



*Lessons from the  
Asia Pacific Community,  
Rights and Gender (CRG)  
Platform and Technical  
Assistance Provision*





**Lessons from the Asia Pacific Community, Rights and Gender (CRG)  
Platform and Technical Assistance Provision**

APCASO  
February 2018

Produced with support from ICASO



# Acknowledgements

APCASO is thankful to the many individuals and organizations for the time and effort in contributing to this manuscript. In particular, APCASO would like to thank Jeffry Acaba for the oversight during the process and for leading the writing of this report; Quentin Batreau for providing support in the conduct of interviews and additional support for write-up; and RD Marte and Jennifer Ho for providing oversight.

APCASO would also like to thank and acknowledge the support received from ICASO which enabled the production of this documentation.

# Table of Contents

Introduction	1
Overview of the APCRG Platform and APCRG TA Provision	5
Most Significant Changes through the CRG Platform and the Technical Assistance Program	9
What We Learned So Far: Lessons and Recommendations	29
References	36

## Case studies

The Formation of ACT! AP (2016)	12
Towards Effective Key Population Engagement in Nepal's Country Coordinating Mechanism (2017)	16
Towards Better Engagement and Inclusion of Civil Society Organizations and Communities in the Regional Artemisinin Initiative (RAI) Grantmaking and Implementation (2015-2016)	21
Mobilizing Key Population Communities towards More Meaningful Engagement in Sri Lanka	26

## Appendices

List of Interviews	37
ACT! AP Commitments to Action	38
Nepal Charter of Principles for HIV, TB, and malaria community and civil society	41
Nepal Engagement Framework and Plan	43
Malaria Civil Society Positions on RAI 2018-2020	54
Sri Lanka Community Recommendations on the National Strategic Plan 2018-2022	55
Malaria Mapping Report in Viet Nam	59

# Abbreviations and Acronyms

ACT AP	Activists' Coalition on TB Asia Pacific
APCRG	Asia Pacific Community, Rights and Gender
APLMA	Asia Pacific Leaders Malaria Alliance
CCM	Country Coordinating Mechanism
CRG	Community, Rights, and Gender
CSO	Civil Society Organization
CSS	Community Systems Strengthening
FPM	Fund Portfolio Manager
GCTA	Global Coalition of TB Activists
GMS	Greater Mekong Subregion
MDR-TB	Multi-Drug Resistant Tuberculosis
NAP+N	National Association of People living with HIV Nepal
NFM	New Funding Model
NSACP	National STI & AIDS Control Program
NSP	National Strategic Plan
OSF	Open Society Foundation
RAI	Regional Artemisinin-resistance initiative
RSC	Regional Steering Committee
RST	Regional Support Team
SI	Strategic Initiative
SOGIE	Sexual Orientation and Gender Identity and Expression
STBP	Stop TB Partnership
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/ AIDS





# Introduction

## Background

Community and civil society mobilization is essential to safeguarding human rights of key populations and affected and vulnerable communities. This plays a crucial role towards improving uptake of health services, including those for HIV, TB, and malaria; scaling up interventions to the level necessary; accessing hardest to reach groups; advocating for transparency and accountability; and keeping implementation costs sustainable.

In Global Fund grants, communities and civil society play important roles in ensuring community-centered, rights-based, and gender-transformative (CRG) HIV, TB, and malaria programming. In affirmation of this, the Global Fund Board in 2014 allocated USD15 million from 2014 to 2016 for a set of CRG Special Initiatives (CRG SI). The CRG SI has two objectives: (a) for communities and civil society to be meaningfully engaged in the design, implementation, and monitoring of supported programmes; and (b) to ensure the inclusion of technically sound interventions to address human rights, gender equality, and community systems strengthening (CSS).

The CRG SI aims to support effective community and civil society engagement in Global Fund processes through the following core programmes<sup>1</sup>:

- 1) Supporting the long-term capacity development of national and regional HIV key population networks for more effective engagement in Global Fund processes;
- 2) Short-term technical assistance towards effective engagement of community and civil society groups in Global Fund country dialogues and concept note development (up to grant signing); and
- 3) Regional CRG Communication and Coordination Platforms

Under the short-term technical assistance (TA) program of the CRG SI, APCASO has been deployed to several TA assignments across the three diseases from 2014 to 2017. In addition, from August 2015 APCASO launched and served as the host of the Asia-Pacific CRG Platform (APCRG). As host of the APCRG, APCASO has been positively reviewed by external partners for having facilitated solidarity-building, information exchange, and cross-learning amongst

<sup>1</sup>Middleton-Lee, S. (2017). Evaluation: Community, Rights and Gender Special Initiative 2014-2016. The Global Fund to Fight AIDS, Tuberculosis and Malaria.

community and civil society (CS) networks working on and across HIV, TB, and malaria in the region. APCASO as APCRG produced and packaged resources and tools to support advocates unpack Global Fund processes and to help ensure that disease programmes are inclusive of CRG interventions. It has also brokered linkages and CRG-relevant communications and concerns between community and CS partners and the Global Fund CRG Department, technical assistance provider platforms, funders, and UN partners.

As part of its APCRG hosting role, as well as part of its CRG TA provide duties, APCASO has supported the establishment and strengthening of regional CS advocacy platforms on malaria and on TB. Select assignments of APCASO as a CRG TA provider include supporting development of the key population engagement plan as part of the CCM reform in Nepal in early 2017, and inclusion of CRG issues in the 2017 series of country and regional dialogues for the Mekong Subregion malaria funding request submission of the Regional Artemisinin Resistance Initiative (RAI) grant.

## Purpose of this report

This documentation report aims to capture insights and lessons from its APCRG hosting and select CRG TA provision work from 2015 to 2017, and provide recommendations that will guide future similar work and initiatives.

Specifically, this report aims to:

1. Produce a compendium of case studies and an analysis on the significant change and contributions of selected APCASO CRG work, in particular:
  - a. technical assistance that supported the Regional Malaria CS Platform engagement with the 2017 RAI funding request development (2015-2016)
  - b. technical assistance that supported the establishment of the Activists Coalition on TB Asia-Pacific (2016)
  - c. technical assistance that supported Nepal community and CS engagement with the New Funding Model (2017)
  - d. technical assistance towards community mobilisation of KP networks in Sri Lanka (2017)

This report intends to look at the most significant changes and contributions of APCASO's CRG work wherein partner organizations and communities were involved. Through the narratives, effective practices will be identified that can be referred to as guidance in future TA provision and platform hosting.

## Scope and Methods

The scope of this report will focus around four areas of inquiry following the objectives of the third core programme of the CRG SI (i.e., the Regional Communication and Coordination Platforms), which are the following<sup>2</sup>:

1. Improve the knowledge of civil society and community-based organizations on the GF and on how to access TA to improve the inclusion of CRG-related interventions in their HIV, TB, and malaria programmes;
2. Coordinate with other TA providers in the region;
3. Improve understanding on the TA and capacity gaps of CS and community-based organizations to promote and/or implement CRG-related interventions; and
4. Promote strategic CRG-related capacity-building initiatives in the region

The CRG technical assistance component are short-term and time bound grants provided to community organizations under the following areas: situational analysis or needs assessment, engagement in country dialogues and related processes, and supporting programme design; or on a case-to-case basis<sup>3</sup>. For these programs to be reviewed and analyzed, the four similar areas of inquiry above will be employed.

Two levels of data gathering methodologies were employed for this project. The first level includes a literature review of the relevant documents, such as concept notes, meeting reports, CRG starter kits, and evaluation reports<sup>4</sup>. The second level included interviews with regional network and platform partners, organizational partners, Global Fund partners, and recipients of technical assistance both regionally and at the country level<sup>5</sup>.

<sup>2</sup> APCASO (2015). Regional Platform Launch Meeting Concept Note.

<sup>3</sup> Middleton-Lee, S. (2017). Evaluation: Community, Rights and Gender Special Initiative 2014-2016. The Global Fund to Fight AIDS, Tuberculosis and Malaria.

<sup>4</sup> A full list of references can be found at the end of this report

<sup>5</sup> A full list of interviews can be found at the end of this report

A semi-structured questionnaire was devised for the interviews, which includes the following questions:

1. Tell me how you became involved with APCASO's CRG work, in particular (mention TA).
2. From your point of view, describe the most significant change that has resulted from your engagement with (mention TA). Describe what happened: who was/were involved, where, when.
3. Why is this significant to you?
4. What kind of information did you or your organization gain from the CRG TA?
5. What are the levels or areas of support that APCASO supported in the development of the TA request? How was it done?
6. How were community networks engaged and capacities strengthened?
7. Looking back over the few months after the TA, what do you consider as the most significant outcome of the TA provided to you and your organization?
8. Looking back over it now, what do you think would you consider as the most significant contribution of the TA that was provided? Why so?
9. What are the lessons that you learned from this TA process that we can improve for future work?
10. What else can you share that you may have missed?

# Overview of the APCRG Platform and CRG TA Provision

From 2015 to 2017, APCASO has been the host of the Global Fund-supported Community, Rights, and Gender Regional Coordination and Communication Platform for Asia-Pacific (APCRG). As part of the CRG Special Initiative (SI), Regional Platform work aims to contribute to the SI's overall goal of building the capacities of civil society and communities towards effectively engaging in, and contributing to, the development, implementation and oversight of, Global Fund-supported programs.

APCASO, in its workplan in 2015, proposed the following activities:

1. Enhancing civil society and community knowledge on the Global Fund and technical assistance access,
2. Coordination with other technical assistance initiatives such as the Technical Support Facility (TSF),
3. Improving understanding of technical assistance and capacity development gaps for civil society and community groups, and
4. Strategic capacity development initiatives

As part of its launch in 2015, APCASO aimed to harness its presence in 11 countries<sup>6</sup> in the region through its focal point country partners, as well reach out to existing key regional HIV, TB, or malaria community networks. Before APCRG was established, there have already been regional HIV key population networks which are well-established, a Global Coalition of TB Activists (GCTA) but without a regional counterpart, and the Regional Malaria Civil Society Platform. APCASO leveraged on the existence of these networks and worked on strengthening the partnership with TB and malaria networks, and expanding APCASO's reach in locations where APCASO's relationship needs to be develop, or wherein no current focal point partners are present.

<sup>6</sup> These countries include Cambodia, China, India, Indonesia, Lao PDR, Malaysia, Nepal, Philippines, Sri Lanka, Viet Nam, and Australia

To date, the work of the APCRG can be summarized into the following:

1. Framework-setting and strategizing towards an effective APCRG platform, which includes the following activities:
  - a. APCRG conducted a series of needs assessment exercises in six countries as well as the regional grant support to the Regional Artemisinin Initiative (RAI) that would support and frame the technical assistance needs of the countries
  - b. A consultation on the development of a regional manual on incorporating CRG issues in Global Fund programmes were also conducted.
  - c. Conduct of sessions on access to affordable medicines, deep-dive into gender and sexual orientation and gender identity and expression (SOGIE), and human rights in the context of the three diseases
2. Partnership-building and outreach with wider HIV, TB, and malaria networks and with other CRG regional platforms, Global Fund advocates networks (including Women for Global Fund), the HIV Regional Partnership Forum, and regional HIV networks of key populations, the Global Coalition of TB Advocates (GCTA), Stop TB Partnership (STBP), and the Greater Mekong Subregion (GMS) Civil Society Malaria Platform. The APCRG has had some success through strategic engagement with country coordinating mechanism (CCMs), donors and technical agencies and the inclusion of civil society representatives at the Asia-Pacific Leaders Malaria Alliance (APLMA) senior officials meeting was a significant achievement.
3. Establishment of strategic information, communication and coordination of CRG-related documents and materials, to include a range of online communication platforms that have been developed such as APCRG sub-website within the APCASO website. An APCRG list-serve for sharing information has also been established to promote CRG issues and approaches that can be utilized in engaging with CCMs and Fund Portfolio Managers (FPMs) and through presentations at various fora. A series of regional resources were also developed, such as the following:
  - a. A CRG Starter Kit that contains information sheets and FAQ on CRG short-term technical assistance
  - b. A desk review of CRG issues in The Global Fund concept notes
  - c. A training module on CRG for community groups

Along with the CRG platform hosting are a number of technical assistance grants provided by APCASO. These are the following:

1. From 2015 to 2016, technical assistance support for the Regional Malaria CS Platform engagement with the 2017 RAI funding request development
2. In 2016, technical assistance that supported the establishment of the Activists Coalition on TB Asia-Pacific
3. In 2017, technical assistance that supported Nepal community and CS develop a CCM key population engagement plan as part of the eligibility requirements of the country's CCM
4. In 2017, technical assistance to support strategizing of communities in national Global Fund processes in Sri Lanka



NEPAL COMMUNITY and CIVIL SOCIETY CRG TECHNICAL ASSISTANCE WORKSHOPS

7-11 July 2017, Gokarna Forest Resort, Thali, Kathmandu

Organizer:



Coordinating:

Country Coordination Mechanism (CCM), Nepal  
And  
NAP+N





# Most Significant Changes through the CRG Platform and the Technical Assistance Program

Significant Change 1: The APCRG Platform and TA Program filled the gap in community engagement of tuberculosis and malaria affected communities and strengthened the capacity of tuberculosis and malaria networks by supporting the development of regional malaria and TB civil society platforms and networks.

Both the formation of ACT! Asia Pacific, or the Activists' Coalition of TB Asia Pacific, as well as the strengthening of the Regional Malaria civil society Platform, GMS in its engagement in the RAI benefitted from the APCRG Platform and TA Program of APCASO. APCASO's shift in its mandate to go beyond HIV to respond towards other, equally important, health challenges in the era of Sustainable Development Goals provided an opportunity for the network to see the gaps with regards to issues on health, social justice and human rights, as well as gaps in community engagement of key, vulnerable, and affected populations and communities in these diseases. This change in mandate<sup>7</sup> allowed the organization to organize meetings that discusses cross-cutting issues on universal health coverage and health financing, and invite community organizations in a space that looks beyond diseases and into common issues that affected populations' access to health services and enjoyment of their rights. In turn, the organizing of these meetings paved the way to establish regional mechanisms that connects people with similar priorities, may it be HIV, TB, or malaria, together.

<sup>7</sup> APCASO's revised mandate is guided by three core beliefs: first, that ending AIDS, tuberculosis, malaria, and other health challenges can only happen when the human rights of ALL people are respected, promoted, and protected; second, the task of 'ending AIDS' is not merely biomedical in nature but an end to stigma and discrimination against key affected communities, the barriers that make them vulnerable to the epidemic in the first place; and third, that while we need to remain steadfast in our commitment to ending AIDS, we need to be cognisant of, and address, other key health and social development issues faced by communities most in need – including those affected by tuberculosis and malaria.

*We didn't know the people in the Philippines, Indonesia, PNG, so creating these networks was definitely a benefit and something we hope to be able to build on. KHANA works only in the country, but from within ACT! AP, we could bring issues to be discussed at the regional level. - Chamreun, KHANA, ACT! AP Co-Chair*

The platform provided for groups to come together was a contribution in itself to both TB and malaria networks that were formed through APCRG. Both TB activists and malaria advocates who were engaged in the technical assistance program towards the ACT! AP formation and the RAI, emphasized that APCASO played a significant role in creating a regional space wherein communities can bring and voice their issues, learn and exchange effective tools, and share first-hand experience of other activists in their respective countries. Such creation of networks also exemplifies the voices of the communities who are continuously neglected in programming and policy decision-making, and are usually only treated as patients or beneficiaries of Global Fund grants.

APCASO also filled the gap on the need to establish regional platforms that were initially absent. In the case of Asia-Pacific, a regional TB community network does not exist prior to ACT AP's establishment. In the case of malaria response, while the Regional Malaria CSO Platform, GMS has been established since 2014, APCASO, through its CRG TA provision, augmented the needed support both in terms of funding and enabling community advocacy particularly in areas of community engagement, gender, and human rights – key areas that did not have focus prior to the RAI technical assistance grant.

