comes to involving key populations on Global Fund Country Coordinating Mechanisms, and those involved frequently struggle because they are not adequately equipped and supported.
- For country dialogues to be truly participatory, countries should allow themselves adequate time and not rush into developing concept notes. Civil society needs support to participate effectively (e.g. as in Cambodia, with the support of the country team). A number of the early country dialogues happened quickly due to tight timelines for the pilot applicants under the new funding model, but there were mixed experiences with community input into what was prioritized.
- Countries lack adequate data on key populations and human rights, including evidence for rights-based interventions (for example, police training), so it is difficult for the Technical Review Panel (an independent panel of experts who review requests for funding) to assess whether proposals adequately address these issues, and easy for countries that lack political will to leave things out.
- Applicants are unlikely to use the optional human rights module in their requests for funding, and governments will continue to consistently neglect community-based programming. Some participants in the meeting urged the Global Fund to impose conditionalities on grant agreements, or set a minimum threshold for rights-relating funding in grants. Other participants noted that conditionality on grant agreements could backfire and result in retaliation against domestic advocates and discontinuation of services and argued against setting human rights conditions.

Issues for the Global Fund to consider

- More investments in advocates and advocacy are needed.
- Some participants suggested that the Global Fund should designate a focal point to support civil society participation in country dialogues. Others noted that this is the responsibility of UNAIDS and other technical partners in countries.
- It would be useful to obtain commitments from governments that there will be no surveillance and no reprisals for key populations that take part in country dialogues. This is a risk in some countries. In countries where the risk is high, the Global Fund should continue its current practice of encouraging country dialogue consultations to take place in non-governmental "safe spaces", such as nongovernmental organization offices, offices in United Nations (UN) agencies or locations outside of the country.
- The Technical Review Panel should retain its flexible approach to accommodating gaps in data when assessing programming for key populations.
- More effort is needed to systematically work with partners at the country level.

"From donor collusion in drug detention centers, to ineffective UN drug treaties, to using condoms as evidence to arrest and detain people, to criminalizing men who have sex with men without even having any provision in the penal code, to the fragile status of migrants, we can clearly understand what is impeding access to health care services".

Meeting participant

Tajikistan © The Global Fund / John Rae

Panel 2:
Criminalization and restrictive settings

The panel shared expertise and reflections on several topics:

POPULATION SIZE ESTIMATES

While the need for improved epidemiological data on key populations was recognized, concerns were expressed about potential harms that could result from population size estimate studies funded by the Global Fund unless adequate measures are included in these efforts to protect the confidentiality, security and human rights of key population groups.

Withdrawal of Global Fund funding in middle-income countries where governments will not prioritize human rights and key populations was noted as a serious concern.

DRUG DETENTION CENTERS

A researcher into these centers in Asia described his experiences interviewing former drug detention center detainees and gave an overview of the poor conditions, forced labor and other human rights violations that take place in them. He noted that for many years donors – including the Global Fund - had funded health services in the centers, and some donors (though not the Global Fund) had maintained that there were "no abuses" in them. He emphasized the importance of the Global Fund and other donors undertaking due diligence processes, and examining the human rights records of grant recipients, to ensure that there is no support for such programs in the future. He noted that information sources should extend beyond UN agencies and include civil society and independent research organizations. Further, other agencies are also attempting due diligence processes, such as in the case of the World Bank on environmental and indigenous issues.

DRUG USE AND HARM REDUCTION

A critique of global illicit drug policy and the "war on drugs" was provided, including the harms inflicted by this approach on drug users. The speaker argued that a growing body of evidence shows that the global "war on drugs" has fueled the fight against HIV, and that many agencies have now called for an end to this approach.

While the Global Fund has been the biggest global donor to harm reduction, it was argued that overall funding for harm reduction remains inadequate. A panelist gave the example that, while 90 percent of the 16 million injecting drug users in the world fall within the Global Fund remit, only 18 percent of Global Fund grants go to prevention. As a result, global coverage of opioid substitution therapy

is only 8 percent, antiretroviral (ARV) therapy coverage for drug users is 4 percent and injecting drug users receive an average of only 1-2 needles per user/month globally. The panelist expressed great concern that 14 of the 58 countries where the Global Fund previously supported harm reduction are now ineligible for support, and ten received no allocation in 2014; 26 of the 58 countries have been categorized as "over-allocated". Willingness to pay for such interventions should also be a factor in determining eligibility, rather than just capacity to pay.

IT WAS NOTED THAT HUMAN RIGHTS ABUSES AGAINST DRUG USERS INCLUDE:

- Denial of harm reduction services and barriers to HIV/HCV treatment;
- Abusive police and law enforcement practices, based on meeting arrest quotas and targets. In Georgia, for example, a crackdown in 2007 led to 4 percent of the male population being forcibly drug tested, and 35 percent of these were imprisoned.
- Drug registries are kept in many countries in Eastern Europe, Central Asia and South East Asia. These prevent people from accessing services and can lead to denial of employment, travel, immigration, and child custody.
- Coercion in the name of 'treatment', including drug detention centers and abuses in private detoxification centers. For example, a recent International Network of People Using Drugs (INPUD) study in Manipur found that 75 percent of people who use drugs had heard of a death in a private detox center, and 95 percent had heard of forced returns to such a center after escape.
- Women, sex workers and young women who inject drugs face other barriers, and abuses, including forced sterilization, the need to conceal pregnancy, and denial of access to services.

WHILE RIGHTS-BASED RESPONSES TO HIV AND DRUG USE COULD INCLUDE:

- Access to justice services;
- Community empowerment;
- Legal reform, including decriminalization of drug use and public heath alternatives to incarceration;
- Funding scale-up essential to achieve the required level of harm reduction services;
- Abolition of drug registries;
- Closure of drug detention centers and private detox centers in Eastern Europe, Central Asia, South East Asia and Latin America and the Caribbean;
- Abolition of restrictions on HIV and hepatitis C treatment and care services on the basis of current drug use.

ISSUES FOR SEX WORKERS

An overview of human rights issues for sex workers was presented, noting that many governments are focused on numbers of people tested and number of condoms distributed; there is little interest in human rights, conditions or programming for sex workers. In many countries, police use possession of condoms as evidence of criminal activity. As a result, many sex workers choose not to use condoms or only think of them for pregnancy prevention. One speaker raised the case of China, where such practices are reportedly common. The speaker noted there is little meaningful civil society participation in national planning processes in the country. Discrimination against sex workers in accessing health services is widespread, and community-based organizations struggle to find funding now that the Global Fund has ended funding for the HIV response in China. Recent reports have documented an extensive "custody and education" system that involves arbitrary detention of sex workers. The Global Fund was urged to reconsider its approach to withdrawing funding from upper-middle income countries, where community-based and key populations-led organizations struggle to survive.

ISSUES FOR MEN WHO HAVE SEX WITH MEN AND TRANSGENDER PEOPLE

A panelist focused on the role of key population networks in human rights monitoring, providing legal aid and other services, and advocacy on human rights violations based on sexual orientation or gender identity. In Africa, two-thirds of countries include men who have sex with men or transgender people in national strategic plans, but far fewer implement interventions, and there is widespread discrimination, stigma, police harassment, media antagonism and both *de jure* and *de facto* criminalization. Movements of men who have sex with men and transgender people are emerging, but with growing visibility has come further repression.

The challenges faced by men who have sex with men and transgender people are systemic. Criminalization of same-sex relationships is a major challenge in many countries. There is limited understanding of these issues among the judiciary and law enforcement officers, and cases of people being thrown in jail without due process based merely on reports of their homosexuality; these detainees frequently have difficulties finding a lawyer who will represent them. Complaints to domestic human rights mechanisms are often ignored. The possession of condoms is often used as evidence against people accused of same-sex activity. The presenter noted that in many African countries where men who have sex with men and transgender people are subject to rights violations, Global Fund Principal Recipients include Ministries of Health and some Ministries of Justice and that the Global Fund should therefore exercise due diligence to ensure that its grant recipients are not complicit in rights violations against key populations.

Key points raised in the discussion

- Key human rights challenges for key populations include illicit drug policies, criminalization, policing, arbitrary detention, the use of condoms as evidence, the use of arrest and confession quotas by law enforcement authorities, criminalization of HIV non-disclosure, exposure and transmission, criminalization of same-sex behavior and lack of recognition of transgender identities, and impunity for violence against key populations.
- The presentations raised the key issue of whether and when the Global Fund should take a public stance on rights violations, or whether it is more effective to "let the money speak".
- More funding is needed to enable civil society groups to monitor rights violations, recognizing that this is a major challenge where there is no effective civil society present.
- People particularly vulnerable to TB who are hard to reach include prisoners, miners, migrant and indigenous populations. Rights violations based on TB and HIV status are frequently coincident.
- Health care providers are frequently hostile to key populations and may willingly or unwillingly contribute to rights abuses.
- The Global Fund's ability to have impact is only as great as its ability to address structural barriers, and a key challenge is to ensure that programs to address those barriers are included in concept notes.
- Fund Portfolio Managers have relatively little capacity to monitor and respond to rights violations, and need to connect effectively with partners at the county level.
- However, partners with human rights expertise are themselves under-resourced. A forthcoming UNAIDS report finds that funding for health and human rights work is actually diminishing, leading to many organizations with long experience in this field closing down.

Issues for the Global Fund to consider

- The Global Fund should consider its position on a number of policies and practices that have been shown to have negative impacts on human rights, including the impact of "100% condom use" programs, the detention of TB patients, drug registries, limitation of services for active drug users, forced sterilization, and use of condoms as evidence. The Global Fund was urged to end funding for health programs in drug detention centers, and to ensure that it does not support or promote mandatory HIV testing.
- Some of these issues are already addressed in Global Fund information notes, which are based on UN and World Health Organization (WHO) guidance, and others (such as testing without informed consent) will be addressed in the minimum standards in the Global Fund's grant regulations.
- Some decisions, such as a position on whether or not to fund health interventions in drug detention centers, may need consideration by the Board. Currently, the Global Fund's information notes state that the Global Fund will support health interventions in drug detention centers if there is independent monitoring of the conditions, but in practice it has been difficult for the Global Fund to find an institution willing and able to engage in this monitoring.
- More funding is needed to support key population-led organizations and harm reduction programs, including in middle-income countries.

Nepal © The Global Fund / John Rae

Panel 3:
Challenging operating environments

This panel discussed background papers commissioned by the Global Fund on two key areas where health needs are acute and human rights abuses are prevalent, and that present particular challenges to the Global Fund and other donors.

RESEARCH TOPIC 1: CONFLICT SETTINGS

The paper Taking a human rights-based approach to health service delivery in conflict areas (Annex 2) was prepared and presented by the Geneva Academy for International Humanitarian and Human Rights Law. It sought to describe the risks of human rights violations in Global Fund-supported programs in conflict-affected areas and to provide relevant policy recommendations.

The Global Fund currently supports 118 active grants in 20 of the 25 countries designated as having armed conflict in 2012, and has invested more than US$3 billion in funding for these 20 countries. The paper focused on Syria, Egypt, Congo (Democratic Republic), Bahrain, Myanmar, Sudan, Central African Republic, Afghanistan, Nigeria and Iraq, drawing upon data from Rounds 9 and 10. Major human rights concerns identified were:

- **Discrimination in the provision of health** care (e.g. in Central African Republic, where religion is a factor underscoring the current conflict, health workers frequently discriminate on the basis of religion.)
- **Attacks on health care facilities and health workers** (e.g. in Syria, systematic, brutal attacks by the state on patients, health facilities and health workers have created such a climate of fear that many patients will not go to hospitals. In Iraq, attacks against health workers led to the flight of qualified health professionals, severely diminishing access to health services).
- **Torture and cruel, inhuman and degrading treatment of conflict-related detainees** (e.g. in Afghanistan, there are reports that conflict-related detainees are denied access to medicines and treatment, and can be subjected to torture and brutal abuse).
- **Violations of women's rights** (e.g. sexual violence is widely prevalent in the conflicts in Central African Republic and Syria, and there can be a lack of access to services for victims of sexual violence. Culturally appropriate health services for women are often not available).
- **Contextual barriers to access** (Many conflict areas are underserved by quality health care facilities because of destruction of facilities, for example, in Congo (Democratic Republic) and Côte d'Ivoire).

Challenges for the Global Fund in conflict settings include difficulties undertaking monitoring and evaluation, engaging with key populations, and having adequate capacity to address human rights issues in the face of pressing health programming challenges. Flexible and differentiated approaches, including targeted investments, are likely to be needed in different settings.

POTENTIAL RECOMMENDATIONS TO THE GLOBAL FUND FOR DISCUSSION

- Develop comprehensive and clear human rights guidelines;
- Improve and tailor monitoring and evaluation processes in conflict settings;
- Create a formal multistakeholder grievance mechanism to address violations related to Global Fund grant activities in these settings, and
- Provide staff and stakeholder training, build capacity, and strengthen internal advocacy on issues related to Global Fund-supported programming in conflict settings.

RESEARCH TOPIC 2: PRISONS AND PRETRIAL DETENTION SETTINGS

Ian Grubb prepared and presented the paper *Health risks and human rights violations in prisons and pretrial detention settings: Issues for consideration by the Global Fund* (Annex 3).

Global Fund support for prison health services: Global Fund policies and human rights guidance permit and encourage funding of HIV, TB and malaria programming in prisons and the Global Fund has supported a considerable amount of prison-based programming over the last decade, notably in Eastern Europe, Central Asia and southern Africa. In 2014, the Global Fund announced that it would cease funding any activities in Viet Nam's notorious drug detention centers, and has indicated that it does not fund activities

in such centers in Cambodia. To some extent, the comprehensiveness of Global Fund prison programming is constrained by national policies that frequently prohibit harm reduction interventions and condoms in prisons; nevertheless, these are being provided in prisons in some countries with Global Fund financing and some encouraging models of comprehensive prison-based HIV and TB programming exist, notably in Moldova. Global Fund support for activities not related to direct health care services, but which could contribute to improved living conditions and health for prisoners, such as prison support groups or community-based monitoring, currently appears to be limited.

Prisoners' rights: Other than rights that pertain to the denial of their liberty, such as freedom of movement, prisoners have the same rights as everyone else, including the right to health. This right has been interpreted as including the right to an equivalent standard of care as is available in the community, including preventive measures and specialist treatment. Health professionals also have the same obligations to prisoners as to other people, including obtaining informed consent to medical procedures. Nevertheless, poor living conditions are reported in prisons in many countries and health services are frequently deficient or non-existent, including lack of access to diagnosis, prevention and treatment of HIV, TB and malaria. Prison health care services are frequently not linked to the national health system. Practices that violate the right to health and other rights - such as forced labor, physical violence against prisoners and arbitrary detention of drug users and sex workers - have been widely reported, and some health care practitioners are complicit in abusive practices that amount to cruel, inhuman and degrading treatment or torture, including denial of treatment and performing tests and examinations without consent. Conditions in pretrial detention facilities that house people awaiting trial are frequently worse than for those under sentence, and people may languish in such facilities for months or years.

Health risks in prison settings: In nearly all countries, incarcerated populations have more risk factors associated with acquiring and transmitting HIV, hepatitis C and TB, including injecting drug use, unsafe sex, alcohol use, untreated mental illness and lower socioeconomic status. High rates of these diseases are reported in prisons in many countries as compared to the general population. Prisons present a high risk of transmission of disease through high-risk behaviors such as consensual sex, rape, sharing of needles and other injecting equipment, tattooing and piercing. Malaria interventions appear to be poorly implemented in prisons in many endemic countries, in part because prison officials fear that nets will be used as ropes. High TB rates in prisons are the result of overcrowding and poor living conditions, including poor ventilation and inadequate screening and diagnosis. An important consideration for the Global Fund is that TB in prisons may account for up to 25 percent of a country's TB burden. Addressing prison health needs to be a key part of public health programs, and infectious diseases in prisons should be a high priority.

Specific cases of concern include drug user and sex worker detention centers, pretrial detention settings, and involuntary medical procedures, including forced sterilization.

Challenges for the Global Fund include increasing its investments in prison programming, ensuring adequate standards of care (equivalence) and access to services in prisons and pretrial detention facilities, and monitoring and responding to human rights risks and abuses in prisons. An overarching question with regard to Global Fund-supported prison programming is whether the support being provided by the Global Fund is helping to address rights violations that have been identified by international monitors and nongovernmental organizations in many countries.

Potential recommendations to the Global Fund for discussion

- Develop policies on the Global Fund's expectations of countries with regard to prison-based programming and elaborating on the types of programs that the Global Fund will and will not support;
- Endorse or develop minimum standards for prison-based health care services supported by the Global Fund, based on the core principles of equivalence, consistency with international guidance on HIV, TB and malaria in prisons, and the need to ensure that prison-based and public health programs are closely linked;
- Develop procedures that Principal Recipients, Country Coordinating Mechanisms and/or Global Fund staff will follow if they witness or learn of human rights violations in a prison or pretrial setting;
- Describe the implications for Global Fund support of human rights violations in prison settings, especially where national authorities fail to act on poor prison conditions'
- Elaborate upon the role of the Global Fund Inspector General in monitoring prison programming supported by the Global Fund;
- Consider the need for specific safeguards or conditions in grant agreements to protect prisoners' health and other rights;
- Adapt current risk assessment procedures to include issues related to prisons and pretrial detention settings.

Other activities that may help to increase the awareness and engagement of Global Fund staff, Country Coordinating Mechanisms, the Technical Review Panel and other stakeholders, include dissemination of best practices in Global Fund-supported prison programming, engagement of participation by Ministries of Justice/Departments of Corrections on Country Coordinating Mechanisms and further encouraging country teams to visit prisons. More broadly, the Global Fund may also consider developing guidelines on due diligence processes for Fund Portfolio Managers and Principal Recipients that assess grant recipients' human rights records and monitor rights violations in prison settings.

Key points raised in the discussion on the two research papers

- ICRC and UN Committee on Torture guidance and practices may help inform the Global Fund's approaches to funding programming in both conflict and prison settings. "Independent access" is a key ICRC principle that the Global Fund could explore. The Global Fund was urged to engage in more policy advocacy around prison health and to report to UN human rights treaty bodies. This also sparked discussion around whether a donor should report to treaty bodies about its grantees.
- There is a need for practical instruments to assess legal and human rights environments, appropriate safeguards in grant agreements, and human rights indicators in grants. Can the Global Fund set targets within programs for structural reforms and evidence-based health outcomes that need to be met?
- The Global Fund should not find itself in a position where it cannot "follow the money". It needs to work with country-based partner -, including by providing support to civil society groups - to monitor human rights situations more effectively.

Panel 4:
Health donor accountability

This panel focused on the emerging area of health donor accountability and included a presentation on legal aspects of donor accountability and presentations by two leading donors that have been working to apply human rights approaches to grant-making.

Legal aspects of health donor accountability

Rebecca Schleifer of the Yale Global Health Justice Partnership presented her research and recommendations, summarized below, on legal aspects of donor accountability for human rights violations.

There is no single, **legal definition** of public-private partnerships, such as the Global Fund. The paper focused on public-private partnerships that are separate legal entities, such as the Global Fund and the GAVI Alliance, but which occupy an unusual legal space in terms of accountability in that they are neither international organizations nor businesses, both of which are subject to international law or agreements. The Global Fund nevertheless describes itself as an international organization. In this context, the former UN Special Rapporteur on the Right to Health, Paul Hunt, has stated that "the requirement of human rights accountability… extends to international actors working on health-related issues." It can therefore be argued that the Global Fund's accountability should extend to the intended beneficiaries of its grants, and should include meaningful participation in Global Fund processes.

Established concepts of international accountability for human rights frequently address the accountability of states, especially member states of international organizations that have responsibilities to protect human rights under international law and treaties to which they are party.

Accountability frameworks for international organizations and businesses have begun to evolve over the last five years, notably in the UN's "protect, respect, remedy" framework and the Guiding Principles on Business and Human Rights. These have arisen in response to complicity by these actors in violations of human rights, such as the UN's involvement in the cholera outbreak in Haiti, and business practices that have had negative impact on human rights. A common emerging approach for both international organizations and businesses is to undertake "due diligence" processes and/or human rights assessments to identify, prevent, mitigate and account for human rights harms that are directly or indirectly linked to their work. It was suggested that the Global Fund should also consider adopting such processes and may refer for guidance in this regard to the growing number of online tools designed to assist public and private actors in conducting human rights impact assessments, as well as guidance from the United Nations Office on Drugs and Crime (UNODC) and the UN Human Rights Due Diligence Policy on UN Support to Non-UN Security Services.

