FROM GUIDELINES TO THE BOTTOMLINE

Assessing the Inclusion of Community, Rights and Gender priorities in Global Fund concept notes in Asia and the Pacific

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Acknowledgments

Abbreviations

APCRG	Asia-Pacific Community, Rights and Gender Platform
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
CRG	Community, Rights and Gender
CSO	Civil Society Organization
CSS	Community Systems Strengthening
FPM	Fund Portfolio Manager
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
MSM	Men who have Sex with Men
PLHIV	People Living with HIV
PNG	Papua New Guinea
PWUD	People Who Use Drugs
RAI	Regional Artemisinin Initiative
RCNF	Robert Carr for Civil Society Networks Fund
STI	Sexually Transmitted Infection
TG	Transgender
TRP	Technical Review Panel

Executive Summary

Global Fund partnerships, to date, have saved over 20 million lives in the course of fighting AIDS, malaria and TB. Gender-transformative, rights-based, and community-centred interventions remain as key ingredients to effective, high-impact and sustainable HIV, TB and malaria programmes. The Global Fund has implemented a range of measures to address gender inequality, realise human rights, and strengthen community systems to improve responses to the three diseases; the most recent is the Community, Rights and Gender Special Initiative. However, there remains a huge gap between community, rights and gender programming guidance from the Global Fund and what gets implemented on the ground.

This study was commissioned as part of the initiative by APCASO, that hosts the Asia-Pacific Community, Rights and Gender Platform, to:
1. assess how community, rights and gender priorities have been included in Global Fund concept notes;
2. identify challenges and enabling factors for inclusion of community, rights and gender priorities in concept notes; and
3. develop recommendations to inform work to increase inclusion of community, rights and gender priorities in future concept notes.

The study consisted of a desk review of 17 concept notes and key informant interviews with representatives from the Regional Artemisinin Initiative (RAI) and civil society organisations (CSOs) in participating countries. This study builds on a series of studies by the Asia-Pacific Community, Rights and Gender Platform aimed at promoting and understanding the inclusion of community, rights and gender priorities in Global Fund grants including a review of community and CSO experiences with the Global Fund New Funding Model.[1]

Findings

The study identified strong patterns in the nature and extent to which community, rights and gender priorities are included in Global Fund concept notes, as well as common challenges and enabling factors. Based on concept notes and key informant interviews, it was clear that across all countries civil society and community networks are both a contributing factor as well as an outcome to the inclusion of community, rights and gender priorities in concept notes. The findings are as follows:

1. All concept notes, across all diseases focussed on addressing the epidemic among key populations.

   - Requiring minimum budget allocations to key populations has been successful in focussing concept notes.

   - Concept notes are often not detailed enough to determine whether the different needs of key population subgroups are addressed

   - Young key populations in particular are overlooked.

[1] APCASO (2016) *The Global Fund New Funding Model: Civil Society and Community Experiences in 4 Countries of Asia.*

1. Community, rights and gender priorities were better represented in HIV concept notes than in malaria and TB concept notes.

   - When TB and HIV concept notes were combined, TB funding requests benefitted from the comparatively advanced state of community mobilisation, rights and gender advocacy under HIV responses.

   - The inclusion of CRG priorities differs significantly across the three diseases and within countries.

2. Human rights and gender are poorly understood, particularly in the context of malaria and TB responses.

   - The term "gender" tended to be understood either as a proxy for women or biological sex. The benefits of understanding how men and women, boys and girls experience the diseases and responses differently have rarely been realised.

   - Narrow conceptions of human rights mean that rights to collectivise are rarely included in work to remove legal barriers to effective responses.

   - There was a cascade or drop off effect in the inclusion of rights priorities from narrative and analysis sections of the concept note to the funding request section and Performance Framework.

   - Efforts to increase understanding and inclusion of rights and gender priorities have been promoted to varying degrees, with mixed impacts.

The cyclical benefits of community systems strengthening and critical enabling factors for the development of concept notes that promote community, rights and gender priorities

Supportive factors
+ Past investment in communities
+ Technical assistance
+ Collaboration with HIV community advocates
+ Community-friendly Global Fund staff
+ CSO/Community principal recipient
+ Enabling environment for key populations and community mobilisation
+ Existing research on how CRG issues in country that can be drawn on for concept note development

Strong existing civil society and community-based organisations

Global Fund concept notes that promote CRG priorities, including community systems strengthening

Challenges
- Suppression of community organisations
- Criminalisation of key populations
- Poor engagement of communities during community dialogue and national strategic plan development
- Poor understandings of CRG among communities, country coordination mechanisms.and Global Fund support staff

4. All concept notes included references to community-led activities and CSS, though the meaning of these terms was not always clear or consistent with newer understandings of CSS as a means of empowering communities and promoting key populations as equal partners in decision-making.

 - Most CSS activities fall short of the empowerment and sustainability goals of newer understandings of CSS.

 - Promoting greater understanding and inclusion of community priorities in concept notes is complicated by the lack of a clear definition of "community" or "CSS".

5. Funding allocations for CSS, rights and gender priorities tended to be low, relegated to above allocation funding or among the most precarious commitments made in concept note development. The following enabling factors were important to ensuring CRG issues survived the concept note development process for inclusion in Global Fund grants.

 - Strong existing community systems
 - Meaningful community dialogue
 - CSOs/CBOs as principal recipients
 - Supportive Global Fund staff

Quality and inclusion of community, rights and gender priorities in concept notes by country

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Recommendations

The following recommendations are made based on the findings from this study. Most are relevant to a range of actors involved in the development of Global Fund concept notes, grant expenditure, and in-country community systems strengthening (CSS) interventions; such actors include the Global Fund, Country Coordination Mechanisms (CCMs), national governments, UN agencies, NGOs, CSOs and CBOs, and other advocates. While some of these actors will have the power to implement recommendations directly, all can advocate for their enactment.

1. Building on the success of efforts to focus responses on key populations

1. **Recognising key population subgroups.** Concept notes should identify and describe activities aimed at responding to the needs of specific key population subgroups. This is essential for accountability and for ensuring particular marginalised subgroups are not excluded.

[2]Ibid.

2. **Representation for key population subgroups.** Representatives from all of the most critical key populations for all of the diseases should be included in CCMs to ensure coverage of diverse needs and build the support-base for community representatives.

3. **Young key populations.** Activities for young key populations should be included in concept notes and young key populations should be supported to participate in concept note development processes.

2. Promoting and improving understandings of CRG priorities

1. **Collaboration.** Opportunities for malaria and TB advocates to learn from the experience of HIV community networks and community-based organisations (CBOs) should be encouraged, and opportunities for collaboration across the three diseases should be promoted (including through CCM processes).

2. **Technical assistance on rights and gender.** Technical assistance and guidance should address poor understandings of human rights and gender, particularly in the context of malaria and TB responses, including through practical programme intervention examples.

3. **Building shared understandings of "community" and "CSS".** Technical assistance and guidance should provide specific details on how the terms "community" and "CSS" should be understood and operationalised to empower key populations in the context of HIV, malaria and TB responses. The CRG Special Initiative should develop a clear definition of "community" in the context of its mandate.

4. **CRG in difficult working environment.** Global Fund and supporting mechanisms such as the CRG Special Initiative and APCRG should develop detailed guidance about working on CRG issues in difficult working environments including under conservative cultural, religious, and political environments and where community mobilisation is still in its infancy and unlikely to be able to advocate adequately for their own capacity building, in order to highlight interventions that have been endorsed and effective in other contexts.[3]

5. **Better use of guidance.** New and existing guidance on human rights and gender in Global Fund work must be promoted and disseminated more effectively. This should include promotion of guidance in relation to the "removing legal barriers" module under the Performance Framework in relation to TB and malaria responses.

6. **Promoting CRG for sustainable responses:** CRG principles should be promoted as essential to sustainable responses to HIV, TB, and malaria, particularly through increased support for CRG priorities through domestic funding. Directions on counterpart financing should require countries to demonstrate support for CRG priorities.

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[3]Ibid.

3. Strong communities as a foundation for further strengthening community systems

1. **Community Dialogue.** Global Fund and other stakeholders should systematically support early, sustained, and independent engagement of CSOs, CBOs, and key populations in the country dialogue as well as ongoing monitoring.[4]

2. **Building strong communities.** Initiatives to build and strengthen communities and to develop their capacity to participate in concept note development such as the Community Advocacy Initiative and work under the CRG Special Initiative should continue and be promoted for increased uptake.[5]

3. **CSOs and CBOs as principal recipients.** The benefits of CSOs and CBOs as principal recipients should be promoted and capacity building should be tailored to enable interested organisations to operate as effective principal recipients.

4. **Full-funding cycle support for communities.** All actors in the HIV, malaria, and TB responses must commit to sustained community engagement to ensure CRG priorities are included in concept notes and realised through grant implementation. This requires full-funding cycle support including core funding to ensure CSS gains are not lost, capacity building and in-person assistance to ensure communities are treated as equal partners in decision-making and ending the epidemics.

4. Making Global Fund mechanisms work for community

1. **Global Fund Allies.** Global Fund staff are important allies for advocates working to increase the inclusion of CRG priorities in concept notes. Capacity building for Global Fund staff should cover the importance of CRG priorities; how those priorities can be operationalised; and the role that Fund Portfolio Managers, Technical Review Panels, and others can play in supporting community and the inclusion of CRG issues in concept notes, including during the development and budget negotiation process.

2. **CCMs.** CCMs should be sensitised around meaningful engagement of key populations, gender, and human rights programming perspectives. This should be supported through oversight and country visits by Fund Portfolio Managers and the APCRG, and through requirements for inclusion of multiple community representatives in CCM technical working groups including the budget review committee.[6]

3. **Effective Review.** Ensure that CRG components are included in concept notes and Performance Frameworks are properly reviewed and covered in feedback as part of the Fund Portfolio Manager, Technical Review Panel (TRP), and Global Fund Advisory Committee reviews for all diseases.

5. Improving accountability

1. **Minimum Funding Allocations.** Global Fund strategy requiring minimum funding allocations to key populations has been effective. Countries should also be required to make minimum funding allocations to CRG priorities. This could be achieved through stipulations in the Global Fund concept note template, in overview by the Technical Review Panel or agreed within each country coordination mechanism.

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[4] Ibid.

[5] The Community Advocacy Initiative (CAI) 2008-2015, supported community and civil society to translate international HIV financing frameworks into credible, relevant and effect national advocacy. CAI was been jointly implemented by APCASO and the Australian Federation of AIDS Organisations, in partnership with HACC, Cambodia; CHAIN, China; LaoPHA, Lao PDR; and, SCDI, Viet Nam. CAI was funded by the Australian Government. An independent evaluation can be found at: http://apcaso.org/lessons-from-the-community-advocacy-initiative/

[6] Ibid.

2. **Performance Frameworks.** A gender module should be included as an essential supporting module.

3. **Community charters.** The APCRG should support Asia-Pacific countries to develop charters of CRG priorities in preparation and use in ongoing community dialogue and future funding rounds, building on experience in East African countries.

4. **Making key documents publicly available.** Concept notes are available on the Global Fund website but key attachments including Performance Frameworks that are essential for community monitoring and advocacy are not publicly accessible. All concept note attachments and other key documents essential to holding countries accountable to commitments made in concept notes must be made accessible, and in local languages, without the need for request to the CCM or government.

PART 1

INTRODUCTION

*That is the beauty of community – once you are there, you can grow...
Because the system comes from within the population; it is genuine, it is non-political. Today you have this political party, tomorrow another. The community is still the community... Community systems are systems of people.*

Dr. Khuat Thi Oanh
Centre for Supporting Community Development Initiatives, Viet Nam

Global Fund partnerships have saved over 20 million lives in the fight against AIDS, malaria, and tuberculosis (TB). Yet as the world moves from containing its three deadliest diseases toward ending the epidemics, strategies must shift. Community engagement and recognising the rights of key populations are critical enablers for high-impact, sustainable responses to the three diseases but rights violations and gender inequality continue to hinder progress.

The Global Fund has implemented a range of measures to address gender inequality, realise human rights, and strengthen community systems to improve responses to the three diseases. Evaluations, however, have found 'a mismatch between Global Fund rhetoric and reality', and that investment in community systems strengthening remains 'low'.[7][8]   In 2014, the Community, Rights and Gender (CRG) Special Initiative was established to 'provide technical assistance to civil society organisations (CSO) and community-based organisations (CBOs) for participation in country dialogue and concept note development, and to support the long-term capacity development of CSO/CBO networks.[9]

This report was conducted as part of that initiative, to assess the extent to which CRG priorities have been incorporated into requests for Global Fund grants and how they might be better included in future funding rounds. It examines HIV, malaria, and TB funding requests (to include concept notes and Performance Frameworks) for the period between 2014-2017 from seven Asia-Pacific countries and one regional malaria grant for the Greater Mekong Subregion. Findings indicate that while the need to focus on key populations is now clearly recognised, CSS continues to be understood in a range of different ways that empower key populations to varying degrees. Rights and gender priorities are poorly understood and underrepresented in most concept notes, particularly those seeking funding for TB and HIV. The recommendations consider how CSO and CBOs might be assisted to engage in Global Fund processes and more effectively advocate for the inclusion of CRG priorities in Global Fund concept notes, and how Global Fund systems might better support that process.

This first part of the study (Part 1: Introduction) outlines the context in which the report was commissioned, the study objectives, and research methodology, and provides a guide to using the report.

[7]Pangaea Global AIDS Foundation (2011) *Formative Evaluations of the Gender Equality and Sexual Orientation and Gender Identity Strategies of the Global Fund to Fight AIDS, Tuberculosis & Malaria.*
[8]Global Fund (2015) *Global Fund Secretariat Activities to Increase Community Engagement and Promote Human Rights and Gender Equality under the New Funding Model.*
[9]Global Fund (2015) Thirty-third Board Meeting – Community, Rights and Gender Report GF/B33/09.

1.1 Context

This study forms part of a series of reviews by the Asia-Pacific Community Rights and Gender Platform for Communication and Coordination – APCASO – aimed at promoting and understanding the inclusion of CRG priorities in Global Fund grants. The first review examined community and CSO experiences with the Global Fund New Funding Model in four Asian countries and the second review developed CRG needs assessments.[10] This review of the inclusion of CRG priorities in Global Fund concept notes is the third study in the series.

Why CRG?

Human rights should guide all social policy and programming, from the design through to the implementation, analysis, monitoring and evaluation stages – rights are therefore relevant to both *what* programs we want to achieve and *how* those goals are achieved.[11] Rights are universal, inalienable, interdependent and indivisible – all humans have human rights; these rights cannot be denied except to prevent the abuse of another right, and because enjoying one's right depends on realising others, they cannot be separated. This means that all rights, not just the right to the 'highest attainable standard of health', are relevant to Global Fund programming.[12] Gender equality is a human right recognised under all major human rights instruments.[13] Collectivisation and community participation in decision-making are also human rights. The 1978 UN Declaration on Primary Healthcare recognised that

> 'people have the right and duty to participate individually and collectively in the planning and implementation of their health care. Primary Health Care requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation, and control of primary health care'.[14]

Recognition and implementation of CRG priorities are therefore all relevant to a human rights-based approach.

Stigma, inequality and human rights abuses all hinder effective responses to HIV, TB, and malaria. The epidemics do not affect all people equally. Key populations – groups of people who 'experience a high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalised or otherwise marginalised' – can be identified for every disease.[15] Ending HIV, TB, and malaria will not be possible without addressing the epidemics among key populations.

Communities and community systems are a crucial pathway to key populations and other hidden, vulnerable, and marginalised groups often beyond the reach of formal health systems. 'Community systems are the structures, mechanisms, processes, and actors through which communities act on the challenges and needs they face', because they represent and are comprised of people from affected and at-risk populations, they have a 'unique ability and responsibility to identify the needs of those who are marginalised and vulnerable in societies, and who are, as a consequence, affected by inequitable access to health and other basic services'.[16] [17] Community systems often work on challenges beyond health rights, providing more people-centred programming and safe spaces for discussion. They are often more

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[10]APCASO (2016).

[11]Jessica M Rockwood and Autumn W Straub (2015) *Strengthening community engagement in Global Fund malaria grants*; UN (2005) *The Human Rights-Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies*

[12]Article 12(1), *International Covenant on Economic, Social and Cultural Rights 1976;* Article 24(1) *Convention on the Rights of the Child 1990.*

[13]See for example: Article 3, *International Covenant on Civil and Political Rights 1967;* Article 3, *International Covenant on Economic, Social and Cultural Rights 1976;* Article 3, *Convention for the Elimination of all forms of Discrimination Against Women 1979.*

[14]Article 22, *International Covenant on Civil and Political Rights 1967.*

[15]Global Fund (2015).

[16]Rockwood and (2015); Stop TB Partnership (2014) *Communities Systems Strengthening and TB.*

[17]Rockwood and Straub (2015).

responsive than formal health systems but 'the power imbalance between the formal health system and community systems, mean that efforts to strengthen community action on health have been chronically under-supported'. Capacity building is therefore often necessary to enable communities to participate as equals in decision-making institutions.

Working with communities and community systems is an essential element of the Global Fund's commitment to partnership and the design and implementation of responses that effectively address epidemics among all populations. CSS to enable task-shifting to community and peer outreach are now also widely recognised as critical enablers for high-impact sustainable responses to the three diseases.

Even with effective community systems in place, human rights abuses create significant barriers to accessing essential services. Promoting and protecting human rights can benefit the HIV, TB, and malaria responses by:[18]

- •enhancing disease prevention

- •increasing accessibility of health services

- •service uptake

- •promoting individual agency

Stigmatised and criminalised populations are reluctant to seek prevention, testing, and treatment services for fear of arrest, exposure, and abuse by law enforcement and healthcare providers. Stigmatisation and discrimination against people living with the diseases and risk behaviours (particularly HIV and TB) mean that lack of confidentiality creates a deterrent to health-seeking, including for persons under 18, who in most Asia-Pacific countries cannot seek medical treatment without parental consent.[19] Citizenship-based limits on access to health services and subsidies among mobile and migrant populations is increasingly recognised as a rights issue. Human rights abuses such as violence and unsafe work conditions also contribute to risk of disease transmission. Addressing these challenges would increase demand and access to services, promoting agency and enhancing disease prevention. The role of human rights has historically been better understood in relation to the HIV response than for TB and malaria. Malaria is not associated with the same stigma or discrimination as HIV and TB. Malaria and TB are however, 'causes and consequences of poverty and inequality' and disproportionately impact poor and politically marginalised populations.[20]

Gender inequality and failure to understand how gender impacts risk of infection and health-seeking behaviours also limit the potential impact of responses to all three diseases. Gender inequality creates barriers to accessing services for women and girls by limiting freedom of movement, through social restrictions on seeking services from male health providers, preference for the health needs of men and boys in family budgeting and limited access to education. Gender-based violence specifically contributes to the spread of HIV, including for MSM and transgender women; PLHIV also experience higher levels of violence, which breaches their human rights and impacts treatment adherence.[21]

Understanding how men and women experience life differently can add value to HIV, TB and malaria responses. Gender differences can impact:[22]

[18]UNDP (2013) *Discussion Paper: The role of human rights in response to HIV, TB and malaria*.
[19]UNESCO (2013) *Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health.*
[20]Global Fund (2014) *Global Fund Information Note: Human Rights for HIV, TB, Malaria and HSS Grants*; Rockwood and Straub (2015).
[21]Global Network of People Living with *HIV* (2011) *People Living with HIV Stigma Index – Asia Pacific Regional Analysis.*
[22]Katherine Clegg (2006) *Sex, gender and health.* Accessed on 28 September 2016 at: http://ocw.jhsph.edu/courses/socialbehavioralaspectspublichealth/pdfs/unit2gender.pdf.