*As an activist, it is our role to bring that coalition forward; that a regional space has been created is important and is much needed due to the TB epidemic in the region. - Manoj, ACT AP member*

The formation of these networks also presents opportunities to solidify community voices regionally. In attending international conferences, for instance, the presence of a regional platform facilitated by APCRG and APCASO ensures that Asia Pacific issues and priorities are highlighted and remain in the agenda.

## Significant Change 2: APCRG created a one-stop hub that provides communication, coordination, and technical support for communities

APCASO, both as APCRG platform host and CRG technical assistance provider from 2015 to 2017 provided a good opportunity to combine its communication and coordination role and technical assistance provider based on its expertise and the expertise of its staff. Communities saw this integrated approach of the APCRG that APCASO played as a platform “to house a coalition...and because of its technical ability, was able to provide strategic leadership that the coalition needed.” It also made the APCASO perform tasks that are not piecemeal approach. For example, the combined technical capacity and coordination role of APCASO towards ACT! AP enabled the coalition to become more collaborative and to leverage resources that has helped the coalition moved forward.

At the country level, the combined technical support and communication role of APCASO as APCRG platform was advantageous in that there was a swift exchange in the translation of and relay of information i.e., Global Fund-related documents. It was easier to request for both information about Global Fund processes and technical assistance on advocacy and strategizing at the country level. In the Sri Lanka technical assistance program, for example, the APCASO-supported Sri Lanka country TA provider would contact APCASO Secretariat as necessary to clarify things with regard to concept note development and inquiries on National Strategic Plan (NSP) review process and this informed work to support community groups’ engagement with Global Fund processes within the country.

## The Formation of ACT! AP (2016)

For Asia-Pacific which is home to five of seven TB high-burden countries, and which accounts for almost 87% of new TB cases globally, the absence of a regional civil society platform that addresses TB poses a challenge in putting the disease as a regional priority. ACT! AP was established in light of this.

The Activists' Coalition on TB Asia Pacific (or ACT! AP) is the Asia-Pacific coalition of individuals, community, and civil society groups working for effective, people-centered, rights-based, and sufficiently and strategically resourced TB responses. The regional coalition emerged from the GCTA and APCASO-led regional meeting held from 8<sup>th</sup> to 10<sup>th</sup> November 2016 wherein TB and multi-drug resistant (MDR)-TB survivors, Stop TB Partnership Challenge Facility grantees, TB REACH grantees, Global Fund TB primary and sub-recipients, members of the World Health Organization (WHO) TB Civil Society Taskforce, as well as representatives from regional and national HIV networks participated in the meeting. The meeting was collaboratively funded by Global Fund External Relations Division, GCTA through the Global Fund's Community, Rights, and Gender Special Initiatives (SI), and APCASO through the Open Society Foundations (OSF) core funding and APCRG Platform funding from CRG SI.

At the meeting, the newly-formed ACT! AP agreed on the following Commitments to Action<sup>8</sup>:

1. To ACT on the political attention that TB deserves
2. To ACT by presenting CRG models to the prevailing biomedical approach to TB
3. To ACT in overcoming barriers to accessing TB treatment and diagnostics
4. To ACT in securing adequate and strategic investments for TB with specific one-year and five-year targets, especially through FACT\$ (funding champions for TB)
5. To ACT by coordinating and building capacities of TB community and activist movements



<sup>8</sup> See Appendix A. Access the full version of the Commitments to Action here: <http://apcaso.org/new-asia-pacific-coalition-of-tb-activists-launched/>

At the same time, ACT! AP membership formed a Steering Committee that will lead on the strategic directions of the Coalition moving forward. One of the roles envisioned for ACT! AP is becoming a network of country networks of support groups of people who have and have had TB, civil society organizations, and community organizations who are affected by the disease (e.g., people living with HIV groups).

This convening of ACT! AP came at a right time when the need to increase advocacy towards putting more attention to TB was imminent and community movements are beginning to be built around the world.

*(ACT! AP) is very important because if you only speak alone, it may get an attention but not so much. If our voice is louder, that is the contribution. Asia-Pacific needs more noise and needs to speak out more. (ACT! AP) is the coalition that speaks on behalf of the people who are affected by TB.*

**- Elvi Siahaan, MAP Internasional & ACT! AP Co-chair**



The technical assistance that APCASO provided through the CRG SI helped in such a way that while APCASO's strength was not on tuberculosis, the technical expertise of APCASO with regard to community mobilization and strengthening steered the conversation towards engaging TB communities together and helped create the coalition. "There is no ACT AP without

APCASO," said one respondent. This highlights the critical role APCASO played in the formation and in supporting the coalition in its birthing stages.

*APCASO started the process at the right juncture. Everybody was in the process of putting up the next proposal for The Global Fund with the country dialogue and the process was there to begin. APCASO involved TB communities and those that are involved at the time. APCASO helped in providing information about grant-making and what is needed in the proposals. - Manoj Pardeshi, NCPI, ACT AP member*

The commitment from GCTA towards supporting ACT! AP also helped moved the convening forward. When at the beginning there seemed to be no funding resources to establish a regional TB network, APCASO and GCTA's recognition of the need of a regional network, and the sheer will to establish despite resources limitation saw ACT! AP establishment through. In the process resources became available from CRG SI in the form of funded technical assistance coursed through APCASO. APCASO likewise leveraged its existing core (Open Society Foundations) and project funding (mainly under APCRG), and organizational reserve funds to pull off the first regional convening as well as to support ACT! AP hosting and steering committee meetings in its first year.



### Significant Change 3: APCRG fostered solidarity and cross-learning among civil society and key population networks across the three diseases.

Ensuring that there is an equitable attention to HIV, tuberculosis, malaria, was critical towards the success of the APCRG as a platform. APCASO, despite its lean staffing at the Secretariat, was able to utilize its networks and capitalize on its expertise on health and human rights as well as on gender and community empowerment in enabling cross-learning across communities working with and affected by the three diseases.

In the course of the APCRG platform hosting and technical assistance provision, APCASO reached out to regional HIV community networks and included them in different meetings. This was done in an effort to ensure community voices and linkages between regional and country networks, and creating interest and buy-in on the work from communities in both regional and country levels. APCASO and its partners saw how disease-specific organizations who took part in APCRG meetings began to take on work in other diseases and integrate them in their current focus area; for instance, TB and HIV.

The meetings that were organized at the regional level were also utilized as a platform to share information and learning from different countries and communities working in different diseases including on community development approaches and issues expertise. This cross-disease platform setting is one beginning of work to close the gap on the perennial issue of communities working in isolation for their own specific issue.

The support that APCASO provided to countries also helped facilitate and patch long-standing conflicts among community organizations. For instance, in Sri Lanka, the technical assistance supported the different HIV key population communities to come together for the first time and discuss as a singular coalition. While there were tensions between organizations on a level of issues, driving the different organizations to focus on a more urgent priority, which is their engagement in the Global Fund processes in the country, helped organizations mend their relationships with each other towards a more important task at-hand.

*APCASO supported this “partnership forum” approach, inviting the key population organizations and would need to meet up and discuss and sort out issues and meet regularly. – Roshan DeSilva, Sri Lanka*

## Towards Effective Key Population Engagement in Nepal's Country Coordinating Mechanism (2017)

Since its formation in 2015, the CCM of Nepal was deemed ineligible to apply under Window 3 of the New Funding Model because of performance issues due to political, technical and financial reasons. While efforts were made to comply with the CCM Eligibility Criteria, the CCM still lacked effective mechanisms to ensure meaningful engagement of all stakeholders most especially key populations. Because of this, the National Association of PLHIV in Nepal (NAP+N) applied for a technical assistance request to The Global Fund CRG technical assistance program. The request is towards developing a CCM engagement plan for key populations, which incorporates plans to support key population representatives on the CCM to develop clearer ways of working and consulting with their own constituencies and across constituencies during Global Fund country dialogue and related processes. APCASO has been selected as the CS-peer provider for this short-term technical assistance request. A site visit and workshop took place from 7<sup>th</sup> to 11<sup>th</sup> July 2017 in Kathmandu, Nepal, preceded a month earlier by a scoping visit to plan with NAPN+ and other country stakeholders by APCASO's executive director which led APCASO team for the Nepal TA deployment.



Through the CRG SI support, APCASO, working closely with NAPN+, the country CCM and other local partners, facilitated a process that enabled communities to better engage, communicate, and coordinate with their constituencies and understand their role in country dialogue process and related processes of the NFM concept note development. The community and CS workshop done under the TA assignment

included sessions wherein participants underwent the basics of Global Fund processes, including understanding the NFM and their roles in engaging with The Global Fund through various platforms, including the CCM. In one of the sessions, a dialogue that took stock of the successes of the CCM were also conducted. As a result, community participants representing their respective KP and CS networks developed and signed a "Nepal Community and Civil Society Charter of Principles." The Charter of Principles (COP) sets out key values, principles, and ways of working that Nepal HIV, TB, and malaria vulnerable and



key population networks and civil society organisations agree to bind themselves to. Being both inspirational and aspirational, the values and principles in this COP frame their reason for existence and set standards for how they conduct their work and engagements - within and across their networks, and with other stakeholders.

The workshop facilitated the needed dialogue between the current CCM community and CS representatives and their constituencies. They drafted an engagement plan, building on the SWOT analysis, the Charter of Principle, and the expectations from networks and CCM members.



APCASO leveraged its existing partnership with NAP+N and communities in Nepal to map out the needs and identify ways and means of engagement with the different communities prior to the workshop in Nepal. The network's expertise in providing technical support to partners and strategizing helped NAP+N facilitate the consultation meeting in a structured, participatory, and effective manner.

APCASO's technical expertise, particularly on CRG issues and community mobilisation and managing community dynamics proved to be helpful to local partners.

*APCASO helped us make key populations who sit in the CCM know their roles and reinforce their knowledge; and our engagement plans became really comprehensive. - Mahesh Dhungel, CCM Coordinator*

Through the technical assistance support of APCASO, different stakeholders, who may have differences in politics and agenda, were brought on an equal footing. This allowed them to engage and exchange towards reinforcing a shared goal, which was to reinvigorate the needed cooperation to make the CCM functional again. In terms of network capacity building, it was an opportunity for the stakeholders to see how the engagement plan can function, and to better understand the role of CCM and their scope of work, both as CCM members and as representatives of key population networks.

This bringing together of different key population networks was also vital in understanding that HIV is a cross-sectoral issue that needs to be addressed cross-sectorally. As one of the interviews noted, “there are many issues that can be chosen, and any issue would be able to help people start respecting each other, and take on each other’s issues. Sex worker issues, for example, shouldn’t be only the sex workers’ problems, it can be brought up by the migrants, etc.”



## Significant Change 4: APCASO supported and contributed towards strengthening of civil society and community's articulation issues on community engagement, human rights, and gender equality

Consequently, the formation of and/or strengthening of different coalitions - both at the regional level as in the case of ACT! AP and GMS Platform, as well the coming together of key population communities in Nepal and Sri Lanka - entailed APCASO being able to rally partners on common grounds of concern. Meetings and other opportunities facilitated by APCASO as APCRG or a CRG TA provider became venues to share issues, identify commonalities, and consider joint advocacy actions. In the case of ACT! AP, the mobilization of TB activists brought about the development and consensus of a Commitments to Action, and later on, an action plan. In the case of the civil society engagement among community and civil society organizations in the RAI, a list of civil society priorities was developed for the RAI Phase 2 Programming. These engagements also became an opportunity to discuss CRG issues that were not previously discussed or considered in malaria or TB platforms

*We also need to consider rights and gender issues, and once they are able to frame the issues of communities, they will start to demand it. - Shree Acharya, Coordinator, Regional Malaria GMS Platform*

### **Who is the Regional Malaria CSO Platform, GMS?**

The Regional Malaria CSO Platform, GMS was established in 2014 through the initiative of the RAI Regional Steering Committee members, Louis de Gama and Promboon Panitchpakdi, responding to the need to understand the gap in coordination and communication among civil society and community organizations working in malaria and serving vulnerable populations including mobile and migrant populations and indigenous populations at the national and regional levels. Since its inception, the platform was able to create a network of more than 50 members in Greater Mekong Region.

The Platform aimed to provide a common space for civil society organizations in the Greater Mekong Region to share information, harmonize programmatic work on malaria, strengthen capacities of its members, and build a coordinated effort to bring focus towards addressing malaria issues among vulnerable populations through advocacy.

*Source: <http://www.malariafreemekong.org/cso-platform/>*

## Towards Better Engagement and Inclusion of Civil Society Organizations and Communities in the Regional Artemisinin Initiative (RAI) Grantmaking and Implementation (2015-2016)

In 2016, APCASO, in partnership with Regional Malaria Civil Society Platform identified priority areas during a needs assessment and a roundtable discussion that explored the experiences of civil society and communities on the Global Fund New Funding Model. These priority areas resulted to a proposed malaria technical assistance programme that aimed to work to achieve three primary objectives across the Greater Mekong Subregion (GMS), including within its individual countries of Cambodia, Lao PDR, Myanmar, Thailand, and Viet Nam.

Meaningful engagement and strong capacity of malaria civil society is critical in mounting an effective response to multi-drug resistant malaria strains in the Mekong. The CRG SI Malaria TA programme was an effort by the Global Fund to provide the needed support in response to this. The Global Fund Malaria Technical Assistance Programme had the following objectives:

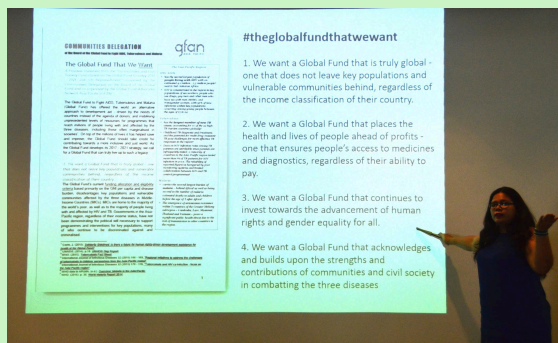
1. Increase meaningful representation and inclusion of civil society and community voices in Global Fund processes related to malaria within and across the proposed programme countries;
2. Enhance the understanding and analysis of community responses, human rights and gender related barriers in responses to malaria; and,
3. Contribute to effective inclusion of relevant community efforts and programs to address identified human rights and gender barriers in delivery of Global Fund supported malaria programs and future Global Fund funding requests, in order to achieve more sustainable and effective responses.

APCASO as APCRG has provided technical assistance to the Malaria Regional CSO Platform in their key meetings and convenings, even before Global Fund-supported GMS Malaria TA Programme (MTAP) was secured. MTAP provided additional resources and mandate to APCASO to formalise its support to malaria CS and community networks, particularly in the lead up to regional and country processes towards the planned lodging then of the multi-country the Regional Artemisinin Resistance Initiative Phase II (RAI 2) funding request.



Under MTAP, a regional CS preparatory meeting was held in December 2016. This was the first step in a comprehensive and funded plan to support effective input by malaria CS in RAI 2 funding request development, and ensure their meaningful engagement in country dialogues. With technical assistance from APCASO, the helped the Malaria CS Platform develop and craft its RAI 2 priorities:

1. Development and strengthening of community systems to respond to malaria, an approach that enables communities to mobilize, empower, and fund community-based organizations and networks of those who are affected by the malaria epidemic; and
2. Removing barriers to accessing malaria-related services, which includes advocacy for policy coherence for effective malaria response within and across local and national borders, and harmonization and coordination in national and regional policy implementation and monitoring.



Further along the MTAP implementation, during the funding request development, APCASO as the CRG TA provider contributed in the introduction of human rights and gender, and the importance of community engagement. There were also MTAP resources allocated to conduct a deep-dive analysis on CRG issues in the context of malaria, to support malaria CS

partners in their advocacy towards a CRG-inclusive malaria programs.

*You may have noticed that people are struggling to understand CRG in malaria. Now, they have a better understanding of how to reach communities, what is rights, and what are the community issues are and how this is linked to people's health rights. - Shree Acharya, Coordinator, Malaria Regional CSO Platform*

APCASO's facilitative nature leveraged the partnership between the network and the malaria CSOs. Cognisant that it does not have much experience in malaria work, APCASO ensured close collaboration with the Malaria Regional CS Platform to keep the MTAP work relevant and useful -- from coordination, to in-country planning and coordination, and the actual implementation.