In responding to violations, the Global Fund should also consider principles of **due process**, including the right to a forum to be heard, the right to an effective remedy, and/or guarantees of non-repetition of the violation.

Switzerland, the U.S. and seven other countries have agreed to grant the Global Fund the **privileges and immunities** normally reserved for international organizations. There is currently a lively international debate about the circumstances in which international organizations should waive immunity or have immunity waived in the case of complicity in human rights violations. It was suggested that the Global Fund should consider itself bound by the emerging norms attached to international organizations.

Presentation on European Investment Bank approaches

A representative of the European Investment Bank (EIB) provided an overview of its risk-management approach, which began with an explicit statement in 1998 that it will "not finance projects which result in a violation of human rights" nor fund in countries "declared off limits" for European Union financing by the European Council. This policy was most recently updated in 2008 and new operational standards were developed in 2013 after examining the approach taken by the IFC and performing a human rights gap analysis.

The EIB adopts a "risk-driven approach" focusing on those who are affected, rather than just beneficiaries. The EIB's work is guided by European Union law and conventions and is supported by delegations on the ground, including European Union human rights focal points. Standard human rights language is included in all agreements. The bank employs a due diligence system and tools, rather than standalone human rights assessments. It recognizes that there will always be trade-offs between aspirational standards and implementation, and it is often necessary to make context-specific, case-by-case decisions. EIB safeguards and standards aim to bring about change at the project level, rather than the national level, but these can provide a useful entry point for broader change. A smaller number of around ten standards is seen as preferable to a very complicated framework.

An important question for the EIB has always been how to respond when the human rights situation in a country is less than ideal. Does the EIB "help the client to grow" or is it allergic to risk? How can it engage with risk in a productive manner? The bank's approach is what is described as "a phased move towards compliance". Potential steps include intensified monitoring, imposing disbursement conditions, delaying disbursements or ceasing funding. Third party monitoring, including by civil society, has recently been adopted as part of the EIB approach.

As a result of much effort, the EIB business model has evolved over 20 years from one that was not compatible with human rights, to a far more responsive system.

Presentation on World Bank approaches

A former World Bank employee provided an overview of environmental, social and governance issues related to accountability from the World Bank perspective. These relate to the World Bank Group's public (World Bank) and private sector (International Finance Corporation, or IFC) lending and grants, and are summarized in Table 2.

Safeguard policies: The World Bank may impose environmental and social safeguard policies on the borrowing country. These are accompanied by baseline assessments of the potential positive and negative impacts of the project. The IFC approach is more detailed, and includes explicit sustainability and human rights assessments.

Management systems: The IFC has an IT system that can monitor commitments for the lifetime of a project.

Disclosure and community engagement: The World Bank has a comprehensive disclosure policy with regard to commitments made by borrowers. The IFC Policy is much more limited because of business/client confidentiality constraints, but the IFC has a very vigorous requirement for engagement with affected communities.

Redress mechanisms: The World Bank uses an ad hoc approach but is beginning to be more systematic with the creation of a panel that determines responsibilities between the Bank and its clients. The IFC has a two-tiered system in which the client manages a grievance system that allows community complaints to be received. Communities also have access to an institutional mechanism to make direct complaints to the IFC. The IFC's focus is on dispute resolution.

Remedies: Project withdrawal is possible in the case of both the World Bank and the IFC. Frequently, the client will be encouraged to provide remedy, which may take the form of a written agreement.

	WORLD BANK (PUBLIC)	INTERNATIONAL FINANCE CORPORATION (PRIVATE)
Policies standards and procedures	Safeguard policy	Sustainability, policy, performance standards, (human rights explicit) procedures
Management system	Some	For IFC and for IFC clients AIP client community engagement
Disclosure and community engagement	Access to information policy	AIP client community engagement
Redress mechanisms	Ad hoc project level inspection panel	Project level CAO
Remedies	Bank withdrawal project CAP	IFC withdrawal project CAP

Table 2: World Bank Group approaches to human rights risk management

Key points raised in the discussion

- The presentations show that two powerful institutions have grappled with these issues, but they do so with clear mandates from the UN and the European Union. The Global Fund is a different entity and there is a pushback from recipient countries on conditionalities and human rights (e.g. addressing the needs of key populations), so how far can and will the Global Fund go? It needs a strong rights and accountability framework, but is the Global Fund really prepared to impose conditions, are conditions the most effective approach to supporting domestic rights advocacy, given concerns raised by some communities, and how much is it prepared to invest in these types of processes?

- The Global Fund needs to have a clear understanding in any particular case about what its leverage is and where and when to use it. This will involve considering a range of potential outcomes from "do no harm" to imposing conditionalities (the evolution of the Global Fund's approach to drug detention centers in Viet Nam is a good example of this).

- Operationalizing a phased move towards compliance involves specifying a number of standards and being clear about when these standards are triggered and its impact on the grant. Specific interim improvements could be required between specified disbursements.

Potential actions

HUMAN RIGHTS IMPACT ASSESSMENT AND DUE DILIGENCE PROCEDURES

- Integrate human rights risk assessment in current risk assessment tools to identify human rights impacts of proposed projects;

- Develop and implement clear policy guidance regarding situations that justify withholding or freezing funding in cases of human rights risks;

- Develop and implement effective mechanisms to identify actual and potential human rights problems throughout the life of a project and flag them to be addressed on an urgent basis;

- Develop and implement mechanisms to collaborate with external donors and implement agencies to monitor settings where there are real risks of human rights abuses;

- Potentially, identify specific types of projects or contexts where the Global Fund will not provide funding.

ENSURE ACCOUNTABILITY

- Ensure that independent grievance mechanisms are available and accessible for people to raise concerns about alleged human rights violations in the context of Global Fund activities

  1) Promote information on these mechanisms and processes in local contexts

  2) Provide clear guidelines on safety of persons raising concerns (including confidentiality as well as real time response processes);

- Formulate clear guidelines regarding the scope of Global Fund immunity (including situations in which immunity should be waived);

- Ensure internal accountability mechanisms are available, transparent and accessible.

COMMIT TO A RIGHT TO A REMEDY

- Work with other donors, governments and members of relevant populations to promote remedies for victims of human rights abuses.

  1) Consider a range of remedies and redress, including apology, compensation, guarantee of non-repetition, support and services that respond to the harms experienced.

  2) Provide training on the use of these mechanisms

CONNECT RIGHTS TO REMEDY WITH GUARANTEES OF NON-REPETITION

Ensure an adequate flow of information, with due regard for confidentiality and privacy concerns for all affected, to persons and mechanisms necessary to respond in the future as well as to specific cases.

Summary of key issues raised on Day 1

- An intensive discussion that may have raised more questions than answers.

- There are similarities with other institutions and opportunities to follow up with them on their approaches.

- How and when should the Global Fund engage in human rights advocacy or should it "let the money speak"?

- How can the Global Fund better align its messaging and work with UN partners, given that it has no country presence? What happens when UN partners are so closely aligned with governments that they avoid raising "sensitive" human rights issues?

- How can the Global Fund involve civil society more meaningfully, and how should it work in countries where there is little or no independent civil society? It is important to finance this engagement to the extent possible. Non-Country Coordinating Mechanism proposals offer a potential last resort.

- Due diligence in grant-making is a good idea and participants expressed strong support for this, but human resources to do it at the Global Fund and in partner organizations are limited. How can this be addressed? Some pragmatism is required - e.g. the language in the grant regulations had to focus on what could realistically be implemented.

- What will the Global Fund do if and when countries push back against new approaches or conditions?

- Are donors such as the Global Fund obligated to provide remedy to people who experience rights violations in programs that they support?

- Participants expressed quite strong support for clear, operational human rights guidelines that address all aspects of human rights in grant-making, concept notes and implementation, for use internally by the Global Fund.

District of NGABA, Kinshasa.
Mother and Child Hospital © The Global Fund / Georges Mérillon

Day 2:

Working groups and development of recommendations

On Day 2 of the meeting, participants broke into four working groups and developed recommendations for consideration by the Global Fund. The recommendations emerging from the groups appear at the end of this report, organized by stakeholder group.

The four working groups were:

1) Risk assessment and management
2) Partnerships and procedures to address rights violations
3) Prisons and closed settings
4) Conflict areas, with particular attention to women.

Key points raised in the discussion

- The current way in which human rights are addressed in the QUART tool is too limited, as there are human rights dimensions beyond "health issues". Human rights should be integrated into other sections of QUART and it should include issues related to governance and Country Coordinating Mechanism non-compliance, e.g. participation by key populations on Country Coordinating Mechanisms, and lack of programming for key populations. However, this raises additional questions about how Fund Portfolio Managers and others who participate in risk assessment (such as Local Fund Agents) should assess this risk, given that some are not equipped with human rights expertise.
- The Office of the Inspector General must be careful in managing expectations about individual complaints that come through the hotline and work with governments and partners to ensure that there are no reprisals against people who make complaints e.g. by applying the Whistle-blower Policy. Especially where the issue is not related to Global Fund-supported programming or cannot be addressed by the Principal Recipient, other partners and national human rights institutions are better placed to help complainants seek redress.
- There is a need to distinguish between individual complaints for which the Global Fund cannot itself provide redress, and policy-level complaints that relate to more systematic practices in Global Fund-supported programming. The Global Fund will have a clear responsibility to seek some form of "systemic redress" or improvements in the quality of services in the latter case. The Global Fund could consider the lack of mechanisms for redress as a contributing factor in risk assessment.
- While many participants supported the idea of more comprehensive due diligence processes, Global Fund staff emphasized that it is necessary to determine what is feasible beyond existing processes, and not further burden already over-burdened staff with additional tasks and bureaucratic processes.
- Global Fund staff noted that many Fund Portfolio Managers currently do manage the issues raised in this meeting on a regular basis. However, they stressed that additional human resources will be required to implement all the recommendations emerging from this meeting – for instance, knowledge management of fast-moving and developing human rights issues.
- Several participants commended the Global Fund on its progress on human rights over the past period, while noting that much more needs to be done.
- Building civil society capacity needs to continue to be seen as a key element of the Global Fund's human rights agenda, including support for peer-led networks, for prisoner support groups and other groups working with prisoners, legal aid to reduce the use of pretrial detention and alternatives to incarceration for people who use drugs.
- It is recommended that the Global Fund makes more public statements on its opposition to compulsory forms of detention for people who use drugs, sex workers and others.
- The meeting concluded with a plea from networks of people living with HIV for the Global Fund to facilitate easier access to the Global Fund's systems and processes, including more Global Fund documents in basic English and other languages, and for continued strong Global Fund engagement with key population networks.

Recommendations to the Global Fund

The following recommendations were drafted by participants in the workshop, and subsequently reviewed by members of the workshop who led discussion groups on the second day, and members of the Global Fund Human Rights Reference Group, who added some clarifications. Because some of the workshop recommendations that related to work in conflict settings were seen as duplicating tasks that are already underway, they were shared with Global Fund staff managing grants in those settings, who provided valuable input and elaborations. All the workshop recommendations were shared with Global Fund staff at an informal lunch briefing.

TO THE BOARD

Create a Global Fund policy on **not funding programs in drug detention centers**, as well as sex worker or LGBT "rehabilitation" programs.

Clarify whether the Global Fund will **engage in regular statements and advocacy around human rights policy** (a range of topics was proposed, ranging from prison health to international drug policy and laws that criminalize key populations). Clarify whether the Global Fund will systematically and consistently speak out publicly on human rights violations, or take a more "quiet diplomacy" approach.

- Consider the recommendations of the Global Commission on HIV and the Law for a wide range of issues on which policy statements from the Global Fund would be helpful, including on intellectual property and treatment access.
- Consider expanding the Global Fund's engagement with UN treaty bodies and human rights mechanisms by Board Members, including those who represent UN member states.

TO THE TECHNICAL REVIEW PANEL

Continue to increase human rights capacity and expertise on the Technical Review Panel through briefings and training.

Review concept notes to check that they include: an effort to bring international standards of HIV care and overall living conditions into work supported in prisons, including a package of essential services in prison settings prevention, treatment and care programs for HIV, TB and malaria in countries where prevalence is high in those settings increased investment in community systems strengthening and human rights programming in fragile states, in order to build capacity by the community to support continuity of services if the situation deteriorates further.

TO THE SECRETARIAT

Develop (or revise existing) operational guidance to address human rights and include:

- identification of risk of human rights violations in Global Fund grants, including mainstreaming human rights considerations throughout the QUART
- mechanisms and expectations about reporting and managing allegations of rights violations in Global Fund grants, including those that are shared through informal communications
- situations where human rights violations may justify reprogramming or suspension of funding
- guidelines that enable funds to be reallocated from one country to a neighboring country to fund health programs for refugees
- guidelines on whether funding can be temporarily withheld from grantees when medical facilities are attacked
- requirement that grant recipients purchase political violence insurance, and consider support for private security guards for medical facilities
- clarification on when Global Fund staff can speak out publicly on human rights issues, in support of civil society and other partners who are also doing so.

On data:

- Increase efforts to gather **disaggregated data about victims of conflict**; share data with other agencies and service providers working in conflict settings, including international organizations and local service providers
- Support capacity building for data collection by community-based organizations
- Use **emerging technology, such as cell phones**, to enable rapid data collection and response in hours or days instead of weeks in conflict settings
- Gather more data about **what the Global Fund currently funds in prisons** and closed settings to identify best practices and gaps.

Explore **new or enhanced partnerships** with agencies that can support the Global Fund in key areas of human rights:

- **On prisons:** Explore a global partnership with ICRC, and with Council of Europe Committee for Prevention of Torture, UN Subcommittee on Prevention of Torture to encourage them to consider

human rights violations that fuel HIV, TB and malaria in their regular prison monitoring.

- **On conflict settings:** Establish framework partnership agreements with certain agencies (such as United Nations High Commission on Refugees (UNHCR), ICRC and Médecins Sans Frontières (MSF)) to enable rapid and streamlined disbursement/procurement in emergencies; explore partnerships with communications companies to address use of cell phone technology to gather data in emergencies; consider a partnership with Humanitarian Accountability Project and other organizations that do consultation with communities in conflict settings
- **On UN human rights:** Expand partnership with UN human rights mechanisms and the Office of the High Commissioner on Human Rights (OHCHR), and explore feasibility of country teams briefing, or being briefed by, UN Special Procedures and human rights mechanisms
- **On intellectual property:** Collaborate with the United Nations Development Programme (UNDP) and others to convene a meeting of human rights experts in order to take the Global Commission's recommendations on intellectual property law forward.

Consider **adding a staff position** to provide technical advice and manage partnerships on prisons and conflict.

While the use of country profiles on human rights, gender and communities is welcomed, consider the needs to properly **resource sharing frequent updates on human rights information** for all country teams.

Update the Human Rights Information Note and other Global Fund technical guidance to include the following:

- Minimum standards and a package of recommended interventions in prisons and other closed settings
- Fund post-rape care-related services as part of HIV package (without discrimination, including termination services) in conflict settings
- Encourage countries to use their flexibilities in intellectual property law (whether TRIPS or other applicable agreements) to the full extent so as to maximize equitable, affordable access to medicines
- Consider adding a specific subsection to the Human Rights Information Note addressing human rights considerations in health care settings (including on involuntary sterilization of women living with HIV, HIV testing without informed consent, and steps to take to ensure non-discrimination against key populations)
- Address steps that should be taken to ensure access to services for people with disabilities
- Amend the concept note format to include questions assessing human rights issues in conflict settings, and assessing the country's legal frameworks related to treatment access.

Revise the QUART (Global Fund risk assessment tool) section 3.4 on human rights to address the following points:

- Human rights should not be limited to section 3.4 of the QUART but rather should be reflected also in governance issues (representation of key populations in Country Coordinating Mechanisms) and throughout the QUART
- Ensure that human rights violations are defined in line with international human rights standards, and that human rights risk is understood to be risk of these rights violations occurring in or impeding delivery of Global Fund-supported programs
- Severity of human rights risk should not be determined based on percentages of populations affected (for instance, even if only 3 percent of women with HIV experience involuntary sterilization, that is a significant number of people and a serious rights violation)

TO THE OFFICE OF THE INSPECTOR GENERAL:
Consider whether the Global Fund should investigate individual cases, or only use these to identify policies or systemic practices that result in widespread rights violations.

When there is a complaint, the Global Fund should either convene or participate in a national process to investigate rights violations, drawing on regional support. The process must have credibility, no conflicts of interest, and needs checks and balances.

- Ensure peer-led networks are engaged in the process domestically and regionally
- Include several tiers to manage allegations, so that there is a local and immediate response to the abuse survivor.
- Work with UNDP, UNAIDS, the President's Emergency Plan for AIDS Relief (PEPFAR) and other donors, plus relevant civil society and key populations networks, to coordinate investigations at the country level (with regional support as needed); consider whether or how to work with the UN to address complaints of human rights violations

The report should be taken to the government to correct the policy/practice of widespread rights violations.

Annex 1: Meeting Agenda

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA
INVESTING FOR IMPACT: GLOBAL FUND STRATEGY 2012-2016,
IDENTIFYING AND MANAGING THE RISK OF HUMAN RIGHTS VIOLATIONS

22-23 MAY 2014
VENUE : AUDITORIUM JACQUES-FREYMOND, RUE DE LAUSANNE 132, 1202 GENÈVE

Agenda – Thursday 22 May

Time	Session
9.00 - 9-30	**Welcoming Remarks** Marijke Wijnroks, Chief of Staff, Global Fund Prof. Andrew Clapham, Director, Geneva Academy of International Humanitarian Law and Human Rights
9.30 – 9.45	**Overview of the agenda and objectives of the meeting**
9.45 – 11.00	**Panel I: Update on Secretariat work streams and Timelines** • Discussion
11.00 – 11.15	Coffee Break
11.15 – 12.30	**Panel II: Criminalization and restrictive settings** • Discussion
12.30 – 13.35	Lunch Break
13.30 - 15.00	**Panel III:** **Research and recommendations; challenging operating environments** Ian Grubb, Consultant, Community Rights and Gender Department, Global Fund Christophe Golay, Geneva Academy of International Humanitarian Law and Human Rights Moderated by Anand Grover, UN Special Rapporteur on the Right to Health • Discussion
15.00 – 15.15	Coffee Break
15.15 - 16.30	**Panel III: Research and recommendations; health donor accountability** • Discussion
16.30 – 17.00	**Wrap- up of day one and concluding remarks** Marijke Wijnroks, Global Fund
19.30	**Participant Dinner at Perle du Lac** **Dinner conversation:** Anand Grover, UN Special Rapporteur on the Right to Health Marijke Wijnroks, Chief of Staff, Global Fund

Friday 23 May

Time	Session
9.00 – 9.15	**Recap of day one and overview of day two's agenda** Marijke Wijnroks, The Global Fund
9.15 – 11.00	**Working groups** Working group one: Risk assessment and management Working group two: Partnerships and procedures to address violations Working group three: Recommendations on prisons and closed settings Working group four: Recommendations on conflict areas, especially in reference to women
11.00 – 12.30	**Reports from each of The Working Groups** • Discussion
12.30 – 13.35	Lunch Break
13.30 – 15.00	**Working groups (continued)**
15.00 – 15.15	Coffee Break
15.15 – 16.30	**Reports from each of the working groups** • Discussion
16.30 – 17.30	**Concluding observations and next steps**

Paraguay © The Global Fund / John Rae

Annex 2: Research Paper

HEALTH RISKS AND HUMAN RIGHTS VIOLATIONS IN PRISONS AND PRETRIAL DETENTION SETTINGS: ISSUES FOR CONSIDERATION BY THE GLOBAL FUND

DISCUSSION PAPER
IAN GRUBB, MAY 2014

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EXECUTIVE SUMMARY

A range of international policies and standards has been developed to address HIV, TB, malaria and drug dependence in prisons, yet comprehensive interventions are rarely provided. These policies and standards emphasize equivalence with the standard of care in the community; the importance of integrating prison health with the broader public health system; the need for adequate funding of prison health that reflects the greater needs of prison populations, with appropriate emphasis on disease prevention, early detection and treatment; the importance of recognizing the specific health needs of women in prison, such as sexual and reproductive health; the need to address stigmatization of the most vulnerable people in prisons, including drug users, adolescents and young people, people with disabilities, lesbian, gay, bisexual and transgender (LGBT) people, indigenous people, ethnic minorities and undocumented people, and the importance of broader prison reform, including efforts to improve living conditions, reduce the excessive use of pretrial detention, implement alternatives to incarceration for drug users and people with mental health problems, and ending the use of compulsory detention for people who use drugs and for sex workers. All of these approaches are essential if the health and other rights of prisoners are to be fully realized.

