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Strengthening Community, Rights, and Gender Concepts for Communities and Civil Society on Country Coordinating Mechanisms

Guidance Tool

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Acknowledgements

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Abbreviations and Acronyms

ACT	Artemisinin Combination Therapy
ART	Antiretroviral Therapy
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CLAC	Community Leadership and Action Collaborative
CPR	Civil and Political Rights
CRG	Community, Rights and Gender
CSS	Community Systems Strengthening
ESCR	Economic, Social, and Cultural Rights
Global Fund	The Global Fund to Fight HIV, Tuberculosis and Malaria
GMR	Greater Mekong Region
HIV	Human Immunodeficiency Virus
HRBA	Human Rights-Based Approach
IPTp	Intermittent Preventive Therapy in pregnancy (for malaria)
ITN	Insecticide-treated bed nets
MSM	Men who have sex with men
NFM	New Funding Model
OHCHR	Office of the High Commissioner on Human Rights
PEP	Post-exposure prophylaxis
PLHIV	People Living with HIV
RCNF	Robert Carr civil society Networks Fund
RSSH	Resilient and Sustainable Systems for Health
SDG	Sustainable Development Goal
SOGIE	Sexual Orientation and Gender Identity and Expression
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
TA	Technical Assistance
TB	Tuberculosis
TRP	Technical Review Panel
UHC	Universal Health Coverage
WHO	World Health Organization

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Introduction

Introduction

In 2014, The Global Fund to fight HIV, Tuberculosis and Malaria (Global Fund) introduced the "Communities, Rights and Gender Special Initiative (CRG SI)"[1] to promote and advance community systems strengthening (CSS), human rights, and gender equality in its New Funding Model (NFM). The Global Fund had been trying to integrate human rights and gender equality throughout grant cycles, and the CRG SI filled an urgent gap in the technical assistance (TA) and capacity building architecture in terms of community/civil society engagement.

The aim of the CRG SI was to ensure that:

- Communities and civil society are meaningfully engaged in the design, implementation, and monitoring of Global Fund-supported programs and interventions.

- Technically sound interventions supporting human rights, gender equality, and CSS are included in Concept Notes for HIV, tuberculosis (TB), and malaria.

It had three core components: (a) short-term technical assistance for country dialogues and Concept Note development, (b) long-term capacity development of key population networks through partnership with the Robert Carr civil society Networks Fund (RCNF), and (c) creation of six regional coordination and communications platforms for communities and civil society to enhance responses to the three diseases by strengthening information, coordination, engagement and supporting technical assistance for communities and civil society. APCASO serves as the Asia-Pacific Platform on Community, Rights and Gender (APCRG).

APCASO's *Strengthening CRG Concepts Tool* is meant for civil society members of Country Coordinating Mechanism (CCM), a multi-stakeholder governance structure composed of representatives from different stakeholders of the three diseases, such as government

> ### Box 1. Civil Society Representation on the CCM
>
> Civil society is the term used to designate stakeholders who are neither government bodies nor private sector enterprises: groups such nongovernmental organizations, advocacy groups, faith-based organizations, networks of people living with the diseases, and so on. In 2014, the Global Fund updated the CCM governance requirement, noting that people living with HIV, tuberculosis and malaria as well as key populations be represented on CCM bodies.

[1] The CRG department was established in late 2013, and served as the focal point for and convener of Secretariat-wide efforts to increase capacity and collaboration on CRG in the rollout of the NFM.

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agencies, private sector groups, civil society organizations, communities affected by or living with the diseases, academics, and international and multilateral development institutions. The objective is to build capacity of community and civil society members on community engagement, human rights, and gender equality in relation to meaningful country dialogues, planning and budgeting, and program design in Concept Note submissions to the Global Fund for the three diseases (HIV, TB, and malaria).

Structure of the Tool

Building capacity happens through principles of active engagement, particularly on issues that directly affect the community itself. The APCASO Strengthening CRG Concepts Tool therefore uses a participatory hands-on approach and a wide range of methods that include:

- Building knowledge through explanation of a concept
- Using points of reflection by asking why for initiating discussion
- Creating sample activities with case studies, games, and examples

The information is designed to incorporate the perspective of all three diseases and to be used in a range of cultural settings. However, some aspects may be more appropriate than others and based on the epidemiology of the three diseases. The points of reflection and sample activities therefore can be changed and modified to reflect a more recognizable, local reality.

The framework for the tool is based on the structure of the *Community, Rights and Gender Report 2016*[2] presentation of CRG activities at the 35th Board Meeting of the Global Fund and the 2017 Technical Briefs on each of three diseases and human rights and gender equality. The four focus areas included are:

1. Overview of CRG in the Global Fund Strategic Framework 2017-2022
2. Promoting and protecting human rights
3. Promoting gender equality
4. Strengthening community engagement

The tool is meant for community and civil society members of CCM bodies, and its intended outcome is to strengthen knowledge and strategic thinking on defining, promoting, and applying CRG issues in the country dialogues and in the development of Concept Notes. It is about how communities, especially TB and malaria-focused communities/civil society and key populations, can meaningfully engage and mobilize support for human rights, gender equality, and community participation in Global Fund processes. The APCASO CRG Guidance

[2] Global Fund. (2016). Community, Rights and Gender Report 2016. The Global Fund 35th Board Meeting. GF/B35/15. 26-27 April 2016. Abidjan, Cote d'Ivoire.

equality, and community participation in Global Fund processes. The APCASO CRG Guidance tool is not a primer on the New Funding Model or Global Fund structures.[3]

REFLECTION 1

Take an audit of CRG knowledge on the CCM. Brainstorm your understanding of human rights, gender equality, and community engagement. Write out an answer for each question:

- What are human rights?
- Describe an example of a human rights violation?
- What is gender equality? Describe a situation concerning gender equality.
- What is community engagement? Why is it important and how is it expressed?
- In your experience on the CCM, how is each of these concepts included in Concept Notes? Discuss if such information is only included in the background or is it also reflected in programming.

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[3] For the latest information on the Global Fund Funding Cycle refer to: ICASO/MSMGF. 'The 2017-2019 Global Fund Funding Cycle Highlights of the Differentiated Funding Application Process.' ICASO.