- exposure to risk factors
- access to and understanding of information about disease management, prevention, and control;
- subjective experience of illness and its social significance;
- attitudes towards the maintenance of own health and that of other family members;
- patterns of service use; and
- perceptions of quality care

For example, it is more socially acceptable for men to smoke in many countries, increasing their risk of TB. Men are also more likely to work outdoors, placing them at greater risk of exposure to malaria. Men in many instances are also less likely to seek medical services due to a range of reasons including gender expectations that prize 'toughness' as masculine and unavailability of services in remote work locations. In some countries men are more likely to seek health services through private pharmacies, an approach with serious consequences for managing drug resistance where quality control and regulation is limited. Women's caring roles and biological vulnerabilities during pregnancy place them at heightened risk of contracting TB and malaria but also makes them crucial actors in responding to all three diseases. Programming that address gender norms that limit health-seeking behaviour or address needs and recognise different gender roles as creating entry points for interventions can help build stronger responses to all three diseases.

1.2 CRG and the Global Fund

The Global Fund has implemented a range of systems to address gender inequality, realise human rights and strengthen community systems. In 2008-2009 it released strategies on gender equality and on sexual orientation and gender identity (SOGI),[23] as well as a framework for CSS.[24] An evaluation found 'a mismatch between Global Fund rhetoric' and programming on gender equality.[25] While the Global Fund has always promoted CSS, investment in these activities is low and the concept has been 'understood in diverse ways by governments and policy-makers'.[26]

The Global Fund has since sought to operationalise CRG strategies, through measures including the Key Populations Action Plan (2014-2017), explicit recognition in the objectives of the Global Fund Strategic Plan 2012-2016,[27] and tailored guidance and support to countries.[28] The Global Fund concept note template prompts countries to identify key populations, barriers to accessing services and gender considerations. Middle-income countries are also required to show that at least 50% of funding is allocated to key or underserved populations.

The New Funding Model (see diagram X) was introduced in 2013 and the 2014-2016 concept notes reviewed in this report are the first to implement the approach, including its increased emphasis on community dialogue. The concept notes reviewed for this study will also be the last developed under the current "Global Fund Strategy 2012-2016 – Investing for Impact".

In 2014, the Community, Rights and Gender Special Initiative was established to 'provide technical assistance to CSOs and CBOs for participation in country dialogue and concept note development, and to support the long-term capacity development of CSO networks.[29] The Community, Rights and Gender Special Initiative is another Global Fund mechanism for

[23]Global Fund (2008) *The Global Fund Strategy in relation to Sexual Orientation and Gender Identity.*
[24]Global Fund (2009) *Community Systems Strengthening Framework* (updated in 2014).
[25]Pangaea Global AIDS Foundation (2011).
[26]Global Fund (2015).
[27]Global Fund, *Investing for Impact: The Global Fund Strategy 2012-2016.*
[28]Global Fund (2015).
[29]Ibid. Note abbreviations added.

improving programming human rights, CSS and gender inequality under Global Fund grants. The Special Initiative was approved in 2014 as a US$15 million project to 'provide technical assistance to CSOs for participation in country dialogue and concept note development, and to support the long-term capacity development of CSO networks. Current funding for the CRG Special Initiative expires at the end of 2016, though ongoing funding for the technical assistance component of the program has been confirmed. Further funding will be informed by an ongoing evaluation of the three program components.

A new Global Fund strategy has now been released for the 2017-2021 period. The "Global Fund Strategy 2017-2022: Investing to End Epidemics",[30] builds on the commitment to CRG issues under the existing strategy. Strategic Objective 3 requires the fund to 'promote and protect human rights and gender equality' and includes operational objectives to:

- Scale-up programs to support women and girls, including programs to advance sexual and reproductive health and rights

- Invest to reduce   health inequalities including gender- and age-related disparities

- Introduce and scale-up programs that remove human rights barriers to accessing HIV, TB and malaria services

- Integrate human rights considerations throughout the grant cycle and in policies and policy-making processes

- Support meaningful engagement of key and vulnerable populations and networks in Global Fund-related processes.

CSS is an operational objective under Strategic Objective 2 'build resilient and sustainable systems for health there are seven operational objectives'.

With a growing number of high-burden countries in Asia and the Pacific moving toward middle-income status and out of Global Fund eligibility, planning for transition to smart, sustainable domestic funding responses is therefore crucial for the region. Improving the efficiency of national responses through continued investment in high-impact interventions for key populations, the removal of legal barriers to effective responses and strengthening community systems to take on a greater role in shaping and delivering responses to the three diseases is also important in this context. While Global Fund assistance is likely to reduce overall funding for a number of countries in Asia and the Pacific, the new Global Fund Strategy may contribute to increased allocations to CRG priorities.[31]

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[30]Global Fund, *Investing to end epidemics: The Global Fund Strategy 2017-2022.*
[31]Ibid.

Box 1: Global Fund fundamentals

What is the Global Fund and how does it work?

The Global Fund: The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) is a funding institution established to provide support to countries responding to the world's three deadliest infectious diseases. It is also a partnership between governments, CSO, the private sector and people affected by the diseases. These partnerships and continual evolution are keys to the effectiveness of the fund. Its core principles are partnership, country ownership, performance-based funding and transparency.
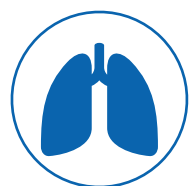
Concept notes and Performance Frameworks: Eligible countries submit concept notes to request grants from the Global Fund, typically every two to three years depending on the length of the grant or extension periods. Concept notes are submitted with a corresponding Performance Framework based on a template developed by the Global Fund. The current Performance Framework sets out a set of essential core and supporting modules. The essential supporting modules include CSS and removing legal barriers, each of which is defined through a list of relevant activities. The Performance Framework requires that countries include the modules set out in the template and corresponding activities under the concept note.

Concept notes are the result of a planning and consultation process beginning with the development of national strategic plans. The national strategic plan and concept note should be informed by an ongoing country dialogue, to ensure that all sectors and people involved in the HIV, TB and malaria responses are part of the development process. Concept notes are prepared by the country coordination mechanism (CCM), a national committee including representatives from every sector involved in responding to the three diseases. Grants are implemented by organisations known as principal recipients and smaller organisations that receive funding through principal recipients, known as sub-recipients.[32] Before grants are approved, concept notes are reviewed by the Global Fund Technical Review Panel, who can request changes be made so that the document can be recommended to the to the Global Fund Grants Approval Committee . This process, known as the New Funding Model (see diagram X) was introduced in 2013 and the 2014-2016 concept notes reviewed in this report are the first to implement the approach.

Box 2: Other funding sources

Co-financing and counterpart financing

Global Fund is not the only contributor to HIV, TB, and malaria funding. As a condition of receiving Global Fund grants, countries must contribute funding to the national responses ('counter-part financing') based on their income status (ie. lower-income countries for example must contribute 5% of the Global Fund grant, this rises

[32]Global Fund, "Overview", The Global Fund. Accessed 28 September 2016 at: http://www.theglobalfund.org/en/overview/

to 20% for lower-middle income countries). International donor organisations and donor countries can also contribute directly to domestic responses as 'co-financers'. CRG priorities can be funded through co-financing and counter-part financing. Critical work to remove legal barriers to an effective HIV response in Papua New Guinea (PNG) are for example being funded by the PNG Government as counterpart financing.[33] In Cambodia, programming for entertainment workers is being co-financed by the President's Emergency Plan for AIDS Relief (PEPFAR).[34]

National responses may then include activities to promote CRG priorities that are not reflected in requests to the Global Fund, however, the bulk of funding for CRG issues comes from international donors. In 2014, 80% of funding for key populations came from external funding sources.[35] Increasing domestic funding for CRG issues is therefore essential to building sustainable national responses to HIV, TB, and malaria.

Box 3: What is the CRG Special Initiative?

The Community, Rights and Gender Special Initiative is a Global Fund mechanism for improving programming on human rights, community systems strengthening, and gender inequality under Global Fund grants. It was approved in 2014, as a US$15 million project to 'provide technical assistance to CSOs for participation in country dialogue and concept note development, and to support the long-term capacity development of CSO networks. The initiative consists of three components:

1. the *CRG technical assistance program*

2. the long-term capacity development of key population networks, operationalised in partnership with the Robert Carr for Civil Society Networks Fund (RCNF)

3. six *regional CSO and community coordination communication platforms* (Anglophone Africa, Francophone Africa, Middle East and North Africa, Eastern Europe and Central Asia, Asia and the Pacific, and Latin America and the Caribbean)

[33] PNG Concept Note – HIV 2015-2017.
[34] Cambodia Concept Note – HIV 2015-2017.
[35] APCASO (2014) *Don't leave communities behind – Civil Society Perspectives on Progress in Achieving Universal Access to HIV Prevention, Treatment, Care and Support in Asia and the Pacific*.

1.3 Study objectives and research methodology

The objectives of this study were to:

- •assess how CRG priorities have been included in Global Fund concept notes;
- •identify challenges and enabling factors for inclusion of CRG priorities in concept notes; and
- •develop recommendations to inform work to increase inclusion of CRG priorities in future concept notes.

Global Fund concept notes are essentially funding requests so CRG priorities must be included in concept notes if they are to receive any allocations under the subsequent grant. Assessing the extent to which CRG priorities are included in concept notes is therefore essential to understanding why gender inequality, gender norms, human rights abuses, legal barriers to essential services, and lack of meaningful engagement with communities continue to hinder national responses. To date, APCASO's work as the Asia-Pacific CRG Platform has examined experiences of the new funding model, including the community dialogue process and conducted needs assessments in order to identify entry points for technical assistance. Determining how concept notes can be more effectively used to promote CRG priorities is an essential step toward ensuring that the inclusion of CRG issues is maximised at all stages of grant request, preparation and implementation.

The research methodology combines a desk review of concept notes for the period between 2014-2017 (and accompanying Performance Frameworks) with key informant interviews conducted with representatives from CSOs involved in the development of the concept notes assessed. Key informants were asked about their experiences of the concept note development process – what they thought had been useful in advocating for the inclusion of CRG priorities and what challenges they had encountered. Their responses informed individual concept note analysis, findings, recommendations and the identification and discussion of recurring themes.

Concept notes and Performance Frameworks were assessed individually under country profiles to provide a clear impression of the inclusion of CRG priorities for each disease, and within each country. Assessment began with an examination of CRG issues raised in the country context and any CRG activities included in the funding request and Performance Framework. Where activities were included they were assessed in light of the country context and Global Fund guidance including goals such as engagement of key populations and communities as equal partners in decision making, and transformative and empowering programming. Only those activities included in the concept note are found in the "Funding Request" section or the Performance Framework were treated as being 'included' in a country's grant request. This approach was based on findings from a review of human rights in Global Fund concept notes for malaria that found a cascade from inclusion, to funding and measurement.[36] This approach seeks to create a more realistic impression of commitment to CRG priorities by excluding activities that will not be funded and those that no one can be held accountable for implementing.

[36]Ralf Jurgens and Hyeyoung Lim (2016) "Scaling up programs to reduce human rights barriers to services", Global Fund presentation.

All concept note assessments were then compared to identify patterns and differences, inform findings and develop regional recommendations. Comparison across the region assisted with the identification of key challenges and enabling factors as common themes emerged across multiple countries and among national approaches to the three diseases. Findings and recommendations were developed based on this regional comparison and verified in consultation with the Asia-Pacific CRG Platform and key informants.

A basic pictorial ratings system was developed to provide a user-friendly overview of CRG priorities in each concept note but was not used to inform analysis given that the diversity of activities included in concept notes cannot be directly compared (see "Using this report").

Box 4: Key resources

Country / Regional initiative	Concept note	Key informants
Cambodia	•HIV •Malaria •TB	•HIV/AIDS Coordinating Committee •KHANA
India	•Malaria •TB/HIV	•Global Coalition of TB Activists •National Coalition of PLHIV in India •Sahara Centre for Residential Care and Rehabilitation (Stop TB Partnership)
Indonesia	•HIV/TB •Malaria	•Spiritia Foundation •GAYa NUSANTARA Foundation
Pakistan	•HIV/TB •Malaria	•APLHIV
PNG	•HIV •Malaria •TB	•IGAT Hope
Philippines	•HIV •Malaria •TB	•Achieve •TLF Share •Global Fund Advocates Network
Viet Nam	•HIV/TB •Malaria	•Center for Supporting Community Development Initiatives (SCDI)
Regional Artemisinin Initiative – Greater Mekong Subregion (Cambodia, Myanmar, Laos PDR, Thailand and Viet Nam)	•Malaria	•Malaria Consortium •Raks Thai

Ratings system

A ratings system was developed to provide a quick user-friendly overview of the concept note assessments. A pictorial system was chosen in recognition of the reality that the diversity of activities included in concept notes cannot be directly compared. Numerical values were attributed to the different ratings for the purposes of producing charts used throughout this report, while specific numerical breakdowns are not provided to prevent direct comparison but the charts have been used as they clearly illustrate broad patterns supported by the research.

The ratings reflect a spectrum with concept notes that do not contain any activities specifically aimed at addressing CRG priorities at one end and transformative programming at the other. Receiving the highest rating therefore does not mean that improvements cannot be made to that aspect of a concept note, only that it includes strong or transformative activities. Charts comparing CRG priorities in different countries and concept notes across the diseases were developed by attributing numerical value to the symbols ranging from 0-3.

?	✓	✪	✪★
Not included: No activities specifically aimed at addressing community/rights/gender priorities are included.	Included: Activities that make reference to community, rights or gender priorities are included but will not have any impact beyond the life of the activity.	Promising: Includes activities that address causes of inequality and create a foundation for ongoing benefits by building capacity to empower communities and underserved populations.	Strong: Includes activities that challenge existing power relations and institutional structures that shape risks and inequalities to create lasting, transformative change.

Defining CRG priorities

CRG Special Initiative Guidance does not provide definitions of "community", "rights" and "gender" in the context of the project mandate. A similar study created a baseline for comparison using charters of civil society priorities developed by eight East African nations.[37] Asia-Pacific countries however, have not developed comparable documents.

This study uses Global Fund strategic and guidance documents and international human rights instruments used to define "community", "rights", and "gender" priorities. The Global Fund Performance Framework template was specifically used to define activities considered to contribute to community and rights priorities based on the supporting modules: "Community Systems Strengthening" and "Removing Legal Barriers". As there is no gender module in the Performance Framework, gender priorities have been defined using the Global Fund Gender Equality Strategy. In order to capture the breadth of potential programmes to promote CRG priorities and different priorities for different diseases and country contexts, this study uses broad conceptual definitions in conjunction with programme examples. The definitions, key concepts, and programming examples used to assess concept notes in this study are set out in Box 5 for quick reference. More detailed explanations of the definitions are included below. This study also acknowledges considerable overlap between the three concepts and that although distinguishing between the three is sometimes artificial, it is useful for the identification of specific gaps in knowledge and formulation of practical recommendations (see Figure 1).
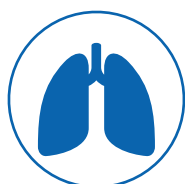
Community priorities

Community priorities were defined using the Global Fund CSS Framework, the Performance Framework and Key Populations Strategy.[38] The Global Fund CSS Framework explains that "community" is a 'widely used term that has no single or fixed definition. Broadly, communities are formed by people who are connected to each other in some way, and 'may be connected by living in the same area or by shared experiences, health and other challenges, living situations, culture, religion, identity or values'.[39] This social definition is distinct from purely geographical concepts of community that may be used, for example, to refer to services that operate at the local level, which may or may not be based on social concepts of community linked to community ownership or leadership.

For the purposes of this study, community priorities are defined as comprising two core components:

- investment in CSS; and
- investment in key populations

These components are defined in detail below.

CSS

"Community systems" are defined as 'Community-led structures and mechanisms used by communities through which community members and CSOs and groups interact, coordinate and deliver their responses to the challenges and needs affecting their communities'. They may be small and informal or larger networks with multiple components.[40]

Historically, CSS was understood to refer primarily to building the capacity of communities (particularly communities of key populations) to conduct outreach activities and deliver services such as testing, referrals and treatment supervision. This approach recognised the practical benefits of having services delivered by communities rather than formal government or private providers, particularly in terms of reaching hard-to-reach populations. The CRG Special Initiative seeks to build on this approach based on (1) growing recognition of the value of rights-based and empowerment approaches to development; and (2) the importance of communities to sustainable responses in the context of transition to domestic funding.

This new understanding of CSS goes beyond community service delivery. It incorporates support for community advocacy to hold governments accountable and to participate in decision-making, programme and policy design 'as equals'.[41] This includes the capacity building necessary to allow community representatives, civil society, and community-based organisations to mobilise communities, to effectively participate in decision-making processes, and to advocate on their issues. Global Fund guidance now reflects this more empowering concept of CSS. The Global Fund Performance Framework includes the following interventions as examples of CSS:

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[38] Ibid.
[39] Global Fund (2014) Community Systems Strengthening Framework.
[40] Ibid.
[41] Ibid.

•Community-based monitoring for accountability
•Advocacy for social accountability
•Social mobilisation
•Building community linkages
•Collaboration and coordination
•Institutional capacity building
•Leadership and development in the community sector.

This empowering concept of CSS is used for this study. Service-delivery focussed activities that fall short of this definition are still identified as CSS but not rated as highly as those that meet the empowerment and sustainability goals of the newer definition.

Key populations

Investment in key populations is recognised as a crucial component of CRG work, and for the purposes of this study has been classified as a community priority. The Global Fund Key Populations Strategy defines key populations as groups of people who 'experience a high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalised or otherwise marginalised'. CSS must include and will benefit key populations as 'equal partners'.

Rights priorities

For the purposes of this study, rights are interpreted in line with international human rights instruments including conventions, covenants and declarations, and authoritative guidance such general comments and official statements by treaty bodies and special rapporteurs. This covers a potentially vast range of subject areas even in the more limited context of responding to the three diseases. Rights that impact vulnerability to the three diseases incorporate issues as broad as poverty, gender inequality, access to education, discrimination against key populations, and political rights that allow people to elect officials that support effective responses to the diseases.[45] This study seeks to maintain this broad view of rights consistent with the indivisible nature of human rights whilst focussing on legal barriers to access, consistent with the Global Fund Performance Framework, which incorporates an essential supporting module on "removing legal barriers". This module has also been used to identify examples of activities that represent rights priorities (see Box 5 examples for rights priorities).

Gender priorities

Gender refers to:

> the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. Whereas biological sex is determined by genetic and anatomical characteristics, gender is an acquired identity that is learned, changes over time, and varies widely within and across cultures. Gender is relational and refers not simply to women or men but to the relationship between them.[46]

[42]Global Fund (2015).
[43]Global Fund, *Key Populations Action Plan 2014-2017.*
[44]Global Fund (2014).
[45]Global Fund (2014).
[46]Global Fund (no date) *Global Fund Gender Equality Strategy.*

Gender should be understood as distinct from biological sex, which refers to the biological characteristics, which define humans as female or male. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but these characteristics tend to differentiate humans as males and females.[47]

This study defines gender priorities based on the Global Fund Gender Equality Strategy. Gender priorities are activities aimed at addressing the impact that biological and social differences have on men, women, boys' and girls' vulnerability to HIV, TB and malaria.[48] This necessarily includes activities to better understand those impacts including gender analyses and collection of gender-disaggregated data.

The Global Fund Performance Framework does not currently include a gender module and thus does not provide guidance on activities that reflect gender priorities. The Global Fund Gender Equality Strategy does however include a guide to gender analysis that is used for the purposes of evaluating the quality of gender activities (see Figure 2). Understanding gender activities as discriminatory, gender blind/neutral, sensitive or transformative has also provided a useful means of assessing the inclusion of activities aimed at addressing biological vulnerabilities as distinct from those that address gender. For the purposes of this study, activities that address biological vulnerabilities are considered essential to addressing gender inequality in standards of health but distinguished from activities that utilise gender as a tool of analysis and means of strengthening responses to the three diseases.

