

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



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Executive Summary

The importance of human rights-based interventions in the global response to HIV/AIDS is indisputable. Empowerment of people living with and vulnerable to HIV as autonomous actors in the AIDS response can be the difference between marginalizing, authoritarian programs and ones that are effective and sustainable. Yet a truly rights-based HIV response is a challenge to any person or organization because it entails courageous confrontation of sexism, homophobia, moral judgmentalism, unjust criminalization, and cultural norms.

The Global Fund to Fight AIDS, Tuberculosis and Malaria is a crucial actor in the worldwide response to HIV. In less than ten years, it not only has provided billions of dollars for AIDS programs, but also has created processes and collaborations that have opened doors to meaningful participation in AIDS programming for people living with and vulnerable to HIV.

With respect to rights-based programming, the Global Fund faces an inherent dilemma: it explicitly espouses human rights-centered approaches to HIV, yet it also claims as a central principle of its work that the programs it funds should result from “country-driven” processes. When the countries that drive “country-driven” processes have policies and laws that undermine human rights, including the rights of people living with and vulnerable to HIV, the Global Fund—if true to its human rights commitments—should interrogate its policies and decide whether something other than a *laissez-faire* strategy is called for. Indeed, the Global Fund has numerous regulations and recommendations for funding applicants, many of which are explicitly geared to enhance the human rights grounding of HIV responses.

The objective of this paper is to examine the human rights content and impact of the Global Fund’s work in three areas—grant-making processes, grants, and advocacy, especially to see how this unique institution manages the balancing act to which its principles lead. Without pretending to have conducted an exhaustive investigation, we examine some experiences of empowerment of criminalized and marginalized persons living with and vulnerable to HIV in Global Fund processes and ways in which these processes have and have not resulted in human rights-friendly changes in policy and national decision-making. We also consider both the ways in which Global Fund support has strengthened legal and human rights activities and the ways in which it may inadvertently have reinforced activities or institutions that undermine human rights. Finally, we consider the way in which public advocacy by the Global Fund has advanced human rights responses to HIV.

That Global Fund grantmaking, proposal processes, and advocacy have made a positive difference for the cause of scaled-up rights-based responses to HIV in many countries is clear. People living with HIV and those at risk, including people whose

participation is challenged by criminalization and social exclusion, have been meaningfully included in Global Fund processes in some countries, though there is much more to be done. Global Fund grants have supported legal assistance and other direct human rights activities in some cases, though in relatively few compared to the need. In a few countries, Global Fund support to services in institutions such as detention centers for people who use drugs raises human rights concerns. Nonetheless, there are many achievements, including recent efforts to improve the capacity of country coordination mechanisms on gender-related human rights issues.

We offer some suggestions for how the Global Fund might build on this progress, including in the following areas:

- ▶ dealing with applicants in countries with laws that criminalize homosexuality, sex work, possession of drug paraphernalia, and minor drug crimes;
- ▶ sharpening the Global Fund's already significant work in the area of gender-based human rights;
- ▶ evaluating the application of the relatively new Global Fund policies on Community Systems Strengthening and Dual Track Financing with an eye toward human rights impact; and
- ▶ addressing the case of countries that give priority to compulsory drug treatment and other programs that undermine human rights.

I. Introduction

We call on the Global Fund, the World Bank and other donors to support action to address human rights abuses as a central element of HIV/AIDS programs and to—by December 2006—increase funding for programs to eliminate human rights abuses against people living with and at high risk of HIV/AIDS—including sexual and gender-based violence; discrimination; and violations of the right to complete and accurate information about HIV/AIDS prevention, treatment and care.

—“A call for political leadership: community sector recommendations for the UN Political Declaration of HIV/AIDS,” by 253 civil society organizations, May 2006 (see ICASO, 2006)

Admittedly our dual commitment to human rights and to country ownership sometimes poses challenges, particularly when countries fail to implement rights-based policies and programs or have policies that undermine human rights. But one thing is clear: we do not support interventions that are not evidence-based or that infringe human rights.

—Michel Kazatchkine, Executive Director of the Global Fund (June 11, 2010)

The statements above reflect the importance of human rights-based interventions in the global response to HIV/AIDS. It is widely recognized that basing HIV programs and policies in human rights principles has been a crucial part of success against the epidemic (UN General Assembly 2009). Experience in country after country has shown that empowerment of people living with and vulnerable to HIV as autonomous actors in the HIV/AIDS response is the difference between marginalizing, top-down programs and ones that are effective and sustainable. Because those most affected by HIV include women facing gender-based subordination, people who use illicit drugs, sex workers, gay and bisexual men, prisoners and migrants, a rights-based HIV response means grappling with hard issues of criminalization, sexism, homophobia, moral judgmentalism, unjust criminalization, and cultural norms.

In less than ten years of work, the Global Fund has not only provided billions of dollars worth of funding for AIDS programs, but also created processes and collaborations that have opened doors to meaningful participation in AIDS programming for people living with and vulnerable to HIV. The Global Fund has also become an important advocacy voice on the global AIDS scene, including on challenging human rights issues. While the programs supported by the Global Fund are derived

from country-driven processes and not conceived by the Global Fund in Geneva, the Fund is nonetheless in a position to shape HIV responses to some degree. At many points, it has had and will continue to have the choice to proceed in rights-based or non-rights-based directions. Those choices are likely to be very important for the future of HIV and those affected by it.

The objective of this paper is to examine the human rights content and impact of the Global Fund's work in three areas—its grantmaking processes, grants, and advocacy. We examine some experiences of criminalized and marginalized persons living with and vulnerable to HIV in Global Fund processes and ways in which these processes have and have not resulted in human rights-friendly changes in policy and national decision-making. We consider both the ways in which funded grants have supported legal and human rights activities and the ways in which they may have inadvertently supported activities that undermine human rights. Finally, we consider the way in which advocacy by the Global Fund has advanced human rights responses to HIV and identify opportunities for future advocacy.

II. Methods

A wide search was conducted of published and grey literature on the Global Fund, its processes, and the programs it has funded. Researchers and NGOs have documented country coordinating mechanism (CCM) processes in a number of countries, as have the Global Fund and its formal evaluators; these reports have been consulted. In addition, we interviewed key informants, including members of country coordinating mechanisms, persons involved as grantees or sub-grantees in Global Fund-supported work, NGOs that have observed Global Fund processes, and staff of the Global Fund secretariat. A selected group of persons who have participated in Global Fund processes responded to a structured questionnaire on human rights elements of those experiences. Time did not permit a more exhaustive assessment, but we hope that the issues raised in this report will lead to further investigations both within the Global Fund and by independent observers.

III. Functioning and Principles of the Global Fund

III.A Principal Structures

The Global Fund, in its own words, is a “public-private partnership dedicated to attracting and disbursing additional resources to prevent and treat HIV/AIDS, tuberculosis and malaria” (see www.theglobalfund.org, where additional basic information can be found). It describes itself as a new kind of collaboration among “governments, civil society, the private sector and affected communities.” The Global Fund does not implement programs but rather is a financing mechanism that funds technically sound and evidence-based proposals developed usually by **country coordinating mechanisms (CCM)**, which are meant to include government, private sector, key affected populations, and civil society representatives concerned with the health problem in question. The CCM is generally not a program-implementing body but rather is charged with preparing and submitting proposals to the Global Fund, nominating the program implementors, and overseeing the implementation of any funds granted. The Global Fund’s legal grant agreements are with one or more **principal recipients (PRs)** designated by the CCM, which are the chief implementing partners and may in turn make agreements with service-providing **sub-recipients (SR)**.

All eligible proposals are considered by the **Technical Review Panel (TRP)**, an independent group of experts, which assesses proposals for their soundness of approach, feasibility, and potential for sustainability and impact. The TRP then makes funding recommendations to the Global Fund Board. With respect to “soundness of approach,” the TRP is instructed to consider whether a proposal addresses:

issues of human rights and gender equity and use[s] human-rights based approaches to address the three diseases, including by contributing to the elimination of stigmatization of and discrimination against those infected and affected by tuberculosis and HIV/AIDS, especially populations that are marginalized or criminalized, such as injection drug users, men who have sex with men, transgender communities, sex workers and other key affected populations.

(Global Fund 2010e: 9)

The TRP is also instructed to consider whether the populations listed in the quotation above as well as women, girls, and youth, are given “due priority” and appropriately targeted in programs proposed for Global Fund support (Ibid.).

The Global Fund **Board** includes representatives from “donor and recipient governments, civil society, the private sector, private foundations, and communities living with and affected by the diseases.” The Global Fund **Secretariat** in Geneva manages grant portfolios, including releasing funds and overseeing monitoring and evaluation of funded activities.

III.B Requirements, Recommendations, and Guidelines for CCMs

The Global Fund’s “framework document” expressing its fundamental principles notes that it bases its work on “programs that reflect national ownership and respect country-led formulation and implementation processes” (Global Fund undated-3: 1). The founding principles of the Global Fund also include that it will support proposals that:

- ▶ strengthen the participation of communities and people, particularly those infected and directly affected by the three diseases;
- ▶ are consistent with international law and agreements, respect intellectual property rights, such as TRIPS, and encourage efforts to make quality drugs and products available at the lowest possible prices for those in need [...and]
- ▶ aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children, and vulnerable groups.

The founding principles also underscore that the Global Fund itself is not a program implementing body (Ibid.: 3).

The vast majority of Global Fund grants are in response to proposals from CCMs, which are the principal drivers of the “country-driven” processes to which the Global Fund entrusts program development. Because CCMs are the primary vehicle through which funding is requested and channelled, it is important to examine their structure and processes.

As of Round 9, “CCMs are recommended to include representatives from key affected populations in their membership” (Global Fund 2008a:4). Or, as the CCM guidelines state with respect to “vulnerable and marginalized groups,” the Global Fund “strongly encourages CCMs to consider how to improve the representation and participation of representatives from such groups on the CCM, taking into account the scale of the national epidemic of the three diseases and the key affected populations...” (Global Fund 2008b:3). Based on the UNAIDS definition, the Global Fund

defines key populations to include “women and girls, youth, men who have sex with men (MSM), injecting and other drug users, sex workers, people living in poverty, prisoners, migrant laborers, people in conflict and post-conflict situations, refugees and internally displaced persons” (Ibid.). To this list the Global Fund has since added transgender persons (Global Fund 2009a).

CCMs are required to include a member who is living with HIV. This requirement is one of six minimum requirements for eligibility of applicants, which were established at the November 2004 meeting of its board and updated at the April 2006 meeting. The other five are as follows (Global Fund undated-4:2):

1. CCM members from the nongovernmental sectors “must be selected by their own sector(s) based on a documented, transparent process, developed within each sector.”
2. CCMs must have a “transparent, documented process to solicit and review submissions” that might be integrated into a Global Fund proposal.
3. CCMs must have a “transparent, documented process” to nominate PRs and oversee program implementation.
4. CCMs must have a “transparent, documented process” to ensure that proposal development and grant oversight benefit from the input of a “broad range of stakeholders.”
5. CCMs must have a written plan to avoid conflict of interest if the PR and the CCM chair or vice-chair are from the same institution.

These requirements, except possibly the last, are important to meaningful participation of marginalized persons in Global Fund processes and, in turn, the development of rights-based interventions. Number 1 on this list, for example, addresses the case of a CCM dominated by government that wants to limit CCM participation to NGOs that are friendly or not threatening to government rather than including those that best represent the interests of their constituencies.

The Global Fund also has channels by which non-CCM entities can apply for grants. These entities include regional (or multi-country) coordination mechanisms (RCM) and regional organizations (RO), which are required to show approval from the CCMs of the countries included in the regional proposal. In addition, nongovernmental organizations can apply for grants in three circumstances:

- ▶ when there is no legitimate government in the country;
- ▶ when the country faces conflict or natural disaster; or
- ▶ when countries have suppressed or failed to establish partnerships with civil society entities (Global Fund undated-3, point VI.B.7).

As discussed below, organizations representing the most marginalized and criminalized persons affected by or at risk of HIV are likely in many countries to be among those with which governments have not established partnerships.

As of Round 8, applicants may also include support for Community Systems Strengthening (CSS) in their proposals. CSS funding is intended to support activities that contribute to “strengthening of community-based organizations (CBO) in order to improve knowledge of and access to improved health service delivery” (Global Fund 2008d). CSS funds may be applied to building capacity of CBOs for management, strategic planning, monitoring and evaluation, and other basic organizational functioning. The CSS guidelines specifically recognize the capacity challenges of organizations of “key affected populations,” “including people who may not be visible to existing service access points due to geographic, social or other factors” (Ibid.). Another initiative important to civil society is “dual track financing” by which, as of Round 8, the Global Fund recommends that CCMs routinely include both government and non-government entities as principal recipients (Global Fund 2008h). Again, the Global Fund recognizes this initiative as a means of addressing the exclusion of “key affected populations” (Ibid.).