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Overview of **Community**, **Rights**, and **Gender** in the Global Fund Strategic Framework 2017-2022

Overview of Community, Rights, and Gender in the Global Fund Strategic Framework 2017-2022

The Global Fund Strategy for 2017-2022, *Investing to End Epidemics*, prominently features its commitments to community engagement, human rights, and gender equality. Under Strategic Objective 3, *Promote and Protect Human Rights and Gender Equality*, there are five operational objectives:

a. Scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights (SRHR)
b. Invest to reduce health inequities including gender- and age-related disparities
c. Introduce and scale-up programs that remove human rights barriers to accessing HIV, TB, and malaria services
d. Integrate human rights consideration throughout the grant cycle and in policies and policy-making processes
e. Support meaningful engagement of key and vulnerable populations and networks in Global Fund-related processes

In addition, Objective 2, *Building Resilient and Sustainable Systems for Health*, recognizes the Global Fund's important role in supporting women's, children's and adolescent health and promoting integrated platforms for the delivery of disease-specific and other health services to these populations (Strategic Objective 2b) and the important role played by community in health responses and systems (Strategic Objective 2a). Under Strategic Objective 1, *Maximizing Impact against the Three Diseases*, Operational Objectives 1e supports sustainable responses for epidemic control and successful transitions.

The Global Fund Strategy is unequivocal in supporting interventions that remove human rights barriers, reduce gender inequality, and eliminate stigma and discrimination in health systems and society. These factors are key drivers in HIV, TB, and malaria and undermine effective responses, and need to be addressed through programming that is tailored to the current needs and conditions of the country.

REFLECTION 2
Using the information above, discuss:
- What are some of the structural barriers that prevent persons at-risk of and living with HIV, TB, and malaria from accessing health services?
- Differentiate barriers in healthcare facilities from broader societal barriers.

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1. Make a table with four columns. Write down each disease in the header of each of the three columns.
2. Through a group discussion, list the structural barriers that a person living with any of these diseases might face in accessing health services for each disease. You can specify in parenthesis if a barrier is of particular relevance to a man or a woman, persons in particular age categories, or of different ethnic or minority background, or member of a key population (sex workers and their clients, persons who use drugs, men who have sex with men (MSM), transgender people, migrants, or persons in closed settings).
3. Draw lines between or encircle with colored pens those that are common between all three diseases.
4. In column four, put header Global Fund investment, and describe activities that have been supported to address structural barriers.

Structural barriers could include: poor quality services, lack of identification card, finances and costs, long distances and transport, fear of arrest, fear of violence, stigma and discrimination etc. (Note: The facilitator can also construct a list of structural barriers based on the earlier discussion, and then ask participants to place these in the relevant column.)

REFLECTION 3
Based on your completion of the chart above, discuss how successful Global Fund investment has been, or not, in building resilient health systems and addressing human rights and gender-related barriers. What are the positives? What are the negatives? How has the community been involved and included in the responses?

Human Rights, Gender Equality, and Community Engagement

Human Rights, Gender Equality, and Community Engagement

Human rights are a broad concept, underpinned by a set of shared common values such as fairness, respect, equality, dignity and autonomy. Although expressed throughout history in different ways, the modern concept of human rights emerged at the end of World War II and was enshrined in the International Bill of Rights that includes the Universal Declaration on Human Rights and the two International Covenants on Civil and Political Rights (CPR) and Economic, Social and Cultural Rights (ESCR). The key characteristics are:

- Universal – Human rights belong to everyone, regardless of circumstance.
- Inalienable – Human rights cannot be away from you by anyone, but rights can be limited or restricted.
- Indivisible and Interdependent – ALL different human rights are important for persons to flourish and participate in society.

The United Nations has developed human rights guidance and machinery with committees and procedures[4]. In addition to the international system, there are also regional systems of human rights, and many countries also have domestic human rights legislation and machinery.

The inherent right to the highest attainable standard of health is enshrined in the constitution of the World Health Organization (WHO). The APCASO tool focuses on the basic concept of human rights in health and health programming associated with the three diseases. It is meant as an introduction and not an exhaustive list of health and human rights issues.

The International Right to Health[5]

The legal basis of the right to health is recognized in numerous human rights instruments (Table 1), and includes underlying determinants and complementary rights such as right to food and potable water, housing, adequate sanitation, safe working and environmental conditions, and health-related education and information including on sexual and reproductive health (SRH).

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[4] You may find more information at the UN Office of High Commissioner on Human Rights (OHCHR) website at http://www.ohchr.org

[5] Based on Toebes, Brigit C.A. (1999) The Right to Health as a Human Right in International Law. Intersentia. Antwerp. And FXB Center for Health and Human Rights (2103). Health and Human Rights Resource Guide. FXB and Open Society Foundations. Boston.

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TABLE 1. THE RECOGNITION OF THE RIGHT TO HEALTH IN INTERNATIONAL HEALTH LAW

Human Rights Instrument	Article or General Comment	Synopsis
World Health Organization (1946)	Preamble	...the highest attainable standard of physical, mental, and social well-being
Universal Declaration on Human Rights (1947)	Article 25	Health combined with other social issues under the right to an adequate standard of living
Covenant on ESCR (1966)	Articles 7, 9, and 12	The right to safe and healthy working conditions. The right to social security, including social insurance. The right to the enjoyment of the highest attainable standard of physical and mental health.
	General Comment 14	Expands on the concept of the highest attainable standard of physical and mental health.
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979)	Articles 11 (1)f, 12, and 14 (2)b	Protection of health and safety in working condition, including safeguarding reproductive functions. Access to health care facilities, including information, counselling and services in family planning.
	General Comment 24	Expands the access to health care including reproductive health
Convention on the Rights of the Child (1989)	Article 24	The right to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health for all children below 18 years old.
International Convention on the Elimination of All Forms of Racial Discrimination (CERD) (1965)	Article 5 (e) iv	The right to public health, medical care, social security, and social services without distinction as to race, color, nationality or ethnic origin.
Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990)	Article 28	The right to receive any medical care that is urgently required for the preservation of their lives.
Standard Minimum Rules for the Treatment of Prisoners (1957)	Rules 22 to 26	Provide detailed principles for the treatment of sick prisoners including availability of health services, doctors, and medicines.