A number of catalytic activities were conducted within MTAP:

1. Mapping of malaria CS and community stakeholder groups and individuals in the 4 GMS countries. This was done to support more inclusive and broader stakeholder mobilisation.
2. Providing support to SCDI, a Viet Nam CS organisation, to mobilise indigenous groups and other community stakeholders from endemic areas in the malaria response. This enabled convening of a meeting that, for the first-time, brought indigenous people's groups in the same discussion table as national programme representatives to share their perspectives and understanding of roles for the last mile efforts in malaria elimination.
3. Development of a civil society CRG in the context of malaria framework paper
4. CRG-oriented interventions to drafts of the RAI 2 funding request
5. Supporting in-country CS preparatory meetings taking place before each of the RAI 2 country dialogues to scope and prioritise country level CS issues



### **Viet Nam in-country mapping exercise (2016)**

In Viet Nam, APCASO and the Malaria CSO Platform partnered with the Center for Supporting Community Development Initiatives (SCDI) to conduct the mapping exercise of the different malaria issues and identify communities and organizations that work on malaria in the country.

Malaria was not SCDI's field of expertise, but the technical assistance program enabled SCDI to learn about the areas that are prevalent to malaria, as well as identify the communities that are heavily impacted by the epidemic. SCDI also supported the communities identify their priorities and learn about CRG-related issues.

*Before, we do not see the role of human rights and gender in malaria response, but now, we can see the communities participating in the country concept note and regional concept notes for the Global Fund.*

*- Dr. Khuat Thi Hai Oanh, Director, SCDI*

Through the APCRG, the convening together of the communities and civil society has contributed in making sure that the priorities of the civil society are in the regional and country Global Fund grant and beyond.



## Significant Change 5: APCASO facilitated increase in access and understanding of Global Fund processes among community networks

Significant strengths of APCASO include its critical understanding of Global Fund processes; experience in facilitating community dialogues, capacity development and mobilisation; and ability and nimbleness to apply and assert CRG-approaches in analysis of issues, CS strategising and advocacy. APCASO develops in-materials that demystify Global Fund concepts, terminologies and processes; share information with TB, HIV, and malaria communities in the different meetings it convenes or are able to access; and facilitate, create, and foster processes for communities to identify their priorities and advocate for these priorities in relevant national or regional spaces.

In order to establish a wider reach across the region, APCASO created an APCRG home page within the APCASO website wherein users can access the CRG Starter Kit, a seven-part guide that communities can use as reference in understanding the New Funding Model, CCM engagement, and CRG. To date, the tools have been translated into five languages, namely Khmer, Sinhala, Thai, Urdu, and Vietnamese.

*The information about GF allocations and the catalytic investments, strategic initiatives, and timeline for submitting the fund requests are helpful. I wrote and forwarded the information to our partners and mentioned the CRG team.*  
- **Bikas Gurung, Program Coordinator, ANPUD**

Through the CRG technical assistance program, country level engagements, as in the case of Sri Lanka, benefited from APCRG info-materials on the Global Fund. The outcome was a change in the framing and understanding Global Fund- and related community issues, which in turn raised their interest to participate more meaningfully in the Global Fund concept note development and related processes at the country level.

*[As an outcome of the APCASO TA support] There was also a change in the communication in terms of the process and who is included in the meetings. Before, there was a community forum but only invited were the sub-sub-recipients (SSRs) of the three components. Now, communities demand their engagement in the community forums.* - **Roshan deSilva, Sri Lanka APCASO-supported community peer-TA provider**

## Mobilizing Key Population Communities towards More Meaningful Engagement in Sri Lanka (2017)

Communities were hesitant to engage in Global Fund processes in Sri Lanka because of the lack of engagement to them by the principal recipients and the fear that, as some of them are sub-recipients, their mobilising or advocacy could mean losing their funding. At the same time, communities lack the capacity to strategically engage in the Global Fund processes, including the country dialogues. There were also unavoidable relational conflicts among community organizations that made it difficult for them to work together.

APCASO supported a community peer-TA provider in Sri Lanka to take lead in mobilizing the communities and ensure that they engage in four key national activities: the end-of-term review of the National Strategic Plan (NSP), the development of the new NSP, country dialogues for the upcoming concept note, and the concept note development.

The peer-TA provider supported the mobilization of community groups by initiating discussions on the current NSP and facilitating strategizing among communities to set their priorities as they engage in the new NSP. Throughout the process, there were conversations with APCASO staff centred on addressing additional information needs, including on the Global Fund and CRG, to support the work of the country peer-TA provider.



*(Through the technical assistance program), it was one of the first time all key population representatives were sitting at the same table. There are lots of tensions between these organizations in Sri Lanka, but the technical assistance made them focus on what is needed to be done, which was engagement in the NSP and in the concept note. - Niluka Perera, Youth Voices Count, Sri Lanka*

Global Fund documents in English became one of the barriers for communities to engage in the Global Fund processes. The community peer-TA provider utilized the available materials from the APCRG website including APCASO's CRG toolkit and translated them to Sinhala. This allowed the community members to know Global Fund better and appreciate the importance of their engagement in its country processes.

Through the technical assistance program supported in Sri Lanka, one of the most significant accomplishments was the coming together of the communities and key populations to discuss and work together through a *partnership forum* model. This model includes collaborating towards a joint statement on the communities' positions on the NSP and on the concept note, as well as strategizing their engagement into these two national activities and in collaborating with the National STI and AIDS Control Program (NSACP) of Sri Lanka.



In effect, key populations organizations became vocal and began to engage more meaningfully in the processes, demanding their right to participate and to be invited. Despite the personal and organizational relationship conflicts, they became stronger and were able to focus on the right areas and move forward. This changed the way meetings were organized and how other stakeholders began to be more critical and inclusive of the key population communities.

One of the things that the community peer-TA provider and his team now thinks of is how to institutionalize the partnership forum approach so that a platform is established where people can talk and share ideas and become a partnership.

*We want to continue the platform forward but we don't have a plan yet. We have support from ACPASO until next May, so we want people to see the value of the platform so that we don't impose it on the community partners. The other partners, such as the Family Planning Association who has control on the GF project, is beginning to realize now that communities have the power and that they realize that they had to listen to communities.*  
**- Roshan deSilva**

## ការប្រៀបធៀបនៃថវិការបស់ជាតិ និងថវិការបស់ម្ចាស់ជំនួយ

	ថវិកាជាតិ	ថវិកាម្ចាស់ជំនួយ
កម្មវិធីសុខភាពទូទៅ	៨៤%	១៦%
កម្មវិធីឆ្លើយតបចំពោះ មេរោគអេដស៍	១៩%	៨១%



# What We Learned So Far: Lessons and Recommendations

In the span of two years, the APCRG platform hosted by APCASO and the CRG technical assistance that APCASO provided yielded significant changes to the communities who participated in these programmes. While some of the interviews noted that the impact has yet to be felt given that the interventions only took place for less than five years, some significant changes were already recognized by APCASO's partners.

In this report, five significant changes were noted:

1. The APCRG Platform and TA Program filled the gap in community engagement of, and strengthened the capacity of, tuberculosis and malaria affected communities by supporting the development of their respective regional platforms and networks.
2. APCRG created a one-stop hub that provides communication, coordination, and technical support for communities.
3. APCRG fostered solidarity and cross-learning among civil society and key population networks across the three diseases.
4. APCASO supported and contributed towards strengthening of civil society and community's articulation of issues of community engagement, human rights, and gender equality.
5. APCASO facilitated increase in access and understanding of Global Fund processes among community networks.

With these changes were also lessons and recommendations that were identified by those who were involved in these programs. These recommendations aimed at improving how the APCRG Platform can be implemented better, and the technical assistance supports create more effective outcomes at the country and regional levels.

## Recommendation 1: Strengthen articulation of issues on and across TB, HIV, and malaria, such as sustainability and community engagement as part of APCASO's core programming and a clearer linkage to APCASO strategy

Interviews suggest conduct of more researches that would provide more evidence and information on issues around the three diseases, including a deeper analysis on CRG that would tie up more directly to APCASO's core programming and strategy. While the creation of ACT! AP and the increased engagement of malaria community-based organizations to the RAI were noted, some of the respondents worry that the lack of more definite and long-term malaria and TB programming from APCASO's end may delimit how these coalitions will be sustained after the Global Fund support.

Despite a conscious effort on the side of APCASO to have the APCRG focus more resources and energy on malaria and TB, HIV is still viewed to be a priority of APCASO. At the same time, tuberculosis remains to be a neglected priority in the region, and the communities that are heavily impacted by malaria are still left out of country programs. Not privy to the fact that APCASO in fact invests its own core funding and organizational reserves (and staff time) in support of the development and strengthening of malaria and TB networks, some of the partners are also expecting to see tuberculosis and malaria align more prominently in APCASO's broader strategy and internal work. This is so that TB and malaria will have attention equitable attention to that of HIV, and to ensure that there will be a more proactive, predictable and sustainable way to share information and mobilise funding and other support for TB and malaria groups outside of The Global Fund funding mechanisms.

APCASO may be able to leverage the researches that it would conduct to build its expertise on the technical aspects of tuberculosis and malaria, weaving in CRG perspectives in a more programmatic and sustained (beyond one TA assignment) manner. One particular suggestion was to look at the intersectionality of the populations affected by the three diseases, APCASO employing a people-centered approach in its work.

Partners from ACT! AP also highlighted the need to have a clearer strategy on how APCASO would support the coalition as an institutional member of its Steering Committee. They also would like to see APCASO expand its focal points and engage with the broader TB and malaria community groups. Likewise, they would like to see APCASO reach out to other subregions, such as South Asia and the Pacific.

## Recommendation 2: Improve vertical and horizontal partnership-building, outreach, information sharing

APCASO is recognized by partners as having the capacity to create spaces wherein communities from the three diseases engage with and learn from each other. An additional layer of coordination and partnership which APCASO is encouraged to strengthen is at the global-regional linking. One respondent shared that APCASO as APCRG platform should establish stronger connections with global community organizations that work on tuberculosis and malaria beyond Global Fund's scope.

APCASO's focal points need to benefit in the APCRG Platform and technical assistance support, even if they do are not the directly "beneficiaries" of the technical assistance. This horizontal learning across country focal points is valuable. As a communication platform, APCRG should reach out and inform other country focal points of the different technical assistance work that it implements. Community organizations in the countries are also interested to know how they can tap APCRG and leverage the possible technical assistance support that can it can provide to them.

With regard to technical assistance support, APCASO can also facilitate dialogue with FPM and PR and SRs in the country for them to become familiar of the role of communities from country dialogues to concept note development.

### Recommendation 3: Improve strategic information and communications among stakeholders, especially community partners

The materials and communication products that APCASO produced for the past two years became useful to community partners, especially in their further understanding of Global Fund processes and in identifying ways and means to engage as communities, including representation at the CCM. Partners would like to see more communicate and updates on the different meetings that the APCRG conducts at the regional level.

Some of the partners also shared that many community-level organizations are not reached by the platform, and therefore are not aware of its purpose, as well as the technical assistance support that the programme may be able to provide. APCASO, as the APCRG, should devise ways to make sure that the communication that it produces reach community organizations in the countries. Translation of documents is necessary and crucial, because through this, Global Fund policy documents and even the tools and research outputs that the APCRG produces can be easily more easily be understood and used by the communities. Reaching out to regional and country networks, and expanding its audience base from its social media platforms is also another way to ensure that APCASO is reaching not only to its usual partners but covers new grounds.

In terms of CRG issues, partners would like to see more advocacy materials in the form of advocacy toolkits that could assist in building their relationships with relevant ministries and donors. While it is good that APCRG has developed toolkits and starter kits, these documents may need to be developed into bite-size materials that are easier to understand and use as handouts in workshops. The Global Fund policies may also need to be developed similarly so that community organizations will be aware of the different policies that the Global Fund Board releases that may affect their work and advocacy at the country level.

Apart from the information that are available through the APCRG website, partners would benefit better with being able to access a particular contact point person from the APCRG platform that that local partners and consultants can easily consult with on specific information needs, e.g. application for funding.



## Recommendation 4: Build on the opportunities to support and strengthen country community networks, particularly in grounding the work through increased country-level engagement

Community organizations in the countries are the lifeblood of regional networks. This also holds true with the APCRG platform: without the communities in the countries, there will be no entity to receive the communication and expertise that the APCRG can provide to make sure that Global Fund processes are inclusive of communities.

APCASO is viewed as an Asia and the Pacific network that is already working with community organizations and civil society at the country level. This could be further strengthened.

The APCRG must continue to support the coalitions that it helped build but also link them directly to funders that will enable them to sustain themselves and implement their action plans. APCRG should also think of building capacities of the coalition, beyond coalition establishment, and find ways to access areas of technical assistance that the Global Fund may not support, such as for organizational development.

APCRG should also think about expansion of its reach by supporting mapping exercises and needs assessments even at the provincial level.

## Recommendation 5: Facilitate participation of key populations and those affected by HIV, tuberculosis, and malaria

In order to be truly representative of the communities that it represent, APCASO and the APCRG should continue its efforts to keep on ensuring that those who are living with and affected by the three diseases are meaningfully engaged in the different processes and meetings that it facilitates.

The lack of equitable representation of key populations were also highlighted, and the need to invite community organizations in the country more than the regional networks. Inviting these groups from the country level would benefit these gatherings more. The APCRG must make sure that it prioritizes community groups at the country level than the regional networks to make the engagement more substantial.

APCASO and the APCRG is in a perfect position to build and facilitate community engagement. It needs to set up a structure that relies beyond creating spaces, but having a right balance of people in the room who will be committed to sustain the work beyond a particular meeting or technical assistance assignment.

Strengthening community systems. Advancing human rights.