III.C Gender-related Strategies and Actions

The Global Fund has in recent years made explicit efforts to improve its policies and performance in gender-related human rights, including both the rights of women and girls and what the Global Fund characterizes as rights related to sexual orientation and gender identity (SOGI). For the Global Fund, SOGI concerns are focused on men who have sex with men (MSM), transgender persons, and sex workers (male, female, and transgender) as “people whose sexual orientation, gender identity and/or sexual behaviors do not conform to majority norms and values” (Global Fund 2009a). The Global Fund Board adopted two gender-related strategies, described below, which “seek to secure an empowering environment for action rather than prescribe programmatic content” (Global Fund 2010a).

The strategy on “gender equality,” which focuses mostly on the rights of women and girls, was adopted by the Board in 2008. As of Round 8, which was opened for proposals in 2008, applicants were requested to:

- ▶ provide sex-disaggregated data in their epidemiologic situation analyses;
- ▶ in identifying constraints and gaps, provide a gender analysis of vulnerability to disease, seeking of and access to health services, service options, provider experiences, and health outcomes;
- ▶ identify and use gender-sensitive indicators in planning, programming, and monitoring and evaluation; and

- ▶ include a statement on the capacity and expertise of CCM members on gender issues (Global Fund 2008e).

The SOGI strategy was adopted only in May 2009. It proposes a series of actions as of the upcoming Round 10, including:

- ▶ a request to CCMs for an evaluation of their own capacity on SOGI (as well as gender), which will be passed on with the proposal to the TRP, and technical support for those CCMs unable to perform this evaluation;
- ▶ technical support for CCMs on SOGI-related rights and mentoring for CCM members representing the needs of SOGI populations;
- ▶ inviting non-CCM country and multi-country proposals where it is argued that the relevant CCM or regional coordinating mechanism “has insufficient operations, membership or capacity to understand the needs of MSM, transgender and sex workers...,” with the understanding that non-CCM routes are “intended to be interim and exceptional” (Global Fund 2009a:10); and
- ▶ enhance the SOGI technical capacity of the TRP.

In addition, the strategy says that the Global Fund will work with in-country partners “to raise the discussion of the role of criminalization of consensual adult homosexual behaviours as a potential barrier to effective health interventions” (Ibid.:16). It recognizes that advocacy in this area is a responsibility of “Global Fund leadership at the highest levels” (Ibid.).

As part of the Global Fund’s enhanced focus on gender, the Secretariat added a senior gender advisor, a senior advisor on sexual and gender diversity, and a gender technical officer, who work with an internal gender task team chaired by the director of the Strategy, Policy and Evaluation Cluster (Global Fund 2010a). In addition, the Technical Review Panel added five new members in 2009 recruited for their expertise in gender-related aspects of health, and the TRP was briefed on gender and SOGI subjects before Round 9 (Global Fund 2009b).

III.D Most at Risk Populations (MARPs) in Round 10

The Round 10 guidelines announced in May 2010 advise applicants that they may seek support from special reserve funds for activities focusing on what the Global Fund calls most at risk populations (MARPs) (Global Fund 2010g). MARPs are defined as follows:

- ▶ men who have sex with men, transgender people, and their sexual partners;

- ▶ female, male, and transgender sex workers and their sexual partners;
- ▶ people who inject drugs and their sexual partners (Ibid.: 2).

The guidelines note that this special provision for Round 10 preserves funding for services for persons at high risk of HIV “in the event that there are insufficient resources available to approval all TRP-recommended proposals” (Ibid.: 1).

III.E Guidelines Related to Programs on HIV and Drug Use

As of this writing, the Global Fund does not have a published strategy on funding for programs linked to HIV and drug use in the way that it has gender and SOGI strategies that have been accompanied by guidelines for proposal development. But in 2010 it produced an “information note” on harm reduction that emphasizes the importance of a “comprehensive package of interventions” for HIV prevention, treatment, and care of people who inject drugs (Global Fund 2010f). This package includes needle and syringe programs, opioid maintenance therapy and other treatment of drug dependence, HIV testing and counselling, antiretroviral therapy, prevention and treatment of sexually transmitted diseases, access to condoms, and hepatitis and tuberculosis interventions.

The information note emphasizes the importance of a rights-based approach to delivering services to people who inject drugs, both in the community and in prisons and other detention facilities. It urges Global Fund applicants to include in their proposals measures designed to improve the legal and policy environment for health services for people who inject drugs and access to justice for this population. Suggested measures include legal services for people who use drugs; reform of laws, policies, and police practices that violate the rights of people who use drugs and create barriers to access to HIV services; training for police, judges, and prison staff on drug use, HIV, and related human rights issues; and programs that help people who use drugs to know their rights.

IV. Integrating Human Rights in the Processes of the Global Fund

IV.A Representation of Key Affected Populations in CCMs and Funded Proposals

As noted above, most of the six requirements for CCM composition and processes may facilitate participation of persons living with or vulnerable to HIV who face human rights challenges. The Screening Review Panel (SRP) of the Global Fund reviews compliance with these requirements and determines eligibility of applicants to be referred to the TRP. According to the SRP reports on proposals for Round 8 and Round 9 of funding, these requirements have been met by a significant majority of applicants. Some 73 of 88 CCM applicants (83 percent) in Round 8 were judged to be fully compliant with these rules and the rest either partially or not compliant (Global Fund SRP 2008). In Round 9, 82 percent were finally judged to be compliant (Global Fund SRP 2009).

All but one of the 88 CCM applicants in Round 8 complied with including people living with HIV and, after deliberations, all of the 118 proposals from Round 9 complied. This is a remarkable achievement toward inclusion of people living with HIV (and tuberculosis and malaria) in national program development.

As to selection of NGO members by their own constituencies with transparent processes, in Round 8, nine applicants (10.2 percent) were not fully compliant (or not judged compliant at first, though the judgment may have changed after explanations) (Global Fund SRP 2008). These ranged from the extreme case of the Democratic People's Republic of Korea where "there is a general absence of the civil society sector" to others where documentation of the selection process was poor or NGOs seemed to have been picked by the CCM rather than chosen by any broad constituency (Ibid.). In Round 9, of 118 proposals, six were originally found to be deficient in transparent selection processes, including the CCMs of Iraq, Syria, Yemen, and Haiti (Global Fund SRP 2009). The results of these latest rounds were an improvement over the findings of the year-five evaluation of the Global Fund, which found that 52 percent of NGOs on CCMs were chosen through good processes (Global Fund 2005a).

To the degree that NGOs generally face challenges in achieving meaningful participation in CCM processes, those challenges are likely to be more acute for

organizations representing women, people who use illicit drugs, sex workers, men who have sex with men, migrants, prisoners and former prisoners, and others who may be especially vulnerable to HIV—that is, the core of the Global Fund’s “key affected populations.”

IV.A.1. Women’s Rights

In too many countries, women and girls continue to be subject to violence, denied sexual and reproductive health services, property and inheritance rights, and the basic means to protect themselves from HIV. This must change, and I am committed to ensuring the Global Fund is part of the solution.

—M. Kazatchkine (June 11, 2010), Toronto

As has been extensively observed elsewhere, compounding women’s and girls’ biological vulnerability to HIV is their subordination with respect to such factors as sexual autonomy in the household; legal disempowerment in inheritance, property-holding, right to initiate divorce, and other elements of marriage law; domestic violence; and lack of autonomy in seeking health services. Women’s rights advocates have called for more attention to these factors in national HIV responses and have bemoaned the lack of progress in this area (Dworkin and Ehrhardt 2007).

Funding for rights-based interventions to address women’s vulnerability to HIV could include the following:

- ▶ Legal assistance to help women own and inherit property, seek protection from violence, receive maintenance following divorce or dissolution of a marriage, and gain access to social benefits;
- ▶ Reform of laws and practices that discriminate against women in any of these areas;
- ▶ Reform of legal frameworks that do not adequately protect against gender-based violence;
- ▶ Protecting the rights of women in sex work;
- ▶ Training of police and medical personnel in proper handling of gender-based violence cases, including provision of post-exposure prophylaxis (PEP);
- ▶ Training of judges and cultural structures in fair adjudication of property rights cases in accordance with human rights principles;
- ▶ Interventions with health workers to ensure informed consent in HIV counselling and testing, and to prevent grave abuses such as forced sterilization of women living with HIV; and

- ▶ Strengthening of civil society organizations advancing women's human rights

Some of the above measures are mentioned as suggested activities for inclusion in proposals in an information note on “women, girls and gender equality” produced with Round 10 application materials in 2010 (Global Fund 2010j).

Activities initiated under the Global Fund's gender strategies do not have a long enough history to judge their impact. In early funding rounds, before the Global Fund's in-depth discussions leading to the adoption of the gender strategies, CCMs were asked to take into account “gender inequalities” in their proposals: “A specific focus should be given to the modalities for mainstreaming gender equality through gender analysis and planning...” (Global Fund 2002:8). Again, before the Global Fund had gender strategies, a number of analyses suggested that CCM proposals were falling very short in these areas.

In 2008, Aidsplan reviewed the ways in which women's and girls' concerns were embodied in the activities proposed by CCMs. Its review of the 211 approved CCM proposals from countries in sub-Saharan Africa in Rounds 1 to 7 found that for the most part women figured in HIV proposals mostly through mother-to-child transmission activities and occasionally stigma reduction, though the latter was not always specific to women (Kageni and Garmaise 2008:7). Only three of these 211 proposals included activities related to legal and human rights of women and girls (Ibid.:8). Only one proposal had a focus on developing and promoting gender-sensitive policy (Ibid.).

The Association for Women's Rights in Development (AWID) monitors funding for women's rights organizations, including in efforts related to HIV. In its first major report on funding for women's rights organizations in 2006, AWID was not optimistic that CCM processes would be conducive to generating funding for women's rights, even though subordination of women was well recognized as an important determinant of HIV risk (Clark et al. 2006). It is a constant refrain of AWID's reports that the trend of running bilateral and multilateral support for women's rights through government mechanisms or government-dominated mechanisms, especially in Africa, has been detrimental to sustained grassroots action on women's rights (Kerr 2007).

In response to the lack of inclusion of women-focused activities in Global Fund projects, the Open Society Foundations in 2007 hired three consultants to work with coalitions of women's groups in eight countries in eastern and southern Africa to strengthen their participation in CCM processes and ultimately the inclusion of women's issues in Global Fund proposals (Amakobe et al. undated). The experiences in the eight countries varied, but the consultants noted that in many cases there was little understanding on the part of many CCM members of the basic link between women's rights and HIV (Ibid.). They also noted that the coalitions of women's groups, while competent and active, frequently lacked the specialized capacity to

develop Global Fund proposals and budgets. A conclusion from this experience was the need for long-term investment in building capacity of women's groups to make strategic alliances, develop programs and proposals, improve their program management capacity, and otherwise to be better positioned to participate in CCM processes (Magome 2009). In spite of these challenges, eight of the ten participating coalitions of women's groups managed to have programs included in CCM grants and receive Global Fund support.

AWID raises an important concern for the future of women's rights advocacy, which is that many multilateral and bilateral donors and national governments, through their performance-based indicators, force women's rights groups into service delivery modes at the expense of advocacy activities (Clark et al. 2006; AWID 2008a). The assessment by the International Treatment Preparedness Coalition (ITPC) of CCM experiences echoes this conclusion (ITPC 2008). It is plainly not in the interest of supporting women's rights in HIV responses for the Global Fund or any donor to have processes that discourage human rights advocacy by this key affected population. Indeed, human rights advocacy usually involves challenging governments, and government officials on CCMs may perceive it as an impediment to meeting program goals. The recent gender "information note" (Global Fund 2010j) encourages inclusion of rights advocacy elements that may be indicated by gender analysis. It remains to be seen whether such encouragement is sufficient to make a difference.

AWID also notes that "gender mainstreaming," the strategy preferred by the Global Fund (see Global Fund 2008f), is regarded as detrimental by many women's rights organizations because it effectively eliminates budget lines for women's rights work that does not adequately emerge from "mainstreamed" activities. Nonetheless, in its most recent assessment, AWID expresses that hope that the dual track financing policy, which strongly recommends that CCMs designate at least one PR from civil society, will open new opportunities for women's rights funding through CCMs (AWID 2008b). Other NGOs are hopeful that the recent emphasis on integration of HIV and reproductive health programs in Global Fund proposal guidelines will also be an avenue for increasing resources to women's rights activities (Hardee et al. 2009).

Meaningful representation of women on CCMs is one step toward enhancing women's rights content of CCM proposals. As AWID has noted, simple presence of women as CCM members is not helpful in moving a women's rights agenda forward unless the women in question understand the importance of women's rights for HIV responses and how to strengthen women's rights in pertinent ways. "By having a woman on the CCM it can appear that the Fund is integrating gender equality into its framework, but when the woman is not a gender equality advocate or much less represents women's organizations, then these issues might get left behind" (AWID 2008a:9). In any case, as of early 2008, there was information on the gender composition of about 80 percent of the CCMs and, of these, 33 percent were women (ranging from 16 percent in southwest Asia to 41 percent in southern Africa) (Kageni

and Garmaise 2008:36). Some 21 percent of the CCM chairpersons were women as were 29 percent of the vice-chairs (information available from about 70 percent of the CCMs at the time) (Ibid.). As noted above, CCMs are now asked about both the gender composition and the gender expertise of their members.