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The most immediate obligation is to ensure non-discrimination in accessing health care regardless of resources for all persons regardless of race, color, sex, language, religion, political views, national or social origin, physical or mental status, sexual orientation and gender expression and identity, and health status (including HIV). The foundation of non-discrimination supports four essential elements of the right to health. These include:

A. **Availability** of functioning facilities, goods and services including the infrastructure, trained and professional staff, essential drugs and drinking water and sanitation.

B. **Accessibility** of facilities, goods and services based on principles of non-discrimination, physical accessibility, economic accessibility (including affordability), and information accessibility in terms of seeking, receiving and imparting health information while respecting confidentiality.

C. **Acceptability** of facilities, goods, and services that are culturally appropriate including sensitive to gender and life cycle requirements and respectful of medical ethics.

D. **Quality** of facilities, goods and services are scientifically and medically appropriate with skilled personnel and drugs and diagnostics.

While the State may not be able to fully guarantee all these elements of the right to health, it does have a **minimum core set** of obligations that it can take step towards. This concept of gradual improvement of conditions is known as **progressive realization**. Recognizing that States may not have the necessary infrastructure, trained health professionals or ability to implement legal reforms, it nonetheless has to make continuing efforts to move expeditiously and effectively as possible towards the realization of the right to health.

There are six minimum essential core obligations and five priority obligations[6] that all States are obliged to implement, and viewed as essential to the right to health (Table 2). Most of the obligations should be considered in health programming and in Global Fund-supported activities.

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[6] UN Committee on Economic, Social and Cultural Rights General Comment No. 14. (August 11, 2000) The Right to the Highest Attainable Standard of Health.

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TABLE 2. GENERAL COMMENT 14 ON THE RIGHT TO HEALTH LIST OF CORE AND PRIORITY OBLIGATIONS FOR THE STATE.

Core Obligations (6)	Priority Obligations (5)
☐ Non-discriminatory access to health facilities, goods, and services ☐ Access to the minimum, nutritionally adequate food ☐ Access to basic shelter, housing and sanitation and safe and potable water ☐ Provision of essential drugs ☐ Equitable distribution of facilities, goods, and services ☐ Adoption and implementation of a national public health strategy and plan of action	☐ Ensure reproductive, maternal, and child healthcare ☐ Provide immunizations against major infectious diseases ☐ Take measures to prevent, treat, and control epidemic and endemic diseases ☐ Provide education and access to information on main health problems ☐ Provide appropriate training for health personnel, including on human rights

REFLECTION 4

Discuss how international human rights concepts have been adapted (or not) in national policies and programmatic responses in HIV, TB, and malaria.

ACTIVITY 2. Complete the phrase.

1. Where human rights are not protected, people are more vulnerable to risk of infection of _____. (ANSWER: HIV or TB)

2. The concept of _____ is an immediate obligation in human rights (ANSWER: non-discrimination).

3. The four essential elements of the right to health are: _____, _____, _____, and _____. (ANSWER: availability, accessibility, acceptability and quality).

4. In a human rights framework, all children under age _____ are entitled to the _____. (ANSWER: 18, highest attainable standard of health).

5. The underlying determinants of health linked to the right of health include (list 2): _____ and _____. (ANSWER: any of the following: adequate housing; nutrition; potable water; sanitation; safe working environment; access to education and information.)

6. _____ is an example of a priority obligation of the State, and essential for realizing the right to health. (ANSWER: any of the following: ensure reproductive, maternal and child health care; provide immunizations against major infectious diseases; take measures to prevent, treat and control epidemic and endemic diseases; provide education and access to information on the main health problems; provide appropriate training for health personnel, including on human rights)

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Human Rights-Based Approach to HIV, TB, and Malaria

The Human Rights-Based Approach (HRBA), derived from the principles and instruments above, is a conceptual framework that can be applied to Concept Note development and programmatic interventions. Although there is no one model, there are a number of guiding factors informing the HRBA. These factors include (and also happen to form the acronym PANELS):

Participation of all stakeholders including affected communities and excluded groups;

Accountability for monitoring progress and mechanisms for measuring violations of rights;

Non-discrimination and ensuring that no one is left behind and needs of the most vulnerable are included;

Empowerment by building capacity and placing people at the center of the process rather than treating them as passive recipients;

Linkage to legally enforceable rights and protections

Sustainability and ensuring local ownership and strengthening partnerships among stakeholders

Every CCM member should apply the HRBA in community dialogues (prior to Concept Note development) and during writing of the Concept Note, design and budgeting of programmatic interventions, and in implementation, monitoring, and evaluation of the interventions.

People living with HIV (PLHIV) have used human rights to successfully litigate for universal access to antiretroviral treatment and from protecting HIV-positive women from coerced sterilization.

HIV, TB, and malaria are often considered diseases of poverty and inequality. Not only are poor and marginalized at greater risk of these diseases, but they are also poor as the consequence of these diseases. The poorest people in any society are the least able to afford preventive measures and treatment, and their illness can result in further impoverishing their families. These diseases are preventable and, in some cases, treatable. But the stigma and discrimination, punitive legal and policy environment, and direct and indirect costs related to health services can prevent people from accessing services. Recognition of HIV, TB, and malaria as inextricably linked to human rights is important for four reasons[7]. These include:

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[7] UNDP (2013). The Role of Human Rights in Responses to HIV, Tuberculosis and Malaria. UNDP.

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1. **Enhancing disease prevention.** Whereas stigma, discrimination, and lack of empowerment marginalizes people, pushing them away from health services, human rights-based laws ensuring non-discrimination for key populations have resulted in greater prevention coverage. On the other hand, punitive legal environment, such as criminalizing same-sex relationship, which is a case for a number of Asia-Pacific countries, has been associated with greater sexual violence, restricted condom distribution, harassment by police of illegal conduct, and censoring of HIV and STI prevention materials.