The context of frequently poor health services and other rights violations in prisons in countries where the Global Fund supports national HIV, TB and malaria programs poses a number of important considerations for the Global Fund. These include how to increase its investments in prison programming, the standards of care and access to services in prisons and pretrial detention facilities, the adequacy and scope of Global Fund support for health services in prison settings and how the Global Fund monitors and responds to human rights risks and abuses in prisons. An overarching question with regard to Global Fund-supported prison programming is whether the support being provided is helping to address rights violations that have been identified by international monitors and nongovernmental organizations in many countries.

Global Fund policies and human rights guidance permit and encourage funding of HIV, TB and malaria programming in prisons and, although the available information is currently limited, the Global Fund has supported a considerable amount of prison-based programming over the last decade, notably in Eastern Europe, Central Asia and southern Africa. In 2014, the Global Fund announced that it would cease funding any activities in Viet Nam's notorious drug detention centers, and has indicated that it does not fund activities in such centers in Cambodia. However, the extent to which the Global Fund has responded to reports of human rights abuses in prisons in other regions is not known. To some extent, the comprehensiveness of Global Fund prison programming is constrained by national policies that frequently prohibit harm reduction interventions and condoms in prisons; nevertheless, these are being provided in prisons in some countries with Global Fund financing and some encouraging models of comprehensive prison-based HIV and TB programming exist. Global Fund support for activities not related to direct health services, but which could contribute to improved living conditions and health for prisoners, such as prison support groups or community-based monitoring, currently appears to be limited.

Few other donors publish criteria by which they monitor and assess human rights-related risks in programming that they support; those that do emphasize the concept of "due diligence" in assessing grant recipients' human rights records and monitoring for potential rights violations.

By more actively advancing health and other human rights in prison settings, the Global Fund has an opportunity to remain in the vanguard of international health and development efforts and make a further important contribution to ending the HIV, TB and malaria epidemics. It can do this by:

- Developing policies on its expectations of countries with regard to prison-based programming and elaborating on the types of programs that the Global Fund will and will not support;
- Endorsing or developing minimum standards for prison-based health services supported by the Global Fund, based on the core principles of equivalence, consistency with international guidance on HIV, TB and malaria in prisons, and the need to ensure that prison-based and public health programs are closely linked;
- Developing procedures that Principal Recipients, Country Coordinating Mechanisms and/or Global Fund staff will follow if they witness or learn of human rights violations in a prison or pretrial setting;
- Describing the implications for Global Fund support of human rights violations in prison settings, especially where national authorities fail to act on poor prison conditions, and
- Elaboration of the role of the Global Fund Inspector General in monitoring prison programming supported by the Global Fund.

Such policy work should endeavor to engage the management and Board of the Global Fund more closely on prison-related issues. A number of other activities may help to increase the awareness and engagement of Global Fund staff, Country Coordinating Mechanisms, the Technical Review Panel, and other stakeholders, such as dissemination of best practices in supported prison programming and reports by organizations and individuals that monitor human rights in prisons, engagement of Ministries of Justice/Departments of Corrections on Country Coordinating Mechanisms and further encouraging country teams to visit prisons.

The Global Fund may consider developing guidelines on due diligence processes for Fund Portfolio Managers and Principal Recipients that assess grant recipients' human rights records and monitor rights violations. It could also consider the need for specific safeguards or conditions in grant agreements to protect prisoners' health and other rights, and adapt its risk assessment procedures to include issues related to prisons and pretrial detention settings.

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1. Context: The Global Fund and human rights

The Global Fund Framework Document (2001) states that the Global Fund will support funding proposals that are consistent with international law and that give due priority to the most affected countries and communities. The Global Fund corporate strategy for 2012-2016 calls for the Global Fund to make increased investments in programs that address human rights-related barriers to access and to ensure that the Global Fund does not support programs that infringe human rights. The strategy refers specifically to the need for the Global Fund to encourage and support countries to increase programming that will improve access to health services for affected communities, including prisoners.

This paper is intended to be an information source and means of provoking discussion and thinking about how the Global Fund can more effectively address barriers to the provision of services in prisons, pretrial detention settings and other closed environments[1]. It examines a range of issues relating to health and human rights in prisons, including the major frameworks governing the treatment of prisoners; health and human rights risks associated with prisons and pre-trial settings, and international policies and standards related to HIV, TB, malaria and drug dependence treatment in prison settings. It includes a limited assessment of the scope of Global Fund support for health services or other programming in these settings, and concludes with questions for consideration and potential actions by the Global Fund as it works to fulfill its human rights and funding commitments with regard to prison populations.

2. The fundamental human rights of prisoners

It is estimated that, at any one time, more than 10 million people are imprisoned globally, either as pre-trial detainees or under sentence. Almost half of these are in the United States (2.2 million), Russia (0.7 million) and China (1.64 million).[1] Up to 700,000 people are incarcerated in sub-Saharan Africa; the largest prison populations in the region are reported in South Africa, Rwanda, Ethiopia and Kenya.[2] An additional 650,000 people in China and 150,000 people in North Korea are held in pretrial or "administrative" detention. Overall, some 30 million people globally are estimated to spend time in detention facilities every year; a third of these are pretrial detainees. While many of these people will return to their communities within a few months or years, in some countries, backlogs in courts or inability to pay bail can lead to years of detention without trial.

The right to health

Prisoners have all the rights enjoyed by all people, other than those related directly to the denial of their liberty, such as freedom of movement and, in many countries, the right to vote.

The right of all persons to the highest attainable standard of health is enshrined in the WHO Constitution (1948) and the International Covenant on Economic, Social and Cultural Rights (1966) as a universal right, and is therefore applicable to all people, including prisoners.

Specific health rights for prisoners are guaranteed in a number of other international instruments, including human rights treaties at the international and regional levels, UN resolutions and agreed model standards and guidelines for the treatment of prisoners adopted by the UN General Assembly. The latter include the Standard Minimum Rules for the Treatment of Prisoners (1955), the Basic Principles for the Treatment of Prisoners (1990) and United Nations Rules for the Protection of Juveniles Deprived of Liberty (1990). These rules and principles have frequently been cited in international jurisprudence as the basis for defining standards of detention in international law, notably by the European Court of Human Rights.[3] Some national laws guaranteeing the right to health have been successfully litigated by prisoners, such as South African prisoners who asserted their constitutional right to antiretroviral (ARV) treatment.[4] The health rights of prisoners of war are articulated in the 1949 Geneva Conventions.

A key principle articulated in the Basic Principles for the Treatment of Prisoners is that "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (Principle 9). This principle is affirmed in other documents, such as the UN Principles of Medical Ethics (1982), which states that all health personnel working with prisoners "have a duty to provide them with…treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained". The UN Committee on Economic, Social and Cultural Rights has stated that "states are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees…[to] curative and palliative services". The concept that prisoners are entitled to the same standard of health services as they would receive in the community is sometimes referred to as the "principle of equivalence". The UN Human Rights Committee has affirmed that the principle of equivalence extends to all prisoners, including those under sentence of death.

International case law has also established that the right to medical care of prisoners is not limited to general medical care, but extends to specialist treatment and medicines, provided either in the place of detention or in another facility.[5] WHO has emphasized that the right to health for prisoners includes the right to preventive health measures.[6]

1 Throughout this paper, references to prisons alone should be interpreted as including pretrial detention. Pretrial detention is defined broadly to include police lock-ups and other forms of state custody that may not be strictly classified as "pretrial".

Other rights and their links to health

The International Covenant on Civil and Political Rights (1966) contains a number of articles bestowing other rights that have been interpreted as imposing positive obligations upon countries that have ratified them to ensure the health and well-being of people in detention. For example, the right to life (Article 6) has been interpreted as including the right to medical treatment for prisoners; the right to liberty and security of the person and the provisions dealing with arbitrary detention (Article 9) may be violated if a proper standard of care is not provided in prison; fair trial and due process guarantees (Article 14) may be violated if pre-trial detainees are held in poor conditions, and the right to medical care in prisons may be engaged under the prohibition of torture or cruel, inhuman or degrading treatment (Article 7). The UN Special Rapporteur on Torture has identified several heinous practices in prison settings - such as compulsory detention of drug users, forced sterilization and other medical procedures and experiments undertaken without informed consent - as constituting torture.[7] Prisoners' rights under the covenant also extend to environmental health, such as sanitary living conditions, adequate living space, clean water and food (Article 12).

While these rights are generally well established in international law and have in some cases been successfully litigated in national and international fora[8], enforcing them depends significantly on the extent to which countries respect human rights and the rule of law, and their willingness to honor international treaties to which they are parties. The reality is that, in many countries, prisoners' basic health and other rights are rarely fulfilled, and are frequently violated. This situation is compounded by the wide discretion commonly vested in prison authorities, as well as negative public attitudes towards and stigmatization of prisoners in nearly all countries.

Statements and guidelines on the obligations of medical practitioners

A number of national medical associations[9], the World Medical Association[10], the Office of the UN High Commissioner for Human Rights[11] and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)[12] have issued statements and guidelines setting out the duties and obligations of medical professionals working in prison settings. The CPT guidelines emphasize the importance of equivalence of care, patient consent and confidentiality, preventive health care, the special needs of mothers, children and adolescents, and the need for professional independence and competence on the part of prison-based health service providers. Such guidance is, of course, consistent with the oath taken by many medical professionals that a primary consideration should be to do no harm.

Monitoring bodies

A wide range of individuals and organizations are involved in monitoring and reporting on health and human rights issues in prisons. These include the Office of the UN High Commissioner for Human Rights, the Human Rights Council, the UN Special Rapporteur on Health, the UN Special Rapporteur on Torture, the UN Working Group on Arbitrary Detention, and a number of UN treaty bodies, including the Human Rights Committee, the Committee on Economic, Social and Cultural Rights, the Committee on the Elimination on Discrimination against Women, the Committee against Torture, the Committee on the Rights of the Child and the Sub-Committee on Prevention of Torture and other Cruel, Inhuman and Degrading Treatment. A number of regional human rights bodies and rapporteurs monitor regional human rights agreements, including special rapporteurs on prison conditions in Africa and the Americas. Academic institutions and nongovernmental organizations such as Human Rights Watch also play a significant role.

The European Committee for the Prevention of Torture and Inhuman and Degrading Treatment and Punishment has wide monitoring and prison access powers under the Treaty of Europe and produces an annual report on prisoner treatment.[13]

3. Prisons and health risks

In nearly all countries, incarcerated populations have more risk factors associated with acquiring and transmitting HIV, hepatitis C and TB, including injecting drug use, unsafe sex, alcohol use, untreated mental illness, lower socioeconomic status and belonging to an ethnic minority group[14],[15]. Conversely, these factors also contribute in many settings to increased likelihood of incarceration.[16] As WHO has observed, "penitentiary populations contain an overrepresentation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions".[17]

Infectious diseases are among the major health concerns in prison settings. Reviews of HIV prevalence in prisons show that, in nearly all regions and countries, HIV prevalence rates are several times higher than in the community outside prisons.[18] This is due in part to high rates of incarceration among people who inject drugs, with studies from a large number of countries showing that between 50 and 90 percent of people who inject drugs had been imprisoned at some stage, as well as the high proportion of prisoners incarcerated for drug-related offences.[19] While data on the number of people living with HIV who are incarcerated are scarce, in the five countries with the largest HIV epidemics among people who inject drugs (China, Russia, Malaysia, Ukraine and Viet Nam), many people who inject drugs are detained or incarcerated.[20] According to the Centers for Disease Control (CDC), in the United States, an estimated 1 in 7 people living with HIV pass through a correctional facility each year.[21]

In addition to HIV, high rates of other sexually transmitted infections and hepatitis C are also widely reported in many prison settings. In all regions, prisons present a high risk of transmission of these diseases through high-risk behaviors such as consensual sex, rape, sharing of needles and other injecting equipment, tattooing and piercing.[22] It is noteworthy that injection drug use in African prisons, often overlooked, has reportedly been increasing.[23]

According to WHO, the rate of TB among incarcerated populations is as many as one hundred times higher than that found outside prisons, and in many countries is one of the leading causes of death among prisoners.[24] TB transmission in prisons is greatly facilitated by overcrowding and poor ventilation. Poor medical services and inconsistent access to and use of medication have led to high rates of multidrug-resistant TB in prisons in many countries, especially in the former Soviet Union, southern Africa and parts of Asia.[25] A key consideration for the Global Fund is that TB in prisons can constitute a significant proportion – WHO estimates up to 25 percent - of a country's burden of TB. Furthermore, research in Zambia has associated high TB rates in prisons with higher-than-expected TB prevalence in the surrounding community[26], while another study found that increases in rates of incarceration accounted for nearly three-fifths of the average total increase in national TB incidence in 26 countries in Eastern Europe and Central Asia.[27] The issue of prison health therefore cannot be separated from broader public health concerns, and the fulfillment of the right to health of people in prisons needs to be seen as a part of state obligations to fulfill the right to health of the population as a whole.

While data on malaria in prisons have been difficult to obtain, it is clear that malaria will be of concern in prisons in endemic countries. Poor sanitary conditions in many prisons provide favorable conditions for mosquito breeding, and national malaria control programs are frequently not linked to prison health systems. In some countries, prison authorities have discouraged the use of insecticide-treated nets, fearing that they will be used as ropes, and rates of residual indoor spraying in prisons appear to be low in many countries. A media report from Uganda has noted that malaria infection in prisons is much higher than the national prevalence rate and that control measures and access to malaria treatment have only recently been implemented in prisons.[28]

The growing international concern about mental health in prisons is also noteworthy. According to the UN Special Rapporteur on Health, people with mental health problems are frequently misdirected towards prison rather than appropriate mental health care or support services, while prison conditions tend to exacerbate mental health problems and there is often limited access to even rudimentary mental health services.[29] WHO estimates that, in Europe, as many as 40 percent of prisoners suffer from some form of mental illness, and are seven times more likely to commit suicide. Prisoners with mental health problems, especially women, are particularly vulnerable to violence. Pretrial detention facilities are unlikely to offer access to counseling or recreational activities and are often chaotic and overcrowded, the least propitious environment for people with mental illness.

Health risks in prisons are very often heightened by overcrowded conditions, poor ventilation, food, hygiene and lighting, and infestation by insects and rodents, illustrating the important link between environmental conditions in prisons and prison health. Violence, gang activities, lack of protection for young and vulnerable prisoners, and unsympathetic, untrained or corrupt prison staff also contribute significantly to poor health and living conditions in prison settings.

While the need for effective prison health programs – especially to prevent and treat infectious diseases - is abundantly clear, many prison systems fail to provide even basic health services. In 1993, Human Rights Watch reported that complaints about the poor quality or lack of medical care were among the most frequently encountered[30] and numerous reports since then have emphasized a relative lack of progress globally in improving prison health and living conditions. Few countries implement comprehensive HIV and hepatitis C prevention, treatment and care programs in prisons, and many fail to provide access to screening, immunization or active case-finding programs or to adequately link health services in prisons to national HIV, TB or public health programs.[31] WHO Europe has noted that prison health is often disregarded because Ministries of Interior or Justice, rather than the Ministry of Health, are frequently responsible for prison health services. Its recent report on this subject also health personnel often do not act independently of prison authorities but are involved in conflicts of loyalty between providing health care for prisoners and the efforts of authorities to discipline and punish inmates.[32]

4. Human rights violations in prisons and other detention settings

In addition to poor quality of health services in prisons, other practices violate the human rights of prisoners, undermine the effectiveness of health programming, contribute to poor health and quality of life and, in some cases, amount to cruel, inhuman or degrading treatment, or torture. Several such practices that have been the subject of widespread attention are highlighted below.

Compulsory drug detention centers

An estimated 2.5 million adults use opiates and 3.5 million use amphetamines in China, Cambodia, Laos, Viet Nam and Cambodia.[33] Reports suggest that more than 235,000 people are detained in over 1,000 compulsory drug detention centers in these countries, as well as in Myanmar, Malaysia and Thailand.[34] In Viet Nam and Cambodia, people dependent on drugs are referred to as "patients" rather than criminals. In Laos, "drug addicts" are considered "victims", while Chinese law requires that drug users be "rehabilitated". A common sentiment is that drug users are regarded as having failed morally. In all four countries, drug "detoxification", "treatment" or "rehabilitation" centers hold people suspected of drug use, regardless of

dependence, for extended periods in facilities that are neither prisons nor hospitals. Detainees are frequently taken from their homes, rounded up by police, or reported to authorities by family members. The centers lack evidence-based drug dependence treatment and, often, trained health personnel. While these countries nominally treat drug use as an administrative infraction rather a criminal offence, the conditions in drug detention facilities are often comparable to those in prisons.

Research into practices in these centers has documented lack of access to lawyers, due process and judicial oversight, and lack of information about the period of detention, which may extend from several months to years.[35] Forced medical procedures, such as urine testing, are common, and detainees are subjected to activities such as marching and chanting slogans, forced labor without pay and forced exercise. Lack of routine health care is common, and people formerly on ARV therapy may have access to medicines discontinued. Treatment for TB is rarely available. Poor food, overcrowding, inadequate hygiene, and sexual and physical abuse are also common. A major consequence of these practices is that drug users and former detainees in the community are frequently stigmatized and isolate themselves from social services, including appropriate HIV prevention and drug dependence treatment.

The existence of, and practices in, these centers violate a wide range of human rights, including the right to health. While some reforms to reduce abusive practices in the centers have been reported in China and Viet Nam, and international pressure has led Cambodia to signal plans to reduce the numbers of centers by 2015, they continue to exist.

The Global Fund, World Bank, UN organizations and bilateral donors have been implicated in financing the construction and/or operation of drug detention centers, in some cases with the nominal goal of improving health care in the centers or promoting their eventual closure. Human rights guidance issued by UNODC in 2012[36] includes discussion of human rights risks associated with support for drug centers, emphasizing the need "to work with these institutions to improve human rights conditions, or for UNODC to consider withdrawing its support". While other donors have indicated they will review support for such centers, none has released human rights criteria by which such support will be assessed or how progress will be monitored and followed up. In March 2012 the UNAIDS Secretariat and 11 co-sponsors released a joint statement calling either for the closure of drug detention centers, or a review of detainees' status, the provision of adequate health services and a moratorium on further admissions. The Global Fund position on these centers is discussed in Part 7 of this paper.

Detention of sex workers

A recent report highlighted the arbitrary detention of sex workers in China in conditions similar to drug treatment centers under a system known as "custody and education".[37] Sex workers are routinely arrested, subjected to physical abuse and photographic documentation, incarcerated in large numbers for periods of up to two years and subjected to forced labor, medical examinations and testing for sexually transmitted infections without consent or counseling. Few real opportunities for skills training and education are provided, and detainees are required to pay the costs of their incarceration, treatment of sexually transmitted infections and access to other medical services. People detained are denied a fair trial and lack any procedural rights such as the right to a defence and a hearing.

Involuntary detention of sex workers has also been reported in a number of other countries, including India, Myanmar, Sri Lanka, Viet Nam and Zambia.[38, 39,40] In 2012, the National Assembly of Viet Nam passed a new law on the "handling of administrative sanctions" which effectively ends the practice of detaining sex workers in so-called "05" centers. The law also allows drug users who are subject to compulsory treatment in drug detoxification centers to have court hearings on their cases and legal representation in court.[41, 42] Progress on implementation of the new law has not been assessed for this paper, but it is noted that sex workers may still be detained in so-called "06" centers. Forced testing of sex workers for sexually transmitted infections is reported in many other countries.[43] Transgender sex workers may be particularly vulnerable to these types of abuse.

Involuntary medical procedures

Closer attention has been paid in recent years to abusive health care practices, or conduct by health care workers that amounts to cruel, inhuman and degrading treatment. Such practices may include denial of pain medicine or other needed treatment (such as methadone); abuse and mistreatment of women seeking reproductive health services; denial of abortion and post-abortion care; forced abortions and sterilizations; female genital mutilation, and administration of medical care merely for the purpose of rendering a person fit for further torture. The UN Special Rapporteur on Health has recognized that such practices are particularly likely to occur in institutional settings, including prisons and those which house people with mental or physical disabilities. The Special Rapporteur has also noted the importance of prompt conduct of medical examinations in prisons if a victim makes a complaint of ill treatment, noting that such examinations should take place in a setting free of surveillance and in full confidentiality. However, as noted earlier, prison heath care workers may frequently feel conflict between their obligations to treat patients who have been tortured or physically abused and pressure from prison authorities to disregard or even assist in such abusive practices.