Challenges in making women's rights central to HIV responses through CCM processes remain. A representative of a sub-recipient in a southern African country who preferred to remain anonymous told us that achieving serious consideration of violence against women as part of national strategies as well as in CCM deliberations remains a crucial challenge (Anonymous, personal communication). According to this NGO representative, violence against women is recognized by CCMs in superficial ways, not enough to warrant significant budgetary support. The few organizations that work in this area—in some countries there is only one—are sometimes forced to try to integrate gender-based violence activities into other service areas that are better funded and less controversial.

Women's groups have submitted non-CCM proposals in some cases when CCMs did not incorporate their concerns. An example is the Round 1 grant awarded directly to the Kenya Women's Organization against AIDS (KENWA), which reported difficulties in gaining CCM acceptance of its community-based programs for women living with HIV and caring for others affected by HIV (KENWA 2002; Duvvury et al. 2005).

IV.A.2 “SOGI” Rights Issues (Including Sex Workers)

Marginalization and criminalization of men who have sex with men (MSM), transgender persons, and sex workers compound their vulnerability to HIV infection and impede their access to HIV services in many places. Accordingly, substantial public health benefits could be expected from investing in the following types of human rights strategies for these populations:

- ▶ Reform of laws that criminalize sex work, sodomy, and other acts that expose sex workers and MSM to arrest and prosecution;
- ▶ Legal aid for these populations, particularly to fight criminal charges and prevent incarceration and its attendant health risks;
- ▶ Interventions to prevent and punish rampant police violence and harassment of both these populations and the outreach workers who try to reach them with HIV services;
- ▶ Interventions to address deep social stigma against these populations, as well as forms of official prejudice by government actors that feeds this stigma; and
- ▶ Strengthening of human rights organizations working on behalf of MSM, transgender persons, and sex workers.

Box 1. Senegal: Fighting Entrenched Exclusion Through Civil Society Courage

In December 2008, nine men involved in HIV prevention work were arrested in a police raid of the home of an HIV outreach worker in Dakar, Senegal, on the suspicion that they violated the “unnatural acts” provision of Senegal’s criminal code – that is, they were accused of homosexuality. The police confiscated the condoms and lubricant that were part of their HIV prevention work. Human Rights Watch reported that the men were beaten in custody. They were sentenced to eight years in prison, but following intensive local and international advocacy, including a public statement from the Global Fund Secretariat, they were released. This incident followed the 2008 arrest of five men who had been photographed at an “unofficial” wedding of two men.

It is ironic that in spite of this record of repression of a population heavily affected by HIV, Senegal has drawn widespread praise for its HIV response. HIV prevalence remains below one percent in the adult population, and there is in principle free antiretroviral therapy for all who need it. But the HIV response is plainly undermined by criminalization of men who have sex with men, who live in fear and rely on a few courageous organizations for HIV information and services. Senegal’s epidemic is concentrated among MSM and also sex workers; in both groups HIV prevalence is estimated at about 20 percent. Sex work is not illegal, and about 20 percent of sex workers are registered with the government and eligible for health care in the public sector. The majority of sex workers choose not to be registered because of the stigma attached to sex work, and they face stigma-related barriers to health care.

In 2004, five NGOs of those that had worked to offer services to these marginalized persons formed a coalition called *l’Observatoire de la réponse au VIH/SIDA au Sénégal* (“Watchdog of the response to HIV/AIDS in Senegal”) to shape their common experience into a public critique of the national AIDS response. They pointed out the futility of a national response, as articulated in the 2002–2006 national HIV/AIDS plan, that accorded virtually no funding to services for MSM and very little for sex workers though these were the most affected persons. They protested that the NGOs selected by the government as part of the National AIDS Council did not adequately reflect the interests of MSM and sex workers.

At about the same time, a CCM was formed to seek Global Fund support for HIV programs. Thanks to advocacy from the *Observatoire* groups, the NGO Alliance nationale contre le SIDA (ANCS) was chosen as one of the principal recipients for the Round 1 Global Fund grant. ANCS has channeled

funds to organizations that work with MSM and unregistered sex workers. The performance report for the Round 1 grant indicated that 100 percent of MSM and sex workers targeted for services were “fully involved and benefited from the program.” The government’s national HIV/AIDS plan for 2007–11 also included a focus on MSM and sex workers.

NGOs remain concerned, however, about the still inadequate level of support for work with marginalized MSM and sex workers and the sustainability of that work when Global Fund support stops. Their struggle continues to get government acceptance of and support to HIV services for these populations, as well as to change the criminal law or at least modify the way it is enforced. According to CCM member Daouda Diouf of the NGO ENDA, NGOs have undertaken research to quantify the public health impact of working respectfully with MSM and sex workers and removing barriers to their care and support. Civil society seeks the support of international organizations, including the Global Fund, as the results of these investigations are published and disseminated.

Sources: Dessibourg (2010); O’Neil (2010); Diouf (2007); Global Fund (undated); D Diouf, personal communication (2010); Global Fund grant performance report (2009d).

According to a Global Fund review, 78 percent of proposals submitted in Round 8 and 79 percent in Round 9 included at least one project activity meant to assist MSM, transgender persons, or sex workers (Global Fund 2010b). Furthermore, in Round 8, 10 percent of CCM proposals had some SOGI-related activities; the figure for Round 9 was 27 percent (Ibid.). (The Round 9 figures may reflect some of the early effort associated with the new SOGI strategy, which was adopted in 2009.) As with legal and human rights activities for women discussed above, however, relatively few of these proposals included direct human rights interventions for SOGI populations. In Round 8, three proposals of 83 (3.6 percent) included activities touching on SOGI-related legal issues; in Round 9, the figure was 13 of 80 proposals (16 percent) (Ibid.:37). The Global Fund analysis of the SOGI content of proposals in these two rounds makes the salient point that the TRP looked more favourably on those proposals that incorporated consideration of structural barriers to health services, including human rights violations, in the design of project activities than those that did not (Ibid.:47; see also Garmaise 2010:28). Proposals that included community systems strengthening activities for SOGI populations also had more favorable outcomes in the TRP.

In Round 9, the Global Fund approved a \$47 million non-CCM South Asia regional grant to strengthen community-level responses to HIV among MSM and transgender persons (Naz Foundation et al. 2010). The approved proposal includes significant focus on legislative and policy advocacy as several of the countries covered by the proposal—including Afghanistan, Bangladesh, Pakistan, and Sri Lanka—criminalize homosexuality (Ibid.). Where community-level organizations do not exist to mount advocacy initiatives against this criminalization, the project will seek to build them. Population Services International, the principal recipient of this grant, said that it comes at a time of great urgency to address a growing HIV crisis among MSM in the region (Ibid.). A Round 7 attempt on the part of this coalition to obtain regional funding was rejected because the NGOs involved were unable to demonstrate that they had sought endorsement from the CCMs of the countries included in the proposed activities (Fried and Kowalski-Morton 2008).

Some experiences suggest, not surprisingly, that there is a direct relationship between representation and participation of marginalized persons on CCMs and funds allocated to activities by and for them. This is the conclusion with respect to MSM, transgender persons, and sex workers of a 2009 report based on information from 15 Global Fund grants to eight countries and two regional entities in Latin America and the Caribbean in Rounds 1 through 7 (International HIV/AIDS Alliance 2009). Ecuador and Peru were the only countries to have sex worker representation on the CCM, and those were the only countries that received grants allocating funds to sex worker organizations (Ibid.: 12). Similarly, the CCMs in Ecuador, Peru, El Salvador, and Bolivia had gay men as members, and those were the countries in which gay men’s organizations were designated as sub-recipients. The report notes that the criminalization of homosexuality in the Caribbean countries, as well as strong government ownership of Global Fund processes in the sub-region, has made participation of SOGI populations in CCMs and RCMs very challenging (Ibid.: 20; see also Ciausova 2008).

Criminalization of sex work and homosexuality as a barrier to participation of MSM and sex workers in CCM processes has been documented outside Latin America as well. For example, Fried and Kowalski-Morton (2008) noted that in Botswana, the only NGO working centrally on LGBT rights in the country “has been barred by the government from registering as a legal entity, which also prevents it from receiving donor funding” and makes “accessing Global Fund resources or participating in country-level decision-making processes...near impossible” (p. 1). This is not an isolated case. These authors’ analysis of 65 CCMs found that only five of the 65 included members who were representatives of LGBT organizations (Ibid.). While in some cases organizational allies can represent the concerns of criminalized persons, those allies are not always present or able to convey the lived experience of those most affected.

The Global Fund’s inclusion of transgender persons in the SOGI strategy recognizes both the high prevalence of HIV that has been documented in this popu-

lation in some countries and the extreme stigma and sometimes criminalization that transgender persons face. The International HIV/AIDS Alliance report on the Americas cited above noted that in this region where transgender NGOs are becoming more numerous and visible, only the CCMs in Argentina and Nicaragua had designated a seat for a member who would represent transgender concerns (International HIV/AIDS Alliance 2009:19). The Global Fund SOGI review noted that five Round 8 proposals included specific elements related to services for transgender persons, but none of those gained TRP approval (Global Fund 2010b:40).

Some CCMs and civil society working within them have managed to overcome such steep barriers in these areas, at least to some extent. As recounted in Box 1, courageous civil society leadership resulted finally in financial support reaching gay men's and sex worker organizations for HIV activities in Senegal in spite of harsh criminalization of homosexuality and extreme stigmatization of sex workers. An NGO representative involved in CCM processes in Macedonia notes that with persistence, the CCM has been able to see the value of supporting human rights programs for sex workers, which would have been unlikely to happen otherwise (S Velkovska, personal communication). Improved representation of marginalized persons on the CCM can have many effects beyond funding flows. In Argentina, inclusion of sexual minority interests in the CCM is credited by civil society with having sown the seeds for "a change in attitude toward diverse sexual identities" among health service providers (ITPC 2008:15).

As Fried and Kowalski-Morton (2008) note, persons criminalized because of sexual identity or gender orientation may have to rely on allies to have their interests represented in CCM processes. United Nations agencies, which are represented on most CCMs, have human rights as a founding principle and should be allies in this regard. In Jamaica, a country where criminalization of and social disdain for homosexuality have resulted in heinous hate crimes, assistance from the local UNAIDS office at a key moment contributed to improved CCM processes and civil society representation (see Box 2). Responding to concerns of a wide range of civil society actors, the CCM in India also made a number of changes that may open the door to improved consideration of gender- and SOGI-based marginalization (Box 3).

IV.A.3 Drug Use and Harm Reduction

People who use drugs offer a dramatic example of the importance of integrating human rights interventions into HIV responses. The over-reliance on criminalization and law-enforcement approaches to drug use in countries with injection-driven HIV epidemics results in rampant police violence, over-incarceration without due process in detention environments that fuel HIV infection, and legal and policy restrictions on harm reduction programs such as needle exchange and substitution

treatment. The Global Fund’s “Information Note on Harm Reduction” (2010f) notes that the public health impact of these laws, policies, and practices could be mitigated by the following types of human rights interventions:

- ▶ reviews of laws, policies, and practices related to injecting drug use and HIV, with a view to changing those that create barriers to effective prevention, treatment, and care and/or violate human rights;
- ▶ programs to address the double stigma and discrimination related to HIV and drug use;
- ▶ training and/or sensitization for police, judges, and prison staff in evidence and human rights-based approaches to drug use and HIV;
- ▶ social mobilization and campaigns for people who use drugs to better understand the law and their rights;
- ▶ legal aid/assistance for people who use drugs, ideally integrated in health services; and
- ▶ support to ensure that basic needs and underlying psycho-social vulnerabilities are addressed.

In both health and human rights terms, the sheer volume of Global Fund support that has flowed to harm reduction services for people who use drugs, including syringe exchange and methadone therapy, is in itself an important achievement. Recognizing that “drug users continue to be overlooked by CCMs or are not meaningfully engaged in decision-making,” Global Fund staff note nonetheless that the \$180 million the Fund invested in harm reduction services for drug users in 42 countries through 2009 has been a major leap forward for this neglected population (Atun and Kazatchkine 2010). Experts not associated with the Global Fund have credited it with strengthening and expanding needle exchange services in many countries of Eastern Europe and Central Asia in a hostile political environment and at a time when other funding for syringe programs was very difficult to find (Sarang et al. 2007). Similarly, Global Fund support has facilitated some level of expansion of methadone programs in several countries (Ibid.). Global Fund support assisted the growth of methadone programs in Kyrgyzstan, including the ground-breaking expansion of methadone into a prison (Global Fund 2009f). (See also Ukraine and China examples in section V.B.)