2. **Increasing accessibility of health services.** By addressing stigma, discrimination, violence and social marginalization, programming and resources can reach those most in need. Effective programming based on human rights principles can sensitize health care providers on treating patients with respect, draw community to friendly and non-discriminating services, and increase knowledge and information on disease transmission and risks. HRBA to programming can reduce the burden of stigma and discrimination. Providing health services in prisons and pre-trial detention centers can curb the spread of TB and HIV in closed settings and, consequently, in the general population.

3. **Improving service uptake.** Promoting and protecting human rights creates conducive conditions for uptake of services, especially when those seeking services are confident that they will not face stigma and discrimination; wherein their confidentiality will be respected and they will have access to appropriate counselling and information, and wherein they will not be coerced into accepting services.

4. **Promoting individual capabilities and ensuring sustainability.** A focus on human rights empowers individuals and communities to more effectively participate in the design and implementation of programs that affect them, demand accountability and greater transparency from those providing services, and advocating with the State on removal of human rights barriers and address human rights violations. Knowing one's rights results in an informed and engaged constituency. In Asia Pacific, empowerment of sex workers leads to decreased risk of HIV infections and less harassment by police.

The HRBA to health can result in improved health programming and responsive health systems in which voices of those traditionally marginalized or most vulnerable can be recognized, heard and integrated into the response. The framing of health as a human right allows for raising awkward questions to those responsible for delivery of services and also demand accountability from them. Transparency and accountability are important tools in the rights-based framework.

The rights-based evidence-oriented approach to health programming allows civil society to identify who is going to do what and what can be done when things do not go as planned. Communities can ask, for example, how are their needs being addressed in planned activities? What are the budget allocations supporting services for them or by them? How are the health outcomes related to key populations being measured? What are the indicators? And what happens when outcomes don't improve?

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Other reasons for why human rights are of importance in the HIV, TB, and malaria response include:

- **Prevention** – A rights-based approach addresses the socio-economic determinants of health, especially the vulnerabilities that lead to infection and disease.

- **Access to care** – Diagnosis and treatment are often hindered by costs, lack of information, stigma and discrimination, specific public policies, and lack of social insurance and health services. A rights-based approach removes policy, legislative, and programming barriers and promotes an integrated and multi-sectoral response. It advocates for services that match community priorities, and aims to ensure that health workers are adequately trained (including on removing attitudes of stigma and discrimination in health care settings), and that there is a steady and sustainable supply of diagnostics and medicines, and prevention commodities.

- **Engagement of communities** – A rights-based approach places affected populations and communities at the center of the response as equal partners, driving the agenda and having the tools to claim their space and specific rights especially with regards to stigma and discrimination.

The way in which HIV, TB, or malaria, or a person living with, or at risk of, these diseases is discussed matters. Labels and language are important and HRBA provides a framework of empowerment for those living with, or at risk of, HIV, TB, and malaria. The HRBA to health also fits well with the concept of Universal Health Coverage (UHC), described as the ultimate expression of fairness[8] and one of the key targets related to the health goal of the Sustainable Development Goals (SDGs).

REFLECTION 5
The Global Commission on HIV and the Law, an independent body convened by UNDP, found that human rights-based legal environment plays a powerful role for those communities most vulnerable to HIV. Laws and policies that criminalize certain behaviour or hinder public health efforts perpetuate discrimination and worsen the epidemic. Discuss which laws, legislation, and/or policies in your country undermine human rights and the right to health and negatively impact on people living with, or at risk of, HIV, TB, and malaria.

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[8] WHO (2012). Address by Dr. Margaret Chan, Director-General WHO, to the 65th World Health Assembly. WHO Doc. A65/3.

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ACTIVITY 3. Understanding 'stigma and discrimination'

1. On a square piece of paper write out a label (such as living with HIV, men who have sex with men, person who uses drugs, sex worker, pregnant mother with malaria, prisoner with TB, etc).

2. Place the label on the back of each person (make sure that the person does not see the label attached to them).

3. Let everyone walk around for 5 to 7 minutes and react as a member of society would in response to the label that the person is wearing.

4. Return to your chair and discuss how each person was treated, and see if the person can guess the label that he or she was wearing.

ACTIVITY 4. Create a Venn diagram that has two overlapping circles. Label one Stigma and the other Discrimination.

1. How are these two concepts connected and different from each other for each disease? For men and women? For key populations?

2. Strategize as to what types of programmatic interventions could be helpful in reducing stigma and discrimination?

Box 2. Stigma and Discrimination

Stigma is an unfavourable attitude and belief directed towards someone or something. It can be expressed through language, belief or behaviour.

Discrimination is the treatment of an individual or group with partiality or prejudice. It is often expressed through action. Depending the situation in which discrimination occurs, it may be seen acting against the law because of race, sex, age, sexual orientation or religion or disease.

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HIV, TB, and Malaria in Asia and the Pacific

HIV is no longer the dreaded killer disease it once was because of effective treatment. In Asia Pacific, AIDS-related deaths have declined by 30%, from 240,000 in 2010 to 180,000 in 2015. However, the number of new infections has hardly changed, remaining around 300,000 compared with 310,000 in 2010. Prevention strategies are not working as HIV risk remains concentrated among specific population groups and geographical locations. The fastest growing epidemics are among men who have sex with men (concentrated in major cities) and people who inject drugs. Data on transgender persons are scarce, but where available show high prevalence. Young adults, 15-24 years of age, from key populations are at high risk of HIV infection in the region. Co-infection with TB is also high, and 7 of the world's 41 HIV-TB burden countries are in Asia-Pacific: Cambodia, China, India, Indonesia, Myanmar, Thailand and Viet Nam. There continues to be high levels of stigma and discrimination against people living with HIV and against people who use drugs, sex workers, MSM and transgender people. Punitive laws continue to hinder the HIV response in the region.

HIV is at a crossroads. According to UNAIDS, the trajectory of the epidemic has been bent and unless there is front-loaded investment in the next five years there is risk of the virus rebounding out of control. UNAIDS, in its latest Fast Track Strategy 2016-2021 has called upon global leaders to commit to end the AIDS epidemic by 2030. The Fast-Track Strategy has 3 main targets for 2020 and aims to transform the vision of zero new HIV infections, zero AIDS-related deaths, and zero HIV-related discrimination into programmatic strategies.