People with TB have been imprisoned for "defaulting" on TB treatment and detained pending completion of the course of treatment, which may be up to six months. A video produced by the nongovernmental organization KELIN illustrates this practice in Kenya.[44]

In some jurisdictions, people who are dependent on drugs may legally be considered disabled and are consequently subject to guardianship or considered incompetent as a matter of law to take medical decisions on their own. UN experts, including the Special Rapporteur on Torture (2013 report), among others, have called for the abolition of laws that deprive people with disabilities of their legal capacity, which may be used to justify the administration of involuntary medical procedures, including in prison settings.

It is noteworthy that some jurisdictions, such as the U.S. and Europe, permit involuntary feeding and hydration in the case of detainees who are on hunger strike. This practice has attracted controversy in the case of people detained by the U.S. at Guantanamo Bay in Cuba.[45]

Pretrial detention

In many countries, health and other human rights risks are even more severe in pretrial detention or remand facilities. Even where prisons or other post-conviction settings provide adequate health care, it is rarely available in pretrial detention facilities, including police lock-ups, which are frequently overcrowded, violent and lack basic health and sanitation facilities or adequate food. Qualified health care providers are frequently not available. In some of the worst documented cases, detainees die as a result of conditions in pretrial facilities, while surviving detainees sleep with the corpses. Discontinuation of necessary, chronic medical care and medicine is common for people on remand. Some innocent people may plead guilty with the hope of better conditions upon transfer to
prison.[46, 47] Special concerns exist for female detainees, for whom separate remand facilities and specific health services do not exist in many countries, and about the frequent, inappropriate remanding of people with (often undiagnosed and untreated) mental illness to pretrial detention facilities, rather than psychiatric institutions.

Risks of HIV transmission in pretrial detention are high, as in other prison settings, but HIV prevention, treatment and care services, including access to drug dependence treatment, are rarely available. Detection and management of TB is particularly problematic in pretrial detention as people may be held long enough to contract the disease, but released before they can be diagnosed and treated. A study in Brazil concluded that the early weeks of incarceration were the riskiest for TB transmission. Exposure to diseases in pretrial facilities not only endangers detainees, but may also facilitate transmission to the general public.

In addition to lack of health services and adequate sanitation and living conditions, other human rights violations are common in pretrial detention facilities, which are likely to be less exposed to independent inspections or monitoring by nongovernmental organizations or other groups. Such violations may include violence and sexual abuse, (especially against women), youth and LGBT persons, lack of access to exercise and other activities that are available in prisons, and even withholding of treatment.[48] Backlogs in courts and inability to pay bail mean that people on remand experience such conditions and abuses for lengthy periods of time.

Experts recommend that countries should work to reduce the excessive and arbitrary use of pretrial detention and ensure that it is used only as an exceptional measure. This should also contribute to alleviating the overall problem of prison overcrowding. Pretrial detention facilities should also provide early access to medical assessment and health services to ensure that the medical needs of accused persons are addressed upon arrest or remand, with appropriate links to care in the community or in prison after conviction. Greater involvement of health care professionals in monitoring pretrial detention centers and improved attention to pre-trial detention health issues in health professional curricula are also important.

The examples of Uganda and Zambia

Two reports by Human Rights Watch on prisons in southern Africa vividly highlight the interplay between human rights abuses, poor prison conditions and poor inmate health.[49, 50] In Uganda in 2011, poor conditions, forced and corrupt labor practices, routine violence at the hands of prison wardens, infectious disease, and inadequate medical care were found to threaten the lives and health of the 50,000 inmates who pass through the country's 223 prisons every year. Because of nutritionally deficient food, sex was traded for additional food and boiled water. Proper hygiene was difficult with limited soap, and lice and scabies were rampant. Mosquitoes and malaria were a constant threat, but spraying was uncommon and nets were forbidden for male inmates because of security fears. TB risks were high due to overcrowding and poor ventilation, with limited access to screening and treatment. HIV prevalence in Ugandan prisons is twice the national estimate, but access to prevention and treatment was also found to be inadequate. Condoms were prohibited. The health needs of pregnant women were also largely unmet.

A brutal compulsory labor system was operating in rural prisons countrywide in Uganda, accompanied by extreme forms of punishment and physical violence. Medically unqualified prison officers routinely assessed the health needs of prisoners and then denied their right to access care. More than half the Ugandan prison population was on remand without having been convicted of a crime. Human Rights Watch recommended that the Ugandan Prison Service should immediately stop the use of forced prison labor for private landowners or prison staff; address violence against prisoners and improve health services, including measures to adequately screen for, prevent and treat HIV, TB and malaria. The report called for the country and international donors to secure adequate funding for the prison budget to ensure conditions consistent with international standards.

Zambia's prison system was reported to be in crisis in 2010, housing 15,300 people in facilities built for a third that number. Some inmates were forced to sleep seated or in shifts. Inhuman and degrading treatment, such as corporal punishment, and lack of basic facilities, such as toilets, were reported. The conditions of hard labor were described as closely resembling slave labor. Food was commonly traded for sex or labor. Of Zambia's 86 prisons, only 15 had any health clinic or sickbay, many of these with little capacity beyond distributing paracetamol. TB isolation cells were in such poor condition that even the physician in charge of the prison medical directorate referred to them as "death traps". Access to HIV testing and treatment was reported to have increased, mainly in the larger prisons, but remained uneven, and interventions to prevent mother-to-child HIV transmission were not available at all. The report found that the Zambian Prisons Service had nevertheless shown a desire and openness to improvement by acknowledging problems, conducting an internal audit, appointing a new medical director, and granting access to human rights monitors, but that much remained to be done to improve prison conditions in the country.

5. Policies and standards on HIV, TB, malaria and drug dependence in prisons

HIV/AIDS

International organizations recommend a comprehensive package of 15 key interventions to address HIV in prisons[51]:

- Information and education about HIV, delivered by prison authorities, civil society organizations and/or peer support;
- Condoms and water-based lubricant, easily and discreetly accessible and free of charge, including for conjugal visits;
- Prevention of sexual violence, including separation of vulnerable prisoners, such as LGBT people, young offenders and women, and adequate reporting mechanisms;
- Drug dependence treatment, including opioid substitution therapy;
- Needle and syringe programs, including sterile injecting equipment;
- Prevention of transmission through medical or dental services by the adoption of universal precautions, including the provision of adequate medical supplies;
- Prevention of transmission through tattooing or piercing and other forms of skin penetration, such as measures to reduce the sharing of and reuse of equipment;
- Post-exposure prophylaxis, for victims of sexual assault and others exposed to HIV, based on clearly communicated guidelines;
- HIV testing and counseling, available at any time during detention and offered during medical examinations to pregnant women and prisoners with symptoms of potential HIV infection, with appropriate counseling and informed consent, and access to treatment and care for those who test positive;
- HIV treatment, care and support, at least equivalent to that available in the community, and consistent with national guidelines;
- Prevention, diagnosis and treatment of TB, including intensified case-finding, isoniazid preventive therapy, testing of people with TB for HIV and effective control measures, such as adequate ventilation and light, and segregation of people with TB until they are no longer infectious;
- Prevention of mother-to-child HIV transmission, including family planning and ARV therapy, consistent with national guidelines;
- Prevention and treatment of sexually transmitted infections, particularly those that cause genital ulcers and thereby increase the risk of HIV transmission;
- Vaccination, diagnosis and treatment of viral hepatitis, including free hepatitis B vaccination for all prisoners and hepatitis C vaccination for those at risk;
- Protection of prison staff from occupational hazards, based on universal precautions and appropriate occupational health and safety guidelines, including protective equipment and hepatitis B vaccination.

The recommendations include several important principles:

- Equivalence with the standard of care in the community;
- The importance of integrating prison health with the broader public health system, including providing an appropriate continuum of care for those entering and leaving prisons or other closed settings;
- Adequate funding for prison health that reflects the greater needs of prison populations, with appropriate emphasis on disease prevention, early detection and treatment;
- The importance of gender-responsive interventions, recognizing the specific health needs of women, such as sexual and reproductive health;

- The need to address stigmatization of the most vulnerable people in prisons, including drug users, young adults, people with disabilities, LBGT people, indigenous people, ethnic minorities and undocumented people;
- The importance of broader prison reform, including making efforts to improve living conditions, reduce the excessive use of pretrial detention, implement alternatives to incarceration for drug users and people with mental health problems, and ending the use of compulsory detention for the purpose of drug treatment.

WHO has specifically noted the importance of public and prison health authorities working together to ensure that harm reduction becomes the guiding principle of policy on the prevention of HIV and hepatitis transmission in prisons.[52]

Drug dependence treatment

The UNODC/WHO Minimum Standards on Drug Dependence Treatment (2008) include the following key principles:

- **Eliminating barriers:** Drug dependence and its associated social and health problems can be treated effectively in the majority of cases if people have access to a continuum of available and affordable treatment and rehabilitation services in a timely manner. To this end, all barriers limiting access to treatment services need to be minimized for people to have access to the treatment that best fits their needs. This would include barriers presented by incarceration and inappropriate use of pretrial detention.

- **Recognizing multiple needs:** Drug-dependent patients often have multiple medical, social and economic needs. Diagnostic and comprehensive assessment processes are the basis for a personalized and effective approach to drug dependence treatment planning and engaging the client into treatment. In the context of prison settings, such approaches require that law enforcement officials, courts and prisons closely collaborate with the health system to encourage drug-dependent individuals to enter treatment.

- **Evidence-based approaches:** Evidence-based good practice and accumulated scientific knowledge on the nature of drug dependence should guide interventions and investments in drug dependence treatment, including in prison settings.

- **Rights-based approaches:** Drug dependence treatment services should comply with human rights obligations and recognize the inherent dignity of all individuals. This includes respecting and protecting the right to enjoy the highest attainable standard of health and well-being, and ensuring non-discrimination, including during periods of detention. For people in state custody, as for others, treatment must be voluntary.

- **Criminal justice issues:** In general, drug use should be seen as a health care condition and drug users should, where possible, be treated in the health care system rather than in the criminal justice system. Interventions for drug-dependent people in the criminal justice system should emphasize treatment as an alternative to incarceration.

The standards emphasize that drug-dependence treatment can be highly effective in reducing crime. Treatment and care as alternatives to imprisonment or commenced in prison followed by support and social reintegration after release decrease the risk of relapse in drug use, of HIV transmission and recurrence of crime, with significant benefits for the individual, as well as for public security and social savings. Offering treatment as an alternative to incarceration is a highly cost-effective measure for society. Such schemes bring people with drug dependence out of the criminal justice system into medical and rehabilitation programs and enable drug treatment to take place under a court order, instead of penal sanctions. In this way, treatment is offered as an alternative to incarceration or other penal sanctions, but not imposed without consent. It is very important in such cases that treatment decisions be made by health professionals and not by prosecutors or judges.

Human rights principles apply to all people, including people charged with crimes related to illicit substances. Drug-dependent people in prison have the right to receive the health care and treatment that are provided in treatment centers in the community. In general, drug-using inmates should be offered a range of treatment and care services, including prevention of transmission of blood-borne diseases, pharmacological and psychosocial treatment, rehabilitation, preparation for release, and linkage to community services.

If prisoners go into withdrawal, treatment should be initiated following good clinical practice. For those inmates already in treatment before incarceration, medical treatment, especially pharmacological therapy, should not be discontinued when entering prison. Continuous care in the community upon release is crucial to meaningfully reintegrating drug-dependent offenders into the community.

The standards affirm that there is no scientific evidence justifying the use of detention or forced labor as part of treatment for drug-dependence.

Legal frameworks should support the full implementation of drug-dependence treatment and care options for offenders, in particular treatment as an alternative to incarceration and psychosocial and pharmacological treatment in prisons. Mechanisms need to be in place to guarantee coordination between the criminal justice system and drug-dependence treatment system. Such mechanisms and collaborative work will promote the implementation and monitoring of diversion schemes as an alternative to incarceration.

Criminal justice and prison staff should be made aware of the needs of drug-dependent offenders and trained to support prevention and treatment interventions in prison settings. Staff in charge of delivering drug dependence treatment (either prison health staff or external staff) should be properly trained in the provision of evidence-based treatment and ethical standards, and show respectful, non-judgmental and non-stigmatizing attitudes.

Tuberculosis

International TB guidelines for prison settings emphasize that every prisoner should have unrestricted access to the correct diagnosis and treatment of TB; that delays in the detection and treatment of TB cases should be minimized to reduce further transmission and pressure to self-treat; that unregulated, erratic treatment of TB in prisons should cease; that urgent action is needed to integrate prison and civilian TB services to ensure treatment completion for prisoners released during treatment, and that measures to reduce overcrowding and improve living conditions for all prisoners should be implemented to reduce the risk of TB transmission.[53, 43, 55] Voluntary TB testing early in detention should be offered and systematically linked to evidence-based treatment. Incarceration of people for "defaulting" on TB treatment is an unacceptable practice.

Malaria

Specific guidelines on malaria in prisons could not be accessed for this paper, but key interventions, such as vector control measures - including indoor residual spraying, nets, efforts to address unsanitary conditions that promote vector breeding and effective malaria treatment - should be implemented in prisons in areas where malaria in endemic. Young children in prison with their mothers in endemic areas should be considered at high risk of malaria and its most serious complications, and provided with standard prevention interventions.

6. Some key questions for the Global Fund

The context of frequently poor health services and other rights violations in prisons in countries where the Global Fund supports national HIV, TB and malaria programs poses a number of important questions for the Global Fund. These include:

- In countries where the Global Fund **directly supports** prison-based HIV, TB and malaria programming (as specified in grant agreements):
  - To what extent do these programs reflect equivalence with the standard of care available in the community and other basic health and human rights standards for prisoners?
  - How comprehensive are the programs and how consistent are they with international guidance on addressing the diseases in prison settings?
  - If these criteria are not met, what action does, can or should the Global Fund take to address gaps in prison-based programming that it supports?
  - What action does, can or should the Global Fund take where other types of human rights violations take place in prisons where it supports HIV, TB and malaria programming? What are the specific responsibilities of Principal Recipients, Country Coordinating Mechanisms and Global Fund staff?
  - How does, can or should the Global Fund monitor human rights risks in prison settings in these countries? How should such risks be factored into grant decision-making and management?
- Where the Global Fund does **not directly support** prison-based programming, but supports other aspects of national HIV, TB and malaria programs:
  - How can the Global Fund ensure that prisoners in these countries receive access to the same standard of care that is available in the community with Global Fund support?
  - How does, can or should the Global Fund monitor human rights risks in prison settings in these countries? How should such risks be factored into grant decision-making and management?

A number of overarching issues are:

- Are there ways in which the Global Fund and partner organizations can more proactively support rights-based programming in prisons, for example, as part of the country dialogue and proposal development processes?
- In addition to funding appropriate prison health services, are there other activities that the Global Fund could support to improve conditions that impact upon prison health, for example, by providing support for legal aid services to help reduce overcrowding in prisons and pretrial detention facilities, or community-based monitoring of treatment access?

- In cases where country proposals to the Global Fund do not include any prison- related programming, to what extent should the Global Fund explore or require the existence of alternative sources of funding for such programs? What valid reason is there for not addressing this issue in Global Fund proposals? This question reflects the challenge faced by the Global Fund with regard to the inadequacy of funding sought for gender-based programming and key populations in many countries.
- To what extent are Global Fund country teams generally knowledgeable about health and other rights issues in prison settings in the countries for which they are responsible (for example, through visits to prisons, awareness of rights violations, and understanding of best practices)?

7. Global Fund support for programming in prison settings

Support for human rights programming and prison-based health services is permitted by the Global Fund and encouraged in updated human rights guidance available to applicants.[56] The guidance recommends a human rights-based approach to health service delivery and outlines in considerable detail a possible package of interventions to tackle human rights-related barriers to access. The Global Fund does not have and has not formally endorsed any standards with regard to prison-based health services.

The Global Fund has supported a considerable amount of prison-based programming over the last decade, mainly in Eastern Europe and Central Asia. However, an in-depth analysis of Global Fund support for prison-based health programming across the portfolio was not possible for the purposes of this paper. Where Secretariat staff members were aware of such programs, detailed information - including the full scope of programming and the human rights context - was in many cases not immediately available or could not be accessed at the time of writing this paper. While some Fund Portfolio Managers were reported to have knowledge of prison conditions in the countries for which they were responsible, the extent to which this had been documented could not readily be ascertained. However, the following information was collected through consultation with several managers in the Grant Management division, Fund Portfolio Managers and Program Officers:

Africa

Of the six countries designated by the Global Fund as High Impact Africa-1[2], the Global Fund reported financing TB, HIV or both components in prisons in South Africa, Côte d'Ivoire, Nigeria and Ghana.

Global Fund support for HIV and TB interventions in prisons in **South Africa** through Round 10 and early-applicant new funding model funding in 2013 is of particular interest. The grants come in the wake of a South African Constitutional Court decision, *Lee v Minister of Correctional Services (2012)*, that found the government negligent in causing the plaintiff to contract TB while on remand for a crime of which he was subsequently acquitted. In March 2013, the government announced new TB guidelines for South African prisons and began to progressively scale up TB and HIV programming in them. The two Principal Recipients for the Global Fund grants are the National Department of Health, and Right to Care, a nongovernmental organization. The new funding model grant amounts to around US$75 million over five years. The focus of the grant is implementation of the national guidelines for TB/HIV in prisons, which were developed through a consultative process with the National Department of Health, the Department of Correctional Services (DCS) and partners, including UNAIDS, UNODC and WHO. In announcing the plan, the Minister of Health stated that its goal was to interview every new inmate and current prisoner, referring those with potential symptoms for sputum tests and x-rays based on their responses to a set of questions.

Global Fund financing provides support to the South African DCS in all 242 correctional facilities in the country. Supported activities include:

- Institutionalizing voluntary HIV testing and TB screening for new admissions, follow-up testing where appropriate at six-monthly intervals, and contact tracing for newly diagnosed prisoners;
- Rollout of the GenXpert machine, a rapid TB diagnostic device that can reduce diagnosis time from weeks to a few hours;
- Support for counselors, clinical professionals and data capturers;
- Addressing TB/HIV co-infection through intermittent preventive treatment and ARV therapy;
- Supporting broader health systems strengthening by improving the management of multidrug-resistant and extensively drug-resistant TB;
- Improving education programs in prisons by training and mobilizing peer educators;
- Supporting TB facility risk assessment, and
- Access to condoms. No harm reduction or drug dependence programming is included.

It is noteworthy that the South African National Strategic Plan for HIV, STIs and TB 2012-2016 includes the objective of ensuring that rights are not violated when key interventions are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established. The advocacy groups Treatment Action Campaign and Section 27

2 Democratic Republic of the Congo, Nigeria, Cote d'Ivoire, South Africa, North Sudan and Ghana.

TB Screening in Pollsmoor Prison, Western Cape Province (Credit: R. Vanek, The Global Fund)

publish reviews of the national strategic plan on a quarterly basis. National Strategic Plan Review 4 examines human rights and access to justice issues, including prisons, and National Strategic Plan Review 7 examines TB in prisons.[57]

A recent article reported that, in South Africa, 652 inmates died in 2013 in what were categorized as "natural deaths" by the Judicial Inspectorate for Correctional Services.[58] According to the article, most of these deaths were likely related to HIV and TB. Examples of interruptions in ARV therapy of up to two weeks were reported, and the DCS was reported to have disbanded an HIV-positive prisoner support group that had been advocating on access-to-care issues, deeming it an "illicit pressure group". At the time of writing, the Global Fund was not aware of these concerns.

The Global Fund is reported to support feeding programs in prisons in Côte d'Ivoire, Rwanda, Namibia and Madagascar that help to avert malnutrition and clinical complications among TB and HIV patients.[59] In Côte d'Ivoire, nutrition kits financed by the Global Fund and distributed by the World Food Program contain enough rice, palm oil and fortified flour to supplement the diets of inmates on HIV treatment for six months.

The extent to which the Global Fund had responded to specific reports of rights violations in prisons, such as in Uganda and Zambia (designated by the Global Fund as High-impact Africa 2[3]) could not be ascertained at the time of writing this paper. The Human Rights Watch reports on Uganda and Zambia note that there is an objective for TB in prisons in the Uganda Global Fund Round 10 grant and that some nongovernmental organizations in Zambia have received small grants for prison-based health work as sub-recipients of Global Fund financing.