It is noteworthy that Global Fund support has assisted NGOs in places where civil society, including groups of people living with HIV and drug users, has found it difficult to thrive. In Uzbekistan, where in recent years many NGOs, especially human rights organizations, have been shut down, Global Fund processes and funding are credited with enabling a network of PWA support groups—which include members who use drugs—to function for the first time in eight regions of Uzbeki-

stan (IRIN 2006). The Global Fund leadership has pledged to work to strengthen representation of organizations of people who use drugs and harm reduction organizations on CCMs and “to generate further demand for programs supporting dissemination of evidence to increase awareness on the cost-effectiveness of harm reduction” (Atun and Kazatchkine 2010:3).

As with the populations discussed above, funding flows are linked in part to representation of the concerns of people who use drugs on CCMs (as well as to CCM expertise, TRP expertise, and other factors). As of December 2009, in Eastern Europe and Central Asia, 10 of 23 countries receiving Global Fund HIV grants had CCMs that included organizations working explicitly on harm reduction (Atun and Kazatchkine 2010). Inadequate representation and inclusion of people who use drugs in CCMs has been cited in numerous NGO reports, including a 2008 report by the International Treatment Preparedness Coalition (ITPC) that was based on the experience of people involved in CCMs in seven countries (ITPC 2008). This report underscores that criminalized and severely socially marginalized populations are often the least likely to have the capacity and resources to participate in relatively complex and public processes like those of the CCM. They are the least likely as well to have the resources to network and strategize among themselves to make their participation in CCMs as effective as possible (Ibid.). For example, the concerns of people who use drugs were not judged by the ITPC researchers to be represented adequately on the Cambodia CCM even though drug injection is an important means of HIV transmission (Ibid.:18,20). This CCM, further, has a large number of government representatives, and NGO representatives were fearful of raising controversial or sensitive issues.

The failure of CCMs to ensure meaningful participation of people who use drugs led to some of the first non-CCM grants awarded by the Global Fund. In Round 3, the Global Fund approved a \$1.3 million grant for an NGO coalition including the Raks Thai Foundation “to fill a gap left by the Thai government’s reluctance” to provide HIV treatment and prevention services for people who use drugs (Global Fund undated-1:34). The TRP recognized both the urgent need for harm reduction programs and the political factors behind the CCM’s rejection of these essential activities (Kerr et al. 2004). Another non-CCM grant awarded in 2004 to a coalition of five Russian NGOs funds a program known as GLOBUS that includes prevention and treatment services for people who inject drugs, sex workers, and MSM who had been neglected in government programs (Brown 2006). The work of GLOBUS has been credited with changing Russia’s national AIDS policy “through the lobbying efforts of the organizations it supports” and spurring the national government to greatly increase its funding for HIV programs (Ibid.:438–9).

Box 2. Improving CCM Processes with Help from an Ally

With respect to human rights, United Nations agencies should be supportive partners on the ground. CCMs normally include some representation from local UN offices, and all UN agencies have human rights mandates in some senses. Jamaica is a case in which assistance from the local office of UNAIDS helped to improve civil society representation, including representation of highly criminalized persons.

Homophobia is rampant in Jamaica, fuelled by the lyrics of popular songs, and resulting in heinous hate crimes, including the beating and killing of gay activists (Human Rights Watch 2004). Official participation of gay men's organizations in discussions on the national HIV response has been virtually impossible. For example, the Jamaican delegation to the UN General Assembly High-level Meeting in HIV/AIDS in 2008 excluded NGOs, a move decried by civil society organizations from many countries (SASOD). The ITPC investigation of CCM processes published in 2008 highlighted Jamaica as a case in which the few NGO members of the CCM complained that their participation was tokenistic, that they did not receive information and documents for CCM meetings in time to prepare, and that they did not even always understand the role of the CCM (ITPC 2008). The ITPC report also criticized the conflict of interest represented by the fact that the CCM chair was director of the National AIDS Committee and was a close colleague of the head of the PR, who directed the National HIV/STI Control Programme.

Civil society and government both sought to think about better processes, but it was difficult to know how to come together even to have an informal discussion. In the end, UNAIDS helped broker discussions, including helping to find a space and resources to ensure that everyone could participate (R Carr, personal communication). As a result of these discussions, NGOs through their Civil Society Forum—which includes J-FLAG, the premiere LGBT organization in Jamaica—managed their own election of CCM members for the first time, and the CCM was restructured to include dedicated seats for “key affected populations.” The new CCM includes a respected AIDS and LGBT advocate as a member. A Global Fund report also cited Jamaica as an example of a CCM with an improved conflict of interest policy by which all members will complete a form to disclose conflicts of interest and there will be an oversight committee to monitor conflict of interest concerns (Global Fund 2008i). It may be a long time before gay men in Jamaica can take their rightful place as citizens and enjoy full participation in civil society. NGOs acknowledged the help of the UNAIDS local office as the CCM took a few steps in that direction.

IV.B Transparent and Participatory Grantmaking Processes

According to Global Fund rules, CCMs should ensure that all key public and private stakeholders in public health in a country are involved in developing proposals and implementing funded programs (Global Fund undated-3). The CCM requirements noted above address the participation and transparency that the Global Fund seeks to instill in its grantmaking processes, including the way in which recommended projects are considered for inclusion in grant proposals and the eventual selection of PRs and SRs.

The same factors that can limit the participation of organizations representing people living with and vulnerable to HIV, including women and criminalized persons, can undermine their participation and ability to succeed in proposal review and recipient allocation processes (ITPC 2008). Organizations that are not legally recognized by governments, which is frequently the status of groups representing marginalized persons, often are less likely than other NGOs to have capacity to write polished proposals or even find the information needed to know when and how to submit proposals for consideration by a CCM. They are also less likely in some places to have the capacity to understand and use materials provided in English, as Cambodian NGOs have noted (ITPC 2008:21), and possibly also less likely to have access to the internet. Persons facing criminalization or deep stigma may be more reluctant than other NGOs to attend CCM meetings in a government building; some CCMs meet in government facilities (ITPC 2008:35).

It is undoubtedly true that many NGOs that find themselves on the CCM also do not do what they should to represent the full interests of their constituencies. Again, groups representing heavily marginalized or criminalized persons are even less likely than other NGOs to have the freedom or opportunity to network and strategize, or even to cultivate allies, to make the most of whatever level of participation they may have in CCM processes.

Even organizations with developed funding and infrastructure have expressed frustration with the complexity and heaviness of Global Fund processes. As Nathan Geffen of the Treatment Action Campaign (TAC) of South Africa noted, the Global Fund as a donor is “so complex that it has spawned an industry of expensive consultants with far too much power over the recipient organizations” (cited in Rivers 2008:17). However beneficial or detrimental the work of consultants may be in preparing CCM proposals, organizations representing socially marginalized and criminalized groups are unlikely to be able to hire them. Another NGO leader said that even for organizations with relatively good capacity to represent the challenges of their communities, a proposal “won’t be acceptable ...unless very high-level experts write it” (Ibid.:5). For organizations working on difficult human rights issues that “high-level experts” are unable to convey as well as those who live with human rights challenges, complex processes can be an instrument of exclusion.

Ensuring that entities named as PR and SR will implement grants in ways that adequately account for the rights and needs of marginalized populations is a particular challenge. Where a CCM is dominated by government and the PR is a government entity, criminalized populations may be likely to be excluded from funded activities, as in the case of SR selection by the National AIDS Programme, the PR, in Jamaica with respect to highly criminalized MSM (ITPC 2008). As noted in Box 2, it may be possible to overcome this barrier, but only with concerted advocacy and assistance from allies.

Box 3. The CCM in India Takes Steps to Improve NGO Representation

The India CCM has at times been criticized by civil society for barriers to NGO representation, including representation of LGBT interests, and government dominance of the proceedings (ITPC 2008). In 2009 the CCM was enlarged from 33 members to 40, increasing the number of civil society seats from five to eight (“Indian CCM...” 2009). In this case, the civil society seats were allocated by constituency—two for HIV/AIDS NGOs, two for NGOs working on tuberculosis, one for a malaria NGO, one for an NGO focused on gender or women’s rights, one for an NGO focused on sexual minorities, and one working on children’s issues (“Elections held...” 2009). At the same time, the CCM modified the process for election of members, devoting about US\$12,000 to hiring an independent agency that conducted a nationwide effort to identify NGOs that would be eligible to vote for CCM members, to get them registered to vote, and to oversee the web-based voting process (Ibid.). Over 1,600 civil society organizations registered to vote, and over 500 submitted their candidacy for CCM membership, of which about 100 were judged to have adequate documentation to support their candidacies (Ibid.).

An important milestone was the February 2010 election of Eloverthi Manohar, a noted activist for SOGI and sex worker rights and founding director of the Bangalore-based NGO Sangama, as CCM vice-chairperson (Sangama 2010). (Mr. Manohar’s election in the CCM came only months after the Delhi High Court struck down the country’s penal code provision criminalizing homosexuality as an “unnatural act.”)

V. Funding for Specific Legal and Human Rights Activities

Analysis of recent Global Fund applications shows that still relatively few countries include human rights programs in their proposals, such as long-term campaigns against stigma and discrimination, programs to combat violence against women, or legal services and law reform programs. But this is slowly changing, and we look forward to working with partners in encouraging further advances on this front.

—M. Kazatchkine (June 11, 2010), Toronto

For people for whom HIV risk or barriers to care and treatment are exacerbated by human rights abuses, access to legal assistance and to information about their rights may be as important as health services. In the long run, advocacy to make policy and legal environments friendlier to HIV services may be an essential intervention. Nongovernmental organizations providing HIV-related legal support have played an important role since the beginning of the HIV epidemic, and many Global Fund grantees have integrated legal or paralegal services into their programs with or without Global Fund support to meet the demand from clients.

UNAIDS (2009b) has identified several categories of program interventions that it sees to be directly related to addressing HIV-related human rights in national responses. These are:

- ▶ legal services for people living with HIV and those at risk;
- ▶ “know your rights” information campaigns;
- ▶ programs to reduce HIV-related stigma and discrimination;
- ▶ training of key service providers (e.g. health care workers, judiciary, and police) on non-discrimination, informed consent, confidentiality, etc.;
- ▶ legal audit and law reform programs; and
- ▶ programs to reduce violence against women and girls.

A study carried out by UNDP, the UNAIDS Secretariat, and the Global Fund in 2010 analyzed the frequency and other key aspects—such as beneficiary populations and budget size—of these interventions in successful HIV proposals and

grants in Rounds 6 and 7 (2006-2007) (UNDP 2010). This evaluation found that 95 percent of proposals included some effort to address stigma and discrimination, while only 32 percent proposed provision of legal services and 29 percent included legal literacy programs (“Know your rights/laws”). In these two rounds, programs specifically intended to benefit MSM and/or transgender people were featured in 21 percent of proposals, programs for sex workers in 23 percent of proposals, people who use drugs in 23 percent, migrants in 5 percent, prisoners in 14 percent, women in 12 percent and children in 19 percent of proposals (Ibid.). This study also found that 23 percent of the human rights programs featured in successful HIV proposals did not make it into the work plans agreed under the grant (and hence could not be implemented as they had no budget), and those that remained often had weak or no indicators against which program implementation or outcomes could be judged.

The Global Fund updated some of these figures for Rounds 8 and 9 (Global Fund 2010h). In Round 8, 25 percent of proposals and 33 percent of proposals in Round 9 included at least one of the interventions noted above with respect to any of the key populations (Ibid.: 51). Of the proposals that were funded, some 13 percent in Round 8 and 42 percent in Round 9 included at least one of these activities.

Some of these interventions are considered in more detail below.

V.A Legal Assistance and Rights Awareness (“Know Your Rights”)

Pro bono or affordable legal services for people living with or vulnerable to HIV are sometimes as crucial as medicine or health services, especially where HIV-affected or vulnerable persons are criminalized or socially marginalized. In diverse settings from China and Indonesia to Ukraine, Uganda, Kenya, and beyond, legal assistance services have played a crucial role in enabling access to HIV services for affected persons, especially in places where homosexuality, sex work, and drug use and possession are criminalized (Carey and Tolopilo 2008; Davis 2009; Kalla and Cohen 2007; Mukasa and Gathumbi 2008; Wan 2009). Many models of assistance have contributed to the realization of health rights of marginalized persons, including paralegals who are trained to accompany people to court or tribunals and give basic advice, stationing a lawyer in a needle exchange program or other health facility, and teaching persons vulnerable to arrest how to assert their legal rights (Carey and Tolopilo 2008; Kalla and Cohen 2007). In some circumstances, NGOs have found that just the knowledge that people who use illicit drugs, for example, have access to legal services can improve the way they are treated by the police (Carey and Tolopilo 2008). All of these services, as well as conventional legal services and strategic litigation, are difficult to fund though they may be vital to HIV responses. The Global Fund’s information note on harm reduction also underscores the importance of legal assistance for people who use drugs as part of national HIV programs (Global Fund 2010f).

A Global Fund review of proposals from Round 8 and 9 found with respect to sex workers, transgender persons, and MSM, that only three proposals out of 83 included activities related to legal services or frameworks, of which only one was eventually approved (Global Fund 2010b). In Round 9, some 13 proposals of 80 included activities in this area, of which four were recommended for funding. This report encourages countries to do more to situate their proposals in the context of legal and other structural factors, noting that the TRP has looked favourably on proposals that incorporate this kind of analysis (Ibid.).