Figure 2: Gender Assessment[49]

Gender Negative	Gender Neutral	Gender Sensitive	Gender Positive	Gender Transformative
Gender inequalities are reinforced to achieve desired development outcomes Uses gender norms, roles and stereotypes that reinforce gender inequalities	Gender is not considered relevant to development outcome Gender norms, roles and relations are not affected (worsened or improved)	Gender is a means to reach set development goal Addressing gender norms, roles and access to resources in so far as needed to reach project goals	Gender is central to achieving positive development outcomes Changing gender norms, roles and access to resources a key component of project outcomes	Gender is central to promoting gender equality and achieving positive development outcomes Transforming unequal gender relations to promote shared power, control of resources, decision-making, and support for women's empowerment

[47]Ibid.
[48]Ibid.
[49]Ibid.

Box 5: Defining CRG Priorities

Community

For the purposes of this study community priorities include allocation of funds to support activities for:
1. CSS and
2. key populations as the communities most affected by the three diseases.

There is considerable overlap between the two components – CSS must include and will benefit key populations.

Definition: CSS	Examples
CSS aims to promote 'development of informed, capable and coordinated communities, and CSOs, groups and structures'. CSS activities should enable community actors to 'contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at the community level, including an enabling and responsive environment in which these contributions can be effective'.[50]	The following examples of activities to support CSS are included in the Global Fund Performance Framework Template: [51] •Community-based monitoring for accountability •Advocacy for social accountability •Social mobilisation •Building community linkages •Collaboration and coordination •Institutional capacity building •Leadership and development in the community sector. Additional examples might include: •Core funding to maintain organisations and infrastructure •Investment in capacity building and staff to assist with administration, finances and monitoring and evaluation.
Definition: Key populations The Global Fund Key Populations Action Plan defines key populations across the three diseases according to three criteria. Key populations must meet all three of the following criteria:[52] 1. Epidemiologically, the group faces increased risk, vulnerability and/or burden with respect to at least one of the three diseases – due to a combination of biological, socioeconomic and structural factors; 2. Access to relevant services is significantly lower for the group than for the rest of the population – meaning that dedicated efforts and strategic investments are required to expand coverage, equity and accessibility for such a group; and The group faces frequent human rights violations, systemic disenfranchisement, social and economic marginalisation and/or criminalisation – which increases vulnerability and risk and reduces access to essential services.	**Examples** Examples of activities to support key populations might include: •Allocation of funding to establish mobile clinics for migrant workers in malaria-endemic plantation areas; •Advocacy for the decriminalisation of sex work to reduce barriers to seeking services; •Social housing programs for people living in urban slums to reduce the risk of TB associated with overcrowding, peer-outreach programming to deliver clean needles/syringes to people who use drugs who may risk HIV transmission through sharing needles out of fear of arrest under punitive drug laws. Use of new technologies such as SMS and dating apps to link key populations to information on the diseases.

Rights

Definition	Examples
For the purposes of this study rights priorities are law, policy and access to justice reforms required to realise the human rights set out under international human rights instruments and the advocacy and capacity building activities necessary to push for those reforms.	The following examples of activities to promote the removal of legal barriers are included in the Global Fund Performance Framework Template: [53] •Legal environmental assessment and reform •Legal aid services and legal literacy training/information for communities •Training on rights for police officials and health workers Community-based monitoring on legal rights Specific programming examples might include: •Decriminalisation of risk behaviours •Introduction of laws against discrimination on the basis of disability and risk behaviours •Subsidised health services aimed at achieving universal healthcare •Provision of health services to mobile and migrant populations without access to national healthcare schemes •Development and enforcement of occupational health and safety provisions to reduce risks in the workplace Social protection programming to reduce the impact of poverty on infection and financial barriers to seeking testing and treatment

Gender

Definition	Examples
For the purposes of this study, gender priorities are activities aimed at addressing the impact that biological and social differences have on men, women, boys' and girls' vulnerability to HIV, TB and malaria.[54] Programs that reflect gender priorities should be:[55] •Gender neutral: not reinforce existing gender inequalities •Gender sensitive: attempt to redress gender inequalities •Gender transformative: attempt to re-define women and men's gender roles and relations.	Examples of activities to support gender priorities might include: •Collection of gender-disaggregated data; prevention and response services in relation to gender-based violence given its role in increasing risk of HIV transmission; •Sensitisation training for healthcare workers and police to reduce fear of stigma and increase access to services by transgender people (TG) and men who have sex with men (MSM); •Making malaria testing and information available in antenatal clinics given higher mortality rates among women; •Targeting of mothers with information on TB diagnosis given the risk of exposure inherent in their caring role; •Training of leaders working in sectors that carry high risk of contracting malaria or TB to provide information and reshape health seeking norms among male colleagues; •Care services and social norm change to address factors that impose disproportionate burdens of care and support on women and the elderly and put in place programs to mitigate these burdens;[56] Working with religious leaders to address cultural restrictions on women's movement that prevent their accessing health services.

[50] Global Fund (2014)
[51] Global Fund Performance Framework Template (CSS module).
[52] *Key Populations Action Plan 2014-2017*.
[53] Global Fund Performance Framework Template (Removing legal barriers module).
[54] *Global Fund Gender Equality Strategy.*
[55] Ibid.
[56] Ibid

Methodological limitations

The following section briefly identifies the scope and potential limitations of the study.

The level of detail that Global Fund concept notes can accommodate limits their value as a means of determining the extent to which program implementation will reflect CRG priorities. The role of concept notes as a threshold for funding activities however makes them an important subject for research. Performance Frameworks were reviewed for additional information and key informant interviews were used as 'reality check'. Limited mobilisation and collectivisation within malaria and TB communities means that most key informants were only able to speak on HIV concept note development.

This study does not compare budget allocations. CRG priorities are typically spread across a number of funding modules so allocations to activities that specifically promote community, rights or gender priorities are not individually costed. Establishing what proportion of funding has been allocated to CRG activities is therefore generally not possible. Even with clear budget allocations, meaningful comparison is difficult given that some activities may cost significantly more than others. While sustainable funding arrangements and the increasing shift to domestic financing require an emphasis on efficiency, direct budget comparison risks creating the impression that expensive activities are prioritised more highly than they are, as cheaper activities may be able to be funded in full for less. It is also important to note that efforts by the Global Fund, CSO and community to increase activities and funding as necessary to CRG priorities are based on recognition that these aspects of the response are currently under-invested in. There is no suggestion that these should be the only activities supported by Global Fund grants or that they should necessarily receive the most funding, this will depend on different epidemics and country contexts.

As Asia-Pacific countries have not developed their own list of CRG or civil society priorities (equivalent to the charters of civil society priorities developed in East Africa)[57] and there is no definition of CRG in CRG Special Initiative guidance, this study defined its own broad understanding of CRG priorities. It would be preferable for communities and CSOs to define their own, country-specific priorities and measures of success in relation to CRG and this study recommends the development of such documents. However, the study also acknowledges that in some countries, in respect of some diseases, community mobilisation and understandings of CRG considerations is still limited. By defining a broad set of criteria based on the goals set out in Global Fund guidance, this study compares concept to standards of good practice to allow the report to act as a resource for learning and ensure that recommendations are tailored to development of programs that reflect expert advice. This study does not compare achievements to a baseline set of demands but global guidance.

There is considerable overlap between CRG priorities (see Figure 1 The importance of strong community systems as a foundation for ending HIV, TB and malaria) and drawing distinctions between activities to promote progress in the three areas can be artificial. Activities for example to reduce stigma against TG women may be considered a gender priority, a community priority or a rights priority, in that they contribute to realising rights to health and gender equality as well as needs associated with heightened risks faced by a key population group, based largely on gender identity.

[57]See Civil Society Priorities Charters on AIDS Accountability International's Website, at: http://www.aidsaccountability.org/?page_id=10280&projectid=922.

For the purposes of this study, overlaps were acknowledged with a ✓rating to indicate their inclusion but only rated more highly in relation to community, rights or gender priorities where they demonstrated specific consideration of the benefits of community engagement, particular strengths and vulnerabilities of key populations, rights principles or gender analysis. This is based on the understanding that the Global Fund's promotion of CRG priorities is based in an understanding of the benefits of key population-centred responses, community engagement, gender analysis and rights principles to improving responses to the three diseases. Activities focussed on key populations with incidental benefits for rights or gender priorities would therefore contribute to a higher rating in relation to the inclusion of community priorities than for rights or gender priorities. This allows an assessment of the extent to which CRG priorities are included, omitted and understood; and inform recommendations to promote rights and gender priorities.

Limitations of the ratings system and mitigation measures are addressed under the heading "Ratings system", Section 1.3 "Study objectives and research methodology".

1.4 Report outline

The remainder of the report is divided into three parts. These set out:

- recurring themes for CRG activities in Asia and the Pacific

- findings, discussion, and concept note analysis

- recommendations

Annex A presents summaries of findings from concept note assessments relied on in reaching the regional study findings and developing recommendations.

Recurring themes in Asia and the Pacific

The chicken and the egg? – The importance of strong community systems as a foundation for ending HIV, TB, and malaria

"You need to start from somewhere. And CSS is a good place to start" Dr. Khuat Thi Hai Oanh, Executive Director, Centre for Supporting Community Development Initiatives (SCDI), Viet Nam

Key informants from Cambodia, Pakistan, the Philippines and Indonesia all commented on the importance of CSS, not just as an item for investment under Global Fund allocations but as a foundation for the concept note development process. "It is very important to have community and CSO monitoring and reflecting on what is happening in a constant dialogue" explains Dr. Oanh. "You have to have a system in place so that the country dialogue works".

Country coordination mechanisms are required to ensure that communities are consulted, including through the development of national strategic plans, country dialogue processes and the election of community representatives to the body itself. But having requirements in place cannot guarantee quality or depth of engagement. Strong community-based organizations and CSOs are essential to that, particularly where the CCM is not supportive. "Concept note development is a long process," explains executive director of the Spiritia foundation, Daniel Marguari. "The process will take so many steps and we have to make sure there is community engagement with strong capacity development at every step. It is not easy. If Principal Recipients are not representative of community, we will be missed at some steps in the process, and funding will reduce."

The importance of a strong and active community to drive the community dialogue process was particularly clear in the Philippines and India where community and CSOs advocated for additional meetings when CCM organised meetings failed to reach key populations. Former TLF Share Executive Director, Jonas Bagas, shares, "the first community dialogue meeting had only one transgender representative present. For the second community dialogue we were able to organise a meeting nearby to encourage community to attend".

Viet Nam was a pilot country for the Community Advocacy Initiative (CAI), which included training on the new funding model Dr. Oanh recalls. CAI "inspired CSO to be more engaged with the CCM and the country team to be more open to CSO. CSO now had a knowledge about the new funding model and understand the process so they can participate more effectively". Before the country dialogue process in Viet Nam began, a series of meetings on strategic investment were held as part of the CAI process, "this was possible," Dr. Oanh recalls, "*because* there were already CSOs working in this area".

Community systems building and strengthening is a long and ongoing process. Community movements must be fostered and supported in order to grow and demonstrate their value to national responses. "When we do outreach, it is tangible, people see it and it demonstrates our capacity and the unique position of CSO. And I think that helps. People are pragmatic at the end of the day people say who are you and what can you do", says Dr. Oanh.

A seat at the table – The added-value of community principal recipients

Global Fund programmes are implemented by organisations elected by the Country Coordinating Mechanisms to act as principal recipients. Two or three principal recipients are typically appointed for each concept note and may include ministries of health, international NGOs and sometimes CSO and CBOs. Principal recipients can work through sub-recipients and sub-sub-recipient organisations. CSO and CBOs are more often sub-recipients than principal recipients.

Principal recipient status ensures CSO are present for crucial budget discussions. "CSO principal recipients are very important because negotiation [over funding allocations] occurs between the Global Fund and principal recipient" says Dr. Khuat Thi Hai Oanh, executive director of the Supporting Community Development Initiatives in Viet Nam. "CSO principal recipients help to protect funding... you need to have a strong CSO recipient to participate in that negotiation process". Without a place at the table, "we are just messengers", says Dr. Ly Sangky, a project director from KHANA, Cambodia's largest national provider of HIV prevention, care and support services at the community level.

Indonesia is one of few countries to have elected a local CSO as a principal recipient. The Spiritia Foundation is an umbrella organisation, founded to assist local and regional HIV/AIDS institutions. Spiritia is now also a principal recipient under Indonesia's TB/HIV concept note. "I was a member of the CCMfor twelve years", says Mr. Marguari of the Spiritia Foundation. "We are not starting from the beginning" he explains, "we now have a team that can rework budgets in a day".

Building community and CSOs with the capacity to participate effectively as principal recipients requires investment in CSS. "We are always thinking about sustainability", says KHANA's Dr Sangky. But core funding is limited and staff are expected to volunteer, "so they resign, we lose expertise" he says, "their energy is exhausted". Organisations are operating without offices, secretariats and equipment. Without core funding, Dr Sangy explains, CSS under the concept note exists "in name and shadow only".

Selection of CSO principal recipients with a commitment to community has flow on benefits for community engagement. When Spiritia were appointed as principal recipient they committed to selecting sub-recipients from affected communities. "The mindset, the value, and the vision is very important," says Daniel Marguari, executive director of the Spritia Foundation. "Our outreach workers are 80% from key populations".

"That is the beauty of the community system", says Dr. Oanh, "because it is within the population – it is genuine, it is non-political. Today you have this party, tomorrow another. The community is still the community."

The Association of PLHIV in Pakistan, are experienced sub-recipients hoping to be elected as principal recipients in the next round of Global Fund. "If we are selected as principal recipients, we would go in without stigma or discrimination, with a focus on gender and speaking to community through communities", says Asghar Satti, national coordinator of the Association of People Living with HIV. "I think that would be real empowerment of the communities because beneficiaries would be service providers, beneficiaries would be the community people. That's how we are looking forward."

Stronger together – The importance of CRG allies in the Global Fund

"If you move alone, things will not be in your favour" explains Asghar Satti, national coordinator of the Association of People Living with HIV (APLHIV), one of the sub-recipients under Pakistan's current HIV concept note.

"When the first draft of the [Pakistani HIV] concept note reached federal level consultations we were very concerned", says Mr Satti. Important activities including viral load testing and treatment adherence supports had been relegated to above allocation funding. "We [community and CSO] worked together as a pressure group… we kept following up". The Global Fund heard their concerns and the Thematic Review Panel review required that key issues be brought back within allocation funding.

In India, initial community dialogue meetings failed to engage with TB activists and affected members of the community. Activists wrote to the Global Fund secretariat and were able to stall the community dialogue process until a meeting of community representatives could be convened. "You need a separate dialogue with the community" says Blessi Kumar, Chair of the Global Coalition of TB Activists "when government is there you cannot speak freely".

A number of countries in Asia and the Pacific have recognised supportive fund portfolio managers as critical to the inclusion of CRG priorities in concept notes. "Fund portfolio managers are important", says Dr. Khuat Thi Hai Oanh, executive director of the Supporting Community Development Initiatives, Viet Nam. "They support us, we support them. They want to do a good job too. Everybody wants that so we should be cooperative".

"We highly appreciated the role of the fund portfolio manager" Mr Satti recalls. Pakistan's fund portfolio manager has been working with the country for a long time and championed community interest throughout concept note development. "Our fund portfolio manager has a strong connection to community stakeholders as well as the public sector" Mr Satti explained, "APLHIV have invited him to visit our office and see the work we are doing, how we are caring for the community".

Other key informants' experiences underscored the need for support. Maura Mea, from Igat Hope and community representatives on the CCMrecalls an attitude that community organisations lack capacity. "There were no community representatives on the CCMbudget committee" she says, "we have vast experiences but we can't bring those, lived experience without support. We three [HIV, malaria and TB community representatives] are struggling to speak for ourselves". These statements are consistent with findings from an ICASO study that although country coordination mechanisms are required to include community representatives, 'CSO is still too often constrained in its ability to influence decision-making within them'.[58] Community representatives appreciated Global Fund interventions during an in-country visit and changes made by the Technical Review Panel including the addition of gender programming. "But down the line they start to minus things", Ms Mea explains, tasks allocated to community sub-recipients are reallocated, activities and payments are delayed.

[58] ICASO (2013) 'Effective CCMs and the Meaningful Involvement of CSO and Key Affected Populations: Lessons Learned in ICASO's extensive work supporting CCMs'.

Understandings of CRG priorities and the value of community input must be built among fund portfolio managers and country coordination mechanisms. Strong relationships with community can play an important role in building understanding of CRG issues within the Global Fund. "I can say very proudly that whosoever are the stakeholders in the HIV community, public private or technical centres, communities… We have very strong linkages and strong working relationships" Mr Satti says of APLHIV Pakistan. "The message for other countries is you have to work in close collaboration with the other stakeholders".

Where is the TB community? – Extending the success of the community movement in HIV to TB

"In India over 1,000 people die from TB everyday", says Blessi Kumar, Chair of the Global Coalition of TB Activists, "so of course there is demand but people are not empowered".

The TB response is notoriously medicalised, despite the very human psychological impacts of its lengthy treatment regime and the stigma that attaches to misinformation and fear of transmission. As a result, community-led TB organisations and advocacy are scarce world-over. "The TB response in India's concept note is again, casefinding, casefinding, casefinding" says Dean Lewis of the Sahara Centre for Residential Care and Rehabilitation. "Community involvement [is still] very superficial" adds Ms Kumar, "what have we [Global Fund programmes] done to build their capacity?"

"Funding for community in TB is very limited", says Daniel Marguari executive director of the Spiritia Foundation, a principal recipient under Indonesia's TB/HIV concept note. Yet CSS is particularly important for TB given low levels of community organisation and mobilisation. "There has to be direct funding allocated to the community" says Dean Lewis, of the Sahara Centre for Residential Care and Rehabilitation. "It may be a tiny investment but the outcome will be huge".

"CSO engagement on HIV is not perfect", says Dr. Khuat Thi Hai Oanh, executive director of the Supporting Community Development Initiatives, Viet Nam "but it has opened the door for CSO to engage in TB and malaria as well. It is starting".

CSS activities and existing systems were consistently stronger under the HIV concept notes examined in this study than TB and malaria concept notes, including at the regional level. The benefits of collaboration on the TB and HIV response is also apparent in the Indonesian, concept note, which includes an unusually strong commitment to CSS and rights priorities across both diseases. Work on combined concept notes promotes knowledge sharing between more established HIV community and CSOs and the developing TB community sector. "In some steps we worked together" to develop the concept note, Mr Marguari says, "especially CSS and removing legal barriers".

"The HIV movement has created a space for CSO to engage in the response", says Dr. Oanh. "In order for that to happen for TB and malaria we need to do more groundwork in that area. We cannot say TB community and malaria when we have no one. Capacity building needs to start now, to build the capacity of CSO so that people can sit at the table and negotiate. It is not only the respect people have for you but when you sit there you should be able to engage in conversation".

But work to build TB communities is underway, including collaboration across Global Fund diseases. PNG's current Global Fund grant provides for the building of community groups, "going out to meet people in the villages – that is what I look forward to" says HIV activist turned TB community mobiliser, Maura Mea. "Seed funding is vital to create change in this country" explained Global Fund Advocate and TB survivor Louie Zepeda Teng, speaking about the Philippines TB community. "The advocacy will need an office with a staff that can diffuse these missions in TB burden cities and eventually affect the policy makers with the use of plenary sessions hosted by the leaders of the TB patient group". "There has to be community engagement," she says" an invitation to the former patient or family affected to create a recognized group, just to start the community knowledge".