- **Reducing new infections to 500,000 from 2.1 million in 2015.** In Asia-Pacific, this means reducing 480,000 new infection in 2013 to less than 97,000 by 2030.

- **90-90-90.** 90% of people living with HIV know their status, 90% of people who know their status are on treatment, and 90% on treatment are virally suppressed so that their immune system remains strong.

- **Zero discrimination.** Discrimination is viewed as a critical enabler that needs to be urgently scaled up, especially how best to address the social and structural barriers that deter people from accessing services. Community engagement and mobilization is viewed as critical to the response, and protection of human rights as the bedrock. "Nothing other than zero discrimination is acceptable."

Malaria is a disease of poverty and endemic in certain areas, especially in the Greater Mekong Region (GMR) of Southeast Asia. It disproportionately affects migrants, refugees, indigenous people, prisoners, geographically marginalized communities and people working in high exposure areas. Available evidence suggests that in the event of equal exposure, adult men and women are equally vulnerable to malaria infection. Young children with no immunity and pregnant women are at greatest risk of severe episodes due to decreased immunity. There is treatment and intermittent preventive therapy in pregnancy (IPTp), but only one in two women receive even one dose of the four recommended doses of IPTp.

[9] UNAIDS. (2014). Fast-Track: ending the AIDS epidemic by 2030. UNAIDS.
[10] WHO. (2015). Global Technical Strategy for Malaria 2016-2030. WHO.

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Tuberculosis is among the world's leading causes of death, and responsible for 35% of deaths in PLHIV in 2015. Perpetuated by people who live in conditions of overcrowding, inadequate ventilation, poor nutrition, and poverty, those with TB experience stigma and discrimination. Taking several drugs for 6 to 9 months can treat TB, and the treatment is very cheap. There are two forms of TB: **latent TB infection**, when germs are in the body but sleeping and cannot be passed on to anyone. However, the germs can wake up any time and turn to **TB disease (or active TB)** and these can infect other persons. Medicine is needed to treat both types of TB, but at the moment only active TB is treated because of resource constraints. Prisoners are often excluded from TB prevention, diagnosis and treatment. Yet people with TB are criminalized and patients who default on their treatment are often punished. Asia also has the highest numbers of multi-drug resistant TB, which means that the TB bacteria is resistant to treatment with at least two of the most powerful first-line anti-TB medications, isoniazid and rifampicin. Similar to HIV, there is a global plan to end TB by 2035. The main targets in the End TB Strategy are: to reduce TB deaths by 95%; to cut new cases by 90% between 2015-2035; and to ensure that no family is burdened with catastrophic expenses due to TB.

For any of the HIV, TB, and malaria strategies to work, there needs to be country ownership and leadership, with involvement and participation of communities, and equity in access to health services. There also needs to be innovation and access to new diagnostic tools and medicines. Patent restrictions are one of the key barriers that push up the prices of diagnostic tools, commodities, and live-saving medicines. Many countries face trade-related pressures, and cannot freely negotiate prices with pharmaceuticals or grant compulsory licenses for access to generic drugs and diagnostics. Even in Global Fund grants, access to medicines consumes a large portion of the budget. Civil society needs to advocate for the right to affordable medicines and diagnostics, as an essential human right and integral part of all three strategies.

ACTIVITY 5.

1. Create a Bubble Map on barriers to accessing prevention and treatment services for each disease.

2. Review and see the common barriers, and then label those that result from laws and policies.

3. Address how these can be changed through programmatic activities in Concept Notes for HIV, TB and malaria.

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[11] www.tbfacts.org/end-tb/

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> **Box 3. Global Fund Definition of Key and Vulnerable Populations**
>
> Key populations (KP) in the context of HIV, TB, and malaria are those that experience high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalized or otherwise marginalized.
>
> KP in the HIV response are gay, bisexual and other men who have sex with men, women, men and transgender people who inject drugs, and/or who are sex workers; as well as all transgender people [who] are socially marginalized, often criminalized and face a range of human rights abuses that increases their vulnerability to HIV.
>
> KP in the TB response are prisoners and incarcerated populations, people living with HIV, migrants, refugees and indigenous populations, as well as [those] experiencing significant marginalization, decreased access to quality services, and human rights violations.
>
> KP in the malaria response is a relatively new concept but there are groups that meet the criteria defined above, and include refugees, migrants, internally displaced people and indigenous populations in malaria-endemic areas.
>
> Vulnerable populations are those whose situations or contexts make them especially vulnerable, or who experience inequality, prejudice, marginalization and limits on the their social, economic, cultural and other rights.

Gender Equality

Gender equality recognizing 'equal rights of men and women' is a fundamental principle in the UN Charter, which was adopted in 1945, and discrimination based on sex is prohibited in all subsequent human rights instruments. Similar to income and income inequality, gender is another social determinant of health.

Gender is a social construct, referring to roles and expectations attributed to men and women and gender non-conforming persons in a given society. These roles can vary over time with age and the differing stages of life and relationships. While sex is closely linked to biology, i.e. the ability to bear children, gender construct is about power and power relations. It is the powerlessness and lack of control that underlies its impact on health and access to resources. Both men and women are subject to the health effects of gender, even if the impact of gender appears to burden women disproportionately, and as a result the focus on women's health in the context of gender equality.

The Global Fund through its Gender Equality Strategy[12] has developed a 'gender spectrum' of interventions (Table 3). Gender-negative or gender-blind programming fails to acknowledge that there are different needs or realities for women and men, girls and boys. Gender- sensitive or gender-responsive programming recognizes the distinct roles and contributions of gender and attempts to ensure that women, girls, and gender non-conforming persons equitably benefit from interventions. Gender transformative approaches explicitly seek to transform gender norms and redress existing inequalities.