A number of organizations that provide legal assistance to persons living with or vulnerable to HIV note that Global Fund support has been crucial to initiating or sustaining the services they provide. Healthy Options Project Skopje (HOPS) in Macedonia, a nongovernmental organization founded in 1997, provides free legal advice and assistance to sex workers. Global Fund support enables the organization to retain a part-time legal advisor who offers legal assistance as well as help in securing official documents, making links to government services, and raising awareness of human rights among sex workers (S. Velkovska, personal communication). Legal services helping people who use drugs to secure residence documents and otherwise addressing rights challenges have been supported by the Global Fund in Kyrgyzstan (Atun and Kazatchkine 2010).

The non-CCM grant awarded to the Russian Harm Reduction Network in 2006 has supported legal assistance activities in a number of cities (Russian Harm Reduction Network 2008). In Penza, the local organization supported by this grant has informed its legal service activities by undertaking detailed documentation of the kinds of legal and human rights problems drug users face from policing and state detention, including being denied medical assistance and having drugs planted on their person by the police (Ibid.:25-6). The local organization in Samara, Russia, provides legal advice to sex workers (Ibid.:4). Several of the Global Fund-supported NGOs that have tried to sustain some level of legal assistance or at least referral noted that HIV services for people who use drugs, welcome as they are, are incomplete and likely to be undermined without attention to the diverse legal needs of this population (Ibid.:12-13).

As detailed later in this paper, activities focusing on women's rights and legal protections have not been numerous in Global Fund grants. An exception to this rule is the work of one NGO in Lesotho. As is well documented in a number of countries, especially in Africa, women who survive a spouse or partner who died of AIDS may face actions by the spouse's family to appropriate the marital property or may face other barriers to inheritance and property ownership. This is the focus of Global Fund-supported legal work by the Federation of Women Lawyers—Lesotho (FIDA-Lesotho) in one of the most heavily AIDS-affected countries in the world. FIDA-Lesotho provides legal assistance to women and children living with or affected by HIV, helps them to know their rights, and raises broader rights awareness through

mass media broadcasts and classroom education (Global Fund 2009g). In addition to property and marriage laws, FIDA-Lesotho also seeks to raise broad awareness of laws related to sexual violence, including the requirement to report all incidents of sexual violence among children.

The Round 8 HIV grant to Mauritius included helping women, children, sex workers, people who use drugs, and prisoners to know their rights with respect to sexual violence through peer education and capacity-building for documenting violations, an approach commended by the TRP (Garmaise 2010).

Some organizations involved in Global Fund processes are conducting legal assistance activities for women linked to HIV but without Global Fund support. For example, the NGO CARE International in Kenya is a principal recipient of a Round 7 HIV grant. It runs a project called Sweetening Justice for Vulnerable Women and Children, supported by the Open Society Foundations, that provides paralegal training, rights information, support to community groups seeking to document rights abuses, referral to legal services, and human rights training of local officials on questions related to HIV (CARE 2008). It notes that it would expand these activities, for which there is significant demand, but more funding is needed. A number of Global Fund-supported harm reduction organizations in Russia have similarly sought private funding from the Open Society Foundations to integrate legal aid into their services, but have not been able to take legal aid to any significant scale.

V.B Law and Policy Reform or Improved Policy Environments

With relatively few CCM proposals for legal services, there are even fewer for law and policy reform as such. Again the Global Fund-supported legislative reform activities of the Federation of Women Lawyers (FIDA) in Lesotho are an exception. This NGO has undertaken advocacy that contributed to amendments in 12 laws affecting inheritance and property rights protections for women and children and related issues (Global Fund 2009g).

In Georgia, Global Fund monies were used to support an effort to reform national drug laws. NGOs brought together a group of experts to develop detailed recommendations for amendments to the national drug law, including decriminalization of drug use (D Otiashvili, personal communication). The amendments were submitted to the Parliament in February 2008, but there has not been further action. Nonetheless, efforts such as this can influence political debates and sow the seed for future reform. Also in the area of reform of drug law, the Global Fund leadership notes the Fund's support for legislative change to decriminalize drug possession in Kazakhstan (Atun and Kazatchkine 2010). In Round 8 the CCM of Bosnia and Herzegovina proposed a review of legislation related to health service delivery for all key populations (Garmaise 2010:44).

The cases where Global Fund processes and the “carrot” of Global Fund monies have resulted in rights-based policy change may be as significant as where intentional policy change activities appeared in an actual funded grant. Two university-based researchers not affiliated with the Global Fund assert that CCM processes and China’s strong interest in receiving Global Fund support were important determinants of China’s adoption of harm reduction policies (van Kerkhoff and Szelzák 2006). The Global Fund TRP rejected the Round 1 and 2 HIV/AIDS proposals from China, citing the absence of harm reduction policies in its rejection. By the time China applied again in Round 3, the government had adopted a harm reduction policy, including commitment to expanding access to methadone and syringe programs (Ibid.). These authors note that Global Fund processes were not the only factor leading to this change, but that the rejections galvanized discussions that would probably not have happened otherwise among parties that might not otherwise have been around the table. International consultants were also invited to help with the Round 3 proposal and brought their advice and experience on harm reduction (Ibid.). As van Kerkhoff and Szelzák assert:

The Global Fund application process became a major force in fostering the engagement of officials from health and other sectors with international best practice and experience from other countries. As a result, the policies in China became more outward-looking and moved closer to best practice.

(Ibid.: 631)

Global Fund decisions and processes combined with concerted rights-based advocacy also opened the door for legal grounding for methadone therapy in Ukraine. The history of Global Fund-supported work in Ukraine is one of ups and downs. The Round 1 grant agreement was concluded in January 2003 with the Government of Ukraine as the principal recipient, but by the end of the first year of the grant, the Global Fund suspended its funding, citing concerns about management of the funds and the slow pace of rolling out activities (International HIV/AIDS Alliance in Ukraine [IHAU] 2009). In March 2004, the Global Fund agreed temporarily to pass the management of the Round 1 grant to the International HIV/AIDS Alliance in Ukraine for a period of one year. In that year, in collaboration with a wide range of civil society actors and government entities, the new management expanded access to ART, which had previously reached only 200 people, and enhanced prevention services (Global Fund 2005b). The Alliance was named the PR of the remainder of the grant.

Treatment of opioid dependence remained a sticking point as medically assisted treatment before the Round 1 grant was accelerated consisted of a small pilot using buprenorphine. Methadone, which is much cheaper than the buprenorphine available to Ukraine and would be essential for scaling up treatment, was blocked by the government and also, according to the Alliance, not supported by the general popu-

lation (IAHU 2009). In late 2006, the Global Fund agreed in principle to award Ukraine \$30 million to continue HIV activities in 2007-08, but on the condition that opioid maintenance therapy, including methadone therapy, be scaled up (IAHU and All-Ukrainian Network 2006). According to the NGOs involved, this condition was communicated by the portfolio manager from the Global Fund Secretariat (Ibid.)

There followed a period of intensive advocacy by Ukrainian civil society, supported by some international allies. Ukrainian NGOs asserted the right of people living with opiate dependency to methadone-assisted therapy. By December 2007, Ukraine's president Viktor Yushchenko in a public meeting in front of civil society representatives criticized his government colleagues for not moving on HIV commitments, including methadone scale-up (IAHU 2009). Later that month, with the hard-won endorsement of the public security authorities, the government decreed that methadone could be imported and legally used for medical purposes, and methadone scale-up planning could begin in earnest (IAHU 2007a). The Alliance judged this to be a major victory for people who inject drugs that showed they can be "an organised force for political and social change" (IAHU 2009). Indeed, also in late 2007, dozens of people who use drugs mounted a street demonstration in Kyiv, Ukraine's capital, to advocate for less repressive narcotic control laws in Ukraine, including decriminalization of personal drug use (IAHU 2007b).

In other cases, the fear of losing Global Fund support has led to changes in policy or practice that were not the direct result of human rights advocacy but may set the stage for greater realization of health rights. For example, the government of Tajikistan agreed to introduction of methadone therapy so as not to lose Global Fund support, according to Latypov (2010). In this case, however, it is feared that the agreement was tokenistic to side-step recriminations from the Global Fund about continued stalling on methadone, and that the government has no real intent to make methadone available beyond a small pilot effort (Ibid.). Latypov suggests that civil society is not yet strong enough in Tajikistan to overcome the interests of "narcology" professionals who fear losing revenue from their demonstrably ineffective "detoxification" activities and of the police who would miss the revenue they get from extortion of people who use drugs. Nonetheless, the presence of a methadone service may eventually assist evidence-based advocacy for policy that would help people with opiate dependency realize their right to care.

V.C Other Human Rights Interventions

As noted above, stigma reduction activities have been included in a number of CCM proposals and grant agreements. The Global Fund highlights its work in support of networks of HIV-positive people and stigma reduction in health services in India, for example, as a milestone in the fight against HIV-related stigma suffered by millions

(Global Fund 2007). This work included support for widows abandoned by family and community after their husbands' deaths from AIDS and support for children excluded from schools because of HIV in the family. Stigma reduction among MSM is included in Global Fund-supported work in Ukraine, where the government does not offer stigma reduction programs or special health and information services for this at-risk population (UNAIDS 2009). Training of health workers in Moldova for the purpose of reducing HIV-related stigma in health services was supported by the Global Fund (Government of Moldova 2010), though the International Treatment Preparedness Coalition judges that much more work is necessary in this area in Moldova (ITPC 2009: 35–44).

The UNDP, UNAIDS, and Global Fund (2010) study found that training of police, other law enforcement agents, lawyers and/or judges were included in 39 percent of proposals and 30 percent of the work plans (representing the programs to be implemented under the agreed grant) (UNDP 2010). Some of these activities were intended to benefit vulnerable and often criminalized persons such as men who have sex with men, transgender people, sex workers, people who use drugs, and prisoners, but this is not the only area in which police training can be useful. FIDA-Lesotho has trained hundreds of police officers on how to respond to reports of property-grabbing linked to HIV deaths (Global Fund 2009g). The Round 8 proposal of the Eritrea CCM includes training for both lawmakers and the police on gender-based violence, early marriage, female genital mutilation, and land ownership as part of general training on HIV and gender (Garmaise 2010:29). In Round 8, the Global Fund supported training for police on discrimination against MSM in Thailand (Global Fund 2010h: 52).

Training of health care workers on a range of human rights-related topics has also been supported. In Round 8, the Global Fund supported health worker training on sexual and reproductive rights, gender-based violence, and post-exposure prophylaxis in Swaziland (Global Fund 2010h: 54). Health professionals in post-conflict Côte d'Ivoire were trained in gender-based violence and HIV with Global Fund support (Ibid.).

Attention to populations vulnerable to HIV other than those defined as MARPs (above) has been incorporated into some Global Fund-supported work. For example, at-risk migrants from India to Nepal received information and HIV testing and services in Nepal's Round 7 grant with Save the Children as an implementing partner (Government of Nepal 2010). In its materials for the third replenishment meeting in March 2010, the Global Fund (2010h) highlighted its support for HIV-related services for prisoners in the Dominican Republic, Moldova, and Kyrgyzstan, for example, and for migrants in China and the Dominican Republic.

VI. Funding of Interventions That May Be Linked to Human Rights Violations

In addition to funding activities that contribute to respecting, protecting, and fulfilling human rights, the Global Fund can have a positive human rights impact by withholding support from activities that undermine or potentially undermine rights. Below are some examples of programs that raise human rights concerns and that have figured in or might figure in Global Fund proposals.

VI.A Compulsory Detention and “Treatment” of Drug Users

In 2009, the western Pacific regional office of the World Health Organization (WHO) published a human rights analysis of involuntary institutional “treatment” of people who use drugs in China, Vietnam, Malaysia, and Cambodia (WHO–WPR 2009). WHO raised concerns that the punitive approaches used in compulsory drug treatment centers may negate whatever health benefits they offer, which in turn are limited because services are of poor quality, lacking in transparency and accountability, and lacking in respect for the agency of patients. Reports by researchers and human rights organizations have documented heinous practices that are tantamount to torture—in the guise of “treatment”—in compulsory drug treatment centers in China (Cohen and Amon 2008), Cambodia (Human Rights Watch 2010), and Thailand (Pearshouse 2009). In all of these cases, the impact of grueling forced labor, physical abuse, and horrific living conditions was exacerbated by the absence of good-quality health services. Involuntary detention in these facilities can be for several years without any judicial oversight. As in Vietnam and China, these compulsory “treatment” or “rehabilitation” centers may exist under the aegis of the public security or labor authorities even as more humane out-patient methadone therapy is being expanded as part of national HIV responses (WHO-WPR 2009).

In 2009, the United Nations Special Rapporteur on Torture denounced as cruel and inhuman the police practice of detaining and questioning people who use drugs when they are in drug withdrawal, which is common in some countries (UNODC 2009). Seized by this issue, the UN Working Group on Arbitrary Detention also expressed its concern about torture of people who use drugs and requested

all UN members states to report on the extent of these practices in their jurisdictions (UN General Assembly 2010).