# References

- ACT Asia-Pacific! *The Region's Activists' Coalition on TB*, APCASO, 2016.
- APCASO. *Activists' Coalition on TB Asia-Pacific Steering Committee Meeting*, APCASO, 2017.
- \_\_\_\_\_. *Asia Pacific Regional Platform Meeting Concept Note*, APCASO, 2016.
- \_\_\_\_\_. *Between the lines: Assessing the inclusion of CRG priorities in Global Fund concept notes in Asia and the Pacific*, draft, 2017.
- \_\_\_\_\_. *Asia-Pacific Regional Coordination Platform on Communities, Rights and Gender 2015 Meeting*, APCASO, 2015.
- \_\_\_\_\_. *Asia-Pacific Regional Coordination Platform on Communities, Rights and Gender 2016 Meeting*, APCASO, 2016.
- \_\_\_\_\_. "The Global Fund and CRG Starter Kit." APCASO, 2016, <http://apcaso.org/apcrg/starterkit/>
- \_\_\_\_\_. *Formation of the Asia-Pacific Coalition of TB Activists: Mobilizing the TB Community: Establishing the Asia Pacific Coalition of TB Activists and Crafting a Regional TB Advocacy Agenda Meeting Report*, APCASO, 2016.
- \_\_\_\_\_. *Malaria Civil Society Preparatory Meeting – RAI Regional Dialogue*, APCASO, 2016.
- \_\_\_\_\_. *Reflections + Recommendations for Follow-up Actions: Post-Regional Malaria Civil Society Consultation Workshop (17-18 November 2015) and Post-GFAN AP meeting at the Malaria CS Workshop (18 November 2015)*, APCASO, 2015.
- \_\_\_\_\_. *Strengthening community engagement in Greater Mekong Subregion Global Fund malaria grant – APCASO technical assistance proposal, TGF-16-041*, APCASO, 2016.
- Asia Pacific Platform on Communities, Rights and Gender poster*, APCASO, 2016.
- Davies, Rick and Jess Dart. "The 'Most Significant Change' Technique." CARE International UK, 2005, <http://www.mande.co.uk/docs/MSCGuide.pdf>.
- Global Fund Advocates Network Asia Pacific (GFAN AP). *Global Fund Advocates Network Asia Pacific (GFAN AP) Strategizing Meeting: 2016 Joint Malaria Week*, GFAN AP, 2016.
- Malaria Regional CSO Platform, GMS. *Regional Malaria CSO Platform, GMS: Review*, Malaria Regional CSO Platform, GMS, 2017.
- Middleton-Lee, Sarah. *Evaluation: Community, Rights and Gender Special Initiative 2014-2016: The Global Fund to Fight AIDS, Tuberculosis and Malaria*, The Global Fund, 2016.
- Middleton-Lee, Sarah. *Pilot Programme on Community Engagement, Gender Equality and Human Rights within Responses to Malaria – The Global Fund to Fight AIDS, Tuberculosis and Malaria*, draft, 2017.
- Middleton-Lee, Sarah. *Regional Malaria CSO Platform: Review*, draft, 2017.
- Towards Greatest Impact and Effectiveness of RAI 2018-2020 – Malaria Civil Society Positions*. Malaria Regional CSO Platform, 2016.
- World Health Organization. "Tuberculosis Factsheet." World Health Organization, October 2017. <http://www.who.int/mediacentre/factsheets/fs104/en/>

# Appendix A: List of interviews

## Global and regional networks

Bikas Gurung, Asian Network of People who use Drugs  
Harry Prabowo, Asia Pacific Network of People Living with HIV  
Kay Thi, Asia Pacific Network of Sex Workers  
Niluka Perera, Youth Voices Count  
Shree Acharya, Malaria Regional CSO Platform, GMS  
Steve Krause, Asia Pacific Network of Sex Workers  
Tushar Nair, Global Coalition of TB Activists

## Country partners

Choub Sok Chamreun, KHANA  
Dean Lewis, Touched by TB  
Elvi Siahaan, MAP Internasional  
Khuat Thi Hai Oanh, Center for Supporting Community Development Initiatives (SCDI)  
Korakod Intaphad, ARC Relief  
Mahesh Dhungel, CCM Secretariat Nepal  
Manoj Pardeshi, National Coalition of People living with HIV, India  
Roshan deSilva, consultant

## Other stakeholders

James Malar, Stop TB Partnership (as former APCASO)  
Pauline Mazue, The Global Fund External Relations Division

# Appendix B: ACT! AP Commitments to Action

The members of the new coalition agreed a set of “Commitments to Action” as the basis for their unity, which underlines the areas where the coalition will focus:

## **1. We will ACT to give TB the political attention it deserves.**

The coalition is alarmed that despite the means to prevent TB deaths and disabilities, TB is now the number one infectious disease in the world, with Asia-Pacific bearing the biggest brunt of new infections. This failure is inexcusable, and violates principles of human rights, social justice, public health, and sustainable development. TB continues to fall dismally low in the world’s, and in the region’s, development and political agenda.

ACT Asia-Pacific! calls on the international and regional development communities, governments, funders, researchers, and civil society movements (PLHIV, treatment access, anti-poverty, human rights, women’s, health, right to food, people with disabilities, etc.) to give TB the political attention it deserves, matched with the resources needed to reach the global goal of ending TB by 2030. It is also calling for a more effective TB and HIV responses integration.

## **2. We will ACT to present an alternative model to the prevailing bio-medical approach to TB.**

The coalition will advocate for TB responses that are people-centered and support the meaningful participation of communities in all levels of the response; respect, protect and advance human rights, including of TB key populations; and engrain gender equity and gender transformative policies and programmes as a critical means for an effective TB response.

ACT Asia-Pacific! also believes that disability or harm to one’s well-being should not be the consequence of accessing TB treatment. It will push for a TB response that invests in TB drugs that do not have horrific side effects and in care and support services for TB key populations, such as but not limited to people living in poverty, children, miners, mobile populations, PWUD, prisoners, rural populations, and urban populations.

# ACT!

**ACTIVISTS' COALITION ON TB  
ASIA-PACIFIC**

### **3. We will ACT to overcome barriers to TB treatment and diagnostics access.**

The coalition will work to build the needed support from different stakeholders to overcome key challenges to universal and equitable access to TB drugs and diagnostics, including:

- High prices of medicines and diagnostics, with essential health technologies remaining out of reach for millions;
- Weak health and community systems, weak supply chain management and procurement;
- Inefficient drug regulatory controls;
- Slow movement and low investments in TB research and development;
- Discrimination in healthcare;
- Poorly developed adherence/patient support mechanisms; and
- Absence of informed and mobilised communities and activists to challenge and demand for change in the status quo

### **4. We will ACT towards securing adequate and strategic investments for TB, making sure that these investments go to the right interventions, including by communities.**

Within its first year, the coalition aims to:

- Secure core and programme funding for ACT Asia-Pacific! to foster solidarity, cross-learning and support; coordinate and inspire joint advocacies; support community capacity building and mobilisation; and rally for support from key stakeholders.
- Establish FACT\$ (Funding Champions for TB), a funder-counterpart of ACT Asia-Pacific! whose members will commit to funding and mobilising resources for TB.
- Support civil society advocacy and capacity development for effective, strategic, sufficient and sustained, community-centred, rights based TB investments – from both domestic and foreign donor sources. The network will develop and submit a regional Global Fund funding request in 2017 for this.

organisational thrust is for better representation and leadership in TB framework-setting, policy development, advocacy, programme implementation and monitoring, at global, regional, national and local levels.

In the next 5 years, it hopes to:

- See increased investments in TB, including an increased ability within the Global Fund to support TB responses that is not at the expense of HIV or malaria funding;
- See increased effectiveness of joint HIV/TB programmes and budgets, including through greater involvement of community and civil society representatives in key decision-making and monitoring related to these.

**5. We will ACT to support a coordinated and capacitated TB community and activist movement.**

Drawing from the coalition's strengths, experiences, and lessons and inspired by on-the-ground work by other movements, especially in the HIV response, the network organisational thrust is for better representation and leadership in TB framework-setting, policy development, advocacy, programme implementation and monitoring, at global, regional, national and local levels.

The network will work in a spirit of open dialogue and partnership with TB stakeholders. But ACT Asia-Pacific! will also own the responsibility of calling duty bearers to task - including the WHO, Stop TB Partnership, The Union, national TB programmes, as well as, health, research and development sectors, the private sector, pharmaceutical companies, governments and development partners, technical agencies, and ourselves-communities and civil society.

The coalition's mandate is rooted on common values and principles, primary of which is the respect for the legitimate right and capacity of communities and TB key populations to determine the best solutions to problems that affect their lives.





# Appendix C: Charter of Principles for Nepal HIV, TB, and malaria community and civil society

## CHARTER OF PRINCIPLES FOR NEPAL HIV, TB, AND MALARIA COMMUNITY AND CIVIL SOCIETY<sup>1</sup>

### Preamble

We are networks of people living with, affected by, and most vulnerable to HIV, TB, and malaria in Nepal, and civil society organizations that have mandates to serve these constituencies. This charter sets the key values, principles and ways of working together.

We believe that meaningful community participation, gender equality, and human rights should ground any HIV, TB, or malaria response. In view of this, we reaffirm our commitment to work towards:

- Ensuring the meaningful involvement of members of HIV, TB, and malaria vulnerable and key population constituencies in all aspects of Nepal's social and health development responses;
- Promoting, protecting, and advancing the rights - including to non-discrimination and ensuring access to services - of people living with, affected by, and most vulnerable to HIV, TB, and malaria;
- Gender-transformative HIV, TB, and malaria interventions and responses.

### Individual Ethics

As individual members and representatives of our respective constituencies, networks, and organizations, we commit to:

- A spirit of solidarity and mutual respect based on frank, open, and honest discussion with each other of both common and differing perspectives.
- The support and nurturing for the well-being of each other as peers, along with the care for our own well-being.
- Upholding and non-judgment of one another's exercise of freedom and autonomy regarding lifestyle choices, and ensure others freedom and autonomy.
- Using spaces and resources we access in the name of our constituencies responsibly, and always, to serve and represent the constituencies to the best of our abilities.

### Collective Ethics

As networks and organizations working for HIV, TB, and malaria vulnerable and key population constituencies we commit to:

- Advocating for openness, transparency, and accountability within our own constituencies, networks, and organizations.
- Affirming that being community and civil society networks and organizations is not incompatible with being competent, professional, efficient, disciplined and accountable.
- Using power and authority responsibly, and managing organizational and network hierarchies with respect for all concerned, uplift and empower all members of our constituencies.
- Exercising responsible and collaborative leadership, management, and representation of our networks and organizations to uphold our common stated values and principles at all times.
- Being models of good practice as organization and networks, and ensure that financial resources raised in the name of our constituencies are put to the service of our constituencies.

<sup>1</sup> Developed and adopted from a community and civil society workshop convened from 7-9 July 2017 in Thali, Kathmandu Nepal, by the National Association of PLWHA in Nepal (NAP+N) and APCASO, support from Nepal's Country Coordinating Mechanism (CCMN) and funding from the Global Fund Community, Rights, and Gender Strategic Initiative

- Always remember that our reason for existing, is to serve the interest, and uplift the lives of members of marginalized and vulnerable constituencies.

#### Accountability to this Charter and Our Commitment to Managing and Resolving Conflicts

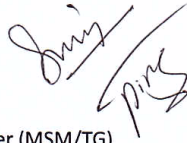
We commit to being held accountable for our behaviors, actions, or decisions that go against the principles of this Charter. We will use this Charter as a guide to decision-making related to conflict resolution, managing internal and cross-network or organisation grievances, and misconduct complaints.

For any conflicts arising within or across networks, in the spirit of the values and principles of this Charter, we commit to make every effort to reach solutions and agreements through dialogue. In cases of no amicable agreements is reached despite all efforts at dialogue, the conflicting parties shall appoint an external mediator to seek mutually satisfactory solutions.

In cases of grievance complaints against any of our member, the leadership or governance body of our network or organisation shall be guided by this Charter to determine how to act on the complaints. We take the responsibility for disseminating this Charter and having our constituencies, networks, and organizations fully understand, adopt, and be kept reminded of it.

Signed 9 July 2017, Kathmandu, Nepal:

Simran Serchan-FSGMN

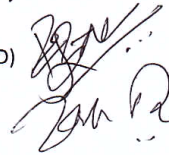


Rajan KC, CCM Member (PLWD-TB)



Pinky Gurung, CCM Member (MSM/TG)

Riddhi Pratap JBR, CCM Member (PWID)



Ashmita Bhandari-JMMS



Usha Jha, CCM Member (NGO-HIV)



Shova Dangol, CCM Member (FSW)



Achut Sitaula, CCM Member (PLWD-HIV)



Sharmila Basnet, NFWLHA



Prakash Nath Yogi, NAP+N



Subash Rai, RN



Dal Bahadur GC, NANGAN



Parashar B Adhikari, YKAP



Bal Krishna Sedai, CCM Member (Malaria)



Shrawan Ranjit, CCM Alt Member (TB-NGO)



Jay Kumar Devkota, CCM Member (Eastern Region)



Laxmi Kunwar, CCM Member (Western Region)



# Appendix D: Community Engagement Framework and Plan

## Constituency Engagement Framework and Plan<sup>1</sup>

of HIV, TB, and malaria key population and civil society networks and their representatives to the Nepal Country Coordinating Mechanism (CCMN)

### I. Purpose

This engagement plan lays out both the framework and details for communication, coordination, and consultation between and among key population (KP) and civil society (CS) representatives to the CCMN and their networks and constituencies. It serves as a reference to support the effective, coherent, and outcome-oriented engagement between and among the CCMN representatives and their networks and constituencies.

Specifically, the Constituency Engagement Plan aims to help ensure that:

- the views and positions expressed by KP and CS reps in CCMN meetings and processes are informed by the views of their constituencies;
- discussion and decision points in CCMN meetings and processes particularly those most relevant to KP and CS constituencies are effectively communicated to KP and CS networks and constituencies;
- KP networks and CS organization support their CCMN representatives to engage effectively in CCMN meetings and processes;
- KP and CS representatives to the CCMN are supported to coordinate and strategies with each other prior to and in between CCMN meetings and processes.

The Constituency Engagement Plan aligns with the commitments endorsed by Nepal HIV, TB, and malaria KP and CS networks in their Charter of Principles, in particular those related to ensuring transparency, accountability, and effectiveness in constituency representation.

### II. Lines of Engagement

This Engagement Plan identifies several parties that are points of engagement in the context of KP and CS constituency representation in the CCMN:

1. KP and CS representatives to the CCMN
2. KP and CS networks and organisations
3. KP constituencies: PLHIV, PUD, MSM/TG, migrants, female sex workers, prisoners in enclosed setting, 2 regional CSO representatives

The relationship and overall lines of accountability, responsibility and communication between the different parties are described below:

---

<sup>1</sup> 1<sup>st</sup> version developed and adopted during a workshop with KP and CS representatives to the CCMN convened from 10-11 July 2-17 in Thali, Kathmandu Nepal, by the National Association of PLWHA in Nepal (NAP+N) and APCASO, with support from Nepal's Country Coordinating Mechanism (CCMN) and funding from the Global Fund Community, Rights, and Gender Strategic Initiative

KP and CS reps to the CCMN	KP and CS networks and orgs	KP and CS constituencies
<p><u>In the context of CCMN representation,</u></p> <ul style="list-style-type: none"> <li>• Are accountable to their constituencies as well as their network/organization</li> <li>• Represents their constituencies (<u>not</u> their individual network/organization)</li> <li>• Reports to their constituency via their network/organizations</li> </ul>	<ul style="list-style-type: none"> <li>• Accountable to their constituencies</li> <li>• Authorizes and supports the involvement of their representative to the CCMN</li> <li>• Supports processes for their CCMN representative to consult, exchange information, and report back to their constituency</li> </ul>	<ul style="list-style-type: none"> <li>• Are represented by the KP and CS networks and organizations</li> <li>• Get updates and information about CCMN discussions and decisions from their representatives to the CCMN via the networks and organizations</li> <li>• Provides feedback, decisions on CCMN discussion points to their representatives to the CCMN via their networks and organizations</li> </ul>

### III. Plan of Engagement

In order to ensure constituency engagement through proper communication and activities all CCMN members representing KP, PLWD and CSO developed their own plan. Engagement plan has one common activity identified and agreed upon is rollout by one organization/network and also collaborate with other CCMN members in implementing engagement activities. Resource required for the implementation will be gathered through their organization and also seek support from CCMN secretariat. This plan may be updated and revised depending on the discussion with their respective network, Alternate CCMN member and constituencies.

This initial set of engagement plans have been developed for a six-month period (1 August 2017 to 31 January 2018). An internal evaluation of the engagement plans will be conducted by the CCMN representatives and their respective network to assess the effectiveness of their engagements. Following which, modifications and adjustments will be made accordingly for the following-12-month period.