TABLE 3. GENDER INTEGRATION SPECTRUM

Type of intervention	Impact	Example
Gender-negative or gender-blind programming and policies	Aggravates or reinforces existing gender inequalities and norms	Lack of collection of disaggregated data in programmatic activities Laws and policies prohibiting women from equal access to land, property and housing
Gender-sensitive	Takes into account distinct roles and contributions based on gender	Availability of antenatal care in ART treatment centers
Gender responsive	Takes into account contributions based on gender and attempts to ensure that everyone equitably benefits from the intervention	Recognition that pregnant women delay seeking treatment, and therefore design outreach services and add more hours of operation
Gender transformative	Actively redefines and transforms gender norms and relations to redress existing inequalities	Challenges and changes uneven access and use of condoms by strengthening abilities of women to insist on condom use by their partners

For each of the three diseases, the Global Fund has identified gender-related vulnerabilities. In malaria, for example, women can face greater barriers then men in accessing services for themselves and their children because they lack economic autonomy, decision-making power, and access to information. Even if services are free, as is the case with insecticide treated bed-nets (ITNs), women may not have access because of the means of distribution. Gender norms may also dictate who sleeps under an ITN, and affect exposure to mosquitoes that is linked to type and timing of work. Forced displacement, detention, or lack of identity documents all effect risk of malaria and access to health services. Pregnant women are at greater risk of malaria because of decreased immunity, and if they are also HIV positive then face additional barriers.

[12] Global Fund (2014). Gender Equality Strategy/Action Plan. Global Fund. Geneva.

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Gender inequality and discrimination is a major issue in HIV, especially for women, girls, and gender non-conforming persons. Gender-specific vulnerabilities can comprise of lack of autonomy, unequal access to educational and employment opportunities, early forced marriage, early initiation into sex work, and various forms of violence in public and private spaces. Many women, girls, and transgender women or effeminate men cannot negotiate safe sex with their intimate partners. They experience high rates of gender-based violence that not only increases their risk of infection but also negatively influences adherence to treatment. Criminalized communities such as sex workers, people who use drugs, men who have sex with men and transgender people face risk of violence from the state, especially those in law enforcement.

Gender inequality in TB affects men more than women because of gender-specific occupations. Men are also more likely to migrate for work, which may interrupt treatment. On the other hand, in some settings women have less access to TB services because women's health may not be considered as important as that of male family members; women are discouraged from seeking services because of lack of privacy or childcare in healthcare settings. Female prisoners are less likely to have access to TB treatment than incarcerated men. TB also causes one third of deaths in PLHIV, and the stigma and discrimination associated with HIV can be amplified by TB-related stigma.

Integration of health services, outreach and facility-based, peer and community support, and government support is critical for addressing gender inequality. Disease-related rights literacy—helping people to understand prevention, transmission, and treatment—and knowing their rights under health regulations and national laws (i.e. patient rights) are also essential. Sensitization of lawmakers, law enforcement agents, health care providers, and judges and empowering communities and developing linkages across diseases on gender equality is important. It is important for laws and policies, such as inheritance and property laws, gender-based violence, and intimate partner violence, to align with the programmatic interventions implemented through Global Fund support.

The Global Fund has encouraged communities to play a watchdog role in monitoring the quality and reach of services, but these efforts have to go one step further towards understanding whether services are gender-responsive. Currently, data that is being collected by Global Fund supported programs is not always gender-sensitive, and countries should develop an agreed upon common set of gender-sensitive indicators.

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REFLECTION 6

Discuss gender differentiated health needs of women and men, boys and girls, and gender non-conforming persons in relation to HIV, TB, and malaria. Brainstorm on the following questions:

1. What are the gaps in understanding?

2. What type of resources and interventions are needed to reduce gender-related vulnerabilities?

ACTIVITY 6. Make a Gender-Integration Spectrum table.

1. Classify the following interventions as gender blind, gender-sensitive and gender transformative.

2. After completing the table, add several examples of your own. Some examples include:

- Distribution of male and female condoms

- Antiretroviral Therapy (ART) for all eligible adults

- Community-based testing for people who use drugs

- Building capacity of sex workers to negotiate condom use by clients

- Ensuring that pregnant women get tested for HIV and TB

- Ensuring privacy in health centers

- Flexible opening hours for health services

- Developing mobile clinics to reach those with restricted mobility

REFLECTION 7

Compare HIV, TB and malaria indicators in previous Concept Notes.

1. Discuss which are sex-disaggregated and which track gender-equality.

2. Indicators to consider but not limited to: percent of budget going towards supporting gender-based violence, percentage of female drug users tested, percentage of female-headed household receiving INT, disaggregation of information by male sex worker, female sex worker and transgender sex worker, etc.

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ACTIVITY 7. Malaria transmission has been steadily increasing in a remote region of XYZ country because of new government's investment in hydropower and mining projects. The government wants to initiate indoor residual spraying but women and female-headed households will not allow access to the male-dominated spraying teams. Discuss the following questions:

1. What are potential solutions for resolving this problem?

2. List the solutions and discuss how the interventions could be included in Concept Notes including gender-sensitive indictors that could be collected.

Community Engagement

The Global Fund has been at the forefront of trying to support communities as complementary extensions of existing health services. The Community Systems Strengthening (CSS) framework, developed in 2010, was meant to help applicants define and quantify community involvement in the Global Fund processes. It promoted the development of informed, capable, and coordinated communities, community-based organizations (CBOs), patient groups, and network structures. The 2017-2022 Strategy includes as one of its pillars the strategic objective on "Building Resilient and Sustainable Systems for Health" (RSSH), which include communities and aims to move beyond the clinical and facility-based health services. It is very deliberate in acknowledging and recognizing that community-based organizations and networks engage those people, especially from key populations, who do not always access health through clinical settings.[13]

There is evidence that community empowerment and advocacy on human rights and gender equality can in fact reduce HIV incidence. Community response in HIV has been a critical factor not only in reducing the incidence and prevalence of HIV through community-based prevention and treatment literacy, distribution of condoms, and adherence support but also in advocacy for greater support, treatment access, and inclusion of key populations.

While the strength of community organizations and networks has been in their ability to adapt more swiftly to needs, new developments, and gaps, they have not fully incorporated into the formal HIV response[14], and are largely absent in TB and malaria Concept Notes. The Global Fund's Technical Review Panel (TRP) in reviewing Concept Notes observed that funding requests for CSS were limited or non-existent even though CSS was mentioned and referenced[15]. The Community, Rights and Gender (CRG) Department has also noted that while the Global Fund has guidance on CSS, gender equality, and key populations, these have not always been prioritized in the actual programming[16].