Most importantly, the Executive Director of the Global Fund recently called for the closure of compulsory drug treatment centers, stating that “All compulsory drug detention centres should be closed and replaced by drug treatment facilities that work and that conform to ethical standards and human rights norms.”

While recognizing the human rights violations inherent in these centers, the Global Fund has approved grants that support a number of HIV-related activities in compulsory drug treatment centers in several Asian countries. According to project documents available on the Global Fund web site, these include, for example, Vietnam (Round 6) where the compulsory treatment centers are referred to as “Treatment and Education Centres”; the grant supports an “essential package of HIV/AIDS prevention, care and treatment,” but this package does not include methadone or any other scientifically sound therapy for drug dependency (WHO-WPR 2009). In Vietnam in Round 8, significant funds were requested for expanding HIV services in these centers, including ART. The proposal for this work aimed for HIV prevention services for 11 percent of people who use drugs and 7 percent of female sex workers and ART for about 8 percent of those in need in both groups (Vietnam CCM 2008:35). Recognizing the high relapse rates of people leaving the “treatment and education” centers, the Vietnam government also requested funds to support community-based services meant to prevent relapse in this population. In its Round 7 proposal, Cambodia requested assistance for “military and police operated drug treatment and rehabilitation centres where no evidence based treatment is available” (Cambodia CCM 2007:50), including technical assistance to “increase knowledge and understanding of drug dependence and treatment, as well as HIV prevention” (Ibid.:94).

Even if expanding ART, for example, in these facilities fulfills a right to care, the benefits of such activities must be weighed against helping to entrench these institutions as part of national HIV responses and possibly reinforcing human rights abuses that occur in them.

The Global Fund is in the process of developing an initiative related to services for people who use drugs that is likely to include some consideration of compulsory drug treatment centers as part of HIV responses (R. Jürgens, personal communication). The June 2010 remarks of Michel Kazatchkine (2010) are worth quoting at length:

In the two years since the last International AIDS Conference, several reports have drawn attention to the fact that in a number of countries, people who use drugs are detained, without due process, in compulsory drug detention centres. In these centres they face what is called ‘treatment’ and ‘rehabilitation’, but in reality is coercion, forced labour and

human rights abuses, including torture. In many of these centres, the services provided are of poor quality and do not accord with either human rights or evidence. Not surprisingly, relapse rates are very high.

It has recently been drawn to my attention that Global Fund grants finance some services in a number of these centres. We have undertaken an initial analysis of our grant portfolio, which indicates that our grants support a range of HIV prevention and treatment services, as well as some training in providing such services, in some centres. Even providing such services in centres where human rights violations occur poses ethical dilemmas.

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

Let me take this opportunity to thank civil society organizations for their strong advocacy and for bringing the serious human rights abuses in these centres to the world's attention. Clearly, we must do everything to ensure such abuses no longer occur.

Specific recommendations on this point are provided in the Recommendations section.

VI.B 100 Percent Condom Use Programs

So-called 100 percent condom use programs (or 100% CUP) are a central part of national HIV responses in a number of countries, including China, Cambodia, Vietnam, Thailand, Mongolia, Laos, and Burma (Rajanapithayakorn 2006). These programs are meant to ensure that condoms are used in all commercial sex transactions and usually target sex workers in brothels or entertainment establishments. Local authorities and the police are inevitably integrally involved in these programs since the idea is to make commercial sex without condoms illegal and to enforce that illegality. Many evaluations suggest these programs are effective in reducing unsafe sex in commercial sex establishments (Ibid.; Zhongdan et al. 2008).

Though these programs are meant to protect sex workers and their clients, they have generally been designed without meaningful participation of sex workers or their NGO allies (Rajanapithayakorn 2006), and sex workers' experiences have

not frequently figured in evaluations of these programs (Loff et al. 2003). An exception is an evaluation submitted to the US-based Policy Project of 100% CUP in Cambodia (David Lowe Cons. 2002). This evaluation, which included interviews with 150 sex workers, found that 100% CUP resulted in forced registration of sex workers and mandatory STI testing and health examinations at health facilities where sex workers were mistreated. Sex workers also reported that they were forced by brothel and nightclub owners to have sex with police in exchange for the police looking the other way when 100% CUP rules were violated.

The Network of Sex Work Projects (NSWP), a global coalition of sex worker organizations that is active in international policy discussions, also has highlighted human rights abuses that occur in 100% CUP, including repressive policing, force-marching sex workers to health facilities with military or police escorts, and public posting of photographs of sex workers who are accused of having had sex without condoms (Loff et al. 2003). The Asia Pacific Network of Sex Workers, a coalition of organizations in the region most affected by 100% CUP, has consistently raised concerns about 100% CUP that include “authoritarian punishment-based HIV prevention and mandatory testing” (Asia Pacific Network 2007). As NSWP and its allies have noted:

Coercive efforts to control or reduce sex work rarely produce good results and have even been associated with abuse of sex workers and their families. Mandatory medical treatment or procedures, raids, forced rehabilitation or programs implemented by police or based upon detention of sex workers are all examples of coercive programming.

(Global Working Group 2007:7)

There is another path to 100 percent or virtually 100 percent condom use, represented by sex worker collectives such as those in the Sonagachi neighbourhood of Kolkata, India, that have developed the solidarity that ensures that all workers in the collective demand condom use (Jana et al. 2004). This experience and many others inspired by it have demonstrated effectiveness in HIV prevention as well as empowering sex workers to stand up to police brutality and stigma in the community (Ibid.).

The Global Fund has supported 100% CUP in Cambodia (Round 2), where repressive practices were reported, as noted above; in China (Round 3) where “it has been difficult to reconcile the roles of public security and public health with respect to the sex industry” (Zhongdan et al. 2008); and in Mongolia and the Philippines (Round 3). Indicators on the performance evaluation tools of the Global Fund include such factors as “number of STI consultations provided to sex workers” and “number of condoms distributed” that are not sensitive to capture repression and other human rights violations in these programs if they exist. Indeed, an indica-

tor such as “number of STI consultations provided to sex workers” may encourage mandatory consultations and testing in the context of 100% CUP.

The Global Fund has also supported HIV activities in detention centers for so-called “treatment and education” of sex workers in Vietnam (Rounds 6 and 8). These centers, like the analogous centers for people who use drugs, reportedly include forced labor and repressive practices as part of the “rehabilitation” package (WHO-WPR 2009).

It is clear that top-down 100% CUP enjoy support among CCMs, even though alternatives are available. For example, Indonesia proposed in Round 9 the promulgation and enforcement of local regulations “so that regular condom use becomes the norm in three places per province where sex is sold” (Global Fund 2010c). Countries’ continued uncritical reliance on 100% CUP raises the question of whether the effective alternatives to these programs are known to CCMs (Crago 2008). The Technical Review Panel should also be fully briefed on 100% CUP and alternatives to it. This is a program area in which the Global Fund may do well to consider providing enhanced CCM guidance and other measures (see the Recommendations section).

VI.C Forced Sterilization

In 2008 and 2009, the Legal Assistance Centre (LAC) of Namibia and the International Community of Women Living with HIV/AIDS in Namibia documented dozens of cases of involuntary sterilization among women living with HIV (Patel and Davidson 2009). These women were sterilized without their knowledge while they were unconscious, they gave consent unknowingly by signing papers that were not explained to them, or their “consent” was obtained under duress in exchange for being able to have a caesarean section or another medical procedure or while they were in labor. Some of the women did not know they were sterilized until some months after the fact (Mallet and Kalambi 2008). These violations took place in public maternity hospitals. Some of the victims of this practice have filed a lawsuit that is before the High Court in Windhoek at this writing.

The Round 2 HIV grant from the Global Fund to the Government of Namibia included support for expansion of voluntary HIV testing and counselling and vertical transmission services in all of Namibia’s public maternity hospitals (Namibia CCM, 2002). According to the performance evaluations of this grant, the targets for HIV testing and provision of prevention of vertical transmission services in public hospitals were exceeded (Global Fund 2009c). While forced sterilization as a result of scaling up HIV testing and vertical transmission services could not have been foreseen, the reports of it should figure in updated performance evaluations and should be addressed by the CCM. The Global Fund should advocate with the Namibian government for measures to end this abusive practice.

VI.D HIV Testing and Related Programs

Human rights safeguards are an important part of all HIV counselling and testing programs, particularly those in which testing is initiated by health providers and consent is presumed unless a patient explicitly “opts out.” Guidance from WHO and UNAIDS (2007) affirms that HIV testing should respect the “three Cs” of informed consent, confidentiality, and counselling, and should be linked to HIV prevention, treatment, care, and support services. Many NGOs and researchers have observed that these protections are often not implemented in practice (Groves et al. 2010; Weiser et al. 2006; Patterson and Jia 2008; Open Society Foundations, UNAIDS, and WHO 2010).

At this writing, there is considerable momentum in HIV global circles about the idea of “ART as prevention” or “universal test and treat”—that is, if HIV testing coverage is very high in an affected population and people tested begin ART promptly, viral load could be suppressed enough to stop HIV transmission over time (Granich et al. 2009). Interest in this approach is contributing to pressure to expand HIV testing dramatically through health facilities but also through community-based campaigns, door-to-door programs, mobile units, and so on. It would not be surprising for mass testing campaigns to show up in Global Fund proposals in the coming years. Even aside from ART as prevention, there is continued interest in rethinking voluntary testing models with the three C’s, which some experts regard as not having enabled sufficiently robust HIV responses (O’Grady and Schüklenk 2008).

In 2009, in preparation for WHO’s first major technical consultation on ART as prevention and while welcoming initiatives of this kind, hundreds of civil society organizations (Academia Mexicana et al. 2009) from around the world raised a number of factors that should be taken into account by donors and implementers of this strategy, as well as HIV testing programs more generally. These include:

- ▶ For HIV testing at any scale and in any setting, testing must still be by informed consent, must be confidential, and should be accompanied by counselling or information that allows people to ask questions about HIV.
- ▶ Testing must be linked to treatment without undue delay where needed and appropriate follow-up services regardless of the test result.
- ▶ As WHO and UNAIDS underscore in the guidelines for provider-initiated HIV testing and counselling (PITC) (UNAIDS and WHO 2007), an adequate social, policy, and legal framework should be in place to do everything possible to prevent discrimination and other abuse that may result from testing, and a mechanism of redress should be available to those whose rights are violated as part of testing. Any institution or government proposing a pilot program or feasibility study of ART as prevention should demonstrate that

there has been an assessment of the legal and social protections, including policies related to discrimination based on HIV status and removal of barriers to treatment access.

- ▶ There must be meaningful participation of people living with and vulnerable to HIV in feasibility or pilot studies of ART as prevention, as well as other key stakeholders in the community.

A prominent recent example of provider-initiated HIV testing is the “Know Your Status” (KYS) campaign in Lesotho, an effort to reach everyone over the age of 12 years in the country with community-based—sometimes door-to-door—HIV testing. This campaign was criticized by Human Rights Watch and the AIDS and Rights Alliance for Southern Africa as having inadequate safeguards for confidentiality, quality of testing, and linking testing to treatment and other services (HRW and ARASA 2008). According to the detailed investigation by these two organizations, the poor quality of the testing and counselling activities in the KYS campaign was due partly to insufficient funding as well as insufficient guidance to counsellors on ensuring confidentiality and testing quality. Global Fund support for 540 counsellors came into the campaign at a relatively late stage. The Lesotho experience was held up by many experts as the opportunity for establishing a model of wider-scale testing especially for resource-constrained countries with poor health infrastructure. As such, its careful evaluation with respect to human rights outcomes should have been a priority. (At this writing, the evaluation report for this Round 8 activity is not available on the Global Fund website.)

The Global Fund has supported HIV testing services on a very large scale in many countries with widely varying policies on HIV testing. Though there are agreed international standards for human rights protections in HIV testing, it is not clear from Global Fund proposals and grant agreements that CCMs are informed of and proposing human rights protections in HIV testing or that this is a central element of TRP review and program evaluations. The increased interest in greatly scaled-up HIV testing that is likely to emerge in some countries warrants a different order of attention to human rights in HIV testing (see recommendations below).

VI.E Inappropriate Detention of TB Patients

The rise in multidrug-resistant TB (MDR-TB) and extensively drug resistant TB (XDR-TB) is significantly slowing global progress in TB care and control. TB patients co-infected with HIV are at a higher risk of MDR-TB compared to TB patients without HIV infection (WHO 2010). Despite the demonstrated effectiveness of voluntary and community-based protocols for treatment of drug resistant TB, there has been an increase in liberty-restricting measures of MDR-TB patients around the world.

Recent measures that have unnecessarily limited the rights of patients include the seemingly arbitrary detention of suspected MDR-TB patients in South Africa without appropriate health care (AIDS Law Project 2009), the incarceration of TB patients in Kenya for not taking their medications (KELIN et al. 2010), and prolonged hospital-based treatment for all TB patients in Moldova (Moldova TB Proposal Round 8). While in-patient MDR-TB treatment can be useful for certain patients based on medical needs or those that, despite repeated efforts, are not able to complete treatment as an outpatient, detention of TB patients has been used in ways that violate patients' rights and are detrimental to public health.