Global Fund staff with responsibility for West African countries indicated in discussions that conditions in prisons in the region were the worst they had ever seen, that people are commonly detained without due process for lengthy periods and frequently lack any health care at all. The proposition that prisoners should have access to nets was thought in many cases to be unfeasible, given the poor and unsuitable sleeping conditions and limited space. In preparations for applications under the Global Fund's new funding model, at least one country has mentioned prisons in its programming gap analysis, but overall, prison programming was reported to be a low priority for countries in the region. Global Fund staff, especially those working in countries with large epidemics, are likely to visit prisons only when there is a Global Fund-supported prison program, but otherwise have limited time to do so.

Eastern Europe and Central Asia

The Global Fund has financed quite extensive HIV and TB program activities in prisons in countries in Eastern Europe and Central Asia since the first grants were made in 2003. Secretariat staff members report dramatic improvements in prison programming and health service delivery in prisons over time, including in Bulgaria, Iran, Macedonia, Moldova and Tajikistan. Supported commodities and activities have been wide-ranging, including HIV and TB screening and treatment, reagents for testing, renovation of TB isolation facilities, training of peer TB educators and information and education, including innovative approaches such as TB education using an e-platform for prisoners.

Global Fund support has contributed to the introduction of ARVs, HIV information, education and testing in prisons in Tajikistan, as well as testing and treatment for TB and multidrug-resistant TB. A separate, prison-based TB hospital with 100 beds was recently inaugurated and handed over to the Ministry of Justice by UNDP, the Global Fund Principal Recipient. A small pilot needle and syringe exchange program has been funded in one prison since 2010, with the hope that it will soon be extended to another prison site. The Global Fund is also working with the Ministry of Justice, UNODC, UNDP and others on plans for a pilot opioid substitution therapy program in one prison in the next year.

3 Ethiopia, Zambia, Kenya, Tanzania, Uganda, Mozambique and Zimbabwe.

The Ministry of Justice of Azerbaijan is a Principal Recipient of Global Fund TB financing and its Global Fund-supported TB program is described by the government as a model for the region.[60] All inmates pass through TB screening in pretrial isolators and 95 percent of the prison population passes through annual obligatory mass screening for TB including a questionnaire, X-ray, and sputum investigation. TB treatment is provided at a specialized treatment center with around 900 beds, achieving up to 90 percent success rates. A training center for both medical and non-medical penitentiary staff recently gained the status of WHO Collaborating Centre. There is also a program for released prisoner follow-up run by a nongovernmental organizational that is often cited as a good example of civil society involvement. Uncompleted TB treatment in the prison system is continued after release.

The HIV program supported by the Global Fund in prisons in Moldova has also been cited as a model of best practice.[61, 62] Rarely among prisons in the world, the program provides needle and syringe exchange, opioid substitution therapy and condoms to inmates confidentially and free of charge. Nongovernmental organizations play a key role in providing prisoners with HIV education and other services. Prison officials from around the world have visited Moldovan prisons to learn from this experience. Introduction of the program has coincided with a major reduction in the number of prisoners and pretrial detainees and was accompanied by other initiatives designed to improve conditions for both prisoners and staff, including measures to reduce overcrowding, increased work opportunities for prisoners, improved food and better pay for prison staff.

The Global Fund and others have successfully advocated for the introduction of methadone in Belarus (though not yet in prisons) and the Global Fund is presently engaged with other partners on issues relating to access to methadone in Crimea. Visits to prisons in the region are reportedly a routine part of country visits by Global Fund staff. In 2013, a training event was held for Global Fund country teams for the region, who visited two Swiss prisons to observe best practices; a delegation of senior prison officials from countries in the region also participated.

At the time of writing, staff did not report any formal complaints having been made to the Global Fund about specific instances of human rights violations in prisons in the region, but recognized that conditions in many prisons in the region are challenging, that prisons are overcrowded, that the availability of adequate health services in prisons across the region is uneven, and that there have been instances of hunger strikes. Overall, staff noted that countries in this region increasingly recognize the significance of HIV and TB in prisons in national epidemics, particularly TB, and that programming in prisons is now widely seen by national authorities as a necessary component of overall public health efforts.

Asia

The Global Fund has reported that it has supported the provision of HIV and TB testing, prevention and treatment services in an estimated 35 drug detention centers in Viet Nam, reaching at least 13,500 detainees.[63] In 2011, the then-Executive Director of the Global Fund publicly stated that the Global Fund did not believe such centers provided effective treatment and rehabilitation. The Global Fund then reviewed its support to detention centers in the region and outlined a policy of limiting it to services that provide direct support, treatment and prevention of HIV and TB, eliminating support for capacity building and activities not considered "lifesaving". As part of a new funding agreement signed with the Vietnamese Ministry of Health in May 2013, the Global Fund specified that its support for services in drug treatment centers was contingent on an independent, international nongovernmental organization monitoring conditions in them. In mid-December, the Global Fund informed the Vietnamese government that the government's proposal to have the Vietnamese Red Cross monitor the centers on a six-monthly basis was not acceptable, and that the Global Fund would reprogram funding intended to treat 900 HIV patients in the centers to treating an equivalent number in the community. The Global Fund has also sought commitments that people in the centers will receive treatment.[64]

The Global Fund has informally indicated that none of its grants in Cambodia is financing activities taking place in centers where drug users, sex workers and others are arbitrarily detained.

At the time of writing this paper, no information on other countries in the region was available, including countries designated by the Global Fund as High-impact Asia.[4]

Latin America and the Caribbean

No detailed information about Global Fund support in prison settings in this region was available at the time of writing. The Global Fund recently reported on "a Global Fund-sponsored" TB screening and treatment program at the Ciudad del Este regional prison in Paraguay.[65]

Middle East and North Africa

No information about Global Fund support in prison settings in this region was available at the time of writing.

Considerations

To the extent that support for prison-based programming was identified in the Global Fund portfolio, it appears to consist primarily of support for prison-based health services, and is occurring mainly in Eastern Europe and Central Asia. The

comprehensiveness of such programming was not assessed for the purposes of this paper; to some extent the Global Fund is constrained by national policies in many countries that prohibit activities such as harm reduction and condom provision. Nevertheless, some encouraging models of comprehensive HIV and TB programming supported by the Global Fund do exist, including Global Fund engagement with Ministries of Justice. Some funding not related to direct health services, but which contributes to improved living conditions and health for prisoners, such as nongovernmental organization support for prisoners, has been provided, but appears to be quite limited. Prison visits by Global Fund staff have been extensive in one region, but may be limited elsewhere, especially in sub-Saharan Africa. An overarching question with regard to Global Fund-supported prison programming is whether the support provided is addressing rights violations that have been identified by international monitors and nongovernmental organizations in many countries.

8. The position of other donors

As noted earlier, few donors have published criteria by which they monitor and assess human rights-related risks in programming that they support.

In its 2012 position paper assessing its responsibilities to respect, protect and fulfill human rights, UNODC emphasizes at a minimum that it and other UN agencies providing support to countries should exercise "due diligence".[66] This is described as "a duty…to make certain that the policies and actions (or inactions) of UNODC do not undermine the human rights of individuals or the human rights obligations of states". Such an approach involves finding "the right balance between ensuring that all activities of the Office promote respect and protect human rights standards, and the broader perspective of remaining engaged with countries through the delivery of technical support that can bring about positive change". The model of the Human Rights Due Diligence Policy on UN Support to non-UN Security Forces (HRDDP, 2011), is cited, which states that "UN support cannot be provided where there are substantial grounds for believing that there is a real risk of the receiving entities committing grave violations of…human rights…and where the relevant authorities fail to take necessary corrective or mitigating measures". The HRDDP also specifies that a UN entity "must conduct an assessment of the potential risks and benefits in providing support", including "an assessment of the human rights record of the intended recipient of support and the adequacy of existing measures in place to prevent human rights violations".

The position paper notes that not every connection between an international organization and government institution will result in complicity in rights violations, provided adequate safeguards and controls are in place, but that increased duration, frequency or intensity of such a connection could increase the risk. It proposes a scale by which levels of risk and engagement can be assessed, ranging from support for activities which directly address human rights violations ("complementary activities"), to the requirement of "safeguards" in contractual relationships with a country, through to a temporary freeze on support where governments fail to take remedial action and, as a last resort, the withdrawal of support. Drug detention centers are cited as an example where the last step may apply. Examples of UNODC having applied this framework in practice were not available at the time of writing.

Issues relating to donor accountability to uphold human rights are discussed in more detail in a separate paper being prepared for the Global Fund. Nevertheless, the approach described above may provide useful guidance to the Global Fund as it works to develop and refine its human rights risk assessment framework, including any approach to due diligence undertaken by the Global Fund or required of its grant recipients.

9. Potential actions for consideration by the Global Fund

Objective 4 of the Global Fund corporate strategy 2012-2016 states that the Global Fund shall:

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

Policy development

Based on these strategic objectives and the context set out in this paper, the Global Fund may wish to consider further policy development with regard to prison and pretrial detention settings. For example, a detailed policy statement could address the following:

- The Global Fund's broad expectations of countries with regard to their need to address HIV, TB and malaria in prisons. This could include discussion of some of the key questions raised in Part 6 of this paper;
- Elaboration of the types of programming that the Global Fund will support, including prison health services as well as other activities that may enhance prison conditions and alleviate overcrowding, such as legal aid, prisoner support groups and community-based monitoring;

- Endorsement or elaboration of minimum standards for prison-based health services supported by the Global Fund, based on the three core principles of equivalence, consistency with international guidance and the need to link public and prison health services, and how these standards will be monitored as part of grants;
- A definitive statement with regard to programming that the Global Fund will not support, such as activities in drug detention centers;
- Procedures that Principal Recipients, Country Coordinating Mechanisms and/or Global Fund staff will follow if they witness or learn of human rights violations in a prison or pretrial setting in the course of their work;
- The implications for Global Fund support of human rights violations in prison settings, especially where national authorities fail to act on poor prison conditions, potentially based on a scale of actions similar to that proposed by UNODC, and
- Elaboration of the role of the Global Fund Inspector General in monitoring prison programming supported by the Global Fund.

This policy work should endeavor to engage the leadership and Board of the Global Fund more closely on prison-related issues. It could be undertaken with regard to prisons alone or as part of a broader human rights policy or strategy for the Global Fund, as has been proposed.[67] The latter approach may be particularly appropriate given that the Global Fund has indicated that work previously undertaken under its SOGI and Gender Equality Strategies (2007 and 2008) will now be advanced through its current human rights work, that the need to more effectively reach key populations is of growing concern internationally, and that there are close links between the criminalization of key populations and high rates of incarceration.

Increasing awareness and engagement

Other potential activities to increase awareness and engagement of Global Fund stakeholders in prison-related issues:

- Training and awareness-raising for country teams, the Technical Review Panel, Country Coordinating Mechanisms and other relevant Global Fund stakeholders on issues related to prisons and pretrial settings, including by the dissemination of this paper, development and dissemination of best practices and experiences with regard to prison programming supported by the Global Fund, and dissemination of reports by relevant monitoring bodies;
- Engaging Ministries of Justice/Departments of Corrections in Global Fund processes, such as Country Coordinating Mechanisms, using these processes to encourage cooperation with Ministries of Health in prison health decision-making, and ensuring participation of nongovernmental organizations that provide services to persons in state custody or recently released, and
- Participation by Global Fund stakeholders in collaborations such as the European Network for Prisons and Health and the African HIV in Prisons Partnership.

Where it is not already happening, Global Fund country teams should be encouraged to undertake periodic visits to prison facilities, both in urban and in rural settings. The mere request for such visits will in many cases signal to national authorities the Global Fund's concern about HIV, TB and malaria in prisons.

Other aspects of the grant cycle

Potential actions related to other aspects of Global Fund processes and the grant cycle:

- Due diligence: Develop guidelines on due diligence processes for Fund Portfolio Managers and Principal Recipients with regard to rights violations at the time of proposal development and/or grant-making;
- Principal and sub-recipient assessment: Require as part of new due diligence and existing assessment processes that Country Coordinating Mechanisms assess the human rights record of proposed Principal Recipients and sub-recipients with regard to prison settings;
- Grant agreements: Include relevant safeguards or conditions in grant agreements to ensure that human rights protections are upheld in Global Fund-supported prison programming;
- Risk assessment: Include issues related to prisons and pretrial detention settings in risk assessment processes, including the QUART tool.

10. Conclusion

Prisoners are among the most marginalized people in the world, and the adequate protection of their rights should be a litmus test for every society, and for donors such as the Global Fund. By more actively advancing health and other human rights for prison populations, the Fund can remain in the vanguard of international health and development efforts and make a further important contribution to ending the HIV, TB and malaria epidemics.

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Somaliland. Awdal province © The Global Fund / Didier Ruef

Annex 2: Research Paper

Geneva Academy of International Humanitarian Law and Human Rights
Académie de droit international humanitaire et de droits humains à Genève
Geneva Academy

TAKING A HUMAN RIGHTS-BASED APPROACH TO HEALTH SERVICE DELIVERY IN CONFLICT AREAS

DISCUSSION PAPER, MAY 2014
PREPARED BY JOIE CHOWDHURY
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AND CLAIRE MAHON)

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EXECUTIVE SUMMARY

This paper has been commissioned by the Global Fund and is part of the organization's commitment to protecting and promoting human rights through integrating human rights throughout the grant cycle. It aims to identify the risk of human rights violations in Global Fund-supported programs in conflict-affected areas, and provide policy recommendations that support operationalizing the Global Fund commitment to not fund programs that violate human rights.

The Global Fund plays a critical role in realizing the right to health through ensuring access to health services across the world. Its continued engagement with countries even where the working environment is challenging (for example, in fragile states and conflict areas) is commendable. Yet it is imperative that the Global Fund find ways of addressing the risks that in these countries, the dynamics that may be driving, at least partially, high incidence of disease, including HIV, TB and malaria, can also lead to violations of human rights.

Addressing human rights-related issues in conflict settings is both critical and urgent for the Global Fund, given the scope of its operations in conflict-affected countries. It currently supports 118 active grants in 20 of the 25 countries designated as having armed conflicts in 2012 by the Geneva Academy War Report.[1] The Global Fund has to date invested more than US$3 billion in funding for the 20 countries.[2] Of concern is that Global Fund grant performance is relatively poor across countries considered "fragile", with low coverage of services for HIV/AIDS, TB and malaria, and an inability to reach large populations, including some of the poorest and most marginalized, often due to the factors explored in this paper.[3] This is relevant for conflict contexts as well since many fragile states are also conflict-affected and both have closely overlapping characteristics.[4]

Human rights violations relating to health care delivery in conflict areas can include, for example, overt discrimination based on conflict-driven factors, vicious attacks on health facilities and health care workers, torture of conflict-related detainees, and pervasive sexual violence and exploitation, as well as a failure to provide needed health services to victims of the conflict. Contextual barriers to accessing health services are another area of human rights concern, and may include the collapse of health infrastructure, geographical inaccessibility of facilities due to insecurity and the destruction of transport routes, and high out-of pocket expenditure.

The aforementioned human rights abuses represent the risk of actual or potential human rights violations and are important for the Global Fund to consider, particularly where such violations may be linked directly or indirectly to programs supported by the Global Fund. Other donor agencies and humanitarian organizations that explicitly adopt a human rights-based approach maintain the importance of such an approach in optimizing health outcomes in the long term. But they also acknowledge the difficulties of implementing a human rights approach in highly fractured, unequal or divided communities, or during emergency situations.

In light of a particular set of challenges, opportunities, and key considerations that confront the Global Fund and are explored in the course of this paper, we offer below a summary of recommendations on how the Global Fund can identify, address and minimize the risk of human rights violations related to its programs.

Summary of recommendations

(expanded on in Section VII of this paper)

A. Develop comprehensive and clear human rights guidelines

- The Global Fund should create clear overarching human rights policy guidelines. This should outline core human rights standards and principles, as well as operational guidance, which will inform the work, including in conflict-affected areas.

B. Improve and tailor monitoring and evaluation processes

- The Global Fund should reinforce its monitoring and evaluation processes for human rights issues in conflict areas through creating context-based human rights profiles that examine the root causes of conflict. It should also increase efforts, wherever possible, to collect disaggregated data about the victims of conflict, and strengthen information-sharing networks.
- There is a need to adjust relevant internal tools and mechanisms at the Global Fund, for example, the QUART, the Global Fund hotline, and the terms of reference for the Local Fund Agents (which conduct external audits of Global Fund programs).

C. Create a formal multiStakeholder grievance mechanism

- The Global Fund should establish a multistakeholder grievance mechanism that handles, investigates and verifies regular, anonymous or confidential complaints, and provides for appropriate remedy and remediation.

D. Develop staff and stakeholder training, build capacity, and strengthen internal advocacy

- If the Global Fund proceeds with policy guidelines, then, based on a capacity- building needs assessment exercise, it should provide necessary training to all relevant staff and stakeholders within the Global Fund.
- Fund Portfolio Managers and Program Officers as well as program implementers will often be in the position of handling the day-to-day operationalization of a human rights approach. If called for, they should be given additional resources to equip them to take on this new role.
- The lessons of operationalizing a human rights approach within multilateral and bilateral institutions clearly demonstrate that consistent, internal advocacy at all levels within the organization is key to bridging the gap between rhetorical endorsement and committed practice.

1. Introduction

"We must understand the role of human rights as empowering of individuals and communities. By protecting these rights, we can help prevent the many conflicts based on poverty, discrimination and exclusion (social, economic and political) that continue to plague humanity and destroy decades of development efforts. The vicious circle of human rights violations that lead to conflicts – which in turn lead to more violations – must be broken. I believe we can break it only by ensuring respect for all human rights." — Mary Robinson, Former United Nations High Commissioner for Human Rights

The Global Fund plays a critical role in realizing the right to health through ensuring access to health services across the world, in particular, in preventing, treating and providing care for people with HIV and AIDS, TB and malaria. To date, the Global Fund has disbursed billions of dollars to support prevention, treatment and care programs for AIDS, TB and malaria in 151 countries and can be said to have saved millions of lives.[5] In its 2012-2016 strategy, Investing for Impact, the organization has also explicitly committed to a human rights approach to health delivery, particularly in terms of facilitating equitable access to health services as well as promoting the meaningful participation of populations affected by the three diseases.

Human rights can force us to focus on the needs of the most vulnerable. Thus the Global Fund policy of supporting programs based on the greatest need[6] aligns with core human rights values. Its continued engagement with countries even where the working environment is challenging (for example, in fragile states and in situations of armed conflict) is commendable. Yet it is imperative that the Global Fund find ways of addressing the risks that in these countries, the dynamics that may be driving, at least partially, high incidence of disease can also lead to pervasive violations of human rights. This is often the case in conflict-affected and post-conflict societies where the risk of actual and potential human rights violations in health care delivery can be high. After all, conflict, often has its origins in patterns of human rights violations, for example, the systematic oppression of vulnerable groups. Such abusive practices frequently continue even after the cessation of active hostilities.[7]

Health-related violations in conflict-affected areas range from conflict-driven discrimination and attacks on hospitals and health workers, to pervasive sexual violence, as well as contextual barriers that impede access, such as the collapse of health infrastructure. A powerful body of evidence demonstrates that human rights violations can actually perpetuate the spread of HIV/AIDS, TB, and malaria.[8] Realities in conflict-affected and post-conflict countries can have an enormously destructive impact on the health of populations and construct seemingly insurmountable barriers to accessing health care. Conflict-related factors affect health not only through direct violence, but also through the breakdown of social structures and health systems, and lack of availability of underlying determinants of health.[9] Moreover, a high risk of increased incidence of HIV/AIDS, TB and malaria has been documented in conflict or post-conflict settings.[10]

Identifying, addressing and minimizing the risk of involvement in human rights violations in conflict areas – especially when they interlinked with its programs – will allow the Global Fund to optimize its impact in these contexts and create sustainable programming that supports its core mandate to positively impact on the disease burden in countries. This will also help insulate the Global Fund against reputational risk and actively advance the commitment the Global Fund has made to protect and promote human rights considerations in its grant-making cycles, particularly in relation to populations devastated by the harsh realities of conflict.

Aim and scope of this paper

This paper has been commissioned by the Global Fund and is part of the organization's commitment to protecting and promoting human rights through integrating human rights throughout the grant cycle. It aims to identify the risk of human rights violations in Global Fund-supported programs in conflict-affected areas, and provide policy recommendations that support operationalizing the Global Fund commitment to not to fund programs that violate human rights.