"That is the beauty of community systems. Once you are there you can grow. At first it is HIV, and service delivery, now drug user and sex worker organisations are recognised in other programs and their spread is growing beyond HIV. I think that's the beauty of the system because it is within the population – it is genuine, it is non-political. Today you have this party, tomorrow another. The community is still the community".

"...but anyone can be bitten by a mosquito" – How is gender relevant to the malaria response?

"CRG (CRG) are very difficult for malaria. Especially the gender element. The community is raised, rights less so. But the "G" especially is tricky", says Natakorn Jittanonta of the Malaria Consortium.

This view is struggle is closely reflected in concept notes, for the Regional Artemisinin Initiative and for individual countries. Global Fund concept notes primarily define risk by geography – a mosquito does not care where you came from, if you are a man, a woman, rich or poor. But these factors determine whether you are in a high-risk area, what help you can access to and how seriously the disease affects you.

Community and volunteer village health workers are a strong component of the malaria response throughout the region, but the extent to which these "community" actors represent affected community or just operate at the community level is unclear. These workers represent a valuable opportunity to empower affected communities, facilitate outreach and build a sustainable community response through strengthened systems, not always capitalised on. Key informants recognise regional projects like RAI as an opportunity to promote community and CSO involvement as cross-border work creates a space for non-government actors. Rights and gender priorities are almost entirely overlooked.

Mobile and migrant worker populations are recognised as key populations not just because of where they are located but because their legal status creates barriers to accessing services. People may be afraid to risk deportation, infection in one country may bar them from accessing services in another and government subsidised health schemes often attach to a person's place of permanent residence, limiting their access to timely services during periods away from home. "At the national level this is very sensitive and working with government raising these issues – the government will close the door the next day. This is the work that needs to come from regional level" says Mr. (Shree).

So where does gender come in?

"I have tried to update staff on gender. They know there is an issue but they don't know how to bring it out because they think about day to day activities they understand gender issues as cultural don't think that is an issue. So those perspectives are not incorporated into programming" Mr Shree explain.

Gender impacts risk of malaria infection, access to services and disease burden in a range of ways. Men are more likely to be infected given their role in outdoor work and sleeping in high-risk areas for example in plantations where use of bed nets is more difficult. Gender roles that promote the appearance of strength among men also create a barrier to health seeking, men in some countries are more likely to seek treatment from private providers than to see a doctor. This results in unregulated drugs entering the market and increases the risks associated with drug resistance for the individual and in terms of spreading resistance. Biologically, pregnant women face graver consequences from malaria with higher rates of mortality. Women's health seeking behaviours are better than men's though gender inequality may impact women and girls' access to health through lack of financial autonomy or preferential treatment of men and boys which results in women and girls' health being treated as a low priority. Caring roles increase the burden of malaria that women experience, through its impact on the way they spend their time.

These gendered experiences represent program entry points. Programs for mobile and migrant workers should target men from a gender perspective, addressing resistance to health seeking and heightened vulnerability based on an understanding of gender roles and how these might shift. As carers, many women are already a significant unacknowledged component of the malaria response, providing training and expanding this role to community education, outreach work, early diagnosis and treatment supervision would increase the value of this contribution and help build and strengthen sustainable community systems. This potentially transformative programming would begin the process of addressing the impact of gender inequality on access to treatment by raising the status of women in communities and increasing economic and political empowerment where remuneration and formal community roles are made available.

Community, rights and gender priorities are as important to an effective response to malaria as they are to HIV and TB but there is a long way to go. Understandings of how right and gender impact access to services are emerging. However the ability to translate this analysis into program activities will require technical assistance, capacity building and advocacy from community and CSO working toward future funding rounds.

PART 2

FINDINGS AND DISCUSSION

Box 6: Concept Note Comparison At A Glance

Country		Community	Rights	Gender
Cambodia	HIV	✪★	✪★	✪
	Malaria	✪	?	?
	TB	✪★	✪	✪
India	HIV/TB	✪★	✓	?
	Malaria	✪	?	?
Indonesia	HIV/TB	✪★	✪★	✪★
	Malaria	✓	?	✓
Pakistan	HIV	✪★	?	?
	Malaria	✓	?	?
	TB	✪★	✪	✪★
PNG	HIV	✪★	✪	✪★
	Malaria	✓	?	✓
	TB	✪★	?	✪★
Philippines	HIV	✪★	✪★	✪
	Malaria	✪	⊠	✓
	TB	✪	?	⊠
Viet Nam	HIV/TB	✪★	✪★	✪
	Malaria	✪	?	✓
RAI	Malaria	✪	✓	✓

The study identified strong patterns in the nature and extent to which CRG priorities are included in Global Fund concept notes, as well as common challenges and enabling factors. Across all countries, concept notes and key informant interviews, it was clear that strong communities are both critical to the inclusion of CRG priorities in concept notes and a product of concept notes that promote CSS and enabling environments for mobilisation. Figure 3 illustrates the cyclical benefits of CSS identified in this study and factors that create an enabling environment for that ongoing process for the promotion of CRG priorities. Detailed findings are set out below.

Figure 3: The cyclical benefits of CSS and critical enabling factors for the development of concept notes that promote CRG priorities

Supportive factors

+ Past investment in communities

+ Technical assistance

+ Collaboration with HIV community advocates

+ Community-friendly Global Fund staff

+ CSO/Community principal recipient

+ Enabling environment for key populations and community mobilisation

+ Existing research on how CRG issues in-country that can be drawn on for concept note development.

Strong existing civil society and community-based organisations

Global Fund concept notes that promote CRG priorities, including community systems strengthening

Challenges

- Suppression of community organisations

- Criminalisation of key populations

- Poor engagement of communities during community dialogue and national strategic plan development

- Poor understandings of CRG among communities, country coordination mechanisms. and Global Fund support staff

1. **All concept notes, across all diseases focussed on addressing the epidemic among key populations; requiring minimum budget allocations to key populations has been successful in focussing concept notes; concept notes are often not detailed enough to determine whether the different needs of key population subgroups are addressed; young key populations in particular are overlooked.**

All countries in this study identified key populations in relation to the three diseases. The Global Fund concept note template requires countries to identify key populations 'that may have disproportionately low access to prevention, treatment, care and support services, and the contributing factors to this inequity' in describing the country context.[59] A minimum funding allocation to 'underserved and most-at-risk populations and/or high impact interventions' is also required. Lower-middle income countries must allocate at least 50% of the budget to 'underserved and most-at-risk populations and/or highest-impact interventions'; for middle-income countries this requirement rises to 100%.[60] The broad expression of the requirement makes it difficult to hold countries accountable to but all countries in this study stated that their budget allocations were compliant. On this basis, it appears that requiring the inclusion of content on key populations and minimum budget allocations through the concept note template has been effective in shaping the activities and focus of concept notes. This approach may also be useful in increasing attention to CSS, rights and gender priorities.

[59] Global Fund Concept Note Template
[60] Ibid.

All concept notes identified key population sub-populations, such as sex workers, slum-dwellers and forest workers in narrative sections of the document and many linked those groups to different barriers to access requiring specific policy and program responses. However, the distinction between these sub-populations was often missing in the funding request section, which tend to 'key populations' as a single target group. These distinctions were most often lacking in relation to malaria, though no subgroups were identified by any Indian concept notes.[61] The only key population subgroup identified in the Indian HIV concept note was PLHIV, despite recognition of different subgroups, including 'bridge groups' such as long-distance truck drivers in the country context that require specific prevention and response programming.

By contrast, concept notes from Cambodia[62], Indonesia[63], Pakistan[64], PNG[65], Philippines[66], and Viet Nam (all) provide strong examples of programming for specific key population subgroups[67]. Cambodia's TB concept note for example provides for community outreach by monks through pagodas frequented by the elderly; its malaria concept note targets mothers as a risk group during pregnancy and young children (also a key population) through work with mothers' groups. The Philippines HIV concept note identifies distinct funding allocations for key population subgroups and Indonesia's TB/HIV concept note provides for separate programs under separate modules.

While lack of detail does not necessarily mean that tailored programming for sub-populations will not be supported, concept notes provide an important means of holding countries accountable for the way funds are spent. Lack of detail creates space for key population subgroups to be overlooked, including references to specific activities may be important for ensuring that under-recognised and most-marginalised subgroups are not excluded from Global Fund supported activities. Young key populations, a major crucial key population group for HIV, were for example only specifically included in one concept note (Philippines – HIV) and despite high rates of malaria among young working-aged persons were only included in one malaria concept note (Viet Nam).

While the detail in concept notes is limited by the template, it is important to include a sufficient level of detail in the document and Performance Framework to enable communities and advocates to understand the commitments made and monitor compliance.

2. When TB and HIV concept notes were combined, TB funding requests benefitted from the comparatively advanced state of community mobilisation, rights and gender advocacy under HIV responses; the inclusion of CRG priorities differs significantly across the three diseases and within countries.

The inclusion of CRG priorities in HIV concept notes was stronger than in TB and malaria concept notes in all countries, and for the countries included in this study, strongest in combined HIV/TB concept notes. India's HIV/TB concept note is an exception due to its poor attention to rights and gender. Pakistan and PNG's TB concept notes are positive exceptions as a result of their strong inclusion of gender

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[61]India-Malaria 2015-2017; India-HIV/TB 2015-2017; PNG-Malaria (no date); Philippines-Malaria 2015-2017.
[62]Cambodia-HIV 2015-2017; Cambodia-Malaria 2015-2017; Cambodia-TB 2015-2107.
[63]Indonesia-HIV/TB 2016-2017.
[64]Pakistan-Malaria 2015-2017.
[65]PNG-HIV.
[66]Philippines-HIV 2015-2017.
[67]Viet Nam-Malaria 2016-2017; Viet Nam-HIV/TB 2015-2017.

priorities through efforts to address barriers to women's access to health in Pakistan and TB and gender-informed programming for men and women in PNG.[68]

The comparison between HIV concept notes and those for malaria and TB is even more stark when the inclusion of rights and gender considerations are compared. The inclusion of rights priorities in malaria concept notes was particularly poor with just one of eight including rights, and those were rated poorly as any gain in terms of rights appeared incidental.[69] Five malaria concept notes included gender priorities but these were rated poorly given they only addressed biological vulnerabilities.[70]

CRG priorities by disease
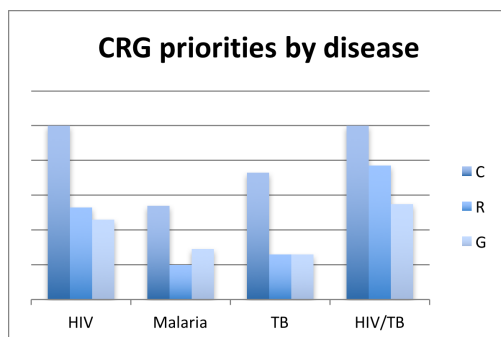
The inclusion of CRG issues in combined HIV/TB concept notes suggesting that rights consciousness in relation to the HIV component may also have informed budget allocation in relation to TB where concept notes are combined. These findings are likely due to the ongoing and historical role of community in driving the HIV response and CRG priorities. As Collins et al note, '[c]ommunity action, including activism, advocacy and service delivery, has been crucially important in the global response to AIDS from the beginning of the epidemic and remains one of its defining features'.[71] TB and malaria responses have been quite different and remain heavily medicalised – a Global Fund Study found that CRG issues were particularly poorly represented in malaria concept notes.[72]

Ratings by country and CRG
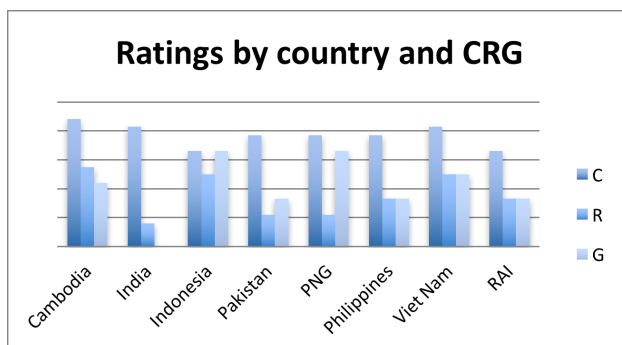
Despite development through a common country coordination mechanism, the quality of concept notes across the three diseases (in terms of their inclusion of CRG priorities) varied significantly. Comparison of country understandings and commitments to CRG priorities was therefore less relevant than comparisons among the disease responses. One country may for example have a very strong HIV concept note but TB and malaria concept notes that demonstrate little understanding of CRG issues. This suggests that efforts to improve appreciation of the importance of CRG issues may need to be tailored to the diseases, and acknowledge the effort required to address the lower level of understandings around how CRG impacts the TB and malaria responses and the capacity of TB and malaria communities to advocate on those issues.

These findings also point to the need for greater collaboration across the three diseases, particularly to enable the TB and malaria responses to benefit from lessons learned through the HIV response in relation to CRG. The benefits of collaboration are already apparent in the comparatively high rates and quality of CRG priorities included in HIV/TB concept notes. Lost opportunities are unfortunately also apparent in the failure to collaborate where positive measures relevant to multiple diseases are included in one concept note but not another.

[68]Pakistan-TB 2015-2017; PNG-TB
[69]RAI Concept Note 2014-2016.
[70]Indonesia – Malaria 2015-2017, PNG, Philippines, Viet Nam and RAI.
[71]Chris J Collins, Matthew N Greenall, Chris Mallouris and Sally L Smith (2016) "Time for full inclusion of community actions in the response to AIDS", *Journal of the International AIDS Society*, 19: 20713, 1-3.
[72]Jurgens & Lim (2016).

Pakistan's recognition of the need for female health workers to reduce cultural barriers to women's accessing health services which are usually provided by men under their TB concept note but not their malaria or HIV concept notes is a clear example of how collaboration within CCMs could benefit responses to all three diseases.

National responses may also include CRG priorities funded through counterpart- and co-financing. A number of country concept notes broadly describe counterpart- and co-financed activities that may contribute to CRG priorities, although the detail available publically through concept notes is not sufficient to determine the value of these activities. Promoting CRG priorities for more sustainable national responses requires advocacy to increase the representation of these issues beyond Global Fund grants and most importantly for sustainability, in domestic funding.

3. Human rights and gender are poorly understood, particularly in the context of malaria and TB responses. The term "gender" tended to be understood either as a proxy for women or biological sex. The benefits of understanding how men and women, boys and girls experience the diseases and responses differently have rarely been realised. Narrow conceptions of human rights mean that rights to collectivise are rarely included in work to remove legal barriers to effective responses. There was a cascade or drop off effect in the inclusion of rights priorities from narrative and analysis sections of the concept note to the funding request section and Performance Framework. Efforts to increase understanding and inclusion of rights and gender priorities have been promoted to varying degrees, with mixed impacts.

More than half the concept notes in this study included no activities specifically aimed at promoting rights and while more concept notes included gender priorities, this was largely due to the recognition of sex-based biological vulnerabilities to malaria. All concept notes discussed rights and gender considerations as part of their country context discussion. The Global Fund concept note template requires countries to identify 'gender inequalities that may impede access to health services'.[73] This requirement however does not appear to have be as successful as requiring minimum budget allocations has been in relation to key populations.

While many of the gender activities included (particularly in malaria concept notes) only addressed sex-based biological vulnerabilities the activities described in Box 7 demonstrate a strong understanding of how gender norms and inequality impact access to health services. Some are strategically tailored to address challenges in the specific country-context and clearly linked to epidemic dynamics such as the growing number of infections among women from outside key populations, historically considered low-risk. Others responded to common challenges within the region such as gender-based violence, intimate partner transmission, risks associated with men's health-seeking behaviour and women's caring roles. These provide examples for implementation in other countries.

[73] Global Fund Concept Note Template

Box 7: Examples of gender activities in concept notes

Thirteen the seventeen concept notes reviewed were classified as including gender priorities.[74] Those activities that were incorporated included:

- Technical assistance to improve understandings of gender equality;[75]

- Gender sensitisation to reduce barriers to TG and MSM access to health service, and women's access to harm reduction services that female PWID often feel excluded from;[76]

- Integration of information and education, family planning, sexual and reproductive health measures into activities to reduce PPTCT;[77]

- Appointment of lady health workers to reduce barriers associated with women's access to health services provided by men;[78]

- HIV prevention among survivors of gender-based violence (including MSM and TG) through improved referral services, expansion of services to MSM and TG, and sensitisation of service providers;[79]

- Gender-specific outreach services and measures to protect female outreach workers during their work;[80]

- Activities to address gender dimensions of risk behaviours by men and women such as higher smoking rates among men and women's traditional caring role;[81]

- Activities to improve services to women based on their recognition as an underserved population;[82]

- Encouraging improved health-seeking behaviour by men through traditionally male unions;[83] and

- Inclusion of intimate partners of key populations in prevention programming.[84]

[74]Cambodia – HIV; Cambodia – TB; Indonesia – HIV/TB; Indonesia – Malaria; Pakistan – TB; PNG – HIV; PNG – TB; Philippines – HIV; PNG – Malaria; Viet Nam – TB/HIV; RAI.
[75]Cambodia – TB.
[76]Indonesia – TB/HIV; Philippines-HIV.
[77]Indonesia – TB/HIV
[78]Pakistan – TB.
[79]PNG-HIV; Indonesia HIV/TB.
[80]PNG – HIV.
[81]PNG – TB.
[82]PNG – TB.
[83]Viet Nam – TB/HIV.
[84]Indonesia – TB/HIV; VN – TB/HIV.

While many of the gender activities included (particularly in malaria concept notes) only addressed sex-based biological vulnerabilities the activities described in Box 7 demonstrate a strong understanding of how gender norms and inequality impact access to health services. Some are strategically tailored to address challenges in the specific country-context and clearly linked to epidemic dynamics such as the growing number of infections among women from outside key populations, historically considered low-risk. Others responded to common challenges within the region such as gender-based violence, intimate partner transmission, risks associated with men's health-seeking behaviour and women's caring roles. These provide examples for implementation in other countries.

The descriptions of gender inequality included in the country context sections of the concept notes however highlight the narrow understanding of gender in many countries. Gender is treated as a proxy for 'female' in most countries, excluding transgender people and cis-gender men from any consideration of gender-based risk and gender inequalities. Sex-disaggregated data is typically included and where men bear a greater burden of the disease, the epidemic is treated as gender-blind – this is particularly common for TB and malaria. As interviews with key informants from the RAI revealed, understandings of how gender is relevant to malaria are particularly nascent. Despite the focus on women and acknowledgment of grave abuses of women's rights in the country context descriptions, these issues are rarely addressed in funding requests. The Cambodia HIV concept note for example cites evidence of pregnant women living with HIV being forcibly sterilised and undergoing coerced abortion yet no related activities are included in the funding request. Gender priorities are therefore often not recognised due to narrow understandings of the concept and those issues that are acknowledged are not translated into funding requests.