The *WHO Guidance on Human Rights and Involuntary Detention for XDR-TB Control* (WHO 2007) describes the conditions that should be fulfilled to restrict individual rights to protect public health, consistent with the Siracusa Principles governing derogations from civil and political rights. This Guidance states that detaining TB patients "must be viewed as a last resort, and justified only after all voluntary measures to isolate such a patient have failed." To fulfill human rights norms, detention should be the least restrictive option, based on scientific evidence and not arbitrary or discriminatory in application, of limited duration, respectful of human dignity, and subject to review. These human rights requirements have, however, proven challenging to implement (Amon et al. 2009). The short WHO guidance on detention of XDR-TB patients does not provide clear enough guidance to governments and as a result, a number have pursued in-patient MDR-TB facilities as their primary treatment option, leading to cases of inappropriate detention.

South Africa, Kenya, and Moldova are countries with a high TB burden that have received funding from the Global Fund to construct and/or renovate MDR-TB in-patient facilities (Round 2, Round 5, and Round 6). All three have had or are developing laws or orders that allow for detention of TB patients without necessary safeguards for human rights. The Global Fund has also funded community-based care programs for MDR-TB, such as in Lesotho (Round 8), that promote patients' rights and public health by providing treatment to patients in their communities.

Without sufficient scrutiny and oversight, Global Fund investments may not consistently go to effective, rights-respecting MDR-TB programs. Support for constructing or renovating MDR-TB facilities in a context of poor human rights safeguards and lack of community-based care options can inadvertently lead to human rights violations. In addition, such investments have the potential to negatively impact the results of other Global Fund-supported projects to scale-up MDR-TB treatment at the country level and compromise their effectiveness by supporting practices that are not evidence-based and fail to promote public health or patients' rights. As an initial step towards addressing this human rights challenge, the Global Fund should work actively with the Stop TB Partnership's TB and Human Rights Task Force to develop guidelines for proposals that reflect human rights principles and recommend community-based care as one component for scaling up MDR-TB

treatment efforts. It would also be important for the TRP to be provided with clearer guidance on assessing proposals that include the construction and/or renovation of MDR-TB facilities.

VI.F Data Collection Among Criminalized People

There is a strong emphasis in Global Fund guidelines for detailed epidemiologic data on HIV (and tuberculosis and malaria), including gender-disaggregated data and information on how epidemics affect “key populations.” Encouraging countries to get data of this kind is generally a laudable strategy and should contribute to better understanding of structural barriers to health services and increase the effectiveness of interventions. It may be useful to recognize, however, that conducting surveys among criminalized people can sometimes put them in danger and should be done with caution. For people who use drugs, even the usual research promise of anonymity and confidentiality of results may not suffice to relieve the fear that participating in a survey will result in their information (or themselves) being turned over to the police (Harrison 1997). Sex workers may live and work in situations where confidentiality is virtually impossible to ensure, and unauthorized sharing of information about health status may affect their livelihood and safety (Beyrer and Kass 2002). We appreciate that the Global Fund’s review of SOGI elements in Round 8 and 9 proposals makes the point that essential services for MSM, transgender persons, and sex workers do not necessarily need to await comprehensive or even good epidemiologic data in these populations, much as having good data is desirable (Global Fund 2010b:47). It may be useful as well to share with CCMs experiences of good practices in data collection among severely marginalized and criminalized persons that minimize risks of human rights abuse.

VII. Engaging in Advocacy on Human Rights Issues

Though the Global Fund may not have been conceived mainly as an advocacy voice in global health policy and program discussions, its stature in the global HIV response puts it in a position where its view is sought on many issues. Because it has publicly espoused the importance of human rights to good-quality health programs, it is looked to all the more for leadership on difficult HIV-related human rights issues. Public advocacy undertaken by Dr. Kazatchkine as the head of the Global Fund has addressed many such issues, including the right of marginalized people to comprehensive HIV services and the potential for law and law enforcement practices to interfere with health service delivery. This kind of advocacy may be motivated by the Global Fund's human rights commitments, but it is also centrally important for the successful realization of programs in which it has invested.

Dr. Kazatchkine's promotion of comprehensive health services for people who use drugs has represented perhaps the most impassioned of the Global Fund's public advocacy, and it has come at strategically important moments. Before the 2009 session of the UN Commission on Narcotic Drugs (CND), which was to revisit and identify future directions for global drug control policy, Dr. Kazatchkine wrote to the chairperson of the session, emphasizing the "abundant and compelling" evidence in favor of harm reduction measures and urging that the session "send a strong message to the world with clear and specific language that calls for comprehensive harm reduction services" (Kazatchkine 2009a).

In the wake of the session, which failed to realize the hope that harm reduction would figure in the declaration, Dr. Kazatchkine's remarks in a public speech were uncompromising:

What upsets so many of us in the harm reduction movement is the CND's abject failure to appreciate how times have changed; how global drug prohibition has made controlling HIV among injecting drug users so much harder....What we cannot accept is an overall [CND] framework that focuses exclusively on reduction of demand and supply when, as the political declaration itself acknowledges, these approaches have to date had such limited success....We must continue to reject the myth implicit in the CND outcome, that harm reduction promotes addiction....We must demand, at a minimum, that serious countries tell the truth when discussing serious matters of policy.

(Kazatchkine 2009b)

He went on to congratulate the 26 countries in the CND that had called for explicit inclusion of harm reduction in the notion of services for drug users, noting that their statement gave “hope that we may eventually have a more nuanced policy in the coming years.” The strength of these statements attests to the independence of the Global Fund on this issue and underscores an important moment in the history of the CND in which member states finally stood up to procedural and ideological forces that have muted debate on evidence-based policies.

Dr. Kazatchkine’s high-profile closing speech to the International AIDS Conference in Mexico City in 2008 also struck a human rights theme in strong language. He cited as areas of concern violence against women, the denial of sexual and reproductive health services, the 71 countries that violate human rights by denying entry to people living with HIV, grotesque examples of public derision and abuse of gay men, the illegality of methadone in Russia, the “masquerade” of methadone availability in other former Soviet countries, and the counterproductive criminalization of HIV transmission and exposure (Kazatchkine 2008).

In addition to speeches and letters, the Global Fund has addressed some issues through media releases. For example, a statement on January 16, 2009 expressed “deep concern” about the December 22, 2008 arrest of and long prison sentences for nine men who have sex with men affiliated with the NGO AIDES Senegal. The statement asserted that “criminalization of sexual orientation and consensual sexual activity is ineffective and counterproductive from a public health perspective and only serves to fuel HIV transmission by further marginalizing those who are most vulnerable to HIV...,” noting also the universality of human rights (Global Fund 2009e). The Global Fund also joined many advocates in public condemnation of the 14-year prison sentence imposed on two men in Malawi because of their sexual orientation (Global Fund 2010i). (The men were released in May 2010.)

The Global Fund issued a press release in January 2010 welcoming the overturning of HIV-based travel restrictions in the U.S. and South Korea (Global Fund 2010c), an example of advocacy not directly related to the implementation of a funded grant. The Board of the Global Fund had earlier decided as a matter of policy that it would not convene its meetings in countries with HIV-related travel restrictions (Global Fund 2007b).

Because of the kind of programs the Global Fund supports and the countries in which it works, it is inevitable that human rights concerns will arise related directly or indirectly to Global Fund-supported programs. The forced sterilization cases in Namibia are one example. Another is the repression of NGOs in Uzbekistan, which has sometimes taken the form of harassment and arrest of leaders in civil society’s response to HIV. In 2009, Maxim Popov, the director of an AIDS NGO, was arrested and eventually convicted and sentenced to seven years in prison because of a manual on “healthy lifestyle” that his organization produced with Global Fund support (Agence France Presse 2010). The manual was judged by the court to be promoting

homosexuality and prostitution. Where repression like this interferes with Global Fund-supported programs, advocacy from the Secretariat is in order.

VIII. Conclusions and Recommendations

The issues discussed in this paper go to the heart of the Global Fund's human rights dilemma: espousing human rights principles while also being committed to allowing HIV responses to be driven by countries, including countries that resist rights-based policies and programs or cling to policies that undermine human rights. The Global Fund's commitment to human rights-based programming has made a difference in many ways, but the tightrope of this dual commitment poses a challenge for maneuvering when action is called for.

Meaningful representation of “key affected populations” in national HIV responses is a central element of rights-based programming and a goal to which the Global Fund has committed itself. The country-level processes that the Global Fund has set into place have demonstrably enhanced that representation in some countries. It is nothing short of remarkable that countries with long histories of homophobia and social demonization of drug use, for example, have included MSM and people who use illicit drugs in national program planning and proposals in more than tokenistic ways, at least in some cases. This engagement of criminalized and deeply marginalized persons has been achieved in different ways from place to place—sometimes perhaps because Global Fund monies are ardently sought, sometimes because of advocacy from UN agencies or other allies, and sometimes as a function of strong courageous civil society leaders or improved processes for selection of civil society representatives in the CCM.

Some CCMs have reached the point of including legal and human rights programs for marginalized persons as program priorities, something that the Global Fund leadership has been proud enough to feature in public statements and articles (Atun and Kazatchkine 2010). But, as important as these interventions are, they have not featured very prominently in Global Fund grants. For some populations living with or vulnerable to HIV, legal and human rights support may be as important as health services. Global Fund materials and officials seem to recognize this fact, but it is not well reflected in Global Fund rules and procedures.

Grants through non-CCM mechanisms have enabled important human rights-based actions in HIV service delivery and legal and policy advocacy. They have empowered civil society organizations to deliver services to criminalized and stigmatized persons who would have been hard if not impossible to reach through government channels alone. The NGO-managed GLOBUS grant, for example, energized services for drug users and people living with HIV and drew health profes-

sionals in Russia into scaled-up HIV service delivery at a time when government commitment to scaling up HIV prevention and treatment was tepid. The benefit of these processes not only in life-saving services delivered but in dignity-restoring engagement of previously excluded persons would be hard to calculate.

Global Fund processes have also generated national policy change, whether intentionally or not. In a few cases, Global Fund support has enabled advocacy that has pressed for law or policy reform. In others, the fear of not obtaining or losing Global Fund money has led countries to reconsider barriers to methadone therapy, for example. In the case of Ukraine, a clear message was sent by the Global Fund indicating that a change in policy was needed. In the case of China, at least by the account cited here, feedback from the TRP on the need for harm reduction programs, along with other influences, contributed to reconsideration of policy. In the case of Tajikistan, the government seems to have made an effort to gauge the minimum level of commitment that would be required to keep the Global Fund from refusing to support HIV activities without actually expanding methadone services in a meaningful way.

In spite of proposal guidelines that encouraged CCMs to incorporate gender analysis and women's rights considerations in their programs, women's rights issues were not widely reflected in grants in Rounds 1 to 7. Identifiable legal and human rights activities for what the Global Fund designates as SOGI populations, including sex workers, were relatively poorly represented in proposals by the Fund's own reckoning in Rounds 8 and 9, though there was some improvement between the two rounds. The Global Fund has responded in a substantive way to gender concerns. It is too early to know whether the several measures taken by the Global Fund to address women's rights and SOGI rights will be sufficient to effect change in this area, particularly in the neglected area of changing the legal frameworks, law enforcement practices, and denial of access to justice that marginalize these populations. There is no indication so far in the two gender strategies adopted by the Global Fund that it will seek to address gender rights issues by changing CCM requirements (vs. Guidelines) as such. Global Fund applicants will report on their gender expertise and experience and will be offered technical guidance and various kinds of gender capacity-building, and the capacity of the TRP in this area has been strengthened. But, perhaps out of a commitment to "country-driven" process, the gender strategies have not added to the CCM requirements already established.

At times, through pointed advocacy and, as in the case of Ukraine, imposing a grant condition related to program strategy, the Secretariat has made its views known and challenged prevailing winds in countries. Determination of when issues are important enough to defy country priorities and values is plainly part of the leadership challenge of the Global Fund. Moreover, while it is a positive thing that there are success stories of meaningful participation of "key affected populations" in CCMs, there is a certain haphazard quality to these successes that is perhaps an

inevitable consequence of a *laissez-faire* approach to “country-driven” processes. It is commendable that Global Fund processes and the carrot of Global Fund support have had a transformative effect in some cases, but it may legitimately be asked whether there are some circumstances where the shaping of outcomes should be more intentional and direct.