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[13] Global Fund (2016). Maximizing impact by strengthening community systems and responses. Global Fund. (November 2016). Geneva.
[14] MSMGF (2013). Community Systems Strengthening and Key Populations. MSGF.
[15] Technical Review Panel to the Global Fund (2015). Referenced in ICASO report.
[16] Community, Rights and Gender Report (2014). Thirty-third Board Meeting. Global Fund.

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Inclusion of community responses and actors has faced antagonism from the formal sector of healthcare service providers, who often view the community as less professional and with limited experience. Nevertheless, certain aspects of community systems such as the community health workers have been incorporated, and are included, in Concept Notes and in the government's budget. Community systems have a much broader scope of work extending beyond service delivery, and include issues such as community-based monitoring, advocacy, mobilization, and building community capacity on human rights, gender, stigma and discrimination.

ICASO has classified community response along a helpful spectrum of more formalized community activities recognized by governments and donors and less formalized activities that lack robust evidence of impact (or rely on anecdotal evidence) (Table 4). The community responses in the far right hand column, which sit outside the formal health sector, are often overlooked, undervalued, and less well supported. There is difficulty in attributing results to these activities even though evidence shows that community engagement and advocacy has resulted in many significant changes including the formation of the Global Fund itself.

TABLE 4. THE COMMUNITY RESPONSE CONTINUUM[17]

Community Responses Formalized under Health Systems	Community Responses Partially Captured under Health Systems	Community Responses Outside of the Formal Health Sector
❑ Community health workers ❑ Integrated community case management ❑ Formalized local governance	❑ Community health education (peer counsellor) ❑ Health commodity distribution ❑ Adherence support, home care	❑ Social and structural determinants (human rights, gender, stigma) ❑ 'Under radar' services ❑ Advocacy, lobbying ❑ Community-led social accountability
More formalized with a more robust evidence base base	⟶	Less formalized with a less robust evidence base

Despite the need to support community activities, recent analysis shows that insufficient resources continue to be allocated for community systems strengthening[18]. This is because community systems are not well understood and clearly described by the Global Fund, governments, and donors. Civil society, namely the Community Leadership and Action Collaborative (CLAC), has therefore put forward a set of recommendations for meaningful community engagement[19].

[17] ICASO/ARASA. (2016). Investing in Community Responses. 2016 report
[18] Ibid.
[19] Baran C., Messerschmidt L., and O'Conner M., (2017). Independent Multi-country review of Community Engagement in Grant Making & Implementation Process: Lessons Learned, Key Principles and Ways Forward. MSMGF.

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Meaningful community has been defined to include four core principles:

1. Effective and proportional representation in planning and decision-making bodies and process

2. Adequate time and resource allocation to communities to understand systems, derive shared priorities, contribute to debate and discussion, and deliver programs

3. Ongoing independent oversight of grant negotiations and implementation

4. Ongoing efforts to strengthen the capacities of community organizations and community leaders, so that they are able to take on increasing responsibilities and have greater impact

The intended outcome is stronger and higher quality of human rights-centered and gender transformative programming. The CLAC recommendations include:

- Adopting and mainstreaming the definition and principles of meaningful community engagement.

- Defining, enforcing and supporting community roles in governance and decision-making structures, including mandating CCMs to regularize community engagement through multi-stakeholder consultations before final submission, during grant making, and during grant implementation; supporting community-led processes to ensure effective CCM representation, and fund mitigating steps to address governance shortfalls; ensuring engagement of underrepresented communities across the three diseases; and financing efforts to strengthen community capacity to engage.

- Mainstream community engagement in quality improvement mechanisms such as community participation in data collection and analysis.

- Standardize accountability and communications channels between communities and the Global Fund such as building or strengthening a 'community communications hub' in the Global Fund Secretariat; defining principal recipient roles and responsibilities vis-à-vis the community and ensure community engagement; and implement human resource practices at Global Fund Secretariat (especially grant management) that reflect the importance of meaningful community engagement.

- Improve the quality, relevance and reach of community information tools, especially in local languages.

The CRG department is in a position to move these recommendations forward, but the community from the three diseases needs to make linkages, expand, and strengthen its sense of collective identity, engagement, and action.

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ACTIVITY 8. Communities are an essential and indispensable partner in the response to HIV, TB, and malaria.

1. Complete the matrix below for each disease based on the following:

    a. Intervention

    b. Type of activity

    c. Indicator

    d. Community support needed to realize the Community Responses and Systems Module.

2. Do not include the formalized and recognized community-based interventions.

Intervention	Description of activity	Indicator	Community Needs for Measuring the indicator
Community-based monitoring			
Community-led advocacy			
Social mobilization, building community linkages and coordination			
Institutional capacity building, planning and leadership			
Other community responses and systems interventions			

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Programmatic Response

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Programmatic Response

The Global Fund in its technical briefs suggests descriptions of the following types of programs that could help applicants and implementers to identify ways to improve health outcomes and reduce human rights and gender-based barriers. The program areas described below (Table 5) are not exhaustive, and countries should choose the interventions that are clearly indicated by the local circumstances and affected populations.

TABLE 5. HIV, TB, AND MALARIA PROGRAMS TO ADDRESS GENDER INEQUALITY AND HUMAN RIGHTS BARRIERS

	Programmatic Intervention	HIV	TB	Malaria
1.0 Programs to reduce stigma and discrimination				
1.1	Assess stigma and discrimination	✓	✓	✓
1.2	Address policies and laws that protect against discrimination	✓	✓	-
1.3	Address policies and practices in workplace, health care settings, schools, and justice and law enforcement settings	✓	✓	-
1.4	Engaging communities in programming through community dialogue, media, edu-tainment; self-help and peer outreach	✓	✓	✓
1.5	Programs to reduce discrimination against women and girls	✓	✓	✓
2.0 Legal/human rights-based programs				
2.1	Programs to sensitize lawmaker and law enforcement agents	✓	✓	-
2.2	Programs to provide legal literacy ('know your rights')	✓	✓	-
2.3	Programs to provide legal services	✓	✓	-
2.4	Programs to monitor and reform laws, regulations and policies	✓	✓	-
3.0 Program to train health care workers on human rights, medical ethics and occupational risks				
3.1	Sensitization on human rights and occupational-related hazards	✓	✓	✓
3.2	Raising awareness on community needs and adjusting services	✓	✓	✓
3.3	Services in prisons and closed settings	✓	✓	✓
4.0 Meaningful participation of communities and affected populations (CSS)				
4.1	Engage community groups to address risks and prevention (occupational group, PLHIV, key populations, youth, and pregnant women)	✓	✓	✓
4.2	Support community-based services	✓	✓	✓
4.3	Support community advocacy and capacity-building	✓	✓	✓