## 1. Engagement Plan-Eastern Region

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Consultation Meeting with organizations within the constituencies	CCMN Member	<ul style="list-style-type: none"> <li>Sharing on CCMN structure and objectives</li> <li>Preparing a plan for meeting and setting up agenda</li> <li>Forming a group of organizations and spread the information across the region</li> <li>Possible collaboration and support in order to implement the engagement plan</li> <li>Sharing of meeting minutes of CCMN meeting and discuss on setting up agenda for next CCMN meeting</li> </ul>	Physical meeting	Bi-Monthly	<ul style="list-style-type: none"> <li>Better understanding on CCMN</li> <li>Create a uniform agenda on three disease</li> <li>Cooperation and collaboration among other CSO</li> <li>Finalization of CCMN agenda for next CCMN meeting</li> </ul>	Technical Support from CCMN, Budget (15,000 x 3=45,000)
<b>III. KP and CS constituencies</b>						
Constituency Mapping-Eastern Region	CCMN Member	Create CSO and KP (working on HIV, TB and Malaria) list with details contacts, "including coordination with KP	Desk research and Coordination	Mapping completed	CSO and KP mapping list in place	NGOCC and other CS networks

Updated on July 2017

		networks with existing regional networks/groups"	with NGOCC of different districts and national KP networks	by end of August; Updated every six-month		
Creating an Email Group	CCMN Member	NGO/CBOs	Pre/post information	As per need	CSO Group Email List	
Periodic field visit to CSO network <sup>2</sup>	CCMN Member	Field trip	Physical meeting	Quarterly	Identify the programme gap and issues regarding three disease from CSOs	Budget (10,000 x 2=20,000)

## 2. Engagement Plan of KP-PWID

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
RN as the National Network will form a joint platform to facilitate cross-coordination, communication, and strategizing. The representative who serves in the CCMN of the PWID component shall also Chair the Joint Platform with Chair of National network or representative assisting as Co-Chair	CCMN representative, thematic Networks and organizations Representing  For example ( Hep C- Union C  Drug Treatment-	<ul style="list-style-type: none"> <li>Sharing the objective of Constituency engagement and CCMN meeting updates</li> <li>Discuss on issues, challenges, gap and lesson learnt regarding PWID issues in depth through thematic desegregation</li> <li>Setting the agenda for upcoming CCMN Meeting</li> <li>AOB</li> </ul>	Physical meeting	Every 2 months	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Forming a group of organizations and spread the information across the region</li> <li>Possible collaboration and support in order to</li> </ul>	Per Meeting/Consultation @ Rs. 8,000 x 6 = 48,000/-

<sup>2</sup> Some of the field visit can be coincide with organizations regular events

Updated on July 2017

	FDDR, OST service Clients-SPARSHA )				implement the engagement plan	
RN ( National Network) Regional Executive Board Meeting	Executive Board members = 23 + 2 resource persons= 25	<ul style="list-style-type: none"> <li>Constituency engagement in network governance and other network/linkages expansion coverage.</li> <li>Discuss on issues, challenges, gap and lesson learnt and recommendations for addressing them.</li> <li>AOB</li> </ul>	Physical meeting	Annually	Documentation of key discussion points, network/linkages expansion coverage, issues, challenges, gap and lesson learnt and recommendations and network/PWID community decisions for addressing them	4000 x 25 = NRS. 100, 000/-
Quarterly Meeting with PWID partners network	CCM member and Network	<ul style="list-style-type: none"> <li>Sharing the objective of Constituency engagement and CCMN meeting updates</li> <li>Discuss on issues, challenges, gap and lesson learnt regarding PWID issues</li> <li>Setting the agenda for upcoming CCMN Meeting</li> </ul>	Physical meeting and community consultations in 5 development regions of Nepal	Every 3 months	Documentation of key discussion points and decisions	Joint constituencies focal persons and technical support from CCMN (25,000 x 5 Regions ) = 1,25,000/-
Communication	CCM Member	Circulate discussion points of regional meeting CCM meeting and other important issues agendas	Email/Social Network set up of e-list discussion group	Pre-meeting and post meeting	All CS and national networks and regional offices will get an update on time	Support from Network and CCMN

Updated on July 2017

Pre-meeting and post meeting	All Stakeholders, and Executive Board members of National Network and national networks and regional	Circulate and discuss the key discussion points of regional meeting CCM meeting and other important meeting to network and network will further circulate to region and other partner	Physical	Pre-meeting and post meeting	All CS and national networks and regional offices will get an update on time	8,000 x 2 (pre/post) x 4 (CCM meetings) = 64,000/-
Form a joint platform to facilitate cross-coordination, communication, and strategizing. The KP and CS representative who serves in the Ex Com of the CCMN shall also Chair the Joint Platform. (Achut Sitaula)	All Stakeholders, and Executive Board members of National Network and national networks and regional	Discussion and documentation of key discussion points, network/linkages expansion coverage, issues, challenges, gap and lesson learnt and recommendations and network/PWID community decisions for addressing them	Physical meeting	Twice a year/ every Six Months	All constituencies KP and CS representative who serves in the CCMN, to facilitate cross-coordination, communication, and strategizing.	15,000 x 2 = 24,000/-
Support visit to region/province	CCMN Member and Network rep	<ul style="list-style-type: none"> <li>Sharing the objective of Constituency engagement and CCMN meeting updates</li> <li>Discuss on issues, challenges, gap and lesson learnt regarding PWID issues</li> </ul>	Field visit and meeting with CS/regional networks/KP Recovering Nepal has under its wing 3 Thematic Networks and service provider 86 organizations	Quarterly	Field trip report, meeting minutes	15,000 x 4 = Budget (60,000)
TOTAL						NRS. 421,000/-

Updated on July 2017

## 3. Engagement Plan of KP-FSW

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Meeting with JMMS Board	CCM Member and Alternate Member	<ul style="list-style-type: none"> <li>Sharing the objective of Constituency engagement and CCMN meeting updates</li> <li>Issues regarding FSW in order to receive services</li> <li>Setting the agenda for upcoming CCMN Meeting</li> <li>AOB</li> </ul>	Physical Meeting	Every two months	Decisions, Way forward	Secretariat support, Financial support (5,000) and Technical support
<b>III. KP and CS constituencies</b>						
Communicating with Networks	CCM Member and	Circulate and discuss the key discussion points to the networks and networks	Email	Regular		No cost

Updated on July 2017

	Networks, including JMMS	will further share with their constituency members				
Meeting with FSW (KP) members	CCM Member/Alt members together with Network	Identify the issues, way forward	Physical (20 pax)	Every three month	Discussion and decision points, photograph, attendance	TA (5,000), Admin support
Field visit to meet KP member from different cluster	CCM Member	Identify issue and share back the decision s of CCM N meeting and Network	Physical	Every three month and as and when required	Discussion and decision points, photograph	Financial (10,000 x 4 times) and technical

Updated on July 2017

## 4. Engagement Plan of CSO-TB

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Coordinating meetings	CCM Member	<ul style="list-style-type: none"> <li>Identify issues relating to national TB Program</li> <li>Create a synergy among CSO to compliment on NTP</li> <li>Improve collaboration and cooperation among TB CSO</li> <li>Identify the issue of NTP and share in relevant platform including CCMN</li> <li>Share the decision of CCMN meeting</li> </ul>	Physical Meeting of National CSO	Bi-Monthly meetings	Documentation of key discussion points and decisions	NPR 10,000 x 4 months =40,000
Orientation Program to CSO on CCMN and NTP	CCMN member	<ul style="list-style-type: none"> <li>What is CCMN and how CSO can contribute and participate in this process</li> <li>Role of CSO in NTP and implementation of Nepal GF TB grant</li> </ul>	Physical meeting at Kathmandu and outside	One off (By Sept)	NGOs/CBOs/Networks have better understanding of CCMN and NTP Documentation of Key decision points	CSOs and CCMN Secretariat, Budget-50,000

Updated on July 2017

		<ul style="list-style-type: none"> <li>Ways of working among CSO (TB) for better impact</li> </ul>				
<b>III. KP and CS constituencies</b>						
Field Visit	CCM Member	<ul style="list-style-type: none"> <li>Reality check visit will conduct in consultation with PR and CCMN</li> <li>Meeting with CSO working at field level</li> </ul>	Field visit	Quarterly	Visit report	Budget and Technical Support from CCMN

## 5. Engagement Plan of PLWD-TB

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies co coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Meeting with TB CSO and Government Partner	CCM Member (PLWD and CS)	<ul style="list-style-type: none"> <li>Identification of all TB program partners to form a loose network among PLWD-TB</li> <li>Sharing of engagement plan with CS partners and take feedback from them</li> </ul>	Physical meeting	Last week of July	Documentation and key decision points of the meeting.	Budget (10,000) and TA from CCMN

Updated on July 2017



		<ul style="list-style-type: none"> <li>Possible structure of PLWD-TB network at sub national and national level</li> </ul>				
<b>III. KP and CS constituencies</b>						
Meeting with TB-PLWD at National and Sub National level	CCM Member/Alternate Member	<ul style="list-style-type: none"> <li>Forming a loose network</li> <li>Sharing an engagement plan</li> <li>Share about CCMN objective and engagement objective</li> <li>Prepare a plan to incorporate PLWD voices in NTP</li> <li>Identifying/nominating PLWD-TB focal point for sub national networks</li> </ul>	Physical meeting/onsite visits	By November 2017	<ul style="list-style-type: none"> <li>5 PLWD-TB loose network formed at national and subnational level</li> <li>Prepare a plan for loose network on PLWD involvement in CCMN process</li> <li>Documentation and key decision points of the meeting</li> </ul>	Budget-(70,000) Technical Assistance/Mentoring
PLWD-TB Meeting	Focal Point and CCMN Member	<ul style="list-style-type: none"> <li>Issues, challenges, gaps and way forward of PLWD_TB at national and sub national level</li> <li>Sharing decisions of previous CCMN meeting and set an agenda for upcoming CCMN</li> <li>Advocacy plan to ensure PLWD voices and role in implementing NTP.</li> </ul>	Physical Meeting – Decisions shared to CCMN Member	Bi-monthly	<ul style="list-style-type: none"> <li>Documentation of key decision points of meeting and share it with CCMN member</li> </ul>	Budget-4000X5X3=60,000 Technical Assistance
Support visit to regional loose network	CCMN member	<ul style="list-style-type: none"> <li>Provide support in conducting meeting</li> <li>Support in documentation and share the updates on CCMN decision and NTP</li> </ul>	Field visit	Quarterly	Trip report	Budget-10,000X4=40,000

Updated on July 2017

#### 6. Engagement Plan of Malaria-CSO and PLWD

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies co coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Roster development of organizations working in Malaria	CCM member	<ul style="list-style-type: none"> <li>By communicating all relevant organizations to update their details.</li> </ul>	letters/email	2017 July last week	An updated roster will be available	Facilitation from CCMN
Coordination Meetings	CCM member	<ul style="list-style-type: none"> <li>NGO updates, any issues arising from NGOs,</li> <li>Share the objective, structure and ways of working about CCMN</li> <li>Way forward on how to collaborate and contribute on the process</li> <li>Sharing of NMSP, best practices, service gap</li> <li>Sharing of CCMN meeting decisions and setting agendas for upcoming CCMN meeting</li> </ul>	Physical Meeting/	First meeting by the end of August 2017- then bi-monthly	Documentation of key discussion points and decisions available. (Shared through email )	Budget and Support from CCMN and EDCD
<b>III. KP and CS constituencies</b>						

Updated on July 2017

Constituency Meeting	CCMN member	<ul style="list-style-type: none"> <li>Meeting with people who are at risk or had malaria at certain foci</li> <li>Share the decision of CCMN meeting and seek suggestion for next CCMN meeting</li> <li>Share about CCMN structure, objective and role of CCMN member</li> </ul>	Field Visit	Quarterly	Trip report	Budget and Assistance from EDCC and CCMN
----------------------	-------------	---	-------------	-----------	-------------	--

#### 7. Engagement Plan of MSM/TG

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
KP and CS Reps Coordination Meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies co coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Orientation on CCMN and role of Network and CCMN member	CCMN Member	About CCMN/GF/ROB/NFM/country proposal and strategy and role of CCMN member and network organization	Physical event	Twice a year	Increase knowledge on CCMN and identify the area of engagement	Budget 60000 TA from CCMN and Network
Meeting	Between CCMN member and Network	<ul style="list-style-type: none"> <li>Sharing the decision of CCMN meeting</li> <li>Setting up agenda for next CCMN meeting</li> </ul>	Physical meeting	Bi-monthly	<ul style="list-style-type: none"> <li>Documentation key decision points</li> <li>Shared with regional network reps</li> </ul>	10000 per meeting
Orientation and sensitization on SOGI issue	To all CCMN member	<ul style="list-style-type: none"> <li>Issue of SOGI</li> <li>Policy Provision</li> <li>Ways of collaboration</li> </ul>	Organize by CCMN as well as MSM/TG constituency	September	27 CCMN member will sensitize on SOGI issue	Budget-50,000 Admin and other support from Network and CCMN
Network and linkage, Interaction program	NGO/CBO, GOV and KAP representatives	<ul style="list-style-type: none"> <li>Improve working relationship between CCMN reps and other networks</li> <li>Discussion on managing conflict and create uniform understanding on COI</li> </ul>	Organize by CSO and KAP constituency	Quarterly	All representative will have common understanding	Budget TA from CCMN

Updated on July 2017

## 8. Engagement Plan of PLWD-HIV

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
Monthly coordinating meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Consultation meeting	Affiliated CBOs of NAP+N through regional offices	<ul style="list-style-type: none"> <li>Share the information on CCMN process and priorities</li> <li>Identifying issues and agendas for next CCMN meeting</li> <li>Share the decision on previous CCMN meeting</li> </ul>	Consultation Meeting, email and other social networking tools	First meeting on 5 <sup>th</sup> August then quarterly		4,20,000/-
<b>III. KP and CS constituencies</b>						
Formation of Back up Team(2-3person) in NAP+N	Executive board and key staff of NAP+N	form a support team to CCM member for the constituency engagement	Meeting at NAP+N	25 <sup>th</sup> July 2017	Formation of back up team to support CCM member for the better engagement of	

Updated on July 2017

					PLHIV constituency and communication	
Orientation to Back up team on CCM	Back up team member of NAP+N	orient Back-Up team member on CCM	Physical meeting	30 <sup>th</sup> July 2017	Trained Back up team to provide assistance to CCM member	
Post-KP and CS Monthly Coordination Meeting follow up (Activity I.1)	CCM rep and Back-up team to constituencies	<ul style="list-style-type: none"> <li>Circulate and discuss the key discussion points of the KP and CS reps with individual constituency members</li> </ul>	Email/Social Network/Mobile communication sent to all network member by CCMN Members	Within one week of the KP and CS reps meeting		5000
Active participation on CCM meeting	CCM Reps	Raise constituency's issue, loudly, in CCM meeting		Ongoing		
Advocacy/Lobbying	NAP+N	Lobbying and advocating issues regarding PLHIV at national and sub national level	Demonstration/lobby, community mobilization, convening dialogues	As and when necessary	Meet the advocacy objective	50,000

Updated on July 2017

## 9. Engagement Plan of CSO-HIV

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
Monthly coordinating meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
Communications with CCM Secretariat	CS –CCM Members	Inform the CCMN Secretariat on the findings from monthly meetings	Through email with cc to CS Secretariat and its executive members	Second week of every month	Updated document to CCMN	
Attending CCMN-Meetings and communicating on behalf of CS members	CS –CCM Members	<ul style="list-style-type: none"> <li>To get the updates from CCMN and other constituencies, oversight committee and other committees;</li> <li>To clearly put the agenda of CS to CCMN and facilitate discussion to get a decision</li> </ul>	Facilitation and discussion during the CCMN meeting	During the CCMN meeting	CS agenda discussed and minuted by CCMN secretariat	
Provide input to NCASC and other development partners as a CCMN	CS-CCMN member	Attend different activities organized by these bodies to share their strategies, updates, challenges and any other relevant issues	Participating in different meetings or communicate with CS network for participation	Meetings	Coordination and engagement of CS-Network members	

Updated on July 2017

member/engage CS-network members						
<b>II. KP and CS networks and orgs</b>						
Information Sharing and Coordination Meetings with Network Ex Com Members	CS –CCM Members	<ul style="list-style-type: none"> <li>Constituency updates, matters arising from Oversight/Exe com Meetings and document feedbacks/recommendations</li> <li>Role of CCMN members and Network to improve the constituency engagement</li> </ul>	Physical meeting	First Friday of Every Month	Meeting minute Documentation of meeting minutes with key decision points	Budget
<b>III. KP and CS constituencies</b>						
Re-documentation of active CS members from all the Province, province wise and development of email network	CCMN members, Networks	Listing of all the NGOs working for HIV Province wise as per the re-structured state and their current status	Communication and with the support from other CCMN members and CCMN Secretariat	Regular	Updated list of CSOs working with HIV in different provinces	Secretariat service