In our view, for example, where there is criminalization of homosexuality and of sex work and where drug laws relegate people who use drugs to lives of police abuse, frequent detention, and social exclusion, CCMs should be challenged to do more than report on the gender expertise among their members, ensure fair elections of members, and so on. Where life-saving services such as methadone therapy are supported in a tokenistic way just to keep the Global Fund from withdrawing support, the “country-driven” principle is not sufficient on its own. When public health priorities of countries include “treatment” of drug dependency in boot camp-like detention centers and 100 percent condom programs that do not respect the rights of sex workers, these circumstances attain a level of concern that that should trigger a process that is more deliberate and less *laissez-faire*. Detention or forced labor centers in the guise of drug “treatment” are counter to every principle of rights-based programming. In the case of 100 percent condom programs, undermining the human rights of sex workers in these programs may not be inevitable, but it has been demonstrated to occur. The fact that there are rights-based alternatives that may achieve the same results through true empowerment of sex workers and thus greater potential for sustained effectiveness weighs in favor of guidance for countries that is more pointed than what is currently offered.

It is unfair to expect too much of the Global Fund in that many other institutions and leaders—political, cultural, social, religious—also have important roles to play in favoring rights-friendly approaches to HIV and opposing measures that violate human rights. We urge the UNAIDS co-sponsor agencies and UNAIDS country representatives, who often have leadership roles in CCMs, to make it a high priority to bring human rights-centered ideas to CCMs and to support human rights NGOs in the CCM as those opportunities present themselves. In addition, in some areas, such as 100% CUP, where the Global Fund might reasonably expect human rights-based guidelines from technical UN agencies, such guidelines have not always been forthcoming. But the Global Fund has made bold commitments, and we hope it will act boldly to ensure that human rights are reflected in the activities it funds. Its priorities in this area should include doing more to ensure that UN actors, government leaders, and other individuals and institutions that influence CCMs have the information and capacity they need to understand and support human rights-based HIV responses.

VIII.A Human Rights and “Conditionality”

Ensuring that Global Fund grantmaking and grantmaking processes are grounded in human rights might at first glance appear to represent unwelcome conditionality—that is, tying assistance to conditions that are imposed by the donor—a practice rightly criticized in the official development assistance of many bilateral donors. But accountability with respect to human rights for the Global Fund and its grantees is wrongly categorized as conditionality. For one thing, all states that would be seeking and using Global Fund grants have already agreed to or are otherwise bound by certain fundamental human rights standards (e.g., in the Universal Declaration of Human Rights) and many have also agreed to be bound under various international or regional human rights treaties of considerable, direct relevance to effective responses to HIV. The relationship between these international legal norms and national HIV responses is articulated in, among other places, the *International Guidelines on HIV/AIDS and Human Rights* (OHCHR & UNAIDS 2006.) Recognizing the need for adherence to these obligations as part and parcel of Global Fund grantmaking and implementation is not to impose such considerations upon recipients. Furthermore, as already suggested in this paper, certain human rights violations and discriminatory marginalization are well understood as barriers to successful HIV programs. Participation of those most affected by HIV in shaping Global Fund-supported programs, for example, is not a donor condition but a principle of good programming with an incontrovertible empirical foundation.

Human rights principles in the Global Fund’s work merit the kind of oversight that the secretariat brings to such questions as corruption and mismanagement. The Global Fund’s inspector general function related to corruption does not seek principally to challenge the sovereignty of governments or the authority of the CCM as an institution. It seeks to ensure that money is well spent and that programs benefit those who need them to the greatest possible degree. We encourage the Global Fund leadership to see human rights accountability in a similar light. Building on the principles already communicated to CCMs with respect to SOGI and gender issues, the Global Fund could build a human rights accountability function that would combine technical support, oversight, and the sharing of good practices. It would have the clout to exclude or delay consideration of proposals or continuation of grants that are unlikely to be associated with successful programs because they do not address human rights barriers or, in the worst cases, because they facilitate or contribute to discrimination and other abuses.

VIII.B Recommendations

We congratulate the Global Fund on its human rights achievements, which are considerable. We offer in the most constructive spirit the following recommendations for building on this record of achievement.

- ▶ ***Evaluation of CSS and DTF:*** Community systems strengthening and dual-track financing should both provide important boosts for civil society participation and representation of marginalized groups in Global Fund processes and national HIV responses. We urge the Global Fund to evaluate these efforts rigorously with respect to the inclusion of “key affected populations,” including whether the NGOs designated as PRs are in fact improving meaningful participation of the most marginalized persons affected by HIV in a given country. CSS funding may be one of the only opportunities for funding for women’s rights organizations and those representing severely marginalized and excluded people in some countries. Failure to evaluate these initiatives with regard to the impact on the most excluded would be a missed opportunity.

- ▶ ***Criminal laws that impede HIV responses:*** The Global Fund should consider incorporating in its gender and SOGI strategies, and in the initiative for people who use drugs (in preparation), some guidance/requirements for consideration of HIV proposals from countries where homosexuality is criminalized with active enforcement of the law, sex work is similarly criminalized and sex workers pursued by law, drug paraphernalia laws impede possession of syringes, drug law imposes criminal penalties on minor drug offenses, including possession of drugs for personal use, and HIV transmission and exposure are criminalized and prosecuted. These may include the following:
 - The CCM or other applicant must submit an independent analysis of the public health impact of the criminal law in question—including the impact of policing, detention, incarceration, and denial of due process and access to justice—on the health of individuals and on the capacity of criminalized persons to conduct advocacy and service delivery as part of national HIV responses.
 - The CCM must report on whether there are challenges to the laws in question and whether there are active efforts at legislative reform.
 - The CCM must produce a concise report summarizing the risks faced or potentially faced by persons covered by these laws in participating

meaningfully in CCM processes and the measures taken by the CCM to address these risks.

- The CCM must produce an analysis of legal assistance needs of persons affected by these laws and of the capacity of legal assistance entities, public and private, to address these needs.
- The CCM should be strongly encouraged to include support for legal assistance and related programs for criminalized persons, which may include training of judges, prosecutors, and police, training of health professionals, and other human rights activities.

The TRP should be briefed on all these points and should include members with expertise on the health impact of criminal laws in these areas. Given the unlikelihood of changes in criminal laws in the short term, the Global Fund realistically should not refuse funding because of unjust criminalization, but it should be ready to deny funding until it is clear that the matters above have been the object of serious reflection.

In addition, we believe that it would be worthwhile to make non-CCM grants more accessible to NGOs that represent criminalized populations. This might be realized by making available funds for capacity-building on proposal preparation and awareness-raising about non-CCM grant opportunities in countries where punitive laws are barriers to national HIV responses. The Global Fund should also make resources available to enable independent bodies to document the impact of criminal laws and related policies on HIV responses. A better understanding of the public health consequences of these laws might generate support for law and policy reform that would lead to more favorable environments for achieving the Global Fund's health mission.

- ▶ ***Scale-up failure and tokenistic program commitments:*** It is of concern that some CCMs will propose a tokenistic program in, for example, methadone therapy to keep from being excluded from Global Fund support without intending to scale up this service. The Global Fund executive director has characterized the failure of methadone scale-up as a “masquerade,” and the practice should be exposed and addressed. The Global Fund's initiative for people who use drugs should include guidance on this point. The Secretariat should consult with health professionals who seek methadone expansion as well as relevant civil society entities and formulate a strategy for encouraging methadone scale-up. One idea may be to encourage non-CCM applications from entities that could provide methadone outside regular government programs.

- ▶ **Compulsory drug treatment:** The Global Fund should not in any way support “treatment” for drug dependency that involves involuntary detention, and it should undertake advocacy, including national-level advocacy, in favor of closing all such detention centers. If compulsory detention centers to “treat” people who use drugs exist and are being run without Global Fund money, the Global Fund should have a policy with clear criteria to judge whether it is possible to assist those who have been detained in violation of their human rights without legitimizing or reinforcing repressive institutions and practices.

The TRP should be briefed on compulsory drug treatment, should have ready expertise to make a judgment as to whether Global Fund support is appropriate, and should preferably include among its members someone with expertise in this area. In addition, the Global Fund should make resources available to ensure that CCMs have access to user-friendly material on best practices in drug treatment, opportunities to visit countries with good practices and demonstrably effective results in drug treatment, and other capacity-building measures.

- ▶ **100 percent condom programs:** It is clear that 100 percent condom programs can be effective in increasing condom use in commercial sex transactions, but the Global Fund, with its commitment to human rights, should have a policy that challenges CCMs or other applicants to be sure that this public health success does not come at the expense of the human rights of sex workers or their clients. CCMs or other applicants that propose 100 percent condom programs should be required to provide detailed information about the implementation of these programs, which might include:
 - the nature and degree of participation of organizations that are legitimate representatives of sex workers in the design, implementation, and evaluation of these programs;
 - measures taken to protect sex workers against abuse by clients, police, or managers of brothels or entertainment venues;
 - measures taken to consider less top-down alternatives to 100 percent condom use programs.

The Global Fund should develop criteria that would trigger rejection of proposals, especially the lack of demonstrable human rights protections for sex workers and their clients. It should invest in capacity-building for CCMs in this area, including exposure to good practices that result in high levels of condom use in commercial sexual transactions based on “bottom-up” empowerment of sex workers. The TRP should be thoroughly briefed on this subject.

- ▶ ***Sterilization of HIV-positive women:*** The reports from Namibia on sterilization of HIV-positive women, which have been rigorously documented, warrant action on the part of the Global Fund. There should be an investigation of these events and guidance to the CCM on how to prevent such occurrences in the future. The Global Fund should also use its advocacy voice to condemn this practice worldwide—and related practices such as coerced abortions among HIV-positive women—and make it clear that it will not support or fund coercive practices. To prevent similar abuses in the future, the Global Fund may want to attach a rider to its grant agreements with principal recipients that requires compliance with key human rights principles, such as the right to informed consent and bodily integrity.

In all these cases, we recognize that heavy requirements may deter some countries from seeking assistance that could be important to health services, legal assistance, and advocacy for criminalized persons. We respect that the Global Fund is experienced in the balancing of the carrot of its funding with the sticks that may shape funded projects in a rights-friendly direction. But we believe that Global Fund processes provide an opportunity for sending a strong message about human rights and rights-centered approaches to HIV.

- ▶ ***Strengthening the gender strategies:*** The gender strategies adopted by the Global Fund should be given a chance to work, but we hope that certain considerations will figure into the evaluation of these strategies with an eye toward strengthening them if need be. In particular, the following questions should be part of the evaluation process:

Are the measures taken sufficient to produce a significant flow of funds into legal services for women, measures that address violence against women, measures that address laws that embody gender inequality in property, inheritance, and marital law, and other human rights activities? If not, should CCMs be asked to investigate these areas and make proposals based on evidence of need and capacity for service delivery? Where gender analysis indicates that gross violations of women's rights are rampant and are barriers to confronting HIV, should CCMs be required to include some human rights programs in their HIV proposals?

Is there a risk that categorizing sex workers with SOGI—when sex work is not *per se* necessarily a matter of sexual orientation or gender identity—will cause sex worker concerns (including the situation and rights of clients) to be lost or underappreciated in CCMs? If so, should there be a separate strategy on sex work, and what should it include?

- ▶ ***HIV testing and human rights:*** The Global Fund has the potential to contribute significantly to the reduction of human rights abuses linked to HIV testing. The Secretariat should produce an information note summarizing the key human rights elements of the WHO/UNAIDS (2007) guidelines for provider-initiated testing and reiterate the importance of these protections to sustainable scale-up of HIV testing and counselling and effective linking of testing to treatment. It should ensure that the TRP is briefed on the importance of these measures and has the tools to evaluate HIV testing proposals according to human rights standards. It should consider requiring applicants seeking support for HIV testing to include information on consent procedures, confidentiality protections, counselling and other information provision, and monitoring of these elements.

- ▶ ***Human rights capacity in the Secretariat:*** The human rights concerns noted in this paper are reminders that particular vigilance is often required to ensure human rights protections in HIV responses. We recommend that the Secretariat hire a senior human rights advisor along the lines of senior technical staff hired to oversee the implementation of the gender strategies. This advisor would work in areas not covered by the gender advisors, which certainly encompass a wide range of concerns to warrant a full-time post. A human rights advisor could establish a monitoring system and indicators to keep track of progress in incorporation of human rights-centered program elements in proposals and grant agreements, as well as to monitor the appearance of program elements that raise human rights concerns. As this paper demonstrates, NGOs and academic researchers have done some analysis of human rights-related program and process factors in the Global Fund's work, but the Global Fund should also make concrete its human rights commitments by investing in monitoring of this aspect of its grant-making and advocacy and having an advisor to guide initiatives in this area.

- ▶ ***Human rights capacity in the TRP:*** It is encouraging that the new TRP guidelines mention a range of human rights issues to which TRP members' attention is drawn and that the TRP has called for new members with gender-related rights expertise. Serious human rights-based assessment of proposals, however, would be best achieved by having the TRP include members with meaningful health-related human rights experience and expertise on a wide range of issues (that is, not just those related to gender). Briefings for the TRP on human rights issues identified in this paper and in a continuing way on new issues are also warranted.

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Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

For more information, see: www.aidslaw.ca.

Open Society Public Health Program

The Open Society Public Health Program aims to build societies committed to inclusion, human rights, and justice, in which health-related laws, policies, and practices reflect these values and are based on evidence. The program works to advance the health and human rights of marginalized people by building the capacity of civil society leaders and organizations, and by advocating for greater accountability and transparency in health policy and practice.

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