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	Programmatic Intervention	HIV	TB	Malaria
	5.0 Programs to promote gender-equality and remove gender-related barriers			
5.1	Gender assessment based on checklist to guide integration of gender equality (UNAIDS, StopTB, RBM)	✔	✔	✔
5.2	Address gender aspects of indoor residual spraying	-	-	✔
5.3	Address gender norms in ITN use	-	-	✔
5.4	Collection of gender-disaggregated data	✔	✔	✔
5.5	Sexual and reproductive health services	✔	✔	✔
5.6	Integrated health services for pregnant women	✔	✔	✔

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Next Steps

Next Steps

As your country prepares for the next Global Fund Concept Note submission (including the Modular Template), there are a series of questions that you should consider. Below are 10 suggested questions (note that this is not an exhaustive list):

1. Is the information disaggregated by sex and age?

2. Have population size estimations been performed for key populations?

3. Is information being collected for key populations, such as condom distribution for sex workers, and not only general numbers? This information can be further disaggregated for female, male and transgender sex workers.

4. Is information collected on intimate partner violence in relation to transmission or health services such as post-exposure prophylaxis (PEP)?

5. How are legal barriers and punitive polices and laws being addressed? Who is being supported for advocacy for these issues?

6. How is stigma and discrimination for key populations being addressed in healthcare settings?

7. Are issues of sexual orientation and gender identity and expression (SOGIE) recognized within programming for HIV and TB?

8. Do antenatal care services have an integrated approach in terms of the three diseases? (Note: Countries submit different Concept Notes for malaria, HIV and TB with HIV/TB being combined in some cases. Review malaria notes to see how gender, human rights and community systems are being included not only in terms of description but actual activities.)

9. Are networks, organizations of people living with HIV, TB, and malaria, women's organizations, key populations, and youth involved in the Community Dialogue? How are their concerns reflected in the Concept Note, not only in the descriptive part of the Concept Note, but also in actual programming and actual budgetary allocation?

10. What are the proposed mechanisms for civil society coordination and inclusion in the implementation of activities? Review whether any funds are allocated specifically for CBOs in non-health care delivery activities.

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REFLECTION 9

What can you do as an activist in your community? Discuss how you can ensure that human rights and gender equality are not only guiding the development of the concept not but also there are actual budgeted activities with clearly described indicators.

There are a number of activities that can be undertaken. Some examples are the following:

1. Conduct a review of laws and policies that criminalize people or behavior associated with these diseases, and advocate for changes in laws and policies.

2. Engage in community outreach on human rights, and specifically the right to health (AAAQ -- accessibility, availability, acceptability and quality of health services in terms of testing, treatment and care).

3. Document cases of stigma and discrimination in healthcare settings, and how these barriers can be addressed in terms of positive change.

4. Mobilize and develop broader coalitions that include multiple diseases with a focus on the community and not individual disease.

5. Lastly, ADVOCATE! ADVOCATE! ADVOCATE!

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Further Resources

Further Resources

There are several tools that have been developed on gender and human rights assessment, including the recent The Malaria Matchbox. Resources, including those used to develop this guidance tool, are provided below and are available through the APCASO APCRG platform.

Global Fund

1. Technical Brief: HIV, Human Rights and Gender Equality. April 2017. Geneva.

2. Technical Brief: Tuberculosis, Gender and Human Rights. April 2017. Geneva.

3. Technical Brief: Malaria, Gender and Human Rights. January 2017. Geneva.

4. Guidance Note: Sustainability, Transition and Co-financing of Programs Supported by the Global Fund. January 2017.

5. Thirty-fifth Board Meeting. The Global Fund Strategy 2017-2022: Investing to End Epidemics. April 2016.

6. Middleton-Lee, S. Evaluation: Community, Rights and Gender Special Initiate 2014-2016. The Global Fund to Fight AIDS, Tuberculosis and Malaria. November 2016.

7. Overview of 2017-2019 Allocation. December 2016. Geneva.

8. Maximizing impact by strengthening community systems and responses. November 2016. Geneva.

9. Thirty-third Board Meeting. Community, Rights and Gender Report. 2014.

10. Gender Equality Strategy

11. Key Populations Action Plan 2014-2017. 2013. Geneva.

12. The Global Fund Gender Equality Strategy. 2013. Geneva.

UNAIDS, WHO, and other Technical Agencies

1. UNAIDS. Investing in Community Advocacy and Services to end the AIDS Epidemic. April 2016. Geneva.

2. Stop TB Partnership, UNAIDS. Gender Assessment Tool for National HIV and TB Responses. 2016. Geneva.

3. UNDP. Gender and Malaria. December 2015. New York.

4. UNDP. Gender and Tuberculosis. December 2015. New York.

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Civil Society

1. Baran C. et. al. Independent Multi-country Review of Community Engagement in Grant Making & Implementation Processes: Lessons Learned, Key Principles, and Way Forward. MSMGF. 2017.

2. FHI360. Gender Integration Framework: How to integrate gender in every aspect of our work. FHI3660. 2012.

3. ICASO/ARASA. Investing in Community Responses. A case for funding non-service delivery community actions to end AIDS. 2016.

4. ICASO/MSMGF. The 2017-2019 Global Fund Funding Cycle: Highlights of the Differentiated Funding Application Process. What you should know and how to engage! 2017.

5. Rockwood J. and Straub A. The Malaria Matchbox. A Toolkit to Shed Light on Human Rights and Gender-related Barriers, Match Responses to Needs, and Ignite Action in the Malaria Response. April 2017.

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