Total Budget: 80,000

Updated on July 2017

## 10. Engagement Plan of Western Region

Activities	Who	What (agenda of the engagement or communication)	How (medium of engagement)	When	Outputs	Resources Needed
<b>I. KP and CS reps to the CCMN</b>						
Monthly coordinating meetings	KP and CS reps with CCMN Secretariat	<ul style="list-style-type: none"> <li>Constituency updates, KP and CS matters arising from Oversight/ExCom Meetings;</li> <li>For the month of a scheduled CCMN meeting, discuss agenda items most relevant to KP and CS and the registry of constituency issues</li> </ul>	In-person and via skype	Every six-weeks, for the month with CCMN meeting, meeting take place beforehand.	<ul style="list-style-type: none"> <li>Documentation of key discussion points and decisions</li> <li>Register of common agenda items for tabling at the next CCMN meeting</li> </ul>	Joint constituencies coordinator (JCC)
<b>II. KP and CS networks and orgs</b>						
Mapping of NGOs actively working in the HIV, TB & Malaria in the western region (including Mid and Far western)	CCM Western regional representative, CCMN Secretariat, PR, DPHO,	Develop an update database of NGOs actively working on HIV, TB and Malaria including coordination with KP networks with existing regional networks/groups	Desk research, Email and Telephone and national KP networks	By the end of July 2017	An updated NGO database will be developed NGO roster	Technical Assistance required from the CCMN Secretariat
Regional Consultation	CCM Members, CBOs, Government Focal Person, Central/Regional PR focal person	<ul style="list-style-type: none"> <li>Brief on Update of KP/CS networks constituency engagement workshop</li> <li>Brief Update on CCMN</li> <li>Formation of Working Group with TOR</li> <li>Identifying Regional Focal Point</li> </ul>	Physical Meeting (1 and ½ day workshop)	By the first week of August	Ad-hoc Group formation, Regional focal Point Formation with TOR (at least 5 people including CCMN rep), Identify communication medium Consultation Report	Financial Resource Required (200,000)  TA support from KP regional networks when feasible

Updated on July 2017

Field Visit	CCMN Rep, Focal Point, Oversight or CCMN secretariat (optional)	To identify and collate issues on HIV, TB and Malaria	Visiting other CS and government and PR/SRs including PLWD	Quarterly	Trip Report, Meeting minutes	Budget (25,000) TA from CCMN Consultation with PR and SR of western region
Joint Coordination Meeting	CCMN rep, Government line agencies PR/SRs, CCMN secretariat regional KP Network representative	<ul style="list-style-type: none"> <li>To debrief about the CCMN progress update, Pre/Post CCMN preparatory meeting</li> <li>To have a constructive dialogue to improve the grant performance and efficiency, Real-time update from PRs and SRs</li> </ul>	Physical Meeting	Quarterly	<ul style="list-style-type: none"> <li>To share post update on CCMN meeting and prepare for the upcoming CCMN meeting</li> <li>To get an update on the real time scenario of the western region on three diseases of the TGF grant</li> <li>Meeting minutes</li> </ul>	Coincide this with other events of PR/SRs

**V. Implementation and monitoring**

The constituencies agree to form a joint platform to facilitate cross-coordination, communication, and strategizing. The KP and CS representative who serves in the Ex Com of the CCMN shall also Chair the Joint Platform.

A (part-time) Joint Constituencies Coordinator (JCC) shall be hired to support the coordination work of the joint platform and implement the Constituency Engagement Plan. The JCC is hosted by the CCM, reports directly to the KP and CS reps to the CCMN, and is accountable to the chair of the joint platform as well as the CCMN Secretariat Coordinator.

Common activity of all constituency will be conducted in consultation all CCM members from KP, CS, PLWD.

Updated on July 2017

# Appendix E: Malaria Civil Society Positions on RAI 2018-2020

## Towards Greatest Impact and Effectiveness of RAI 2018-2020 - Malaria Civil Society Positions

### Background

- Following the Malaria Regional CS Platform consultation and the RAI RSC retreat in October 2016, a CS reflections and priority issues list was shared with members, and provided the framework for a discussion of, the CS Platform during a recent preparatory meeting held in Bangkok, 11-13 December 2016.
- CS Platform members from Myanmar, Thailand, Lao PDR, Cambodia and Viet Nam were in attendance at the 11-13 December meeting organised by APCASO under the Global Fund-supported Malaria Technical Assistance Programme, held in collaboration with the regional Malaria CS Platform and the RAI RSC. CS partners were joined by members of the Global Fund Secretariat, UNOPS, the RSC Secretariat, and the RAI Phase funding request main writers for a series of constructive discussions at the meeting.
- CS Platform members are in full support of the RSC's 'Position paper for the development of the next regional malaria Funding Request' and align our proposed priorities with the overarching principles expressed in this paper.
- CS members discussed strategies to be implemented by CSO in close collaboration with the government and other stakeholders toward the ultimate goal of ending malaria in the GMS by making GF-funded malaria programmes reach the hardest to reach populations and achieve maximum impact.

### Civil Society Priorities for the RAI Phase 2 Program

In line with and in addition to the strategic areas expressed in the RSC Position Paper, the CS Platform proposed two priority areas for inclusion in RAI 2 programming:

1. **Development and strengthening of community systems to respond to malaria.**  
This is beyond strengthening of individual civil society organisations or village health workers - this is an approach that enables communities to serve their own needs. It involves mobilizing, empowering and funding community-based organizations and networks of the people most at risk of malaria, such as ethnic minorities, mobile and migrant populations, to increase their involvement in planning and implementing evidence-based interventions, thus maximizing grant impact.
2. **Removing barriers to accessing malaria-related services.** Recognising that the current policy environment presents several barriers for the hard-to-reach populations to access and utilize services, this intervention would both identify existing barriers, and proactively, advocate for policy coherence for effective malaria response within and across borders. This would serve to maintain national leadership, acknowledge differences in contexts but also ensure harmonisation and coordination in the national and regional policy monitoring and implementation.

The two priority areas are in line with Global Fund's operational objectives #1: focusing on the 'populations disproportionately affected' by the disease, #2: 'strengthen community response and system,' and #3: 'removing human right barriers to accessing services', and 'support meaningful engagement of key and vulnerable populations and networks in the GF-related processes.'

Both approaches are supported in the new GF Strategy are articulated in the GF Community Systems Strengthening Framework, elements of which include:

- Enabling environments and advocacy;
- Community networks, partnerships, coordination;
- Resources and capacity building;
- Community activities and service delivery;
- Organisational and leadership strengthening;
- Monitoring and evaluation and planning.

Civil society platform members commit to work with country and regional partners to implement these two strategies.

### Civil Society and RAI 2 Process-Related Requests

In support of the vision of better coordination, harmonisation and planning across countries through a consolidated RAI Phase 2 grant, civil society:

- Welcome the role of the RSC in providing oversight and guidance to country CCMs; and
- Strongly support RSC representation in country dialogue processes, SR selection, grant writing and negotiation, to the fullest extent possible.

In support of RAI and Global Fund principles of inclusivity, transparency, ensuring meaningful civil society participation in funding request development, grant making and implementation, civil society:

- Welcome the RSC's decision in having three civil society representatives be part of the regional RAI Concept Note writing team;
- Look forward to collaborations with, and support from, the RSC and its Secretariat, and the CCMs towards CS preparatory meetings and processes in the lead up to the country dialogue processes;
- Request for civil society representation in country counterpart 'writing teams' for country components to the RAI funding request.

### Further joint positions regarding the RAI 2 grant

We endorse the principle of dual track financing, and call for increased resources for civil society, including funding of the Regional Civil Society Platform and of local civil society organizations to implement interventions, including for service delivery, community systems strengthening and removing barriers to accessing malaria-related services.

Contact person:  
Shree Acharya,  
Coordinator  
shree222shree@gmail.com



# Appendix F: Sri Lanka Community Recommendations on the National Strategic Plan 2018-2022

## Community recommendations for the development of National HIV Strategic Plan for 2018 – 2022

The New National HIV Strategic Plan (NSP) for the period of 2018 – 2022 is a crucial milestone in the Sri Lankan HIV response. While the global target for zero new HIV infections is 2030, Sri Lanka, with the current low HIV prevalence, has set a national target of zero new HIV infections by 2025. However, according to the Global AIDS Data report 2017, Sri Lanka is one of the few countries in Asia and the Pacific with a rising new HIV infection rate. Sri Lanka is a country with a concentrated epidemic among key populations; gay, bi sexual and other men who have sex with men, transgender people, sex workers, people who inject drugs. Beach boy community is also considered a key population in Sri Lanka. With Sri Lanka estimated to become a middle income country and consequently lose the support from the Global Fund, this upcoming NSP has a vital role to play to ensure the sustainability of the HIV response in the country. The UNAIDS 90.90.90 global strategy should be used as a guiding document for the NSP with the 90.90.90 targets as key targets.

As the communities living with and affected by HIV, including key populations, gay and bisexual communities, we would like to recommend the following to be integral aspects of the new National HIV Strategic Plan.

### Founding principles for the NSP

1. Human Rights for all  
The NSP should recognize and integrate the concept of “Human Rights for all”. Protecting and promoting the Human Rights of people living with and affected by HIV and addressing legal barriers, especially that of gay, bi sexual and other men who have sex with men, sex workers, transgender people, people who inject drugs should be recognized and promoted as an essential aspect of a robust HIV response.
2. Gender equality  
A gender responsive approach should be taken in the NSP for HIV prevention, treatment and care. The modality should go beyond a binary approach to gender and should include gender identity to ensure equal space to transgender people and to those that do not identify within a traditional binary gender spectrum. Zero stigma, discrimination and violence based on gender identity should be acknowledged as an essential aspect of a robust HIV response.
3. Greater involvement of people living with HIV  
The critical role played by the people living with HIV should be further integrated in to the NSP. People living with HIV should be meaningfully engaged in the planning, designing, implementation and monitoring of the HIV response. The active involvement people living with HIV and organizations of people living with HIV in increasing testing and case management should be integrated in to the NSP as an essential aspect of a robust HIV response.
4. Key populations  
As Sri Lanka is having a concentrated HIV epidemic, the key populations are key to the HIV response. The NSP should explicitly define the key populations in the country referring to legal barriers, human rights violations and concentrated epidemic status faced by the key population communities. Acknowledging the key populations, the crucial role played by the organizations of key populations and meaningfully engaging them is key to a robust HIV response.
5. Meaningful engagement of civil society  
Meaningful engagement of civil society is crucial to develop and implement effective targeted interventions. Civil society including key populations should be engaged in designing, implementing and monitoring the HIV response. Representatives from civil society should be engaged in decision making bodies of the HIV response and official positions and platforms for such engagement should be made available to develop a robust HIV response.

### Indicators for measuring the success

1. The indicators for monitoring the NSP should include specific indicators on key populations. As the epidemic is concentrated among key populations, the HIV response needs to be targeted to key populations and the results should be evaluated accordingly.
  - a. Specific indicators on the percentage of key populations on ARV and key populations on ARV with a suppressed viral load should be included.
  - b. Specific indicators on the percentage of key populations identified and treated for STIs should be included.
  - c. Specific indicators on the percentage of key populations on PrEP should be included
2. An indicator should be developed to showcase the percentage of people living with HIV who are on ARVs with a suppressed viral load. Undetectable viral loads lead to untransmittable HIV status and this is a key strategy to avert new HIV infections
3. As Sri Lanka has moved to treat everyone irrespective of viral load, an indicator should be developed to showcase the percentage of people living with HIV on ARVs.
4. A specific indicator should be developed to evaluate the supportive environment and the role of NSACP in facilitating such. The current strategy only includes the PLHIV stigma index. A key populations stigma index should be included in the strategy. This indicator should specifically include addressing legal barriers faced by key populations in the country.
5. An indicator should be developed to measure access to services. The clinics and the staff need to be regularly trained to provide friendly, welcoming and non-judgemental services to key populations and people living with HIV. Such service delivery locations would be key to increased testing and retention in treatment and care.

### Key focus areas

1. Increasing testing  
Increasing HIV testing is a key strategy to achieve zero infections by 2030. Testing should be increased and encouraged among populations who are key to the epidemic. A robust system should be adopted within the new NSP to increase targeted testing among key populations.
2. Pre Exposure Prophylaxis  
PrEP should be integrated within the new NSP as part of the combination prevention package and efforts should be made to make PrEP available for those who are at risk within key populations. The NSP should spell out strategies to raise awareness on PrEP, develop implementation and roll out procedures and guidelines, procurement and etc. The WHO implementation tool on PrEP could be used to inform these strategies.
3. Post Exposure Prophylaxis  
According to the consultants of NSACP, PeP is currently available “after analyzing the reported case”. PeP should be made available to key populations who have had exposure to HIV. Access to PeP should be made easy by avoiding unnecessary case analysis. Awareness among key populations on PeP should be increased.
4. New HIV screening methods  
HIV self-testing, finger prick or saliva, should be rolled out through community based organizations for HIV screening. Number of trainings have been done for community organizations and the NSP should include specific strategies to encourage and support HIV self-testing initiatives.
5. Introduce UIC  
The NSP should develop strategies to integrate a UIC system within NSACP as a pilot with a long term outcome of integration to larger health system in Sri Lanka. Number of complaints have been made regarding the current filing system at the STD clinics especially with regard to the confidentiality of the information and authorized access to them.



#### 6. Use of new technologies

The NSP should focus on using new technologies for services delivery and outreach. Social media platforms and other social networking apps should be acknowledged for the crucial role they can play in extending the outreach to key populations. Strengthening the NSACP role with new technologies for case management, sexual history taking, registration, client data storage should be made part of the new NSP.

### **Harm Reduction**

Harm reduction approaches are still not adequately discussed in the national HIV response. Opioid Substitution Therapy (OST) or needle-syringe exchange program are still not employed by the NSACP. These harm reductions services are crucial if new HIV infections are to be averted within the PWID community. The NSP should include strong strategies to implement harm reduction services to PWID community and address the legal barriers. The initial conversation with the ministry of justice and other government ministries to address legal barriers should be initiated by the NSACP through the new NSP.

### **Young people**

The current data from the NSACP show increasing new HIV infections among the age category of 15 – 34. The NSP should have strong focus on young people in general and young key populations in particular. The key role that young people could play as leaders and collaborators should be acknowledged in the NSP. Legal barriers as consent laws and discrepancies between the laws and general medical practices should be addressed within the NSP. Due recognition should be given to addressing the epidemic among adolescents with reference to addressing cultural and legal barriers to access to services. Youth friendly and sensitive services as a key element of promoting testing, treatment and care should be included in the NSP with strategies to regularly build the capacity of clinic staff to engage with young people. The NSP should also emphasize strategies to include young people in designing, implementing and monitoring activities within the HIV response in the country.

### **Capacity building**

Capacity building of civil society organization especially that of key populations is indispensable for a robust HIV response in the country. The current national strategic plan on HIV states that “Outcome 4.3 - NGOs report increased organizational, financial and technical support from the government as well as development partners”. Two strategic in the same strategic plan also refer to “Build capacities of civil societies (NGO and community based organizations) to ensure access through demand generation and improve quality of services through monitoring and advocacy and to provide continuum of care” and “Provide organizational and technical support to community-based organizations of marginalized groups and young people, so that they can contribute to the national response and advocate for their needs”. The new NSP should have strategies to build the capacity of civil society organizations, especially that of key populations to ensure their effective engagement in the HIV response. Specific indicators should be included to evaluate the success of capacity building efforts.

### **Community System Strengthening (CSS)**

The current NSP does not explicitly refer to CSS as an integral part of a robust HIV response. As much as the new NSP should focus on the Health System Strengthening, it should also emphasize the importance of CSS. The community systems are important to ensure effective reach out to affected communities, ensure retention in treatment and care and also to address legal barriers. The NSP should include specific strategies to strengthen community systems along with health system strengthening.

**Sustainability**

Sri Lanka is estimated to be ineligible for Global Fund support in 2021 provided the current Gross National Income and the economic growth which will eventually lead the country to middle income level. It is therefore vital for the NSACP and the civil society to strategize on the sustainability of the HIV response in the country. The Sri Lankan government currently shoulders approximately 55% of the national HIV response. Along with transitioning of the HIV response from the Global Fund to the government, there is a high risk of key population targeted interventions to be left behind. The NSP should specifically focus on developing and aligning all strategies with a sustainability approach emphasizing the integration of key population in sustainability efforts.