This paper primarily examines the risk of actual and potential human rights violations directly or indirectly relating to Global Fund programs. Human rights abuses that may be linked to Global Fund programs could include, for example, overt discrimination in the provision of health services based on political allegiance or ethnicity. An example of indirect linkage could be where the Global Fund may be supporting a ministry of health, or more broadly a government, that is committing health-related rights violations. The paper will also briefly explore contextual barriers to access – these may include barriers over which the programs and implementers may have no control; for example, discriminatory national laws in the wake of conflict, or treatment disruption caused by the collapse of infrastructure.[11]

This paper predominantly considers those violations that are conflict related, while also occasionally addressing approaches and lessons applicable to fragile states, since conflict areas and fragile states are closely comparable in many ways.

For the purpose of this paper, the terms "conflict areas" or "conflict-affected" will encompass situations deemed armed conflicts under international humanitarian law international humanitarian law, which have been authoritively defined as existing "whenever there is resort to armed force between states or protracted armed violence between governmental authorities and organized armed groups or between such groups within a state."[12] In addition, in the course of this paper, the terms "conflict areas" or "conflict-affected" will also cover situations of armed violence within countries, such as political protests and civil unrest, which do not necessarily amount to armed conflicts as defined under international humanitarian law.

The kinds of human rights violations that are seen in conflict areas can also continue in post-conflict settings. The distinction between conflict and post-conflict status is sometimes imprecise because some conflicts become chronic. In other states, a formal end to a conflict is supplanted by high levels of continuing violence and upheaval, sometimes including a renewal of war.[13] Thus, for this paper, the terms "conflict areas" and "conflict-affected" include countries engaged in armed conflict as well as post-conflict societies.

Since there is no one definition of what is meant by conflict-affected states, the Global Fund might consider adopting a set of criteria which would allow it to categorize countries as conflict-affected or not, for the purpose of applying its own policy guidelines.[14] It is beyond the scope of this paper to focus on the distinctions that may exist in the areas of risk and remediation measures in conflict and post-conflict situations. However, this remains an important area for future Global Fund-related research.

Methodology

The analysis and recommendations in this paper were compiled after an extensive desk review of published and internal documents on the Global Fund, as well as a wide array of other primary and secondary sources in the field, including the work of the UN Special Rapporteur on the Right to Health (in particular his recent report on the right to health in conflict situations), as set out in the bibliography. Interviews were also conducted with a selected group of individuals at the Global Fund as well as external experts.

This paper analyzes the risks faced by the Global Fund through the lens of case studies, primarily focusing on case studies from the following ten countries: Syria, Egypt, Democratic Republic of the Congo, Bahrain, Myanmar, Sudan, Central African Republic, Afghanistan, Nigeria and Iraq. In compiling these case studies, Global Fund grant data (for Rounds 9 and10) for these ten states were analyzed via a human rights framework. In some cases, where there are relevant examples of human rights risk in other countries, such cases have also been considered. Rather than attempting a comprehensive overview, this paper has drawn illustrative examples from countries. Finally a cross-analysis of data available on the Global Fund website, and data available from the Geneva Academy War Report 2012, was conducted, to assess the scope of Global Fund-supported operations in conflict areas.

Structure

Following the introduction, Section II of this paper briefly examines the question of what does taking a human rights-based approach to health services in conflict areas involve for the Global Fund, and provides a brief conceptual framework of the right to health in conflict settings. Section III considers human rights violations relating to health care delivery in conflict areas. Section IV presents key approaches and lessons from the field. Section V then outlines challenges, opportunities, and important questions in light of the Global Fund's support for health programs in conflict settings. Finally Section VI concludes with certain key recommendations.

2. The right to health in conflict areas

What does taking a human rights-based approach to health services in conflict areas involve?

It is possible to optimize outcomes of HIV/AIDS, TB and malaria programming by creating enabling environments for the advancement of human rights, by empowering key populations[15] who often face human rights violations and are disproportionately affected by HIV and other sexually transmitted infections, as well as by addressing program-related violations of human rights.[16] In conflict areas, the protection of human rights is often considered intrinsic to effective humanitarian action.[17] There are development and humanitarian actors (such as UN agencies, bilateral donors and nongovernmental organizations) who recognize that applying a human rights lens to issues that arise in the course of their work, (such as structural inequality), facilitates analysis of the root causes of rights denial which is crucial to structural change.[18] Moreover, in contrast to a needs-based approach, a human rights-based approach empowers beneficiaries as rights holders and transforms, to some extent at least, imbalances in existing distributions of power.[19] The longevity of many conflicts can mean that unless a human rights-based approach is broadly adopted across sectors, the rights of entire generations will continue to be violated.[20]

Facilitating the integration of a human-rights based approach means incorporating the human rights principles of participation, accountability, non-discrimination and equality, transparency, human dignity, empowerment, and the legality of the rule of law into programming at all levels. From its very foundation, as expressed in its framework document, the Global Fund's work has embraced these fundamental human rights principles, such as transparency, accountability and meaningful participation of people living with and affected by HIV, TB and malaria.[21] As Global Fund Executive Director Mark Dybul has noted, "to really defeat HIV, TB and malaria, we have to focus on protecting the basic human rights of the vulnerable".[22] The Global Fund's commitment to integrating human rights considerations throughout the grant-making process; increase investment in programs that address human rights barriers to accessing health services; and ensure that the Global Fund does not fund programs that violate human rights, as per the 2012-2016 strategy, is a cornerstone for the organization in its work in this regard.[23]

Operationalizing these commitments to a human rights-based approach to health services, particularly in times of conflict, is challenging, but can also be addressed through the structure of the Global Fund's three pillars approach: how can avoidance of human rights violations in times/places of conflict be integrated into the grant cycle (the positive approach); how can the Global Fund ensure it does not support programs in times/places of conflict that infringe human rights (the preventive approach); and how the Global Fund can increase investment in programs that contribute to accessing services in conformity with human rights, especially for underserved populations in times/places of conflict (the proactive approach). All three approaches are relevant to conflict and post-conflict settings and the Global Fund's role.

For example, in the same way the Global Fund has, on occasion, spoken out forcefully in defense of human rights – for example, against the recent Nigerian legislation criminalizing LGBT people[24] – it could do so when recipient governments threaten the human rights of groups at risk during times of conflict. Likewise, when the Global Fund has taken firm action in the wake of egregious human rights abuses, for example, when grants supporting interventions in drug detention centers were reprogrammed and even terminated in Viet Nam due to human rights violations,[25] similar action could be taken when Global Fund grants are used or misused to serve aims that are non-human rights compliant during times of conflict. In many ways, such actions are not so different from the actions that the Global Fund would take in circumstances outside of those of armed conflict, however there are issues related to the consideration of human rights in the context of fragile states and conflict affected areas that require particular attention, as addressed further below.

A. Brief conceptual framework

In situations of armed conflict, both international humanitarian law and human rights law concurrently apply to provide complementary and mutually reinforcing protection of affected populations and their enjoyment of fundamental human rights, including the right to health.[26] Where countries experience armed violence that does not meet the legal criteria for armed conflict, as well as in post-conflict societies, international human rights will govern exclusively. This normative framework includes a wide array of legal sources and is monitored by international and national bodies, including the International Court of Justice, UN human rights treaty bodies, regional tribunals and domestic courts.

The right to health is a short expression for the right of everyone to the enjoyment of the highest attainable standard of physical and mental health enshrined in the International Covenant on Economic, Social and Cultural Rights, adopted by the General Assembly in 1966[27]. As defined by the UN Committee on Economic, Social and Cultural Rights, the right to health implies that all health services, goods and facilities must be[28]:

- **Available:** Functioning public health and health care facilities, goods and services, as well as programs, have to be available in sufficient quantity;
- **Accessible:** Health facilities, goods and services have to be accessible to everyone, especially the most vulnerable, without discrimination. This includes physical accessibility and economic accessibility (affordability);
- **Acceptable:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate;
- **Of good quality:** Health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

The right to health also includes underlying determinants of health, including adequate nutrition, safe drinking water, housing, gender equality and so on.[29] It also means freedom from torture and other cruel and degrading treatment, non-consensual treatment, as well as any breach of medical confidentiality.[30]

The right to health, like all human rights, imposes three types of obligations on states. These obligations also apply in times of conflict[31] and can be defined as follow:

- **Respect:** Non-interference with the enjoyment of the right to health (for example, not obstructing access to health services generally or as regards members of disfavored groups)
- **Protect:** Ensuring that third parties do not infringe upon or interfere with the enjoyment of the right to health (for example, taking steps to provide protection for health care workers and patients who may be under attack by rebels in the course of conflict).
- **Fulfill:** Taking positive steps to realize the right to health (e.g. by adopting appropriate legislation, policies or budgetary measures. In conflict contexts, such steps may include, for instance, sexual violence prevention and response training for uniformed services.)[32]

The right to health also implies that the state has obligations vis-à-vis certain non-derogable, minimum essential levels of the right that must be complied with in all circumstances. This minimum core includes the obligation of states to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; the obligation to provide essential medicines, and to formulate a national health plan or policy in a transparent and participatory way with appropriate consideration of the special needs of marginalized populations.[33]

Implementation of legal norms can often be extremely difficult in situations of high political tension,[34] for instance in times of conflict. However a clear legal framework provides the grounds, and indeed impetus, for creating a culture of accountability and taking measures to effectively realize rights.

While these obligations fall clearly on the state, the relationship between the state and the Global Fund becomes of interest: While the state cannot fully delegate its obligations to the Global Fund or its partners, the Global Fund, arguably, as an international actor, particularly one with a stated commitment to protecting and promoting human rights, must ensure it is careful to also respect, protect, and to the extent that it is within its scope, fulfill, the right to health, in accordance with international human rights law.[35]

3. Human rights biolations in conflict areas

A range of different human rights-related areas of concern is considered below in the context of health service delivery and in relation to the main components of the right to health, namely, availability, accessibility, acceptability and quality of health services, goods and facilities. This is however a non-exhaustive list of issues and merely illustrative of key patterns of abuse. It is also important to note that the focus on certain countries in these case studies does not mean that human rights abuses are concentrated in these conflict-affected countries, but simply that more information was available with respect to these particular cases. These should thus be seen as illustrative case studies, indicative of actual or potential risk in other conflict affected countries as well.

A. Discrimination in the provision of health care

Non-discrimination is a core element of the right to health. In relation to accessibility, it implies that health facilities, goods and services be accessible to everyone without discrimination.[36] Discrimination can have a devastating impact on health outcomes, particularly as regards HIV, TB and malaria.[37] Unfortunately, outright discrimination in the delivery of health care is an extremely pervasive human rights violation in conflict-affected areas,[38] based on factors including political allegiance, combatant status or involvement in conflict, minority status, ethnicity, nationality, religion, gender, and internally displaced person or refugee status.[39]

Discrimination can be exercised by the state and other parties to the conflict in different ways, ranging from refusal to treat persons or extending preferential treatment based on grounds of allegiance, mistreatment or stigmatization of those seeking care, to constructing obstacles to access such as travel restrictions or the diversion of medical supplies.[40] Laws and policies may also be passed that overtly restrict or criminalize provision of medical care to people opposing the state. The state may also inappropriately utilize national security laws (such as counter-terrorism laws) to skew the provision of health care.[41] Additionally, conflict-related prisoners and detainees are frequently denied needed health care. Moreover, targeted strategies of discrimination against specific groups may impact not just access to health services but also underlying determinants of health such as nutritious food, clean water and sanitary conditions.[42]

Although human rights, international humanitarian law and medical ethics mandate medical impartiality in the provision of care and services in all situations including conflict, health professionals either due to direct or indirect coercion by the state or rebel groups,[43] or even because of personal bias exacerbated by conflict, often discriminate against sections of the population.

Finally, discrimination based on prejudice – for example, against those living with HIV, men who have sex with men populations, sex workers or drug users – is also rampant in conflict settings. Such discrimination may not be driven by conflict but may be expressed more virulently in conflict settings where there is often little in terms of legal protections and where a culture of impunity for abuses can prevail.[44]

Some examples

- In Central African Republic, where religion is a factor underscoring the current conflict, health workers frequently discriminate on the basis of religion[45]. Meanwhile, government authorities in **South Sudan**[46] have been reported to discriminate against populations in rebel-held areas by blocking access to all goods and services including desperately needed humanitarian aid. This has affected accessibility of health care. In 2012 **Bahrain** passed a law placing legal restrictions on providing medical care to political protestors and harshly penalizing doctors and other health care workers for acting in accordance with their professional duty to ensure medical impartiality[47]. In **Eastern Myanmar**, reports allege that the army targeted patients and health care workers they thought to be affiliated with opposition groups and prevented patients from traveling to clinics, and health workers from providing care[48]. There have also been reports of HIV-related discrimination discouraging people from seeking and continuing treatment in Central African Republic[49].

Ensuring non-discrimination in the provision of health services (integrated throughout all aspects of the Global Fund's work and grant cycle), ensuring the Global Fund does not support programs that include or risk discriminating against groups at risk, and increasing investment in programs that contribute to ensuring underserved populations – those traditionally subject to discrimination – especially during conflict or post-conflict, are able to access services, are ways that the Global Fund can particularly address the risks related to these potential violations.

B. Attacks on health care facilities and health workers

Another key area of human rights concern in conflict contexts is vicious attacks on health facilities and health care workers, often as a conflict tactic. Over the course of 2012, the International Confederation of Red Cross and Red Crescent Societies (ICRC) collected information on 921 violent incidents affecting health care during armed conflict and other emergencies in 22 countries[50]. These incidents involved the use or threat of violence against health care personnel, the wounded and the sick, health care facilities and medical vehicles[51]. Such destruction by states or failure to protect against such abuses by third parties is a clear infringement of both human rights law and international humanitarian law. Such attacks can have far-reaching implications on access and availability of health care, since such violations can lead to the flight of health workers and humanitarian organizations and contribute to the overall collapse of health infrastructure.[42] Here not just the right to health, but the right to life is at stake.

Health facilities with no direct involvement in the conflict, including hospitals and clinics, can also be looted with impunity and intentionally bombed. In some cases, those attacking the premises may demand confidential information about patients or indiscriminately open fire on patients.[53] Mobile units and ambulances can also be shot at as part of military strategy.[54] Health care workers can be attacked due to perceived allegiance to one group or another in the conflict. Attacks on health workers include assaults, intimidation, threats, kidnapping, and killings. If health care workers speak out against such actions or refuse to hand over confidential information regarding patients, they may be harassed, arrested, prosecuted and even tortured in retaliation[55]. As per human rights law, health workers cannot be punished for acting in accordance with medical ethics, the only limitation being medical confidentiality, which is subject to national law[56].

The motivations underpinning such human rights violations are often to disrupt health access to opposing factions, collect information, devastate infrastructure as a military ploy and obtain resources.

Some examples

- There have been systematic attacks and looting of health care facilities as well as brutal assaults on health workers in the **Central African Republic**, particularly in areas where rebels are consolidated.[57] Other countries facing attacks on health care facilities and intimidation of staff include **Afghanistan**[58], **Egypt**[59] and **Nigeria**[60]. **Iraq** is yet another country which has witnessed the killing and kidnapping of doctors. This led to the flight of qualified health professionals in the period 2004-2007, severely diminishing access to health care services.[61]
- Meanwhile, in Syria, systematic, brutal attacks by the state on patients, health facilities and health workers created such a climate of fear that patients would simply not go to hospitals. This led to an underground network of makeshift clinics that was not an adequate substitute for the sophisticated medical services needed.[62] Using medical care as a tool of warfare, the government ordered that medical care should not be extended to opposition-controlled areas and opposition supporters or even civilians. A number of doctors have been killed in an attempt to extend health facilities to conflict areas and hence have fled Syria.[63] Sixty percent of public hospitals are not functioning in Syria and a similar percentage of ambulances have been stolen or damaged.[64]

Due to the Global Fund's work, it is in a different position to many humanitarian organizations in this regard, due to its partnership alliances with implementing agencies and ministries in the field. Yet consideration must still be given to how to best protect human rights during the implementation of programs, particularly when the personal integrity and physical safety of health workers is at risk.

C. Torture and cruel, inhuman and degrading treatment of conflict-related detainees

Torture and cruel, inhuman and degrading treatment of conflict-related detainees are prohibited under human rights law and international humanitarian law. Yet such egregious human rights violations are common in many conflict-affected countries. At times, withholding health care and needed treatment or medication is used as a tactic of torture.

Some examples

- **In Afghanistan**, there are reports by international organizations and human rights institutions that conflict-related detainees are denied access to medicines and treatment and can be subjected to torture and brutal abuse.[65]
- **In Sudan**, there are civil society reports of government security forces beating and torturing persons in detention, including members of the political opposition, civil society activists, and journalists, with these persons being often subsequently released without charge.[66] In **Congo (Democratic Republic)**, there have been reports that rebel detainees have been tortured and their bodies desecrated.[67] Generally the management of prisons and detention centers in **Congo (Democratic Republic)** has raised major concerns, since the lack of food and health care has led to an alarming number of malnutrition cases and deaths in detention.[68]

This issue is of concern for the Global Fund because of its funding of programs within prisons and detention centers (see research paper in Annex Two).

D. Violations of women's rights

While it is beyond the scope of this paper to examine the issues facing all key populations, given the particular vulnerabilities confronting women in conflict settings, some of the major violations of women's rights are considered in this section. Conflict dynamics exacerbate gender inequalities[69] and often render women more vulnerable to ill health, discrimination and gender-based violence[70]. Often in flagrant contravention of human rights law and international humanitarian law, women face multiple violations of their human rights, which can severely restrict their access to health care.

Sexual Violence and Exploitation: Women face a devastatingly high level of sexual violence in conflict and post-conflict contexts by both state and non-state actors, and as rape is increasingly used as a weapon in warfare to terrorize the civilian population and, in some situations, even takes a role as an act of genocide with a view to the elimination of an national, ethnical, racial or religious group. The statistics are disturbing. For example, 94 percent of displaced households surveyed in Sierra Leone had experienced sexual assaults, including rape, torture and sexual slavery, while it is estimated that as many as 500,000 women may have been raped during the 1994 genocide in Rwanda.[71] It should be noted that boys and men are also susceptible to sexual violence, although not to the extent women are, and women and girls are significantly more likely to be infected with HIV. Sexual violence persists even after the cessation of conflict. Often due to a wide range of factors, including the return of traumatized and affected soldiers and other combatants and heightened social and political tension, women are actually more vulnerable in post-conflict contexts.[72] Moreover, women who depend on armed groups and aid agencies may also engage in sex work to meet basic needs such as shelter, food and services. Both realities expose women to an increased risk of HIV and sexually transmitted infections.[73]

Health facilities and health workers in conflict and post-conflict countries are frequently inadequately equipped to provide appropriate treatment, including post-exposure prophylaxis to prevent unwanted pregnancy, sexually transmitted infection and HIV as well as counseling and psychological support[74]. Moreover, due to resource constraints and stress caused by constant pressure and tension, health professionals often lack the necessary sensitivity during initial patient interviews and medical examinations.[75] Another issue to consider is that, in many countries, the notion of shame and disgrace is attached to survivors of sexual violence and not to the perpetrators. This results in exclusion and stigmatization, which discourages women from seeking medical care.[76]

Another related issue in conflict settings is the reality of sexual exploitation in exchange for access to health services. Health services are limited and there is often desperation for treatment and medical care, which health service providers may exploit. Moreover, facilities are often guarded by military personnel or other armed guards who offer an exchange of access to medical treatment for sexual favors; if the woman does not consent, then she may still be abused or raped because of the proximity factor.[77]

Discrimination and lack of access: In some countries women need the permission of a male member of the family to access health services or must be accompanied by a male family member when accessing health facilities.[78] In conflict settings, where male members of the family may have been killed or are away at war, such discriminatory realities impose critical obstacles to women accessing needed health care.