Box 8: Examples of rights activities in concept notes

Just over half of the concept notes reviewed included rights activities.[85] Just one of those concept notes was for Malaria.[86] Rights activities included:

- • funding for technical assistance to provide guidance on human rights;[87]
- •CSS measures aimed at creating an enabling environment for the TB;[88]
- •Creation of discrimination response teams;[89]
- •Establishment of legal services and collaboration with legal aid;[90]
- •Removal of barriers to accessing services through advocacy, workshops to improve awareness of rights-based approaches to HIV services and sensitisation of community leaders to reduce stigma and discrimination;[91]
- •Efforts to address employment discrimination against TB patients;[92]
- •Police and community liaison officers to sensitise police, train communities in their rights under domestic law and facilitate meetings and agreements between police and service providers delivering need/syringe programs;[93]
- •Advocacy for law reform to reduce the legal age for anonymous HIV testing;[94]
- •Activities to address legal barriers to CSO and CBOs' participation in the HIV/TB response;[95] and
- •Capacity-building among CSOs to improve their ability to identify rights abuses, act as paralegals, monitor rights and advocate on rights issues.[96]

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[85]Cambodia – TB; India – HIV/TB; Indonesia – HIV/TB; PNG – HIV and Philippines – HIV.
[86]RAI.
[87]Cambodia – TB.
[88]India – HIV/TB.
[89]India – HIV/TB.
[90]Indonesia – HIV/TB.
[91]Indonesia – HIV/TB; PNG – HIV; Philippines – HIV.
[92]Indonesia – HIV/TB.
[93]Philippines – HIV.
[94]Philippines – HIV.
[95]Viet Nam – TB/HIV.
[96]Indonesia – TB/HIV; Viet Nam – TB/HIV.

The potential value of rights programming is also limited by narrow conceptions of human rights. Viet Nam's HIV/TB concept note is the only request reviewed in this study to identify suppression of community groups as a rights issue and challenge to CSS. Interviews with key informants and research on implementation of the new funding model indicate that limitations on community mobilisation and activities are a serious impediment to community involvement in health responses in Cambodia. That this is not reflected in the concept note country context or funding request may reflect the extent of in-country suppression or an example of the broader failure to recognise limitations on collectivisation this as a rights issue.

Substantial guidance on rights and gender in Global Fund work is now available. However, continuing poor rates of inclusion in concept notes and narrow understandings suggest that dissemination may not have been effective or the guidance not sufficiently practical or tailored to the diseases and country contexts. The need for stronger guidance for TB and malaria is recognised and the Global Fund has committed to releasing more detailed guidance later this year (2016). The inclusion of rights and gender issues in country context and analysis sections of concept notes but not in funding allocations or Performance Frameworks also suggests that the impact of resistance to including gender and rights priorities in a meaningful way should not be dismissed. Interviews conducted as part of research on "Reducing human rights barriers to services through strengthened community engagement in Global Fund malaria grants" described 'push back' from the malaria community in relation to the promotion of CRG issues based on a commitment to universal coverage'.[97] This understanding suggests the need for stronger articulation of how focussing on most-at-risk groups relates and contributes to achieving universal access, particularly given the increased push for universal healthcare under the Sustainable Development Goals.

The failure to include rights and gender priorities discussed in country context analysis in the funding request or Performance Framework identified in this study is consistent with a global review of concept notes conducted by the Global Fund in 2011.[98] That study identified a cascade in the inclusion of human rights in concept notes from analysis sections through to the description of programs and identifiable budget allocations. The cascade is demonstrated in Figure 4, taken from that report.

Figure 4: Global Fund concept notes (malaria) that include Human Rights programs[99]
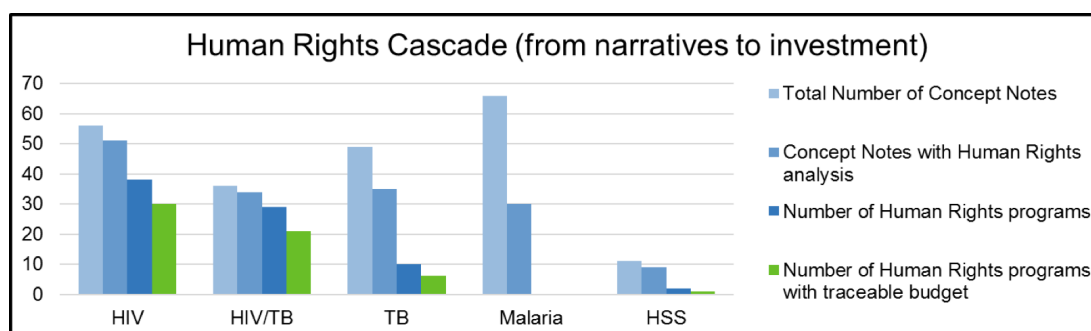
[97]*Global Fund* (2016) *Reducing human rights barriers to services through strengthened community engagement in Global Fund malaria grants: Summary of kickoff interviews.*
[98]Global Fund (2016) *Strengthening community engagement in Global Fund malaria grants: Summary report of Data Analysis.*
[99]Ibid.

The cascade effect was also apparent in this study, in the failure to include measures for CRG priorities in Performance Frameworks. The current Performance Framework template requires the inclusion of a "CSS" and "Removing Legal Barriers" modules as 'essential supporting modules' (there is currently no equivalent for gender activities, though the addition of a gender module has been proposed by studies in the region). [100] However, just five of the 16 Performance Frameworks considered in this study included either "CSS" or "Removing legal barriers" modules,[101] three included both,[102] and PNG included a gender-based violence module in the Performance Framework for its HIV concept note.[103] Despite being described in guidance documents as 'essential', the 'supporting modules' are clearly not considered mandatory, even where rights and CSS activities are included in concept notes. All of the submissions without "CSS" or "Removing legal barriers" in their Performance Framework passed Global Fund processes demonstrating that fund portfolio managers, technical review panels and the Grants Allocation Committee did not enforce the requirement. Performance Frameworks should correspond to concept note content so it is logical that countries whose without rights or CSS activities should not include equivalent modules in their Performance Frameworks. However if Performance Framework guidance characterises "CSS" and "Removing legal barriers" modules as mandatory, this messaging should be consistent across Performance Framework and concept note templates.

Global Fund template requirements have proven effective in improving analysis of rights and gender priorities and funding allocations to key populations and Global Fund approval processes are an important last opportunity to ensure CRG priorities are included. Enforcement of Global Fund guidance and policies through review processes can boost the inclusion of CRG priorities as was demonstrated in concept notes reviewed for this study where fund portfolio managers and technical review panels insisted on the inclusion of CRG priorities in concept notes.[104] In Pakistan Fund Portfolio Manager interventions assisted advocates to ensure full funding of activities by the Association for People Living with HIV, in Cambodia close oversight and emphasis on CRG priorities resulted in a notably strong HIV concept note and in PNG requirements for change by the technical review panel resulted in the addition of gender activities in the HIV concept note and a gender-based violence module in the Performance Framework.

In some instances, failure to include human rights priorities in a substantive way is also due to recognition that governments are not willing to change legislation to comply with human rights and a feeling that investment in this area would be wasted. Guidance and technical assistance should look to how grants to support rights priorities can be used effectively in these contexts. Community representatives in the region regularly request guidance on working in conservative political and religious contexts.[105]

Where rights and gender priorities were included in the concept notes reviewed for this study they tended to reflect understandings of the impact of these issues in-country based on past research and advocacy. The PNG HIV concept note for example reflects the well-established evidence of extreme levels of gender-based violence in the country. Similarly, the inclusion of efforts to address stigma and discrimination against MSM and TG across a number of countries reflects concerted work within the region to

[100]APCASO (2016).

[101]Cambodia – HIV; Cambodia – Malaria; Cambodia – TB; Indonesia – HIV/TB; Philippines – HIV/TB; Viet Nam – HIV/TB.

[102]Cambodia – HIV; Indonesia; TB/HIV; Viet Nam – HIV.

[103]Note: Performance Frameworks for Pakistan were not made available to this study.

[104]See: Cambodia – HIV; Pakistan – HIV; PNG – HIV.

[105] APCASO (2016).

demonstrate the need to reduce barriers to access to services for these populations in the context of the HIV response. These findings underscore the importance of research and advocacy on rights and gender issues to ensuring these issues are recognised and understood in-country for inclusion in Global Fund concept notes. It also suggests that increased uptake of CRG technical assistance is important to improving the incorporation of rights and gender issues in concept notes.

4. All concept notes included references to community-led activities and CSS, though the meaning of these terms was not always clear or consistent with newer understandings of CSS as a means of empowering communities and promoting key populations as equal partners in decision-making. Most CSS activities fall short of the empowerment and sustainability goals of newer understandings of CSS; promoting greater understanding and inclusion of community priorities in concept notes is complicated by the lack of a clear definition of "community" or "CSS".

All of the concept notes reviewed in this study incorporate community-based and CSO-led activities, including service delivery and activities aimed at engaging communities more broadly. However the term "community" is understood in different ways, not all of which reflect an understanding or commitment to the value of engaging and empowering communities of key affected populations. This finding is consistent with a review of Global Fund work on CSS which found that 'the term has been 'understood in diverse ways by governments and policy-makers'. [106]

Box 9: Examples of community-led and CSS activities:

- •Community-led service delivery such as outreach and peer education, community-based testing, distribution of risk reduction commodities and demand creation;[107]
- •Peer-run activities to inform programming, such as mapping of key populations and community-based monitoring of services;[108]
- •Engagement of voluntary/community health workers;[109]
- •Social mobilisation, advocacy, sensitisation, behavioural change communication and information and education communication campaigns;[110]
- •Capacity building for and by community organisations;[111]
- •Engagement of community-based and CSOs in decision-making bodies and advisory boards[112]; and
- •Core funding to CSOs and networks.[113]

In development discourse, the term community is often used to refer to CSOs, CBOs and communities of key populations shared understanding of this meaning is frequently assumed in advocacy, policy and guidelines. This is however not the only meaning attributed to the word. The Global Fund CSS Framework itself explains that 'community' is a 'widely used term that has no single or fixed definition'. Understandings of the term "community" have implications for CSS. The absence of a clear definition of "community" in the context of the CRG Special Initiative's mandate, and the shifting definition of CSS complicates efforts to advocate for and build understandings of the empowerment model promoted by the Global Fund Performance Framework.

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[108]Cambodia – malaria; India-TB/HIV PNG-HIV; Philippines-HIV.
[109]Cambodia – TB; PNG-Malaria; Pakistan-Malaria; Viet Nam-Malaria; RAI.
[110]India-HIV/TB; India-Malaria; Pakistan-TB; Philippines-Malaria; Philippines-TB; RAI; Viet Nam-Malaria; Viet Nam-TB/HIV
[111]Indonesia-HIV/TB; PNG-HIV; Philippines-HIV; Viet Nam-TB/HIV.
[112]India-HIV/TB; Pakistan- TB.
[113] Pakistan – HIV; PNG – HIV.

Some activities identified in this study, such as peer-outreach and education, mapping of key populations and community-based monitoring of services directly engage communities drawn from key affected populations. These were most common in HIV concept notes.

Other activities engage broader communities, for example through mass education and communication campaigns on identifying TB and malaria symptoms. For some activities however, the meaning of 'community' was left unclear. Community-based service delivery, recruitment of voluntary health workers and community clinics did not specify whether implementing staff and volunteers would be drawn from communities of key affected populations or whether the word 'community' referred to a geographic concept of community, in the sense of local-level service delivery. While local-level services are essential to reducing geographical barriers to accessing services and may be entirely appropriate for primarily geographical key populations, they do not fulfil the same requirements as peer-led service delivery. Where key populations are stigmatised, locally-based healthcare providers may create concerns about confidentiality and a disincentive to treatment-seeking.

The Global Fund CSS Framework describes CSS as enabling community actors to 'contribute as equal partners alongside other actors to the long-term sustainability of health and other interventions at the community level, including an enabling and responsive environment in which these contributions can be effective'.[114] However most of the community activities in Global Fund concept notes reviewed for this study seek to promote community as service providers at most. Only two concept notes (Indian HIV/TB and Pakistani TB concept note) described activities that create space for the inclusion of community-based or CSOs in decision-making roles, though CSO the Spiritia Foundation will also have a decision-making role as one of the principal recipients for the Indonesia TB/HIV grant.

Community-led service delivery is an essential component of the HIV, malaria and TB responses and particularly crucial to reaching hard-to-reach populations. However, without the ability to contribute to decision-making, CSS activities fall short of the requirements of the Global Fund Performance Framework. Even where roles on decision-making bodies are created for community, the extent to which this enables them to influence decisions – the terms of the partnership – are not clear from concept notes. Key informants also note that community representatives are frequently outnumbered in these settings and require support to participate effectively in what may be hostile or unfamiliar settings.

The value of community activities in relation to the epidemics in each country context therefore varies significantly, particularly across diseases. Work is required to clarify the meaning of "community" and "CSS" in the context of Global Fund work and the work of the CRG Special Initiative in particular. This should include an emphasis on key populations as equal partners in decision-making and support to representatives to fulfil that role.

114 Global Fund (2014).

5. Funding allocations for CSS, rights, and gender priorities tended to be low, relegated to above allocation funding or among the most precarious commitments made in concept note development. The following enabling factors were important to ensuring CRG issues survived the concept note development process for inclusion in Global Fund grants: strong existing community systems; meaningful community dialogue; CSOs/CBOs as principal recipients;

Supportive global fund staff were critical enabling factors for realising CSS, rights and gender priorities requires years of advocacy and community engagement – from national strategic plan development through to oversight of Global Fund grant implementation. Maintaining this pressure requires long-term support to CSO and CBOs and commitment from all sides to engaging community as equal partners in decision-making. Core funding and capacity development are foundational aspects of that full-funding cycle support. The following factors are critical enabling factors for the inclusion of CRG priorities in concept notes.

Strong existing community systems and meaningful community dialogue
Strong existing community systems were the clearest factor for the inclusion of community and rights priorities in concept notes reviewed for this study. This HIV community's ongoing and historical role in leading the response and interviews with key informants indicate that the inclusion of CRG priorities is strongly dependent on the strength of community advocates. Strong communities are necessary, first to support community dialogue processes and demand that they ensure communities are engaged. This was particularly evident in India and the Philippines where community advocacy was necessary to supplement the HIV community dialogue (Philippines) and demand new meetings to ensure the inclusion of TB activists (India).

Across the concept notes considered, the strongest in terms of including CRG priorities were the Indonesia and Viet Nam combined HIV/TB concept notes, and the PNG and Philippines HIV concept notes. Key informants from Indonesia, Viet Nam and the Philippines all reflected on the role that CSO and CBOs, already well established when the community dialogue commenced played in ensuring that process was representative and that CRG priorities were maintained as far as possible over the course of the concept note development and negotiation. Community-based organisations played a strong role in shaping the PNG concept note and specific organisations are allocated clear roles throughout the concept note, although key informant interviews indicate that this recognition has not always carried through to implementation. This is an important reminder that commitments made in concept notes will not necessarily flow through to implementation and that strong community systems and community-friendly representatives on the CCMand Global Fund staff all have a role to play in protecting gains made during the concept note development process. Key informants also warned that without core funding to CSO and CBOs, gains made in terms of CSS could quickly be lost.

The strength of community systems in Indonesia, Philippines and Viet Nam is widely recognised. Indonesia is also the only country included in this study to have a community-based organisation as a principal recipient. Community-based organisations in Viet Nam also had the benefit of capacity building on the new funding model in the lead up to concept note development. Dr. Khuat Thi Hai Oanh, a key informant for Viet Nam, commented that the Community Advocacy Initiative new funding model training had been beneficial not just in improving knowledge of the process but in creating opportunities to bring community together and coordinate prior to concept note development.

This finding highlights the importance of community strengthening as well as the continuing benefits of investment in communities. The CRG Special Initiative is particularly well-placed to promote these benefits through its technical assistance programme which is currently specifically available for the period prior to grant. Long-term community capacity building through the Robert Carr CSO Networks Fund component of the CRG Special Initiative also has the potential to contribute to this process of building up community, not just through Global Fund grants but to shape funding requests. The importance of strong communities as a foundation for creating high quality concept notes suggests that the benefits of work completed to-date under this component of the program may not be apparent until future funding rounds.

CSO / CBOs as principal recipients

Key informants from Cambodia, Indonesia, Philippines, Pakistan and Viet Nam commented all commented on the value of having a CSO or community-based organisation as a principal recipient. This was identified as particularly important during negotiations on budget allocation and in making changes based on Global Fund Technical Review Panel comments to gain approval for grant. Key informants noted that commitments made during community consultations on CRG priorities and raised within the CCM survive negotiations and are adequately reflected in budget allocations. Although CSO and CBOs were sub-recipients in a number of the countries in this study, [115] all of these organisations were primarily HIV-focussed. This again reflects the more advanced state of community mobilisation in the HIV response and subsequently greater recognition of community capacity. Indonesia was the only country in this study to have a CSO (the Spiritia Foundation) as a principal recipient and its HIV/TB concept note is among the strongest in this study in terms of the inclusion of CRG priorities. Daniel Marguari, executive director of the Spritia Foundation specifically noted the importance of the organisation having the capacity to rework budgets to protect CRG priorities during budget negotiation, during his key informant interview. Dr. Khuat Thi Hai Oanh from the Centre for Community Development, Viet Nam also noted the importance of principal recipient status to having a seat at the table during these negotiation stages. The Pakistan Association of PLHIV, a sub-recipient under the country's HIV grant currently intends to apply for principal recipient status in the next Global Fund round. This finding suggests that the promotion of CSO and CBOs as principal recipients through Global Fund policy and CSS aimed specifically at allowing CSO and CBOs to operate as principal recipients could improve the inclusion of CRG priorities in future concept notes.

Allocations for CSS, rights and gender priorities tended to be low, relegated to above allocation funding or among the most precarious commitments throughout concept note development. Evidence from key informants of commitments to address CRG priorities made at the community dialogue stage but later dropped, or included in the concept note narrative but not funding allocations suggest that CRG priorities were among the most precarious commitments made during concept note development.

This study does not directly assess or compare budget allocations to CRG priorities as they are typically not identified separately but bound up in broader allocations for example to key populations. The Philippines concept note was one of few to provide a breakdown of funding allocations that allowed identification of rights (removal of legal barriers to access) and community (CSS) priorities. These received the equal and second lowest allocations of eight allocation areas, although the adequacy of CRG allocations cannot be measured by the proportion of the allocation. As key informant,

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[115] India – HIV/TB; PNG – HIV; Pakistan – HIV/TB; Cambodia – HIV.

Dr. Khuat Thi Hai Oanh (Viet Nam) explained, budget allocation 'is a balancing act, if you spend more money on one thing you have less to spend on another'. Some activities may simply cost more than others, although Dr. Khuat Thi Hai Oanh also explained that 'what we are not happy with [under the current Viet Nam concept notes] is that it is still heavily heavily focussed on service delivery. It is not focused on community. Compared to other countries our allocation is better but we do not have enough money in the allocation to put to CSS'. Allocations to community activities under the Viet Nam TB/HIV and malaria concept notes were more likely to be above the allocation. This finding is only possible in relation to Viet Nam because the concept note clearly identifies where funding comes from within and above the allocation in relation to specific activities, other countries do not provide the same level of specificity. This further highlights the limitations of concept notes as a means of holding countries accountable to their commitments – a number of key informants, including those from India working across HIV, TB and malaria noted that there should be a minimum requirement for allocations to CSS.

CRG priorities appear to be treated as 'bonus' inclusions in concept notes, while other activities such as treatment and health systems strengthening are considered essentials. While service delivery activities may have the most direct and essential impacts on the three epidemics, CRG impact the effectiveness of those interventions. The priority given to CRG issues in current concept notes does not appear to reflect an understanding of the extent to which the effectiveness of other activities rely on addressing CRG issues. Advocacy to improve this understanding may result in CRG priorities receiving more attention in future concept notes.

Supportive Global Fund staff with a strong commitment to CRG issues.