**Inter -ministerial integration**

The NSP should have strong strategies to promote inter-ministerial integration for a multi sectoral approach to the HIV response. Ministries such as the Ministry of Sustainable Development and wild Life, Mistry of Justice, Mistry of Social welfare, Mistry of Women's Affairs, Ministry of Youth Affairs and etc should be brought together to address specially the legal barriers and social protection. The engagement of civil society organizations in such a multi sectoral platforms should be promoted through the NSP.

# Appendix G: Malaria Mapping Report in Viet Nam



## REPORT ON MALARIA MAPPING IN VIETNAM

*Submitted by: Center for Supporting Community Development Initiatives (SCDI)*

*To: Asia Pacific Council of AIDS Service Organizations (APCASO)*



*March 2017*



## Contents

I. BACKGROUND :	3
1. Introduction:	3
2. Objectives:	3
3. Methodology:	4
II. Malaria in Vietnam:	4
III. The FINDINGS:	6
1. Desk review:	6
a) Public health system	6
b) Private health system:	8
c) Civil society organizations	9
2. Field work:	9
a) Province profile - BinhPhuoc:	10
b) Province profile - Gia Lai:	11
c) Discussions with local health authorities:	12
d) Visits to local households	13
3. CSO consultation workshop	15
4. Participation in country dialogue:	18
IV. Conclusion and Recommendations:	19

## Figures:

Figure II-1 Commune level malaria risk stratification 2018-2020	5
Figure III-1: Overview of the public health system	7
Figure III-2: Map of Binh Phuoc	11
Figure III-3: Map of Gia Lai	12
Figure III-4: Typical vehicles used for entering forests	13
Figure III-5: Accommodations for forest goers or plantation workers	14
Figure III-6: Participants of CSO consultation workshop	16





## I. BACKGROUND :

### 1. Introduction:

APCASO is implementing the project "Strengthening Community Engagement in Global Fund Malaria Grants in the Greater Mekong Sub-region" – a 6-month technical assistance initiative which aims to support malaria civil society and community organisations advocate for community-centred, rights-based, and gender-transformative issues in regional and national Global Fund malaria grants.

Funded by the Community, Rights and Gender Special Initiative of the Global Fund, the APCASO Malaria technical assistance project (APCASO Malaria TAP)<sup>1</sup> is a regional initiative with in-country technical assistance activities supported in Cambodia, Lao PDR, Myanmar, Thailand, and Viet Nam. The current phase of the project spans October 2016 to March 2017, concurrent with the Regional Artemisinin Initiative (RAI)<sup>2</sup> 2017 Global Fund country and regional dialogues and funding request submission processes. APCASO will implement Malaria TAP in coordination with the Malaria Regional Civil Society Platform (RCSP) and the Regional Artemisinin-resistance Initiative (RAI) Steering Committee (RSC) and RSC Secretariat.

To support the objectives of APCASO Malaria TAP, mapping and engagement of organisations (including NGOs and private sector), unions and other entities which are working or providing services in Malaria endemic geographic locations and/or working with or providing services to communities most vulnerable to Malaria in each of the five RAI countries.

As decided with the RCSP, the nominated RCSP focal point organisations in each of the five countries will either take on this consultancy and be responsible for fulfilling the terms and conditions under the ToR or, will identify, the most appropriate RCSP affiliate to conduct the work and fulfil the terms and conditions under this ToR. For Viet Nam, the Center for Supporting Community Development Initiatives (SCDI) is the nominated Consultant Organisation, represented by its Executive Director Dr. Khuat Thi Hai Oanh.

### 2. Objectives:

The Consultant Organisation is responsible for developing of a country mapping of civil society, government and private sector local and international groups working or

<sup>1</sup>Refer to Annex C, *APCASO Malaria TAP Project Brief*, for more information about the project

<sup>2</sup>RAI is a Global Fund-funded regional initiative aimed at averting the spread of artemisinin resistance and accelerating the elimination of *P. falciparum* malaria in the Greater Mekong Subregion (GMS). RAI supports the increased coverage of impregnated nets, diagnosis and treatment, as well as case detection and surveillance, giving priority to areas of artemisinin resistance. Through RAI, the Global Fund allocated \$100-million to cover 5 GMS countries for the period 2014-2016.

<http://www.raifund.org> RAI expects to submit a funding request to the Global Fund in April 2017 to cover the period 2017-2018, with preparations and country and regional dialogues having taken place beginning October 2016.



providing services in Malaria endemic geographic locations and/or working with or providing services to communities most vulnerable to Malaria in Viet Nam. Specifically, the consultancy objectives are to:

- Develop a national mapping and profile of non government organisations, community organisations, private sector organisations, government actors and other entities that work or provide services in Malaria endemic geographic locations and/or work with or provide services to communities most vulnerable to Malaria locally, nationally or internationally.
- Facilitate a workshop of civil society and community actors to raise awareness and sensitise these stakeholders with regard to malaria and malaria communities.

### 3. Methodology:

The assignment was conducted using the following methods:

- A **desk review** was implemented in order to collect related documents relating to malaria control in Vietnam;
- Two **field trips** were organized in Binh Phuoc and Gia Lai in late December 2016 and early January 2017 respectively to learn about the local situation and look for community contacts;
- Based on the results of desk review and field trips, a **CSO consultation workshop** was conducted in 11 January 2017 in Hanoi with participation of civil society organizations and community contacts to raise awareness on malaria and agree on a list of priority activities for CSOs.

## II. MALARIA IN VIETNAM:

The National Malaria Control Program (NMCP) in Vietnam has made significant achievements in the past 20 years. From 293,016 cases (74,329 confirmed) in 2000, the number of malaria cases decreased by three-quarters, to 10,446 (4,161 confirmed) in 2016<sup>3</sup>. Through the years, the number of deaths also drastically went down from 148 in 2000 to only 3 in each of the past 2 years. The morbidity over 1000 populations was 0.11 in 2016, for the first time reaching the target of the National Malaria Control Strategies for 2011-2020. Overall, more than 12 million of the population are living in endemic areas<sup>3</sup>. In the last 7 years, no outbreaks were recorded in the whole country. It is noted that the

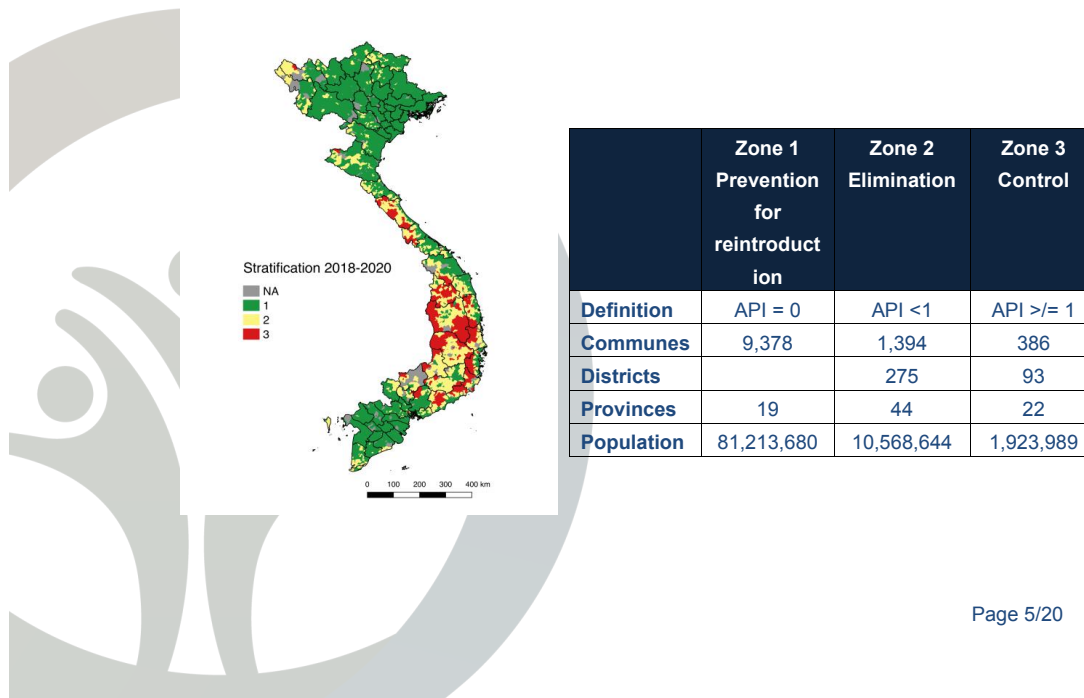
<sup>3</sup>Official data from NIMPE.



above numbers were from public sector only and may to some extent underestimate the real burden of malaria.

Despite the efforts and achievements of the national program, epidemiology of malaria in Viet Nam is still complex, varying by locations and populations. The disease has become more focal, concentrating mostly in hilly and forest areas, and among the migrant, mobile and hard to reach populations. Most endemic areas are in the Central Highland and South Eastern provinces (Figure II-1). Only 6 provinces (Gia Lai, Binh Phuoc, Dak Lak, Dak Nong, Khanh Hoa, Ninh Thuan) together already accounted for 69.4% of confirmed malaria cases in Vietnam. Migration - both domestic and inter-countries - is common in Vietnam and is posing an issue for malaria control activities. Since 1970s, a large number of people moved to central highland and southeast areas - malaria "hot-spots" - to work in rubber, coffee, cassava, etc plantation companies. Moreover, border-crossing from Vietnam to Laos and Cambodia and vice versa in the context of artemisinin resistance worsens the problem. This is not to mention that many migrants are unofficial/ illegal and temporary, thus the number of migrants can be underestimated. Overall, while Vietnam Government has committed to eliminate malaria by 2030, more efforts need to be focused on the key populations and locations, especially mobilizing the involvement of the local at-risk communities in the process.

**Figure II-1 Commune level malaria risk stratification 2018-2020**





### III. THE FINDINGS:

#### 1. Desk review:

A review of documents on malaria and the health system by sectors in Vietnam was carried out in order to understand the situation. Overall, Vietnam has a relatively well-established public health system for malaria, with facilities designated for malaria from central to communal level. Private sector is showing a more prominent role in providing malaria health services to the community, but the linkage to public sector seems few and far between. On the other hand, civil society organizations (CSOs) working in malaria are very few, despite their potential and experience in working with vulnerable and hard-to-reach communities.

##### a) Public health system

Under the Ministry of Health, the National Institute of Malariaology - Parasitology and Entomology (NIMPE) is responsible for malaria control activities in the whole country (Figure III-1). Its functions include conducting research, training/retraining for malaria staff, IEC/BCC, international cooperation in malariaology - parasitology and entomology control, providing technical guidance to lower level facilities in the whole country, and directly guiding 28 provinces in the North<sup>4</sup>. Reporting directly to NIMPE at regional level are QuyNhon Institute of Malariaology - Parasitology and Entomology (IMPE) that is in charge of technical guidance for 15 provinces in the Central region and Ho Chi Minh IMPE that are working with 20 provinces in the South.

In each province, malaria control activities are conducted by Provincial Malaria Centers (in endemic areas) and Provincial Preventive Medicine Centers (in non-endemic provinces). However, following the new regulations by the MOH<sup>5</sup>, several centers at provincial level started to merge together. For example, BinhPhuoc Province has merged Provincial Center for Malariaology - Parasitology - Entomology and Provincial Preventive Medicine Center into Provincial Disease Control Center in November 2016<sup>6</sup> and is planning to also merge Provincial AIDS Center among several other public health agencies. This is in order to simplify the health system and optimize resources at all levels of the system.

<sup>4</sup>NIMPE (2011). *Introduction of the Institute*. Retrieved on 17 March 2017 at <http://nimpe.vn/TinChiTiet.aspx?id=174&cat=55>

<sup>5</sup>MOH and Ministry of Internal Affairs (2015). *Decision 51/2015/TTLT-BYT-BNV: Functions, Responsibilities and Structure of Departments of Health and District at Provincial and District Level*.

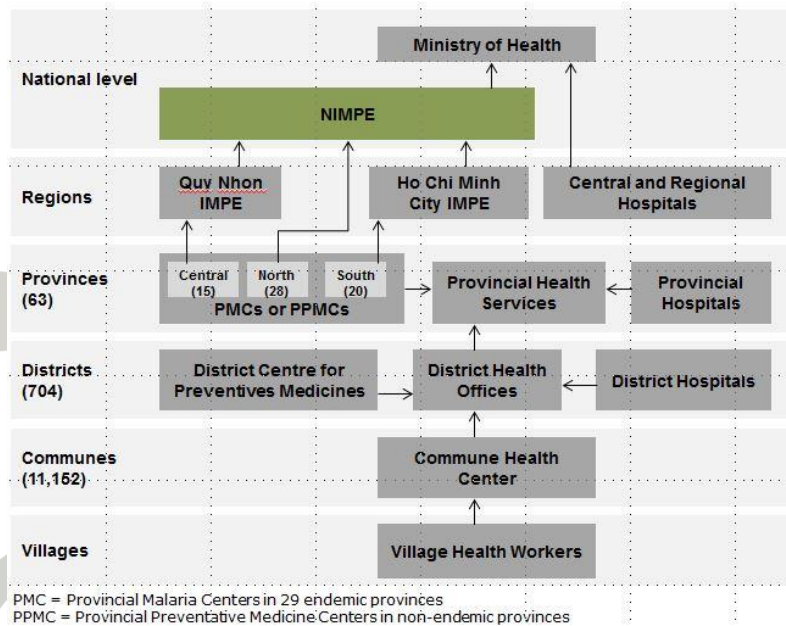
<sup>6</sup>BinhPhuoc Newspaper (2016). *Decision to establish Provincial Disease Control Center*. Retrieved on 17 March 2017 at <http://www.baobinhphuoc.com.vn/Content/cong-bo-quyet-dinh-thanh-lap-trung-tam-kiem-soat-benh-tat-68144>





In each commune, there is a Commune Health Centre (CHC), and in malaria endemic communes these centers have specialized staff for malaria control. At the moment, Village Health Workers (VHWs) are considered the main force for health response at community level in Viet Nam. Working under technical guidance of CHCs, VHWs must at least have preliminary level of medical education or have been trained in MOH's VHW program for a minimum of 3 months<sup>7</sup>. These workers are involved in primary health care, health promotion and prevention. For their work, each VHW receives a monthly allowance equal to 30% (or 50% at difficult communes according to the Government's standards) of the minimum wage<sup>8</sup>, which is around 20 - 30 USD/ person/ month. With a low remuneration and a large area to cover, VHWs have difficulties in reaching to the whole community, not to mention hard-to-reach population.

Figure III-1: Overview of the public health system



<sup>7</sup>MOH (2010). Decision 39/2010/TT-BYT: Standards, functions and responsibilities of village health workers.

<sup>8</sup>MOH (2009). Decision 75/2009/QĐ-TTg on allowance for village health workers.



According to the latest Guidelines on Malaria Diagnosis and Treatment<sup>9</sup>, there are two types of testing techniques that can be used: microscopy and rapid diagnostic test (RDT) which can be done down to communal level. In terms of treatment, Central, Provincial and District level facilities are eligible to provide treatment to all types of patients, while CHCs and private facilities can mostly work with malaria cases without complications (Table 01).

**Table 01: Level of treatment facilities and treatment services<sup>9</sup>**

Type of patients	Level of facilities				
	Central/provincial hospitals	District Hospitals or equals	CHC	VHW	Private facilities
Malaria patients without complications	+	+	+	+	+
Pregnant women	+	+	+		+
Patients with malignant malaria	+	+	Primary care before sending to higher level facilities	Primary care before sending to higher level facilities	Primary care before sending to higher level facilities

**b) Private health system:**

The private sector is playing a more and more significant role in the management of malaria in Viet Nam. According to the new National Guidelines, private facilities were also allowed to treat non-complicated cases and pregnant women (Table 01 above). In 2014, the MOH issued a decision supporting the “mobilization of private sector’s involvement to support early case detection, diagnosis [and] prompt and proper treatment in accordance with the national guidelines”<sup>10</sup>. These show that the Government seems to welcome the private sectors in malaria control. In fact, a survey conducted in Binh Phuoc Province in 2011 suggested that 13% of resident patients and 23% of migrants were seeking initial healthcare from private

<sup>9</sup>MOH (2016). *Decision 4845/QĐ-BYT: Guidelines on Malaria Diagnosis and Treatment*.