Also, health care workers in countries with strongly patriarchal structures and entrenched gender discrimination, as is the case in many conflict areas, may share widespread prejudices, which result in medical care that is not women-friendly or sensitive to the needs of women.[79]

Lack of Culturally Appropriate Services and Attacks on Female Health Care Workers: In some countries, provision of health services to women by male doctors and nurses may not be culturally appropriate. Lack of culturally appropriate[80] services is a human rights issue as per the acceptability component of the right to health framework. However, paradoxically, in some countries where such cultural norms are prevalent, female health workers who would be able to provide appropriate services to women can be targeted and subject to violence providing health services on the basis of gender bias.[81]

Some examples

- Sexual violence is widely prevalent in the armed conflict contexts of the **Central African Republic**, **Congo (Democratic Republic)**, and **Syria**,[82] **and in the situation of armed violence in Egypt**.
- In 2002, there was a widely publicized scandal concerning sexual favors in return for humanitarian assistance with regard to refugee children in **Guinea**, **Liberia** and **Sierra Leone**.[83] In all three countries, agency workers from international and local nongovernmental organizations as well as UN agencies were reportedly the most frequent sex exploiters of children. Most of the allegations involved male national staff, trading humanitarian commodities and services (including medicines) in exchange for sex with girls under 18. The practice appeared particularly pronounced in locations with large established aid programs. "It is difficult to escape the trap of those (nongovernmental organizations) people – they use the food as a bait to get you to have sex with them".[84] (Adolescent in **Liberia**). This is an area of potential human rights violations as reports from the field continue to document sexual exploitation by humanitarian actors.
- In Balochistan, **Pakistan**, women say they are not permitted to travel to hospitals without their husbands[85]. Also male doctors attending to a woman patient may be seen as culturally inappropriate in some areas of the country.[86] In a catch-22 situation, there are reports of female health workers in Pakistan being targeted and subjected to violence and threats providing health services.[87]

Hand-in-hand with the Global Fund's Gender Equality Strategy, a focus on the impact that conflict has upon women and how the Global Fund's commitment to women's human rights can be integrated into all aspects of its programming needs to be prioritized at all levels, with all stakeholders.

E. Contextual barriers to access

Conflict and the attendant violence, insecurity and unsafe conditions, poses enormous barriers to accessing health care. A range of contextual barriers to access include, but are not limited to, a collapse of health infrastructure and flight of health care professionals; geographic inaccessibility of facilities; lack of prioritization by the state or weak capacity; diversion of state resources for military ends; breakdown of the rule of law and a culture of impunity; rampant sexual violence; and high out-of-pocket expenditure. Physical barriers such as forced detours, imposition of travel restrictions in certain areas, arbitrary stops at checkpoints, blockades and curfews can also cause huge access issues for populations.

Moreover, importing and transporting medicines and needed medical commodities can be incredibly difficult, given that road and air services within conflict-affected countries can become unavailable or very dangerous. Further, state or non-state groups can divert or restrict medical supplies, especially lifesaving medicines, for military ends. As the Minister of Health for the Congo (Democratic Republic) recently said, "Years of war have devastated the health system and the effects on the well-being of the population are cataclysmic"[88].

The lack of accessibility and availability often causes treatment disruptions in conflict areas and this has devastating health outcomes for populations. For example, in the case of HIV, unmanaged interruptions to treatment can lead to treatment failure and also, the emergence of drug-resistant viral strains[89].

Some examples

- Many conflict areas are significantly underserved by quality health facilities because of the destruction of facilities, as is the case in **the Central African Republic**, **Congo (Democratic Republic)** and **Côte d'Ivoire**[90]. Treatment adherence is a huge problem in the Central African Republic. Prior to the current crisis, the Central African Republic was already struggling with its AIDS response. Since the violence began, two-thirds of people living with HIV on treatment have fled their homes and are no longer able to access the medicines and care they need.[91] Meanwhile in **Nigeria**, HIV patients who need regular treatment can hardly access it because of Boko Haram highway attacks.[92] In **Syria**, the unrest in 2011 disrupted the activities of the governorate clinics especially in Homs, Hama, Idleb, Derazzor, Kamishle and rural Aleppo, which include 40 percent of Syrian population.[93]

- Contextual barriers to access in **Egypt** included competing interests and priorities after the revolution due to emerging health problems of the wounded and handicapped that were prioritized over HIV and TB, hence delaying the budget approval processes. Additionally the political turmoil since January 2011 has resulted in rapid turnover at the high political and managerial levels. During the period 2011-2012, health ministers were changed five times, which resulted in delayed implementation of some health care-related activities because of the difficulty in obtaining top-level approval in a timely manner[94].

This highlights the importance of health system strengthening as an area of priority for global health, particularly in the context of times and places of conflict.

4. Key approaches and lessons from other donors and humanitarian organizations

Before moving onto Global Fund-specific considerations, it is useful to examine the experiences of other health donors and humanitarian organizations in terms of response to issues faced in conflict areas, particularly in terms of human rights.

In recent years there has been a proliferation of policy papers exploring useful approaches to working in fragile and conflict-affected settings. These document the experiences of humanitarian organizations, international development institutions, bilateral and multilateral aid agencies, health donors and international and local nongovernmental organizations, such as the WHO, UNAIDS, the United Nations Children's Fund (UNICEF), the World Bank, the United States Agency for International Development (USAID), the Department for International Development (DFID), GAVI Alliance (GAVI), ICRC, Save the Children and others. Less commonly examined are experiences in utilizing a human rights approach within such environments. Key examples from both contexts are briefly outlined below.

The Organisation for Economic Co-operation and Development (OECD) has provided critical leadership in considering how effectively to engage in fragile states, including conflict-affected areas. This has led to the Paris Declaration on Aid Effectiveness (2003) and the Accra Agenda for Action (2008). Also pertinent are the OECD's Development Assistance Committee's (DAC) Principles for Engagement in Fragile States (OECD 2007). Of particular note are the specific human rights principles OECD-DAC has developed to consider in development contexts - this may be useful when conducting operations in conflict-affected areas[95].

Also relevant to reference are the principles outlined by Health Unlimited on delivering health services in fragile states and difficult environments[96]. In addition, the SPHERE Project (a cooperative group of nongovernmental organizations working in the humanitarian sector) has developed a series of minimum standards for various critical lifesaving areas of humanitarian response, including health, which include a "people-centered humanitarian response" with recommended actions such as ensuring adequate representation of affected and vulnerable populations in decisions about how aid is being provided, and gradual increase in local ownership of programs[97].

Moreover, to address the many different issues that arise in connection with a human rights approach in conflict contexts, UNICEF and many other agencies and organizations working in conflict and complex emergency situations have drawn on international humanitarian law and human rights and development theory to develop a set of Principles for Humanitarian Action to guide their programming. This includes principles on the humanitarian imperative, impartiality, accountability, cultural sensitivity, coordination, gender differentiation and community empowerment[98].

OECD's DAC human rights principles, 2007	Health unlimited principles, 2007
1. Build a shared understanding of the links between human rights obligations and development priorities through dialogue.	1. Understand the context
2. Identify areas of support to partner governments on human rights.	2. Build trust
3. Safeguard human rights in processes of state building.	3. Share information and evidence
4. Support the demand side of human rights.	4. Provide long term support
5. Promote non-discrimination	5. Take a rights-based approach
6. Consider human rights in decisions on alignment and aid instruments.	6. Reach marginalized communities
7. Consider mutual reinforcement between human rights and aid effectiveness principles.	7. Build on what exists
8. Do no harm.	8. Develop accountability mechanisms
9. Take a harmonized and graduated approach to deteriorating human rights situations.	9. Facilitate an appropriate mix of aid modalities
10. Ensure that the scaling up of aid is conducive to human rights.	10. Focus on health systems as a whole
	11. Address human resource constraints
	12. Utilize appropriate communication approaches
	13. Promote cooperation among agencies

Cross-cutting approaches and lessons

In terms of cross-cutting patterns that emerge from the experiences of different organizations in fragile states (including conflict areas), and are relevant for identifying, addressing and minimizing the risk of human rights violations, it is particularly important to have a thorough understanding of context and to tailor programs accordingly.[99] Another critical consideration is the need for flexibility and differentiation in programming for conflict areas, where needs and opportunities can change swiftly and demand rapid, creative responses.[100] Moreover, in order to optimize impact in difficult environments, many agencies find it vital to work in close partnership with others on the ground.[101]

Other approaches and lessons from donors and agencies engaged in conflict-affected areas that may be particularly relevant for advancing human rights include, among others, the need for combining state-building activities with community empowerment;[102] the importance of building trust;[103] the movement away from aid suspension under the conditionalities matrix and towards a structured dialogue and solution-driven approach;[104] the importance of simple program design and implementation arrangements;[105] and the need for a higher appetite for risk and stronger risk management.[106]

Human rights-specific approaches in conflict-affected areas include: supporting extensive policy dialogue and supporting national authorities to develop national strategic health plans that include human rights considerations;[107] investing in inclusive programming with strong equity, gender empowerment and community emphasis;[108] developing clear monitoring plans for human rights (including the collection of disaggregated data) and building local capacity to do so, especially for the purpose of anticipating where situations may deteriorate and of improving the design and targeting of interventions;[109] and cultivating close engagement with local leaders, key affected populations women and health workers.[110]

Many agencies that explicitly adopt a human rights-based approach (such as UNICEF), while maintaining the importance of such an approach in optimizing outcomes in the long term, acknowledge the difficulties of implementing a human rights-based approach in highly fractured, unequal or divided communities, or during emergency situations.[111]

To consider just one example; in any situation the "indivisibility" of human rights presents significant challenges in terms of resourcing, so that in reality some rights have to be prioritized over others. In emergency settings, given the pressure on agencies to respond quickly and to meet immediate needs, the need for such prioritization is even more challenging as are questions about sequencing, since the fulfilment of some rights is likely to be a prerequisite for being able to meaningfully exercise others.[112] In rapidly changing environments characterized by complex human rights considerations and desperate humanitarian need, prioritization and sequencing can involve making very difficult choices.

Key principles and guidelines

- ICRC Code of Conduct, 1994
- UN Inter-agency Common Understanding on a Human Rights-based Approach to Development Programming, 2003
- Principles of Good Humanitarian Donorship, 2003
- WHO Guidelines for Gender-based Violence Interventions in Humanitarian Settings, 2005
- Sphere Project Protection standards and principles in humanitarian response, 2011
- OECD'S DAC Human Rights Principles, 2007
- Health Unlimited Principles on delivering health services in Fragile States and Difficult Environments, 2007
- ICRC Professional standards for protection work carried out by humanitarian and human rights actors in armed conflict and other situations of violence, 2009
- UNAIDS Guidelines for Addressing HIV in Humanitarian Settings, 2010
- UNAIDS key programs to reduce stigma and discrimination and increase access to justice in national HIV responses, 2012

Certain concrete examples of responses in the field

There are a number of different ways in which donors and humanitarian actors deal with human rights-related issues in conflict-affected countries. It is beyond the scope of this study to examine these in great depth but a few examples have been outlined below for illustrative purposes.

- To ensure equitable access, DFID's partners in southern **Somalia** were able to maintain programs in areas controlled by militia by supporting District Health Boards that continually negotiated access.[113] To increase access for the most marginalized, Health Unlimited's "Primary Health Care Project" in **Cambodia** trained and supported village health volunteers, village health councils and women cluster leaders in 24 remote rural communities to provide health education in their communities. Their success in significantly improving the health knowledge and positively changing the health-related behavior of their communities encouraged the Provincial Health Department to replicate the approach elsewhere[114]. In another access-related effort in the **Horn of Africa**, Health Unlimited invested in radio-based communications (often the only means of mass communication in conflict areas) on issues including HIV, female genital mutilation and safe motherhood and successfully raised awareness of important health issues even with respect to populations that are traditionally hard to reach. This resulted in increased health service usage and positively changed behavior.[115]

- To counter issues confronting sexual violence survivors in conflict areas, organizations have funded a range of different programs. One program that improved access to health services for Burundi refugee women who suffered a high incidence of sexual violence in **Tanzania** was a multisectoral initiative involving the International Red Cross, several nongovernmental organizations, UN agencies, Tanzanian government staff (police, ministries) and the refugee community. This effort established a 24-hour drop-in center staffed by refugee women, and offered a confidential, safe and friendly environment to encourage women to attend.[116] Since the center offered a wide range of services as well as addressing sexual violence, survivors are not automatically stigmatized for seeking assistance. Since conflict-related issues and cultural norms can impede women from seeking health care in the aftermath of gender-based violence, Medica Mondiale emphasizes the importance of conducting a needs assessment in order to develop the necessary structures so that the women in question can be reached. Easy access to medical care via gynecological support has proven to be an ideal approach.[117]

- To address the issue of treatment adherence, an issue all too common in conflict-affected countries especially in the "return period" of conflict, TASO's strategy in **Uganda** of using community members to monitor and track patients, as well as decentralized treatment distribution points in rural areas, allowed TASO to radically reduce lost patients to under 1 percent. St Mary's Hospital in **Uganda** successfully used a similar approach to ensure ARV therapy continuity. Community-based adherence monitors employed by most HIV programs are themselves mostly HIV-positive.[118]

- In response to attacks on health care workers, which is a major area of human rights concern in **Nigeria**, GAVI (while recognizing that it is the primary responsibility of the government to ensure security), intends to take steps to mitigate security risks where they are affecting health care by supporting civil society to assist health workers in different ways and also by engaging in dialogue with religious groups.[119]

- In order to improve monitoring, which plays a critical role in identifying actual and potential human rights abuses in service delivery, GAVI seeks to improve data quality as part of health system strengthening. In **Congo (Democratic Republic)** it is proposed that 20 percent of the health system strengthening quota go to data quality[120] while in **Nigeria** 25 percent is suggested with the aim of closing the gap between country administrative data and WHO/UNICEF best estimates[121].

5. Global Fund support in conflict areas: challenges, opportunities and important questions

As explored earlier in this paper, there have been a number of human rights violations reported in health service delivery systems in certain conflict countries. Such violations represent a potential area of human rights risk that is relevant for the Global Fund to consider. Such risk is heightened when Global Fund-supported program implementers at the country level (Principal Recipients or sub recipients)[122] are state governments reported to be committing human rights abuses in health care delivery contexts. In the case of contextual barriers to access, the Global Fund may not be able to hold program implementers directly responsible for eliminating such violations; however, there are a range of steps that the Global Fund can and does take, which may include, for example, investments in programs that address human rights barriers to access such as legal advocacy programs or exerting political pressure. In the case of program-related violations, the Global Fund is better positioned to address such risk by including, for instance, minimum human rights standards in grant agreements and creating strong due diligence procedures.

Given time constraints, it was not possible to attain intensive feedback regarding the Global Fund's perception of human rights risk in conflict areas as reflected in Global Fund internal assessment tools such as QUART. However, in the very few interviews that were conducted in the limited time period of this research, country teams for conflict areas report having assigned a high risk rating for human rights (ranging from high to very high and even critical).[123]

Addressing human rights-related issues in order to strengthen its work in conflict settings takes on additional urgency given the Global Fund's scope of operations in such countries. It currently supports 118 active grants in 20 of the 25 countries designated as having armed conflicts in 2012 by the Geneva Academy *War Report*.[124] The Global Fund has, to date, invested more than US$3 billion in funding for the 20 countries.[125] Also important to consider is that Global Fund grant performance is relatively poor across countries considered "fragile", with low coverage of services for HIV/AIDS, TB and malaria, and an inability to reach large populations, including some of the poorest and most marginalized.[126] This is relevant for conflict contexts as well, since many fragile states are also conflict-affected and both have closely overlapping characteristics.[127]

Challenges

While there are several issues to consider in the context of challenges that the Global Fund is facing in responding to human rights violations in conflict areas, a particular concern is the difficulty faced in monitoring and evaluation in conflict settings. An immense challenge to effective operationalization of a human rights approach is the difficulty of collecting data on human rights issues in conflict areas. Convergent factors, including security risks, collapse of infrastructure, and also, at times, restrictions on independent monitoring, essentially cripple processes in conflict areas, including internal qualitative assessments through QUART[128]. Security concerns disrupted monitoring and evaluation verification visits to the Global Fund grant sites in Yemen[129] while in Syria[130] only limited supervisory visits outside the capitals were possible because of the ongoing conflict and pervasive insecurity. In Afghanistan, the general security situation renders it very difficult to access different areas for monitoring programs[131] while in the conflict-affected areas of Pakistan, where Global Fund's malaria investments are concentrated, minor programmatic risks exist linked to the prevailing security situation. This situation has posed some challenges to independent monitoring and evaluation of grants.[132]

Local Fund Agents[133] have not, to date, been mandated to consider human right issues as part of their work. As they are primarily accounting firms, they generally do not possess the necessary expertise. The situation is exacerbated by the Global Fund not having a country presence[134]. Uncovering human rights violations in conflict situations is particularly challenging because of a number of factors, including breakdown of trust and incidents of brutal retaliation. The need for "eyes and ears" on the ground is paramount. The Global Fund is thus handicapped - both by its operational structure and by the nature of conflict itself - from being able to collect data that is essential to identifying real or potential human rights abuses in the programs it supports.

Another issue important in this context is the difficulty in engaging with key populations in these difficult environments.[135] While the Global Fund has created multiple avenues[136] to promote health access and engage key populations, HIV/AIDS, TB and malaria prevention and treatment coverage in many conflict-affected settings can be very low in large areas due to factors such as security considerations, states barring access to conflict-affected areas,[137] and conflict-related collapse of infrastructure. Some key populations are often not reached, including the very poor, and in particular women, girls, young children, and displaced populations.[138] In addition, the realities of conflict dynamics can affect proposal design and result in poor grant performance. This also results in core target groups being underserved.[139]

Another aspect of this issue is the representation of key populations (including people living with HIV/AIDS and affected by TB or malaria) in the Country Coordinating Mechanisms[140] for Global Fund grants. In Afghanistan, in terms of representation on the Country Coordinating Mechanism of people living with the three diseases, there is only representation for TB. There is no one for HIV/AIDS or malaria. Neither is there representation and engagement of other key populations. This has been an ongoing discussion with the Country Coordinating Mechanism which will need to incorporate these populations in order to meet minimum eligibility. However, it was raised that part of this is also due to the absence of communities able to step forward to assume this role[141]. An analysis of Round 9 and 10-related grant data for ten countries indicated that key population representation on Country Coordinating Mechanisms was low with no representation of key populations in 50 percent of the Country Coordinating Mechanisms. In addition, there are reports that Global Fund grants are not sufficiently inclusive of refugees and IDPs, two groups that number in the millions and are rendered extremely vulnerable in conflict settings[142]. Internally displaced populations and refugees often have much worse health outcomes than the rest of the population, although in some cases, certain "islands of privilege" may exist allowing them better access to health care[143]. There has been progress on this, with UNHCR and the Global Fund joining together to ensure that refugees and internally displaced populations are not marginalized.[144]

Other considerations when outlining challenges in this context include the lack of an adequately flexible and differentiated approach for conflict areas, which is vital for engaging effectively with such regions and protecting against abusive practices.[145] Also of concern is that Global fund country teams[146] may not necessarily have the human rights capacity that may be needed to effectively operationalize human rights approaches on the ground.

Opportunities

There are also a number of promising developments that the Global Fund can leverage in successfully advancing its objective not to support programs that violate human rights. With an operational endorsement of the human rights approach from high-level officials within the Global Fund, including the Executive Director, and the inclusion of a rights-based approach within the strategic framework of the organization, the Global Fund's commitment to human rights benefits form a rather solid foundation. Additionally, as mentioned previously, in terms of minimizing human rights risk within its programs in conflict areas and operationalizing the strategic objective on human rights, there is a great deal of work being done internally at the Global Fund on human rights, and also on engagement with fragile states – including conflict-affected countries – a stronger connection between the two would be optimal.

Moreover the Global Fund's new funding model,[147] provides meaningful opportunities in terms of dealing with human rights issues in conflict areas. For example, the country dialogue creates a new avenue for engaging with key populations, while the iterative process of grant-making in which the Global Fund Secretariat and Technical Review Panel may recommend changes creates pathways to encourage countries to address human rights related concerns. The ongoing nature of the funding model, through accepting grant proposals on a rolling basis, also allows for human rights issues to be addressed in a timely manner, allowing the Global Fund to integrate its proactive approach, as needed, to increase investment in programs that will contribute to accessing services for the underserved in conflict areas. Another promising development involves the Office of the Inspector General, an independent body that conducts audits and investigations of the Global Fund's work and provides recommendations to promote good practice. The Office of the Inspector General is now taking on human rights as part of its mandate, which is likely to make identifying, investigating and addressing human rights violations easier.[148]

In addition, the Global Fund is already funding initiatives that specifically address actual or potential human rights abuses in conflict contexts. For example, in Afghanistan, a target of the Global Fund-supported health systems strengthening program is to train more female nurses than male nurses in order to increase access to health services for women.[149] The team also plans on conducting a human rights analysis and a gender assessment with regard to Afghanistan, so as to better tailor its approach on these issues[150]. Meanwhile the Positive Health, Dignity and Prevention Approach pilot project in Sudan which seeks to empower affected populations to be advocates for change is a good illustrative example of a positive rights-based program to counter discrimination at the country level[151]. Thus, while the Global Fund will have to overcome a number of challenges, it is also clearly well positioned to effectively implement its strategic human rights objectives.