Key informants also commented on the importance of having supportive or 'community-friendly' Global Fund staff with strong understandings of CRG priorities in-country. Fund portfolio managers were identified as particularly crucial allies,[116] although Technical Review Panel and secretariat staff were also recognised by key informants in some countries for their work to ensure that CRG activities were added to concept notes or that community dialogue processes included key affected populations.[117]

Key informants from Viet Nam and Pakistan described the relationship with Global Fund staff as a supportive one, 'we help each other', Dr. Khuat Thi Hai Oanh said during her key informant interview. Asghar Satti, executive director of the Association of PLHIV in Pakistan also reflected on the importance of communities building relationships with Global Fund staff and assisting them to understand community priorities, "we invited him [the Fund Portfolio Manager] to visit our office and see how we are caring for people" Mr Satti explained. Ensuring that Global Fund staff are sensitive to CRG issues and promoting stronger relationships between community and in-country Global Fund staff, in particular Fund Portfolio Managers may improve the inclusion of CRG issues in future funding rounds.
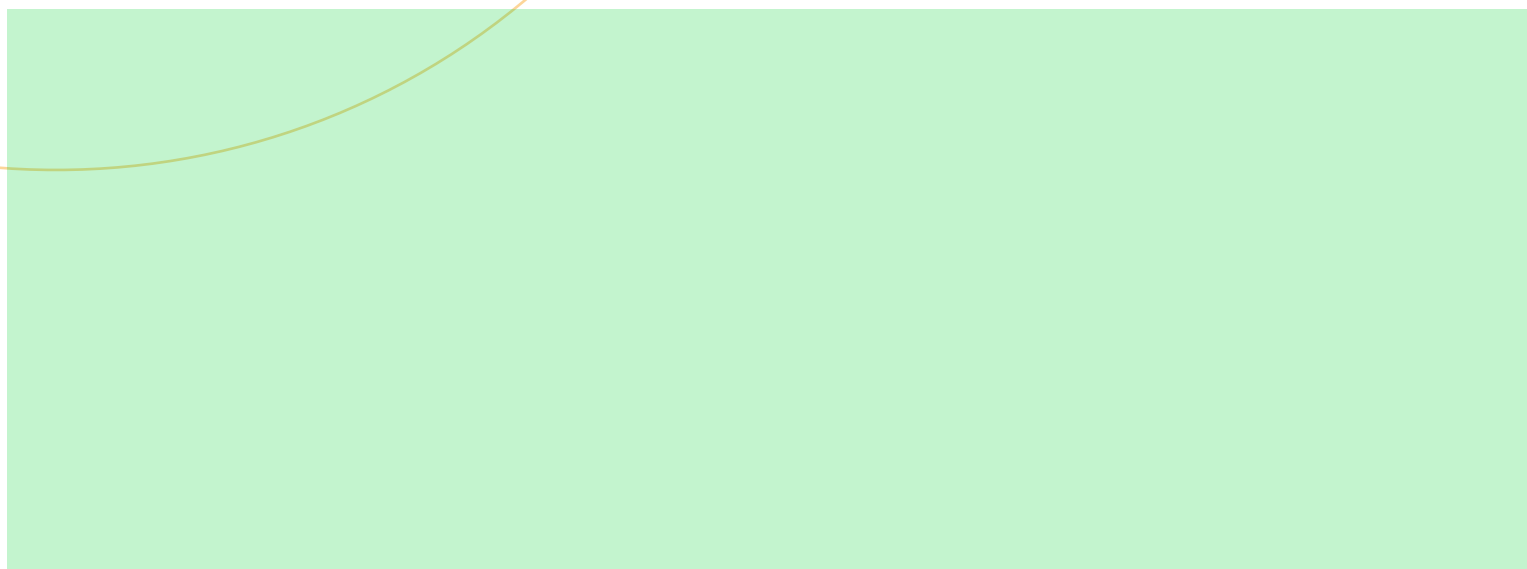
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[116] Key informant interviews: Cambodia and Pakistan.
[117] Key informant interviews: Pakistan and PNG.

PART 3

RECOMMENDATIONS

The following recommendations are made based on the findings from this study. Most are relevant to a range of actors involved in the development of Global Fund concept notes, grant expenditure and in-country CSS interventions. Such actors include the Global Fund, CCMs, national governments, UN agencies, NGOs, CSO and CBOs and other advocates. While some of these actors will have the power to implement recommendations directly, all can advocate for their enactment. The recommendations are as follows:

1. Building on the success of efforts to focus responses on key populations

1. **Recognising key population subgroups:** Concept notes should identify and describe activities aimed at responding to the needs of specific key population subgroups. This is essential for accountability and ensuring particularly marginalised subgroups are not excluded.

2. **Representation for key population subgroups:** Representatives from all of the most critical key populations for all of the diseases should be included in CCMs to ensure coverage of diverse needs and build the support-base for community representatives.

3. **Young key populations:** Activities for young key populations should be included in concept notes and young key populations should be supported to participate in concept note development processes.[118]

2. Promoting and improving understandings of CRG priorities

1. **Collaboration:** Opportunities for malaria and TB advocates to learn from the experience of HIV community networks and CSOs should be supported and opportunities for collaboration across the three diseases should be promoted (including through CCM processes).

2. **Technical assistance on rights and gender:** Technical assistance and guidance should address poor understandings of human rights and gender, particularly in the context of malaria and TB responses, including through practical programme intervention examples.

3. **Building shared understandings of "community" and "CSS":** Technical assistance and guidance should provide specific details on how the terms "community" and "CSS" should be understood and operationalised to empower key populations in the context of HIV, malaria and TB responses. The CRG Special Initiative should developing a clear definition of "community" in the context of its mandate.

4. **CRG in difficult working environments:** Global Fund and supporting mechanisms such as the CRG Special Initiative and APCRG should develop detailed guidance on working on CRG issues in difficult working environments including under conservative cultural, religious and political environments and where community mobilisation is still in its infancy and unlikely to be able to advocate adequately for their own capacity building, in order to highlight interventions that have been endorsed and effective in other contexts.[119]

[116] APCASO (2016).
[117] APCASO (2016).

5. **Better use of guidance:** New and existing guidance on human rights and gender in Global Fund work must be promoted and disseminated more effectively. This should include promotion of guidance in relation to the "Removing legal barriers" module under the Performance Framework in relation to TB and malaria responses.

6. **Promoting CRG for sustainable responses:** CRG principles should be promoted as essential to sustainable responses to HIV, TB and malaria, particularly through increased support for CRG priorities through domestic funding. Directions on counterpart financing should require countries to demonstrate support for CRG priorities.

3. Strong communities as a foundation for further strengthening community systems

1. **Community dialogue:** Global Fund and other stakeholders should systematically support early, sustained and independent engagement of CSO, CBOs and key populations in the country dialogue as well as ongoing monitoring.[120]

2. **Building strong communities:** Initiatives to build and strengthen communities and to develop their capacity to participate in concept note development such as the Community Advocacy Initiative and work under the CRG Special Initiative should continue and be promoted for increased uptake.[121]

3. **CSOs and CBOs as principal recipients:** The benefits of CSO and CBOs as principal recipients should be promoted and capacity building should be tailored to enable interested organisations to operate as effective principal recipients.

4. **Full-funding cycle for communities:** All actors in the HIV, malaria and TB responses must commit to sustained community engagement to ensure CRG priorities are included in concept notes and realised through grant implementation. This requires full-funding cycle support including core funding to ensure CSS gains are not lost, capacity building and in-person assistance to ensure communities are treated as equal partners in decision-making and ending the epidemics.

4. Making Global Fund mechanisms work for community

1. **Global Fund allies:** Global Fund are important allies for advocates working to increase the inclusion of CRG priorities in concept notes. Capacity building for Global Fund staff should cover the importance of CRG priorities, how those priorities can be operationalised and the role that Fund Portfolio Managers, Technical Review Panels and others can play in supporting community and the inclusion of CRG issues in concept notes, including during the development and budget negotiation process.

2. **CCMs:** CCMs should be sensitised around meaningful engagement of key populations, gender and human rights programming perspectives. This should be supported through oversight and country visits by fund portfolio managers and the APCRG, and through requirements for inclusion of multiple community representatives in CCM technical working groups including the budget review committee.[122]

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[120] APCASO (2016).

[121] The Community Advocacy Initiative (CAI) 2008-2015, supported community and civil society to translate international HIV financing frameworks into credible, relevant and effect national advocacy. CAI was been jointly implemented by APCASO and the Australian Federation of AIDS Organisations, in partnership with HACC, Cambodia; CHAIN, China; LaoPHA, Lao PDR; and, SCDI, Viet Nam. CAI was funded by the Australian Government. An independent evaluation can be found at: http://apcaso.org/lessons-from-the-community-advocacy-initiative/

[122] APCASO (2016).

3. **Ensure review:** Ensure inclusion of CRG components in concept notes and Performance Frameworks are properly reviewed and covered in feedback as part of the Fund Portfolio Manager, Technical Review Panel and Global Fund Advisory Committee reviews for all diseases.

5. Improving accountability

1. **Minimum funding allocations:** Global Fund strategy requiring minimum funding allocations to key populations has been effective. Countries should also be required to make minimum funding allocations to CRG priorities. This could be achieved through stipulations in the Global Fund concept note template, in overview by the Technical Review Panel or agreed within each country coordination mechanism.

2. **Performance Frameworks:** A gender module should be included as an essential supporting module.

3. **Community charters:** The APCRG should support Asia-Pacific countries to develop charters of CRG priorities in preparation use in ongoing community dialogue and future funding rounds, building on experience in East African countries.

4. **Making key documents publically available:** Concept notes are available on the Global Fund website but key attachments including Performance Frameworks, essential for community monitoring and advocacy are not publically accessible. All concept note attachments and other key documents essential to holding countries accountable to commitments made in concept notes must be made accessible, in local languages, without request to the CCM or government.

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Country Sources

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	Performance Frameworks: HIV, Malaria, TB.
	Key informants: HIV/AIDS Coordinating Committee; KHANA
India	Concept notes: Malaria, HIV/TB.
	Performance Framework: Malaria, HIV/TB.
	Key informants: Global Coalition of TB Activists; National Coalition of PLHIV in India; Sahara Centre for Residential Care and Rehabilitation (Stop TB Partnership)
Indonesia	Concept notes: Malaria, HIV/TB
	Performance Framework: HIV/TB.
	Key informants: Spiritia Foundation; GAYa NUSANTARA Foundation
Pakistan	Concept notes: HIV, Malaria, TB
	Performance Framework: Not provided.
	Key informants: Association of People Living with HIV
Papua New Guinea	Concept notes: HIV, Malaria, TB
	Performance Framework:
	Key informants: Igat Hope
Philippines	Concept notes: HIV, Malaria, TB.
	Performance Framework: HIV, Malaria, TB.
	Key informants: Achieve; TLF Share; Global Fund Advocates Network.

Viet Nam	Concept notes: Malaria, HIV/TB.
	Performance Framework: Malaria, HIV/TB.
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RAI	Concept note: RAI (Malaria)
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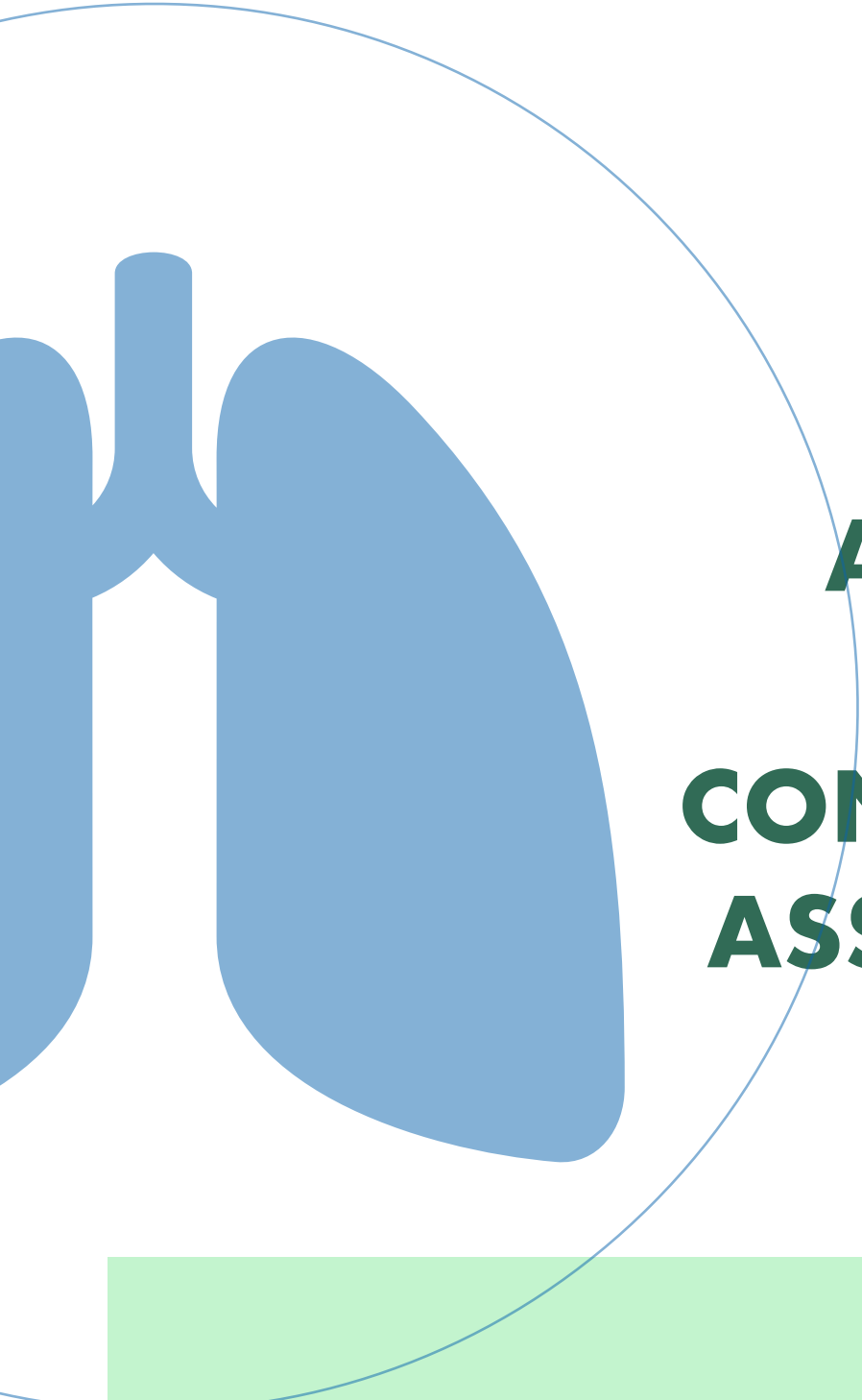
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ANNEX A

CONCEPT NOTE ASSESSMENTS

Cambodia

Epidemic Context		
HIV The epidemic is primarily urban and concentrated among entertainment workers (female sex workers), MSM and TG. Spousal transmission is the most common form of transmission though prevalence among PWID is high and increasing. Stigma, lack of access to clean needles and women's economic vulnerability create barriers to accessing services.	**TB** Cambodia is one of 22 countries in the world with a high TB burden, among those countries it has the second highest TB prevalence and highest mortality rate. High travel costs, challenges reaching indigenous populations, poor referral systems for prisoners and people detained prior to deportation to Cambodia are identified as constraints on the TB response.	**Malaria** More than 50% of the Cambodian population live in malaria endemic areas. Most cases occur among males aged 15-49 years. Key populations are at higher risk due work in endemic locations with limited facilities. Cultural and linguistic barriers and fear of arrest (for illegal forest workers) create barriers to accessing services. Increasing numbers of women and young children moving with male workers to high-risk areas is growing cause for concern.
Key populations	Key populations	Key populations:
• Entertainment workers • MSM • TG • PWID • PLHIV • Prisoners • Migrants	• PLHIV • Pregnant women and children • Prisoners • Internal and external migrants • Indigenous people • Persons with diabetes • Elderly persons • TB contacts • Poor and near-poor	• Construction/ mining workers, • Security personnel (military and police) • Seasonal workers • Indigenous population groups

HIV concept note and Performance Framework	Ratings	C ✪★	R ✪★	G ✪

The HIV concept note has a strong focus on community priorities, primarily through investment in key populations. Prevention, treatment, care and support programming for entertainment workers, MSM, PWUD and TG, and their partners are included, though there is no reference to activities for prisoners or migrants.

The Performance Framework includes assessments of PLHIV and key population network capacities and technical assistance to fill identified gaps including in relation to strategic information, as well as efforts to strengthen linkages between PLHIV and key population networks, broader CSO movements on HIV, TB, malaria, gender, health and human rights at local, national and international levels. Community networks are also assigned tasks under the concept note:

• peer education incorporating delivery of prevention commodities, behavioural change communication, social marketing in relation to condoms and

• engagement of most at risk populations in delivering training, including to frontline officers and police leaders through the Most at Risk Populations Community Partnership Initiative and efforts to link the program to networks of outreach workers and 'other community programming'.

Key informants however noted that lack of core funding for CBOs presents an implementation challenge and noted that funding allocations fail to recognise that engaging hard-to-reach populations in a declining epidemic is more costly and difficult as CBOs are now being asked to locate the epidemic's most hidden populations.

The Performance Framework details rights activities under the "removing legal barriers" module including:

- sensitisation of law enforcement, NGOs and key population leaders on legal barriers to accessing services;
- review of the Most-at-risk Communities Partnership Initiative – this includes activities to address the negative impact of new legislation on PWID's access to services and harm reduction programming described in the concept note
- training for labour inspectors and enforcement of the proclamation on labor rights for entertainment workers
- advocacy for review of the HIV/AIDS Law and to ensure PLHIV are able to access social protection – Cambodia is the only country in this study to recognise and address social protection as a rights and access issue
- Capacity building among communities for monitoring and reporting on the implementation of laws and rights abuses.

Although efforts to reduce stigma and programming for MSM, TG and entertainment workers may address challenges that stem from strict gender norms, just two specific gender activities are included:

- strengthening linkages between PLHIV and key population networks and CSOs working on gender as part of CSS measures and

- review of the Most-at-risk Communities Partnership initiative, including to ensure that it is gender sensitive.

While these measures are promising, they are inadequate in light of the fact that women from outside key populations are now the country's largest cohort of PLHIV.[123] Well-documented incidents of forced sterilisation and coerced abortion among women living with HIV may be addressed through rights activities but are not discussed with a gender lens.

Malaria concept note and Performance Framework	Ratings	C ✪	R ?	G ?

Key populations are prioritised through activities targeting people in high-risk areas and mobile and migrant populations under the vector control module. The concept note contained a standalone CSS module, useful for clearly identifying budget allocations, though CSS activities were also included under the case management module. Activities include

- key population mobile population outreach pilot activities to map areas with high rates of transient/mobile communities and provide information, services and referrals

- building relationships between voluntary malaria workers, health facilities and 'key community members' such as village elders and mothers' groups to improve mobilisation, prevention and referrals through symptom identification.

[123] UNAIDS Stats

The extent to which voluntary health workers are drawn from key populations is not clear from the concept note though recruitment of voluntary health workers from this community including partners of the (mostly) men whose work places them at risk would be a valuable means of improving linkages between community and the health system and addressing this emerging risk group. The Performance Framework includes the number of people who report a voluntary health worker as a first point of contact as an indicator under the CSS module, including the number of volunteers recruited from affected communities may be a valuable inclusion in future funding rounds to ensure that these measures enhance the ability of key populations to participate in the response.

No rights or gender-specific activities are included in the concept note or Performance Framework.

TB concept note and Performance Framework	Ratings	C ✪★	R ✪	G ✪

This concept note stands out among TB concept notes for its commitment to CSS. Funding for activities by NGO sub-recipients is allocated through a standalone CSS module. CSS coordinators will be hired to build capacity among existing voluntary health support groups, community-level clinics and monks for community-based monitoring for accountability, advocacy and social mobilisation. Funding will also be provided for technical assistance on CSS and continued engagement with key populations for ongoing country dialogue, including through expansion of the TB Interagency Coordination Committee to include those who work with key populations and annual focus group discussions with key populations. Assurances relating to ongoing dialogue were won by community representatives during pre-concept note community dialogue, though the extent to which CSS activities place key populations, CBOs and CSOs in a decision-making role is not always clear with coordination and intermediary roles created in several instances that do not appear to be intended for community representatives.