<sup>10</sup>MOH (2013). *Decision No 4717/QĐ-BYT: Action Plan for Malaria Control 2015 - 2020*.



facilities<sup>11</sup>. According to IOM's calculations based on data from HCM IMPE in 2014-2015, migrants were more likely to seek private health facilities than long-term residents (10.1% vs. 3.2% respectively)<sup>15</sup>. Moreover, a research in Binh Phuoc and Kontum province in December 2015 by PSI<sup>12</sup> revealed that while people with health insurance visited public health facilities, private clinics are still the preferred choice as they are more convenient, easier to access, friendlier, and have more appropriate opening hours. Nevertheless, this qualitative study also found that there is a misconception of national malaria policies as the private providers thought they were not allowed to provide malaria care and treatment. Considering the increasing involvement of private sector in providing health care services in Vietnam, the linkage between public and private sector needs to be strengthened.

### c) Civil society organizations

Information on civil society organizations working in malaria is quite rare to find. There are only around 10 organizations that have worked in or are interested in working on malaria (See Annex 1). None have ever been involved in the Global Fund Malaria activities, except for Health Poverty Action (HPA) who worked through NIMPE for their project implementation in Vietnam. However, many of these organizations have experience working with hard-to-reach populations and community development and strengthening, which can be valued assets if the Government wants to move forward eliminating malaria by 2030. Besides, A Network for Migrant Workers (M.net) was also established in October 2014, composed of 6 NGOs working with migrants in Vietnam. Eventhough M.net has never worked in malaria control, they can be a source of contact for advocacy activities to improve health policies for migrants.

## 2. Field work:

Following the desk review, in December 2016, SCDI developed plan to visit provinces with the highest burden of malaria, not only to take a snapshot of the local malaria situation, but also to make contacts with local health authorities and affected communities for future collaboration and coordination. As a result, Binh Phuoc and Gia

<sup>11</sup>Nguyen Qui Anh & Le Xuan Hung, unpublished data, 2011.

<sup>12</sup>PSI (2016). *A Qualitative Study of Malaria Risk Factors & Care Seeking Behavior in the Private Sector, Among High-Risk Populations, Vietnam*. Retrieved on 17 March 2017 at [file:///C:/Users/Piggy%20Wiggy/Desktop/Final%20Report%20Qualitative%20Research%20UCSF%20PSI%20October%2016%20copy%202%20\(1\).pdf](file:///C:/Users/Piggy%20Wiggy/Desktop/Final%20Report%20Qualitative%20Research%20UCSF%20PSI%20October%2016%20copy%202%20(1).pdf)



Lai - #1 and #2 provinces in Vietnam in terms of malaria morbidity - were selected. Both provinces are in the Central Highland, the home of many ethnic minority groups and also the most heated area of the malaria scene. In order to carry out the trips, two main channels were used:

- **Official health system:** The team sent official letters and met with heads of Provincial Center for Disease Control, District Health Centers and Commune Health Centers in the two provinces.
- **Community network:** through community contacts, the team met people who live in the most vulnerable villages, frequently enter forest or sleep in the fields inside/by the forest. Most of them had/ were having malaria and many were from ethnic minority groups. These contacts also took team members to their work sites in the forests.

#### a) Province profile - BinhPhuoc:

Binh Phuoc is located in the South-eastern region in Vietnam, bordering with Cambodia in the North West (Figure III-2). In 2015, the province has an area of over 6,871.5 km<sup>2</sup> and a population of nearly 944,400<sup>13</sup>, of which about 20% are from ethnic minority groups<sup>14</sup>. The province relies on industrial crops (cashew nut, pepper, rubber, cocoa, etc) as its economical priorities with over half of its land are for long-term plantation. As a result, Binh Phuoc has been attracting a large number of seasonal migrants coming to look for agricultural works. It is ranked as among the top-11 provinces with highest in-migration rates, raking in 0.8 per 1,000 populations (2014)<sup>15</sup>.

In terms of malaria, Binh Phuoc had the highest number of confirmed cases per 1000 population in 2015 (1.96)<sup>16</sup>. It is also the first province to have artemisinin resistant cases recorded nationwide in 2009. Within its 111 communes, Dak O Commune and Bu Gia Map Commune in Bu Gia Map District were chosen for site visits, as they are considered malaria hotspots in the province. 88% of cases in the district and 34% of cases in the province are from these two communes alone.

<sup>13</sup> General Statistics Office (2015). *Area and Population Statistics by Provinces*. Retrieved on 17 March 2017 at <https://www.gso.gov.vn/default.aspx?tabid=713>

<sup>14</sup> BinhPhuoc Province Portal. *Overview of BinhPhuoc Provinces*. Retrieved on 17 March 2017 at <http://www.binhphuoc.gov.vn/3cms/tong-quan-binh-phuoc.htm>

<sup>15</sup> World Health Organization, International Organization for Migration and Institute of Malarology, Parasitology and Entomology in Ho Chi Minh City (2016). *Migrant, Mobility and Malaria: A Study on Migrants' Vulnerability to Malaria and Epidemiology of Artemisinin-Resistant Malaria in BinhPhuoc Province, Viet Nam*.

<sup>16</sup> National Malaria Control Program. *Annual Report 2015*.



Figure III-3: Map of Gia Lai



### c) Discussions with local health authorities:

From the discussions with local health authorities, it was understood that malaria services are available, free-of-charge and relatively accessible. However, malaria is still common in some areas and achievements are not always sustainable. Forests are a critical reservoir for malaria as many cases are concentrated among forest goers and sleepovers: indigenous people, mobile seasonal labors, mobile farmers on rented farms, and other people working in forest, most of whom are considered hard-to-reach by the national program due to their frequent mobility. Representatives of these authorities admitted that their capacity in reaching and supporting these populations are still limited. Most of them welcomed the idea of developing a community system to support the malaria work among hard-to-reach communities.



#### d) Visits to local households

There are two types of local people met in these field trips: forest goers and their families. The interviews were carried out both at their homes and their worksites.

In both provinces, forest-goers consisted of people who went to forests for logging, planting on burnt over field, finding mushrooms, hunting animals, etc, legally or illegally. Figure III-4 below shows the motorbikes that were "retuned" specifically for forest voyages. Most families with forest-goers have this type of motorbikes.

Figure III-4: Typical vehicles used for entering forests



Forest goers often went in groups, and often stayed in the forest for at least a few days. When in the forests, or out on working fields, they resided in very simple "houses", sometimes without doors. The places were simply equipped, depending on the length of stay. In the photo on the upper left of Figure III-5 below, the tent was for a family from another province who came to Gia Lai to work on plantation, mostly growing watermelons. They only went back to their hometown once or twice per year for a short time. Outside watermelon season, they went to Pleiku City to work short term for plantation farms. Due to their longer stay comparing to short term migrants, their "house" was more well-prepared, with simple bed,



hammock with net (bought by themselves at 10 USD), table, etc. Similarly, the photo on the lower left corner shows the tent of a family working nearby. For shorter stay, the tent is extremely simple. It was also notice from the interviews that if the stay was too short, forest goers did not even need to have a tent or house.

**Figure III-5: Accommodations for forest goers or plantation workers**



Interviews with families that had malaria patients revealed that malaria seemed to be an "inevitable part" of their life, so common that they did not concern much about it. Some said they used to have malaria at least 3 times per year, but still went to work in the forest without nets. Infected with malaria or not was seen as a matter of "luck", not of choice. It is clear that malaria elimination goals of the country had not reached these populations. It is also noticed that the at-risk populations lacked knowledge on malaria transmission routes. Many still thought that it is transmitted through water, hence using clean and boiled water was believed to be a prevention method. The seemingly more educated people were





not sure if the transmission was through mosquitoes or water. There are loudspeakers and posters on malaria in town centers, but in farther places, it seemed less common. Overall, the public health system's IEC/BCC messages still have not reached these people.

For villagers, mosquito nets were available and they were more satisfied with this year net's quality than last year's. However, using nets when sleeping in the forests were rare. Many forest-goers said that they did not want to use the nets because it was uncomfortable doing so. They reported not sleeping under mosquito net while in the forest, using it as pillow or not carrying it at all to the forest, removing the net from hammock, or not using any measures to prevent mosquito bites. There were also those who frequently drank alcohol after work, and passed out without using the nets. Ethnic minority people were more likely to accept mosquito bites as common, while Kinh people were keener on using preventive methods.

Medical services for malaria are available and seemingly at good quality. Rapid tests are available at border crossings, malaria posts and commune health centers. Microscopes and RDTs are available at commune health centers. Patients who came for malaria treatment are given free treatment and even monetary allowance for food. Nevertheless, not everyone go to public services. Many people choose either to go to pharmacies to buy medicine, or to go to private licensed or unlicensed doctors. There were cases having fever at the moment of interviews after working a few days before in the forest, but did not go to hospitals and waited for the fever to subside instead. Some more experienced forest goers brought fever medicine with them just in case. It is no doubt that illegal forest-goers wanted to avoid public health services. Hard-to-reach populations - despite often infected by malaria - seem to be the least likely to reach public health services.

### 3. CSO consultation workshop

With the information and contacts obtained during desk review and field trips, SCDI conducted a CSO Consultation in Hanoi on 11 January 2017. This is the first time this kind of consultation was conducted for CSOs in malaria in Vietnam. The main objectives of this workshop were:



1. To encourage the participation of civil society organizations and the community in fighting malaria in Vietnam;
2. To collect suggestions from civil society organizations and community representatives on Vietnam's component in the Regional Concept Note to fight malaria in 2018-2020 to The Global Fund;
3. To select representatives from the community and civil society organizations to participate in the Country Dialogue in preparation for the Concept Note to Fight Malaria to The Global Fund.

The workshop was participated by a wide ranges of guests, from representatives of the RSC Secretariat, UNOPS, The Global Fund's Country Coordinating Mechanism (CCM), APCASO, Greater Mekong Malaria Civil Society Platform, to representatives of General Department of Preventive Medicine and NIMPE, civil society organizations working in fields related to health, mobile and migrant populations, ethnic minorities, or near the country border and most importantly, representatives of high-risk groups from BinhPhuoc and Gia Lai (Figure III-6) (for a full list of participants, see Annex 2).

**Figure III-6: Participants of CSO consultation workshop**



The workshop started with RSC's overview of malaria and drug-resistant malaria and strategies to eliminate malaria in the Greater Mekong subregion, followed up by NIMPE's presentation on the malaria situation in Vietnam, including challenges and upcoming priorities. Participants then discussed and identified barriers to malaria elimination in Vietnam. The second session focused on the Global Fund's support to malaria program in



Greater Mekong Subregion, roles of community and civil society organizations, and Community System Strengthening component in GF-supported program. The session then continued with discussion on developing and strengthening community system in order to improve access to malaria prevention, diagnosis and treatment services in focal areas in Vietnam. The workshop concluded with the selection of representatives to attend the Country Dialogue conducted by CCM on 13 January 2017 (See Annex 3 for all presentations)

All the participants agreed that the Government of Vietnam has invested considerable efforts in malaria elimination, shown in the significantly decreased morbidity and mortality in the past 20 years. However, the participants also shared their concerns over achieving elimination target, especially in mobilizing the involvement of some high-risk populations. With experience and the capacity in connecting with other members within their own community of the high-risk populations, experience of non-governmental organizations in supporting the network development for other hard-to-reach groups, and their capacity in connecting to relevant stakeholders, the participants believed that CSOs and community can contribute significantly to malaria elimination in Vietnam, through the activities based on Global Fund's Community System Strengthening Component which has been successfully applied in Global Fund Project for HIV in Vietnam. Therefore, it was proposed by the participants that the community system strengthening component should be included in Vietnam's Proposal to Global Fund in 2018-2020. This component will be implemented by CSOs and community in Vietnam in prioritized areas in accordance with the national strategies, with the coordination and collaboration with the National Malaria Control Program and other entities at central and local levels.

The community groups established in this component ("Community Malaria Action Teams" or CMATs) will be responsible for mapping of high risk groups and reaching out to them to conduct IEC/BCC, distribute preventive commodities and instruct the usage; refer to testing and treatment services; support treatment adherence and timely provide information and feedback to local health services. The community in general will also be motivated to join the elimination movements in their own communities.

The above-mentioned activities are in line with the Regional Statement "Towards Greatest Impact and Effectiveness of RAI 2018-2020 - Malaria CSO Positions" presented at the



Regional Consultation Workshop on 16 December 2016 in Bangkok, Thailand. It was strongly believed that the participation of CSOs and affected populations will contribute sustainably in malaria control and elimination in Vietnam.

#### 4. Participation in country dialogue:

The Malaria Country Dialogue was hosted at NIMPE on 13 January 2017. With the facilitation of CS representatives in the RSC, slots for Vietnamese CSO representatives to participate were increased from 2 to 7 persons, including representatives of SCDI, CHD, Phap Bao Center together with 4 representatives of high-risk populations who had attended the earlier CSO consultation.

At the Country Dialogue, a paper titled "Toward malaria elimination in Vietnam - Inputs from civil society in Vietnam to the Global Fund malaria concept note" - summarizes Vietnamese civil society recommendations to the next Global Fund grant in Vietnam was distributed along-side the regional CSO paper "Towards Greatest Impact and Effectiveness of RAI 2018-2020 - Malaria CSO Positions" (See Annex 4).

Dr. Oanh, on behalf of the CSOs, presented the findings of the field visits in Binh Phuoc and Gia Lai, and CS proposal for the next GF grant (See Annex 5). CSOs proposed to work in 2 components:

##### 1) *Development of a community system in response to malaria:*

- Support the development of self-help/peer groups in malaria high-burden areas; Members are from communities most affected by malaria.
- Build their capacities: knowledge, skills, methods to organize community activities;
- Provide funding for activities;
- Connect groups to form a network to share information, experiences, support referral;
- Closely coordinate with village and commune health workers and malaria program.

##### 2) *CSO participation in service delivery:*

- Mapping of high risk groups;
- Reaching out, conducting direct communication: Correct knowledge on malaria; counseling on prevention; information on services for prevention, diagnostic and treatment;
- Distribute preventive commodities and instruct the usage;
- Promote and support the use of testing and treatment;
- Support treatment adherence;
- Timely provide information and feedback to health services;
- Motivate the community to create an elimination movement in their own communities



All community representatives also had opportunity to speak up, with ideas aligned with Dr. Oanh's presentation. They gave examples of the real situation where they came from, and the importance of developing and strengthening community response to malaria. Overall, contributions from CSOs were encouraged by the chair-person, and appreciated by other participants.

#### IV. CONCLUSION AND RECOMMENDATIONS:

##### The snapshot of the situation:

1. Malaria services available, free of charge, relatively accessibly, however, it is persistently common in some areas and achievements are not always sustainable.
2. Malaria is still a "inevitable part" of life of the populations most affected by malaria – elimination goal has not been transmitted to them;
3. Many people still do not know the cause of malaria, prevention measures, about the disease and its treatment;
4. It is very common for forest goers and forest-farm sleepover to be bitten by mosquitoes.
5. Services are there but many people don't use them. Being untreated, or non-adherence are quite common;
6. Malaria risk is about forests, but the capacity of health sector to reach, communicate, and support these populations is limited.

##### Proposed priorities for CSOs in Vietnam:

1. Support the development of self-help/peer groups in malaria high-burden areas with members from communities most affected by malaria. These groups will:
  - a. Conduct mapping of high risk groups;
  - b. Reachout and conduct IEC/BCC to provide correct messages on malaria and related available services of prevention, diagnosis and treatment
  - c. Distribute preventive commodities and instruct the usage
  - d. Support detection and refer cases to health facilities
  - e. Promote and support the use of testing and treatment
  - f. Support treatment adherence
  - g. Timely provide information and feedback to health services;
  - h. Motivate the community to create an elimination movement in their own communities
2. Build their capacities (knowledge, skills, methods,...) to organize community activities;



3. Connect groups to form a network to share information, experiences, and support referral;
4. Provide funding for activities;
5. Closely coordinate with village and commune health workers and malaria program.