Key questions for the Global Fund

What precisely does a human rights approach mean for the organization and what is the Global Fund willing to commit in terms of time and resources to achieving its human rights goals? What type of action, does, can or should, the Global Fund take against program implementers that commit violations of human rights linked to Global Fund-supported programs? What type of action, does, can or should the Global Fund take against program implementers that commit violations of human rights that have no link with Global Fund-supported programs but affect health services generally or impact key populations (as defined by the Global Fund)? What type of action, does, can or should the Global Fund take in light of contextual barriers to accessing health care services? In both internal and external terms, where does the accountability for addressing the risk of human rights violations in Global Fund-supported programs lie for the Global Fund?

6. Conclusion and key recommendations

Strengthening human rights protection in Global Fund-supported programs in conflict settings will help insulate the Global Fund against potential accusations of involvement in human rights abuse, and effectively advance public health and human dignity. Conflict settings and situations of violent insecurity generate a particularly difficult set of conditions that make the realization of human rights extremely challenging.

The transformative potential of Global Fund's efforts to not support programs that violate human rights as well as its determination to create an enabling environment for rights protection and promotion in the health sector is truly significant. Not only will the Global Fund's actions have influence, but this influence will spread to a range of different stakeholders, for example, the local level implementers of programs. It may be hoped that through the "norm internalization" effect,[152] the Global Fund's human rights approach can contribute, at least to some extent, to a strong culture of human rights promotion and protection at the local level.

It is clear that conflict areas are environments where health delivery services will always be vulnerable to periodic setbacks, especially in terms of human rights related gains. However, the rewards of continued engagement are usually worth the risk; these are also the environments where well-designed programs can really make a difference and elevate the human rights of the most vulnerable.[153]

Key recommendations

To address the risk of human rights violations in relation to the programs it supports, the Global Fund must develop and operationalize due diligence procedures (and it is indeed in the process of doing so). According to its current strategic plan, the Global Fund will apply the principle of due diligence to ensure the Global Fund does not support programs that violate human rights. A recent study outlines the method for conducting human rights due diligence as (1) identifying relevant facts and (2) evaluating those facts in light of a standard of care.[154] The evaluative aspect of conducting due diligence closely resembles the legal analysis method known as IRAC (issue, rule, analysis, conclusion).[155] The evaluation should present a realistic assessment of the situation, followed by the implementation of an action plan to address any actual or potential human rights violations.[156] Like due diligence against corruption, human rights due diligence should be integrated seamlessly and adhered to closely in any organization that takes human rights seriously.[157] The recommendations below touch upon certain aspects that are vital for developing due diligence procedures. For a much more detailed overview of a risk-based approach to due diligence for human rights, a recent paper by Mark Taylor and others is a useful reference.[158]

Our main recommendations are to (1) develop comprehensive and clear human rights guidelines, (2) improve and tailor monitoring and evaluation processes, (3) create a formal multistakeholder grievance mechanism, and (4) develop staff and stakeholder training, build capacity, and strengthen internal advocacy.

1. Develop comprehensive and clear human rights guidelines

The Global Fund should create clear overarching human rights policy guidelines, as has been recommended in the past.[159] Such guidelines should outline the core human rights standards and principles which will inform the Global Fund's work, including in conflict-affected areas. These may include for example, normative principles, such as the human rights principles of participation, accountability, non-discrimination and equality, transparency, human dignity, empowerment and rule of law, or those outlined in the UN Common Understanding of Human Rights Based Approach to Programming. Substantive human rights standards may also be included, for example, standards pertaining to non-discrimination, confidentiality, freedom from torture and cruel and degrading treatment.

The guidelines should further incorporate operational guidance with illustrative examples drawn from the Global Fund's own experiences and those of its partners. In framing the guidelines, input should be solicited from country teams as well as affected communities. It is to be acknowledged that guidelines simply serve as a foundation for action. To effectively bridge the gap between theory and practice it is important to identify and harness strategic leverage opportunities both within the Global Fund and within partner organizations.

The guidelines should assign clear roles within the Global Fund as regards the locus of accountability, both for the operationalization of a human rights approach, as well as in terms of human rights violations. It would be helpful also to outline a range of recommended actions for the country teams, Principal Recipients and sub-recipients to consider when encountering the risk of actual or potential human rights violations (direct, indirect or contextual) within programs. The options should cover issues relating to identification, verification and response in relation to the risk. There would need to be a balance between being too prescriptive – which may be problematic at the local level where context-specific solutions are needed – and having an organization-wide approach and a shared set of parameters to guide action.

In operational terms, the guidelines should also balance short-term measurable goals with longer-term aims focused on achieving structural change. The former set of goals (that may include for instance, the inclusion of key populations in country dialogues or an increase in the percentage of key populations benefiting from Global Fund-supported programs), is important in order to demonstrate tangible progress to internal staff, partners and also donors. The latter is imperative for achieving sustainable gains in human rights.

Moreover, the guidelines ought to elaborate on external consideration of human rights as mandated by the Global Fund. For example, as regards program implementers at the country level, Country Coordinating Mechanism or non-Country Coordinating Mechanism applicants should be required, rather than encouraged, to include human rights-related issues within their concept notes (grant proposals) and an inability to do so must be accompanied with clearly specified reasons.

- *Withdrawing support:*

The guidelines should further include clear criteria based on human rights, which determine what kind of practices and programs the Global Fund will in no circumstances fund, or when funding will be stopped or retracted and under what circumstances.

For example, in the past, the Global Fund has taken a strong stance against supporting drug detention centers. Other examples of practices to consider not funding, especially in conflict settings, include those involving abuses that contradict the organization's core mandate of health service delivery – for example, overt and systematic discrimination that impedes access, particularly for vulnerable population groups. As we have seen, such discrimination is often particularly prevalent in conflict situations.

Another area to consider not supporting is when egregious human rights violations are committed, such as those that threaten the right to life, when this can be directly linked to an implementer. Such a situation arises, for example, if a state government is a Principal Recipient and there are state-driven attacks on hospitals and health care workers, even when such attacks are not at funded facilities. In this context the Global Fund should also consider situations involving violations that constitute torture or cruel and degrading treatment that can be directly linked to implementers (for example, brutal mistreatment of conflict-related detainees in Global Fund-supported facilities or programs or even elsewhere). However, because of the desperate humanitarian need and high disease burden in conflict areas, rather than abruptly ending support, the Global Fund should consider working with the relevant actors to remedy the rights violations within a particular timeframe and if this does not work, have the option of canceling the activities infringing human rights standards adopted by the Global Fund or if necessary, even the entire grant.

- *Conflict-specific operational Issues:*

In the operational section of the guidelines there may be a need to include certain considerations specific to fragile states, including conflict-affected areas. It will be important to arrange for the provision of specialized technical assistance to allow conflict-affected countries to meet the human rights commitments outlined in their proposals.

In addition, the guidelines should allow a flexible, differentiated approach in conflict settings. For example, reprogramming may need to be paced differently in conflict situations to appropriately address human rights violations; country teams may not be able to meet human rights reporting requirements within set timelines; and, depending on the context, there may be a need to reconsider the precise parameters of results-based funding. Such a differentiated approach can vary, depending on whether the country is in a conflict area (which can be further categorized as protracted and chronic crises and shorter-term emergencies), in transition, or in a post-conflict phase.

While human rights issues in these contexts can overlap, they are also quite distinct and the Global Fund should consider whether it has the capacity to tailor approaches depending on the phase of conflict. It has actually already taken this issue into consideration, at least to some extent.[160]

Meanwhile, it is important to recognize that in finding a way forward in conflict areas, there may be a need to reconcile a human rights approach with the need to focus on a narrow range of objectives in fragile states which are prioritized and sequenced on the basis of a set of objective criteria.

- *Working more closely in partnership:*

The guidelines ought to also emphasize the importance of working in partnership. In conflict countries in particular, where actors are so overburdened, it becomes necessary to work closely with partners so as to utilize synergies wherever possible to optimize impact. This applies to collecting and analyzing information, as well as appropriately addressing violations in health

delivery services, especially as related to contextual barriers to access when the comparative advantage paradigm is particularly useful (for example, collaborate with existing health programs such as reproductive health and child care initiatives that are reaching most-at-risk populations that the Global Fund wishes to access). As has been suggested elsewhere, the Global Fund should in particular consider joining in a more systematic manner, health clusters and networks in different conflict-affected countries, for example, the Global Health Cluster (led by WHO) and OECD's International Network on Conflict and Fragility (INCAF).[161]

- *Communication strategy:*

With respect to operationalization, the guidelines should include a clear communication strategy. Two areas are particularly important in this context.

First, the human rights approach can only work if populations are aware of their rights, what constitutes violations of such rights, and avenues for redress. So there must be a concerted effort to raise rights awareness. The cooperation of the program implementers (possibly even mandated through agreement) is vital in this regard as they are well positioned to disseminate this information to program beneficiaries. Investments in creative programs appropriate for conflict settings that educate communities about their rights and remedies such as the radio-based participatory "discussion" programs, or engaging community-based members of key populations as peer educators can be helpful. Educating parties in power (whether states or rebel groups) as well as service providers regarding their human rights obligations, through targeted communication, is also important.

Second, the role of communication in addressing human rights violations is critical. Since domestic justice systems can collapse in the wake of conflict, publicizing violations can be one way to engender some level of accountability, (especially where the state is concerned) and build national and international pressure against abusive practices. This can be done through public advocacy including as outright condemnation in public forums (such as traditional media, human rights reports or social media) as well as quiet diplomacy. If denunciation by another agency (such as a human rights advocacy organization without field presence) would be more effective, there is an argument for the division of labor and information can be passed on, but this involves its own set of complications.[162] The means of communication is always a policy choice dependent on the precise context.[163] The Global Fund already engages in public advocacy. The guidelines could outline a set of strategic criteria to guide choices.

- *Updating guidelines and periodic review:*

Operational guidelines must never be set in stone but adjusted from time to time based on periodic review and reflection concerning what is working well and what is not. Since this is a relatively new area for many partner organizations, creating a best practices database in terms of human rights approaches to health delivery in conflict areas can also provide information that would be useful to reference when updating the guidelines. Publishing an annual human rights report with input invited from a wide range of stakeholders and presented by the Secretariat to the Board will be an essential component of such periodic reflection as well as a transparent platform to convey Global Fund's human rights approach in terms of both successes and challenges to the broader international community.

2. Improve and tailor monitoring and evaluation processes

As we have seen through the Global Fund experience, the implementation of a monitoring mandate, especially regarding human rights violations in conflict-affected countries can prove extremely challenging.

- *Context-based human rights profiles:*

The vital importance of context, especially in conflict settings, has been explored earlier. The Global Fund does have confidential human rights risk profiles for each country that it works with. In the case of conflict-related countries, these profiles should consider, in particular, the existing power dynamics, political realities and root causes of conflict, as these factors can often drive human rights violations and can inform effective monitoring and evaluation and risk management strategies. Lessons from other agencies[164] highlight that alongside such assessments, proper information management and time for strategic thinking is needed to actually feed such contextual analyses into the implementation phase.

- *Need for disaggregated data:*

One other issue to consider is the need for disaggregated data, especially in the case of women and children who are rendered particularly vulnerable to human rights violations in conflict, but also for other key populations.[165] While it may well be impossible to collect any data in certain situations of armed conflict, program design should focus on increasing efforts to collect disaggregated data. Where feasible, combining efforts with other multilateral and bilateral agencies to collect such data is important to avoid imposing additional burdens at the country level.

- *Strengthening information flows:*

To improve data collection, there is a need to strengthen human rights-related information-sharing networks with other similarly placed organizations (international, national and local) as well as community networks. Engagement with community networks can be facilitated by creating safe spaces for conversation and also establishing institutionalized platforms for engagement, such as country dialogues, in-person meetings, voluntary annual "parallel reports' as are prepared for the Universal Periodic Review process, interactive, web-based portals, or secure listservs.

Reaching out directly to communities, key populations and people living with the three diseases, can be a particularly rich source of important information, although at times there is a need to step outside more formalistic approaches to optimize this particular type of information flow.[166] While the Global Fund itself may not engage in these kinds of more creative community-centered interventions, it could consider supporting other organizations to do so. Creating trust in such contexts is also necessary and working with local actors that already have the trust of local communities is helpful.

- *Working with existing tools and mechanisms:*

There is the need to strengthen, adjust or further capacitate relevant internal tools and mechanisms used currently for monitoring and evaluation purposes. For instance:

- **The Local Fund Agent's terms of reference** must be changed to explicitly include human rights concerns and the Local Fund Agents must then be resourced to equip themselves to take on that additional role. Alternatively, this aspect of risk management can be entrusted to another independent entity altogether such as human rights experts or a local human rights organization. Where security conditions permit in conflict areas, frequent monitoring including mandated, unannounced, unimpeded site visits to get early warnings of potential problems is recommended.

- **QUART** (the country level internal assessment tool) addresses human rights in a rather cursory fashion, and appropriate revisions, especially as regards more detailing on what constitutes human rights violations, are important to capture needed information and formulate mitigation strategies. Also QUART is filled out by country teams, members of which are not necessarily able yet to identify the risk of actual and potential human rights violations, or, as we have seen, able in conflict countries to access the kind of data that allows for such risk assessment. Additional resources for country teams on a needs basis will make it easier to operationalize a human rights approach.

- **The Global Fund hotline** which is one other internal mechanism to capture information regarding human rights violations is primarily geared towards fraud and financial mismanagement. The human rights aspect of the hotline needs to be better articulated and publicized and there needs to be a more systematic way in which to record and evaluate incoming human rights related complaints.

3. Create a formal multistakeholder grievance mechanism

A widely accessible and transparent grievance mechanism upholds the principle of accountability. In addition, increasingly organizations are finding their grievance mechanisms useful in detecting problems early and identifying mitigations quickly.[167]

While elements of a typical grievance procedure already exist at the Global Fund,[168] there has been to date no systematic method for investigating and addressing human rights complaints within the Global Fund. Thus the Global Fund should consider establishing an easily accessible and integrated system based on a clear set of criteria that allows for the handling, investigation and verification of regular, anonymous or confidential complaints, and provides for appropriate remedy and remediation, including punitive or disciplinary measures. There is a range of relevant guidelines and existing grievance mechanisms in the field to consider, including ones used by international and humanitarian organizations,[169] as well as from the realm of business

and human rights.[170] The recently established Geneva-based Association for the International Code of Conduct for Private Security Service Providers has a comprehensive section on grievance procedures that could provide useful background material for thinking about how to establish an effective procedure for the Global Fund.[171]

In conflict settings, there are specific needs, and if necessary tailored exceptions can be built into the grievance procedures. Understanding barriers to reporting in conflict areas is critical both in terms of discovering violations and of responding effectively. Such barriers may include, for example, particularly harsh retaliation; a fear that aid flows will stop; high levels of stigmatization exacerbated by conflict-driven factors; breakdown in trust; and a very politically sensitive context.[172]

4. Develop trainings, build capacity, and strengthen internal advocacy

If the Global Fund proceeds with policy guidelines, based on a capacity building needs assessment exercise, necessary training must be provided to all relevant staff and stakeholders within the Global Fund family, with specialized modules on particular contexts, such as the application of the guidelines in conflict areas. In addition, Fund Portfolio Managers and Program Officers as well as program implementers, will often be in the position of handling the day-to-day operationalization of a human rights approach. Thus, in addition to training – if called for – they must also be given additional resources to equip them to take on this new role. For example, country teams may be capacitated by the addition of a team member with human rights expertise, a human rights focal point in each program team or regional team, or (internal or external) advisory groups may be instituted as a source of guidance for country teams (in the context of conflict settings, specialized expertise in the application of human rights in challenging environments would be particularly helpful). For example, an external "hotline", manned by contracted external human rights experts, could be established for the provision of ad hoc advice to Global Fund staff and stakeholders in the implementation of the human rights guidelines. The Global Fund has moved forward on this front by introducing community, rights and gender regional focal points who will be the first point of contact to advise country teams on community, rights and gender-related issues, and a similar scenario could be envisaged for the internal implementation of the human rights-related aspects of the strategy.

Finally, the lessons of operationalizing a human rights approach within multilateral and bilateral institutions (such as UNICEF and DFID) clearly demonstrate that consistent, internal advocacy at all levels within the organization is key to bridging the gap between rhetorical endorsement and committed practice.[173]

It is important to acknowledge that there is no one approach that will work in every context. There is also a need to achieve a proper balance between implementing rigorous human rights mechanisms that meaningfully minimize human rights risk in Global Fund programs, and taking care not to unnecessarily increase demands on staff and program implementers, especially in conflict areas where the challenges can be already overwhelming. Thus, wherever possible, it is vital to create suitable synergies, both internally and externally, develop creative solutions, and invest needed resources to achieve the organization's human rights goals. In terms of immediate priorities in order to allow the Global Fund to better identify, address and minimize the risk of human rights violations in Global Fund programs in conflict areas, the key is adequately improving the capacity of staff and stakeholders to understand the advantages of a human rights approach and providing resources for monitoring and evaluation related improvements.

(Endnotes)

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8 Global Fund et al., 'Africa Civil Society Organisations (CSO) Risk Forum: Effective Risk Management for Successful Implementation of Programmes Supported by the Global Fund, December 5-6, 2013, Cape Town, South Africa', Summary Report, 2014, p. 16.

9 A. Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental health', UN doc. A/68/297, 9 August 2013, p. 3.

10 For example, malaria is fuelled by conflict. See, for example, C. Beyrer et al., 'Neglected Tropical Diseases, Conflict, and the Right to Health', Center for Public Health and Human Rights, Johns Hopkins Bloomberg School of Public Health, 2011. At: http://www.ncbi.nlm.nih.gov/books/NBK62508/. HIV transmission on the other hand does not generally increase during conflict although this is context specific; however post conflict settings are very high risk environments for HIV transmission. See, for example, P. Marwah et al., 'Disarmament, demobilization and reintegration: opportunities in post-conflict settings' in *Forced Migration Review-HIV/AIDS, security and conflict: Making the connections*, Refugee Studies Center, October 2010, p. 12.

11 For a more detailed discussion regarding what constitutes contextual human rights risk (which is referred to as environmental in the discussion) and programmatic human rights risk, especially as relates to the Global Fund, see, Sara L.M. Davis, 'Human Rights and the Global Fund to Fight AIDS, Tuberculosis and Malaria', *Health and Human Rights* (forthcoming, June 2014).

12 ICTY, Prosecutor v. Dusko Tadic, Decision on the Defence Motion for Interlocutory Appeal on Jurisdiction (Appeals Chamber) (Case No. IT-94-1), 2 October, 1995, para 70.

13 R. J. Haar and L.S. Rubenstein, 'Health in Postconflict and Fragile States', United States Institute of Peace (USIP), Special Report, 2012, p.2.

14 It may be of interest that the Geneva Academy of International Humanitarian Law and Human Rights is working on a briefing paper on criteria and indicators for establishing what constitutes conflict areas. This will be published later in 2014.

15 The Global Fund defines key populations as follows: "Key populations face high risk and burden of the three diseases. Their access to relevant services is significantly lower than the rest of the population, and thus dedicated efforts and strategic investments are required to expand coverage, equity and accessibility. They face frequent human rights violations, high barriers to services and limited recourse because of systematic disenfranchisement and social and economic marginalization and criminalization. They contribute valuable insights, guidance, and oversight to implementing organizations and the Global Fund as Board members, staff, grant recipients, technical assistance providers and beneficiaries due to their direct experience and personal investment in the fight against the three diseases." A partial list of some key populations could include: prisoners, migrants, men who have sex with men, transgender people, women and girls, youth, people with disabilities, sex workers and their clients, people who inject drugs, indigenous people, internally displaced people, and others. See, The Global Fund, 'Information Note: Human Rights for HIV, TB, Malaria and HSS Grants, February 2014', p. 3.

16 See generally, UNDP, 'The Role of Human Rights in Responses to HIV, Tuberculosis and Malaria', Discussion Paper, March 2013. Also see, A. Grover, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' UN doc. A/HRC/17/25, 12 April 2011;

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