Key population communities are specifically prioritised through:

• expansion of outreach activities, including development of a network of monks reaching out to elderly people visiting pagodas

• rapid-testing and SMS results notification to allow treatment to begin within five days including in prisons, antenatal and diabetes clinics.

The Performance Framework includes indicators in relation to people reached through outreach for case finding under the CSS module, the other indicator under this module is based on coverage of fast-track mechanisms (under the intervention title 'social mobilisation, building community linkages, collaboration and coordination').

Funding is allocated for technical assistance on rights and gender. Rights priorities also include sensitisation of healthcare providers using the TB Patients' Charter on the rights and responsibilities of patients. Key populations with multi-drug resistant TB will also receive food and transport assistance payments to reduce barriers to treatment adherence.

Additional analysis

Key informant interviews conducted by APCASO identified legal barriers to community mobilisation as a significant challenge. Failure to include this issue in the concept note may reflect the gravity of these sensitivities, as well as the reality that rights abuses against community activists and barriers to community participation are rarely conceptualised as rights considerations or relevant to creating a enabling environment for responses to the three diseases.

India

Epidemic Context	
Malaria While 82% of India's population lives in malaria transmission risk areas, 80% of malaria occurs among 20% of the population. That 20% are located in areas characterised by environmental risks, insecticide resistance, uneven health seeking among different ethnic groups, 'irrational' treatment by private providers, mobile agriculture, conflict zones and cross-border people movement. While prevalence and malaria deaths are relatively low, absolute case numbers are high.	**TB/HIV** India has the highest TB burden in the world and the third highest burden of HIV. It is a low prevalence, high burden epidemic - an estimated 2.1 million people are living with HIV. TB/HIV co-infection is common, 270,000 people die from TB each year and TB is the leading cause of death for PLHIV. The most common form of transmission is sexual (88.7%) followed by parent-to-child transmission. The epidemic is concentrated among key populations and geographically with 22% of infections in 4 provinces. Prevalence is highest among TG, followed by PWID, MSM and female sex workers. Key drivers for the epidemic are urbanisation, overcrowding, poor airborne infection control coupled with host factors including poor nutrition, HIV, diabetes and tobacco use. Key populations in relation to both diseases lack access to essential services. In the case of HIV this is largely due to stigma and poverty in the case of TB.

Key populations		HIV Key populations		TB Key populations:	
•Pregnant women •Children under 5 years •Mobile cultivators •Forest workers •Migrant and mobile populations	•Armed and paramilitary forces •PLHIV •Travellers from non-endemic areas •Indigenous groups	•PLHIV •Transgender •PWID •MSM •Female sex workers (FSW)	•"Bridge" populations: clients of sex workers, partners of PLHIV, truck drivers and migrants	•Tribal populations •People living in urban slums •Migrants •Refugees •Prisoners •People resident in remote areas •Contacts of TB cases	•Miners •People with co-morbidities or host conditions including HIV •Persons in exposed to silica

Malaria concept note and Performance Framework	Ratings	C ☢	R ?	G ?

The malaria concept note reflects community priorities in its attention to key populations, though primarily key populations are primarily defined based on geography with little attention to sub-populations. The extent to which non-geographical factors that increase vulnerability to the disease are addressed may therefore be limited. Funding is however specifically allocated to research on mobile and migrant populations are however specifically targeted for research and technical assistance is sought for cross-border work.

CSS receives the smallest identified budget allocation and a large proportion is above allocation making it difficult to determine which activities listed will receive funding. The concept note acknowledges that India's malaria response relies heavily on community health workers and that this represents an opportunity for empowering community through 'close to client' services. Funding is sought for capacity building to scale-up case management and development of new training and guidelines is identified as CSS. Other activities funded include school-based initiatives to create change agents through child-to-child and child-to-parent information dissemination, an approach not seen elsewhere in this study that engages with children as a key population. India's concept note is also unusual in seeking funding for advocacy targeting decision-makers, and campaigns to sensitise community leaders. Community consultations are included as advocacy activities though no activities point to increased opportunities for key

populations to participate in decision-making.

Universal healthcare is highlighted as a policy priority and means of addressing inequity in access to services. Given that achieving universal health coverage may take some time and that marginalised populations are often the last to benefit the rights of key populations need to be considered in the context of work toward universal coverage, particularly migrant and mobile workers who's citizenship status may exclude them from healthcare even expanded cover.

No interventions are specifically aimed at addressing gender priorities or applying a gender lens to policy design despite acknowledgement in the country context discussion of men and women's different vulnerabilities to the malaria.

HIV/TB concept note and Performance Framework	Ratings	C ✿★	R ✓	G ?

This concept note primarily prioritises key populations through treatment and CD4 testing for PLHIV as well as testing for coinfection among TB and HIV patients. Prevention and CSS are supported by continued funding to HIV/AIDS Alliance activities for outreach, support, care and reduction of loss to follow-up. A standalone CSS module is included covering community-based monitoring by community advisory boards (including representatives from key populations) at all care and support centres. Further activities include:

•district-level 'social accountability' activities by HIV/AIDS Alliance to support sensitisation of government service providers, private sector and community leaders

•state-level advocacy to increase PLHIV access to social protection

•government-PLHIV meetings on national HIV policy

•capacity and leadership development by HIV/AIDS Alliance to build district-level organisations for service provision, social mobilisation, monitoring and advocacy.

In contast to the HIV response, the concept note sets out in detail how different community actors and interventions will be engaged to reach out to specific key populations, including through workplace outreach for key populations made vulnerable by occupational factors, outreach to opinion leaders in urban slum clusters, mobile service for tribal populations and sensitisation of staff within prisons. Greater involvement of CSO is promoted through service delivery by community members, community education and advocacy for support from local administration. CSS activities will include the creation of enabling environments, advocacy, strengthening of community networks; resource and capacity building; organisational and leadership strengthening, monitoring and evaluation and planning.

The CSS activities in this concept note are comprehensive across TB and HIV. This may in part be due to the appointment of two HIV CSOs as a principal recipients, which key informants noted had 'created a place at the table' for community. TB activities are also notable given the typically medicalised response, though key informants cautioned that community input to decision-making remains low and that in reality implementation of activities has been limited.

Rights priorities may be supported by activities to create an enabling environment for the TB response, though insufficient detail is provided in the concept note. District-level Discrimination Response Teams will be appointed to assist PLHIV – a promising measure that should be evaluated for potential replication in other countries and across diseases. Key informants noted that evaluation of principal recipients against human rights and gender outcomes would likely improve responses in these areas. No gender-specific activities were included despite the impact of gender inequality and gender-based violence on access to health services and HIV transmission in India, acknowledged in the country context discussion.

Indonesia

Epidemic Context

Malaria

Indonesia's malaria epidemic is complex with multiple species of malaria carrying mosquito in different parts of the country and high-transmission "pockets" within lower risk areas. The five easternmost islands, which is home to just eight per cent of the population accounts for 70% of malaria cases. Poverty, residence in high-risk areas and makeshift accommodation are the most significant contributing factors.

TB/HIV

Indonesia is a high TB, high TB/HIV and high multidrug resistant TB burden country, and one of just 9 countries in the world where HIV infections are rising. It has the world's second largest TB prevalence burden. Rapid urbanisation, migration to urban areas and subsequent overcrowding contributes to HIV and TB transmission.

TB prevalence in men is more than double that in women, though TB is the fourth highest cause of maternal mortality.

The HIV epidemic has shifted from one driven by unsafe injecting practices to unprotected sex and high rates of STIs are a factor in increasing efficiency of transmission. Papua and the West Papua provinces have generalised epidemics where lower levels of education, knowledge of HIV prevention, access to services, condom use and male circumcision in combination with the country's highest rates of STIs contribute to transmission. Stigma, discrimination and punitive laws limit access to services for key populations.

Key populations		HIV Key populations		TB Key populations:	
•Miners •Migrant workers •Fisher people •Plantation workers	•Linguistic minorities •Pregnant women •Children under 5yrs	•TG/*waria* •PWID •MSM •Female sex workers (FSW)	•Prisoners •PLHIV •Sexual partners of people from the above populations	•PLHIV •People aged 65+ (men over 55 years will also be prioritised) •Prisoners •Urban poor	•Contacts of bacterially positive pulmonary TB •People with diabetes

Malaria concept note and Performance Framework	Ratings	C ✓	R ?	G ✓

Key populations are targeted on a geographical basis, with 90% of funding identified as allocated to rural areas. Services to difficult to reach populations will be improved through outreach, including by faith-based organisations like the principal recipient that have had success in reaching forest populations and through integrated services including integrated services covering information on other causes of death in young children and expansion of testing for malaria in pregnant women. CSS funding is requested for innovative programming including 'task-shifting' interventions to engage communities, NGOs and faith-based organisations for improved sustainability of the response and to reach the hard-to-reach. These activities however target existing organisations rather than seeking to mobilise communities of malaria affected persons through CSS.

There is no evidence of rights-specific activities, though expansion of services will address access rights including among marginalised ethnic groups.

Mosquito net distribution will target pregnant women on the basis of biological vulnerability. This intervention while gender-sensitive is not transformative – it does not address issues gender equality issues that limit women's access to services. Despite higher rates of infection among men due to gender roles that lead to their working in high-risk environments and the geographical focus of the request, no measures are described as specifically targeting men on this basis.

HIV/TB concept note and Performance Framework	Ratings	C ✿★	R ✿★	G ✿★

The concept note is strong in its focus on key population subgroups with community-led and tailored interventions included for MSM and TG, sex workers and clients, PWUD and partners. These include rare and innovative measures such as structural interventions for sex workers, creation of clinics for clients of sex workers, integrated TB/HIV testing and prevention activities, and integrated sexual and injecting transmission information and referral, and opioid substitute treatment and psychological support for PWUD and their partners.

CSS activities include empowerment of PLHIV through funding for home visits, peer support, focus groups and study clubs and improved services to TB key populations through increased work with CSOs. Community-based monitoring, advocacy for social accountability, social mobilisation, building community linkages, collaboration and coordination, institutional capacity building, planning and leadership in the community sector are also supported. Recognition of the importance of CSS is strong – the concept note states that 'a sustainable community response to HIV and TB will largely depend on sustainable CSOs'. This commitment is reflected in the appointment of a CSO as principal recipient. Relevant indicators are also included in the Performance Framework.

The concept note is rare in its attention to rights priorities, particularly in relation to TB. Funding is requested to remove barriers to access through increased awareness of rights-based approaches to HIV services among stakeholders through advocacy workshops and training, establishment of legal services, collaboration with legal aid and provision of rights-based information. Training of paralegals and community monitoring of rights will also be included. Removing legal barriers is intended to address rights abuses across TB and HIV including employment discrimination against TB patients. Relevant indicators are also included in the Performance Framework.

A range of gender sensitisation activities are included in relation to different to key populations including:

- integrated prevention of mother to child transmission, and family planning, HIV counselling and testing, education and communication for all pregnant women and an increased focus on former key populations who may not know their status;

- inclusion of partners of PWID in prevention programming to empower the growing number of women infected through spousal transmission;

- gender sensitisation to reduce stigma as a barriers to accessing services for MSM and TG.

Cross-over between HIV and TB key populations means that these HIV-focussed activities will also benefit some TB key populations. The addition of activities specifically targeting occupational and behavioural risks among men (such as smoking) and risks flowing from the disproportionate impact of poverty on women, preparing food in poorly ventilated housing (particularly given urban slum dwellers are identified as a key population) and risks associated with caring roles would be valuable additions for TB key populations.

This concept note is one of few to acknowledge the need to prepare for transition to domestic funding as Global Fund eligibility reduces (Indonesia is expected to transition to upper middle income country status by 2018). It makes reference to the investment case analysis and two optimisation analyses conducted in relation to the HIV component of the program and their value in identifying an approach to deliver a cost effective program based on disability adjusted living years saved. The inclusion of task-shifting to community in the malaria concept note also reflects progress toward more sustainable programming.

Pakistan

Epidemic Context		
HIV Pakistan's epidemic is primarily concentrated among PWID, male and hijrah sex workers, although reliable data is scarce. Access to services is limited by stigma and discrimination, including in healthcare settings. Punitive laws relating to drug use also create a deterrent to health seeking among PWID and gender-based violence against hijrah and 'feminised men' is believed to contribute to transmission.	**Malaria** Pakistan is rated as a moderate malaria endemic country. Risk factors include unpredictable transmission patterns, low immune system of people in low endemic areas, poor socioeconomic conditions and mass cross-border migration. Conflict and political instability and related people movements, as well as socio-cultural limitations on women's freedom of movement create barriers to service delivery and access.	**TB** Pakistan ranks fifth among the 22 high burden countries for TB and the 27 multi-drug resistant TB burden countries. Geographic, socio-cultural and economic factors (poverty) limit access to services among particular population groups. Gender discrimination including restrictions on women's movement, seeking health services from men and prioritisation of boys' healthcare over girls' also restricts access to services.
Key populations	Key populations	Key populations:
• MSM • TG/*hijrah* • Sex workers • PWID • PLHIV • Adolescents from the above populations • Refugees and internally displaced persons • Clients of sex workers • Spouses of key populations • Street-associated adolescents • Prisoners • Migrants	• Pregnant women • Migrant workers • Nomads • Internally displaced people • People living in underdeveloped and low socioeconomic regions.	• Geographically hard-to-reach populations • Urban slum dwellers • Occupation-based risk populations: brick kiln, coal miners • Refugees and internally displaced persons Children • Elderly • Women • PLHIV

Key populations are targeted on a geographical basis, with 90% of funding identified as allocated to rural areas. Services to difficult to reach populations will be improved through outreach, including by faith-based organisations like the principal recipient that have had success in reaching forest populations and through integrated services including integrated services covering information on other causes of death in young children and expansion of testing for malaria in pregnant women. CSS funding is requested for innovative programming including 'task-shifting' interventions to engage communities, NGOs and faith-based organisations for improved sustainability of the response and to reach the hard-to-reach. These activities however target existing organisations rather than seeking to mobilise communities of malaria affected persons through CSS.

There is no evidence of rights-specific activities, though expansion of services will address access rights including among marginalised ethnic groups.

Mosquito net distribution will target pregnant women on the basis of biological vulnerability. This intervention while gender-sensitive is not transformative – it does not address issues gender equality issues that limit women's access to services. Despite higher rates of infection among men due to gender roles that lead to their working in high-risk environments and the geographical focus of the request, no measures are described as specifically targeting men on this basis.

HIV concept note and Performance Framework	Ratings	C ✿★	R ?	G ?

Key populations are prioritised through sub-population specific interventions. TB testing, treatment, care and support for PLHIV and prevention programming for MSM and TG including testing-kits for CBOs and detoxification services and opioid substitution therapy for PWUD are funded. Above allocation funding is requested for social and basic healthcare services for PWID, living support to spouses of PWUD living with HIV, and equipment for mobile testing. Significantly funding for the advocacy component for opioid substitution therapy is also above allocation, which the concept note acknowledges will face political opposition. Technical Review Panel comments resulted in all viral load testing and critical adherence interventions being brought within the funding allocation.

CSS funding for activities by the Association of PLHIV is all within allocation including a helpline, participation in provincial monitoring and District AIDS Councils, feedback and advocacy activities. Psychosocial and clinic-based support will be provided by peer adherence mobilisers recruited by the Association of PLHIV and female peer outreach workers are being recruited to support spouses of PWUD returning from detoxification programming and commencing anti-retroviral therapy.

Despite recognition of the impact that criminalisation of same-sex relations, sex work and drug use have on access to health services no activities to promote the removal of these legal barriers. The impact of gender-based violence on HIV transmission (including among MSM and TG), and barriers to accessing health services created by cultural and religious limitations women's movement and preferential treatment of sons are acknowledged. However, no gender programming is included.

Malaria concept note and Performance Framework	Ratings	C ✓	R ?	G ?

As a low-income country, Pakistan is not required to make a minimum budget allocation to key populations. The concept note includes strategies to address the needs of key populations including nomads, migrant workers, internally displaced persons and refugees although the ultimate goal of the national strategy is universal coverage based on the view that 'all age and sex groups are vulnerable to malaria'. CSS activities cover:

- •Community-level information and behavioural change communication activities are funded, including use of World Malaria Day as an opportunity for advocacy to policy makers.

- •Involvement of community and CSO in the malaria response to promote empowerment and ownership at the national, provincial and district levels, including through the use of lady health workers and advocacy by local NGOs and CSOs.

Activities have been included to expand services to refugee and displaced populations though this will be managed through humanitarian response measures rather than through changes to laws to create rights for these populations to access services.

Despite recognition of barriers to accessing health services created by limitations women's movement and preferential treatment of sons, no gender activities are included.

TB concept note and Performance Framework	Ratings	C ✪★	R ✪	G ✪★

The concept note specifically identifies and targets key population subgroups with tailored prevention and treatment programmes including expansion of prison detection programs, paediatric presentation of treatment for children and guidelines for screening among the

elderly; integrated TB/HIV programming; and social support for enrolled drug resistant TB patients to address loss to follow-up and including food baskets, travel incentives and supervised visits to patients.

CSS activities include community mobilisation and advocacy are supported through 'chest camps' and local communication channels such as theatre, sports events, school and church based educational sessions and engagement of community leaders.

Rights are not specifically referred to though funding will also support for continued engagement of CSOs through provincial technical working groups making recommendations on policies, regulation and legislation regarding TB notification. This is an important CSS measure and though detail is limited these forums could be used to address rights to confidentiality and discrimination related to TB notification.

Pregnant women are targeted through detection and treatment measures on the basis of biological vulnerability and training of lady health workers is proposed to address barriers to women accessing health services. Employment of women as lady health workers may also have empowerment outcomes.

Papua New Guinea

Epidemic Context		
HIV The epidemic is 'mixed', with more populous urban areas disproportionately impacted by high prevalence among key populations. The most common mode of transmission is heterosexual sex and risk of transmission is increased by STI prevalence, commonality of concurrent sexual partners and high rates of anal sex among heterosexual couples. Gender-based violence is a significant problem in PNG and increases HIV risk. Laws against sex work and same sex relations between men create barriers to accessing services.	**Malaria** In 2010, malaria ranked 5th in terms of disability adjusted living years in PNG and was the leading cause of mortality in children under five years in 2012. Geographical inaccessibility, conflict and linguistic diversity continue to pose a challenge for the malaria response. 90.7% of the population living in high-risk areas of malaria and the remaining population is located close to and move between high-risk areas. Gender analysis identifies gender inequality as limiting women and girls' access to health and education services.	**TB** PNG has the second highest TB prevalence in the Western-Pacific region. Prevalence is highest in the urban, National Capital District, despite this area accounting for just five per cent of the population. TB/HIV co-infection is high though testing among PLHIV remains low. Three high multi-drug resistant TB provinces have been identified. Low levels of education among key affected populations and subsequent inability to effectively participate in decision-making about their own health.

Key populations		Key populations		Key populations:	
•Sex workers •MSM •TG •PLHIV •People diagnosed with TB and people diagnosed with STIs	•Survivors of sexual and gender-based violence •PLHIV, including pregnant and post-natal WLHIV	•General population are the main 'target group' •Underserved populations in rural and remote communities	•Antenatal mothers •Children under 5 years •People in prisons and boarding schools •PLHIV	•Urban poor •Children •PLHIV •Sex workers •MSM	•Others with 'alternative lifestyles' who lack access to services due to stigma.

HIV concept note and Performance Framework	Ratings	C ✿★	R ✿	G ✿★

The HIV concept note is strong in its focus on key populations and recognition of the importance of CSS. Eighty-five per cent of funding for interventions is allocated to PLHIV, sex workers, MSM and TG and almost one-fifth of the total funding allocation is for developing and maintaining key population networks and outreach. The programmatic framework emphasises work with CSOs representing key populations, development of key population engagement guidelines, and a partnership model that incorporates capacity building for key populations to participate in the program.

CSS and measures targeting key populations are integrated. The first objective of the funding request is to address the lack of access to community-based programs for HIV prevention, testing, treatment, care and support for sex workers, MSM and TG through peer-led outreach. Training of peer leaders in outreach, advocacy and gender sensitisation is a particularly strong example of integrated CRG programming. Gender and behavioural "hot spot" mapping is identified as a mobilisation activity for peer outreach workers enabling key populations to contribute to data as input to programming. Monthly meetings between peer outreach teams and clinical staff will allow peer feedback into programming. A TB/HIV coordinator will also be appointed to support integrated activities.

Although the Performance Framework does not include a removing legal barriers module, sensitisation training for local leaders, gatekeepers and law and justice staff is however included in the concept note and Performance Framework (under workplan tracking measures) to reduce stigma and discrimination against key populations.

Gender priorities are strongly reflected in PNG's concept note, particularly in their recognition of gender as impacting male and TG experiences of HIV. Improved referral and support for family support centres (including for sex workers, MSM and TG) and sensitisation of clinic staff to help identify patients who have experienced gender-based violence and provide relevant services are included as are gender-specific outreach and provision for the security of female outreach workers based on peer network's reports of risk regarding gender-based violence. The Performance Framework also includes milestones and targets for gender-based violence activities, which no other requests reviewed for this project do.

It is important to note that gender was only included in the concept note following feedback from the Technical Review Panel despite the focus on gender-based violence in the country's National Strategic Plan. This demonstrates the need for sustained attention to gender throughout the concept note development process and the benefits of CRG-supportive Global Fund mechanisms. Continued in-country support is however still needed as key informant reports indicate that implementation deviates from the concept note, particularly in relation to gender activities added based on Technical Review Panel comments.

Malaria concept note and Performance Framework	Ratings	C ✓	R ?	G ✓

The concept note states that the general population is the 'primary target group' for all response activities based on the reality that 90.7 per cent of the population lives in malaria endemic areas. The concept note does however include a 'particular focus' on 'reaching those underserved in the rural and remote communities and extending access to effective prevention, diagnosis and treatment interventions' including through mosquito net distribution to antenatal mothers, populations in boarding schools and prisons and PLHIV via HIV voluntary testing and counselling services.

CSS activities include an advocacy, social mobilisation and communication strategy component incorporating activities to develop evidence-based behaviour change communication campaigns for vulnerable communities. This measure will also include the establishment of SMS information services and radio programming to discuss child health issues and training of village health volunteers to deliver messages around child health relating to malaria.

Gender analysis in the concept note recognises that gender inequality limits women and girls' access to health and education services, though this acknowledgement does not translate into programming aimed at addressing these inequities. Distribution of mosquito nets to mothers will address biological vulnerability and may utilise the caring role of mothers to ensure children under five are also protected. While potentially gender-sensitive, this is not gender-transformative programming. No rights priorities are specifically addressed.

TB concept note and Performance Framework	Ratings	C ⚙?★	R ?	G ⚙?★

This concept note stands out, particularly among TB concept notes for the strength of its CSS priorities. These include assistance to form associations and CBOs, and links between existing organisations and TB health services. Associations will be established with representatives from the church, tribal leaders, women's associations and PLHIV and registered with the Investment Promotion Association and their capacity built to allow them to operate as an intermediary between existing CBOs and the TB health system. CBOs will also be engaged in review of the effectiveness of efforts to strengthen national TB prevention programming and appoint treatment support persons in underperforming health districts to promote treatment adherence through monthly provider-patient meetings covering challenges, lifeskills training and transport support. Advocacy and recommendations to improve housing and settlements in urban and semi-urban areas for the urban poor as a key population are supported as part of biannual meetings of the National TB Taskforce (though it is nor clear whether positions on the taskforce will be reserved for affected populations or community representatives).

Other activities prioritising key populations will include integrated TB/HIV programming, TB and treatment and prevention in clinics used by the urban poor and their children, specific interventions to address childhood TB and the appointment of a paediatrician as a national focal point on children's TB.

Rights priorities are not explicitly addressed, in part due to circular rights analysis that identifies TB as an indicator of poor rights realisation (such as poor access to the right to health) rather than rights as barriers to the TB response.

The country context analysis notes that gender norms contribute to risk among men and women, through women's role in caring for sick family members and the greater likelihood that men will engage in risk behaviours such as smoking and alcohol abuse. This analysis is strong in its recognition of how gender impacts risk for both men and women but is not translated into activities under the funding request. Gender priorities are however reflected in activities including community engagement and support through tailored, gender-sensitive messaging by facility outreach workers for women and interventions to improve services in underserved areas that specifically identify women as a target group.

Philippines

Epidemic Context		
HIV HIV prevalence in the Philippines is low but it was one of just 9 countries to register a 25% increase in incidence between 2001-2011. 90% of cases are among men. The primary mode of transmission is sexual, with 84% of transmission occurring between MSM. Intersecting risk factors are also recognised. Punitive laws against drug use, religious conservatism and lack of legal protections against discrimination on the basis of sexuality and gender identity create barriers to seeking health services.	**Malaria** Historically, malaria was a leading cause of morbidity and mortality in the Philippines, though cases and effected areas have reduced. Access to health services is limited by poor socioeconomic conditions, geography, lack of public infrastructure and transport, low levels of education, traditional beliefs about disease transmission and treatments. Men consistently account for 57-58% of total cases largely due to occupational exposure and children under 5 years account for 23-25%.	**TB** The Philippines remains one of the world's 22 high burden TB countries. TB remains the 6th highest cause of mortality in the Philippines. The country is ranked 8th among countries with a high burden of multidrug resistant TB. Barriers to an effective response identified in the concept note include poverty, malnutrition, overcrowding, stigma and poor health seeking behaviours, under-resourcing of the health response, weak drug regulation, poor management and failure to reach vulnerable populations.

Key populations		Key populations		Key populations:	
•MSM •TG •Sex workers	• PWUD • PLHIV • Young key populations	•Indigenous peoples •Forrest and agricultural workers •Military •Children under five •Pregnant women	•Internally displaced persons •Communities in development project areas •Workers and visitors in and returning from endemic areas (workers)	•Indigenous peoples •Urban poor •Elderly	•People with disabilities •People with TB co-morbidities including HIV and diabetes

HIV concept note and Performance Framework	Ratings	C ☼★	R ☼★	G ☼

The Philippines concept note describes community and key population led interventions as 'a strategic game changer', although key informant interviews indicate that this was the result of strong advocacy by community rather to ensure adequate representation in the community dialogue process. Three per cent of the funding allocation is reserved for CSS, the equal smallest allocation of eight funding areas. This covers:

•peer outreach and coalition building between networks of key populations

•technical assistance and financial support to develop advocacy plans, manage commodity supply chains, strengthen communication and networking skills, financial management, monitoring and evaluation, accountability, sustainability planning and governance

•CBO- and NGO-led planning exercises, branding of prevention commodities and information and education communication tools, advocacy for policy and legislative change and to reduce stigma.

Key populations are the clear focus of the concept note – prevention programs for MSM and TG receive the largest proportion of funding (34%), followed by treatment, care and support for PLHIV (23%), and prevention programs for PWID (15%). The funding request includes support for demand creation targeting MSM and TG through an internet/mobile phone communication strategy; employment of support staff to reduce loss to treatment; youth sensitive programming for young key populations including mapping, building capacity among peer educators and development of local budget allocations for young people most-at-risk. The Performance Framework includes the number of local government unit-CBO partnerships formed and number of local government units implementing communication plans for key populations as indicators under the CSS module.

Rights priorities are recognised through a module on removing legal barriers to access, which receives four per cent of the budget allocation. An advocacy and communication officer will be employed to oversee advocacy by CBOs to reduce the legal age for anonymous HIV testing and identify discrimination issues and sensitisation training. A police and community liaison officer will also be employed to train police, work with CSOs to increase legal literacy, to facilitate meetings between NGOs and CSOs, and agreements between police and service providers delivering needle/syringe programs to promote acceptance of harm reduction approaches. The Performance Framework includes the 'number of local government units developing and implementing HIV-related stigma reduction policies and programmes' as a coverage indicator.

Gender priorities are reflected in support for gender-sensitive programming to improve access by women who inject drugs, often excluded from harm reduction and HIV services for transgender people. Activities to reduce stigma against MSM and TG may also address gender priorities.

It is important to note that recent extrajudicial killings of PWUD and suppliers have created a far less enabling environment for the HIV response and measures included in the concept note developed in 2015 may now face substantial implementation challenges.

Malaria concept note and Performance Framework	Ratings	C ✿	R ?	G ✓

The funding request targets key populations through a geographical focus on priority provinces with activities targeting key populations within those areas including expansion of services for universal access to quality diagnosis. Activities targeting indigenous communities include rapid diagnosis and testing, use and culturally appropriate means of communicating information on malaria control and prevention. CSS activities include promotion of mosquito net use by leaders from indigenous communities, health workers and CSOs, and research on appropriate interventions for indigenous populations. Grant funds are also allocated to promote opportunities for partnership in provinces affected by political instability and those with a risk of displacement.

Although emphasis on the country's movement toward universal health coverage reflect broad efforts to realise the right to health, no rights-specific activities included.

Pregnancy packages are included to address women's biological vulnerabilities associated with pregnancy. Though no gender-sensitisation or transformative programming is included.

TB concept note and Performance Framework	Ratings	C ✿	R ?	G ?

The long history of engaging community volunteers in the Philippines TB response is acknowledged, noting that community systems weaknesses continue to include difficulty sustaining participation by community volunteers; weak feedback systems, inadequate logistical support and lack of supportive supervision. The concept note prioritises key populations, including through CSS activities such as enhanced TB/HIV collaboration and the deployment of HeathAIDERS (for accelerating implementation of directly observed treatment enhancement to reach special populations) with a focus on the urban poor, working with CBOs and NGOs and community education. Families, support groups and community health workers will also have their capacity built to support Programmatic Management of Drug-resistant TB patients and reduce patient default rates

No rights or gender-specific activities are included through attention to vulnerable populations, in particular the poor will address their right to health. Given women's traditional caring role CSS activities to build capacity for family support will likely include more women.

Viet Nam

Epidemic Context	
Malaria Viet Nam's malaria epidemiology is complex due to the variety of species in the region (including drug resistant forms), rapid changeability due to large-scale population movement for seasonal labour and development. Malaria in Viet Nam is closely associated with poverty and marginalisation, malaria control must therefore 'target the least privileged' Most infections are among adult males who may hunt or work during the night and early morning, or are employed in the areas sometimes by large projects with poor healthcare schemes.	**TB/HIV** The HIV epidemic is concentrated among three key populations. Injecting drug use is the leading HIV transmission mode. Modelling of sexual partners of key populations suggests that 29% of new infections in Viet Nam occur in low risk women. The country currently rates 12th among the 22 B high burden TB countries and has a case detection rate of 76%. Case detection appears to be lower among men than women, more men than women contract TB, this is thought to be attributable to smoking rates among men (2% of women and 44% of men in Viet Nam smoke) and higher rates of HIV among men. Key populations for both diseases face barriers to accessing services based on biological, socio-economic and structural factors. People living in remote areas, miners, migrants and the elderly also face barriers to accessing services

Key populations		HIV Key populations		TB Key populations:	
•Established villages (ethnic minority groups and ethnic majority) and new settlements •Plantation settlements	•Traditional slash-and-burn paddy field farming communities •Seasonal agricultural labourers •Military patrols •Forest workers formal/ informal •Camps associated with large scale construction projects	•PWID •MSM •FSW •Key population sexual partners •Clients of sex workers and their sexual partners	•"PLHIV •Prisoners •Pre-trial detainees •People living in remote areas •Miners •Migrants •Elderly people	•PWID •MSM •FSW	•PLHIV, •Prisoners and pre-trial detainees

HIV/TB concept note and Performance Framework	Ratings	C ✪★	R ✪★	G ✪

The concept note prioritises key populations, HIV key populations are allocated 83.7% of programming budget and 81% of TB funding is earmarked for TB key populations. Arrangements for integrated HIV/TB treatment and prevention include measures for key population subgroups and measures to address risk factors for both diseases such as expansion of methadone therapy services. Other activities target HIV and TB key populations separately, through CSS. These include:

•Training of community partners including peer educators, VHWs, PLHIV support groups, networks of key populations and CSOs to build treatment literacy, confidence in the health system, treatment demand and support adherence to antiretroviral therapy.

•Community-based HIV and testing and counselling for key populations and their partners and peer outreach to concordant and serodiscordant couples.

- engagement of communities in referrals and collaboration with border police health posts for improved TB detection in mountainous areas

- Hand-over and scale-up of existing community TB care delivery, including to the Farmers' Union.

- Diagnosis of multidrug resistant TB and management in prisons through collaboration with civilian services.

- Establishment of Stop TB partnerships comprised of all stakeholders including key population representatives, who will be trained to advocate on TB control and increased provincial-level funding.

The Performance Framework includes the number of CBOs participating in HIV services and peer educators mobilised as quantitative measures of implementation under the CSS. Significant above allocation requests for innovative programming for key populations and CSS were also included in the concept note including piloting HIV self-testing among MSM and training of CSOs to raise awareness among Stop TB of the benefits of working with key population representatives.

This is the only concept note reviewed in this study to treat legal barriers to collectivisation and CBO and CSO activities as a rights priority. Activities are identified under the "Removing legal barriers" module in the Performance Framework including:

- Providing peer comments and feedback on the Draft Law of Association and successfully register an Association for Vulnerable People, including key populations.

- Increase awareness and knowledge of the rights of key populations for relevant stakeholders

- Community monitoring tools and training developed by community for community.

Advocacy will be conducted through sharing results from community-based monitoring with government officials and other duty-bearers, and with the public and activities to facilitate community initiatives to reduce stigma and discrimination.

The concept note is also rare in its inclusion of gender activities for men. Lower access to health by men is in addressed by work with the Farmers Union (though some of these activities require above allocation funding). The country context analysis notes that men experience higher levels of TB in part due to significantly higher levels of smoking among men, prevention activities for TB unfortunately do not capitalise on this opportunity for gendered prevention programming. Interventions for the partners of people from key populations address` gender priorities through recognition of the epidemic among low risk women and its link to gender roles in which women often have less control over HIV prevention based on gender roles in relationships, particularly in the context of high levels of gender-based violence against women in Viet Nam.

Malaria concept note and Performance Framework	Ratings	C ✪	R ?	G ✓

This concept note goes beyond other malaria concept notes by targeting key populations based on non-geographic criteria including forest-goers, seasonal, agricultural and plantation workers. This allows for mosquito net distribution through employers and focussed testing and screening

CSS activities include community-based diagnostics and treatment services delivered by voluntary health workers, and incentive payments for volunteers, although the extent to which voluntary health workers are drawn from affected communities is unclear. Most CSS activities are covered by above allocation funding including behavioural change communication including a workshop to assess and revise methodology and approaches, a mobile-phone based program targeting migrants and mobile populations, and an annual large-scale community mobilisation event on World Malaria Day, targeted public services announcements via mass media and socialisation of malaria.

Implementation arrangements note that voluntary health workers will provide awareness raising and education to women on malaria in pregnancy and youth in relation to bed net distribution. Bed nets will also be distributed to women through antenatal clinics for use with new born babies – while this mode of distribution recognises women's role as carers it appears to address the vulnerability of their children rather than increased vulnerability during pregnancy. In practice however, distribution during pregnancy may allow women to make use of the nets during a period of heightened need.

No rights-specific measures are included although vector control, testing and treatment measures will improve access to the right to health among key populations.

Regional Steering Committee for the Regional Artemisinin Initiative (RAI)

Epidemic Context

Regional context

Artemisinin combination therapies are currently the principle means of treating uncomplicated facilparum species malaria but artemisinin resistance is emerging in the Greater Mekong Subregion (GMS). Halting the spread of artemisinin resistant parasites in the GMS is crucial to further spread to Africa where resistant parasites are more prevalent. The concept note states that the spread of other forms of drug resistant malaria from this area to Africa resulted in the deaths of 'millions of African children'. An independent review by the World Health Organisation (WHO) found that efforts to address artemisinin resistance in the area have been inadequate. The review provides the basis for the Regional Artemisinin Initiative, which aims to:

- interrupt transmission through universal coverage and usage of insecticide treated bed nets

- provide universal access to quality diagnosis and treatment for static populations and through community malaria workers

- provide access to prevention, diagnosis and treatment for mobile and migrant populations

- halt marketing and sale of oral artemisinin mono-therapies in the private sector

establish and operationalise rigorous surveillance linked to a focal response mechanism.

Countries: Greater Mekong Subregion
Cambodia, Lao PDR, Myanmar, Thailand and Viet Nam.

Key populations
- Mobile villagers who visit the forest to gather forest products
- Longer-term forest dwellers and families that accompany them to work on plantations and construction projects
- Military and government workers who regularly visit high risk areas
- Minority groups based in high risk areas. Including indigenous peoples
- Migrant workers

RAI (Malaria) concept note and Performance Framework	Ratings	C ✪	R ?	G ?

The concept note states that '100%' of target populations for the funding request are mobile and migrant populations living and working in high risk border areas and among the lowest-socio economic and most underserved populations in the region. Key populations are primarily targeted through vector control though the monitoring and evaluation module seeks to improve understandings of migrant health-seeking behaviour (Thailand) and sociology, anthropology and behaviour among mobile populations to identify appropriate interventions (Viet Nam).

CSS activities are included under the case management, and advocacy, communication and social mobilisation modules. CSS activities under the case management module primarily seek to scale up and roll out village and volunteer malaria worker schemes to border regions. While key informant interviews indicate that voluntary and community health staff are only sometimes drawn from affected populations, these activities have strong potential to increase participation from affected communities, build their reputation among government partners and strengthen more sustainable community systems.

The advocacy, communication and social mobilisation activities included are more diverse, these include:

- Elimination-specific community-based advocacy and mobilisation will be supported through village health volunteers in 8,251 village (Cambodia)

- Participatory health education campaigns will be delivered in an estimated 200 villages and Lao-language behavioural change communication messages will be played on buses. Training and advocacy and communications materials on drug quality control and treatment for communities, health staff and private providers will be developed, and a new IT tool will also be introduced to share information via a toll-free mobile phone system about imitation drugs. Cross-border coordination meetings will be held between government and malaria control authorities to determine whether migrant populations are being reached, though it is not proposed that community members be included in these meetings (Lao PDR)

- RAI specific behavioural change communication activities covering all aspects of malaria elimination with a focus on mobile/migrant populations (Myanmar)

- Local and international NGOs working with migrant populations on the Thai-Myanmar border will be invited to submit proposals for community mobilisation and behavioural change communication activities (Thailand)

- Development, production and distribution of information and education communication materials to target key populations (Viet Nam).

Key informants note that the regional project was considered a means of increasing community participation as state control is more limited in cross-border work. This presented a particularly important opportunity given suppression of community activities in some of the countries included. Key informants were however disappointed in the level of community control and roles made available to community actors though are confident that evaluation of the program provides strong evidence to advocate for increased inclusion of community priorities in the future.

None of the activities described in the RAI concept note refer directly to rights or gender as priorities. This is unfortunate given the clear link between challenges to managing malaria in border areas and barriers to mobile populations accessing health services based on citisenship rights and place of residence. Interventions aimed at legal and policy change to realise the right to access health services may have provided a more sustainable solution than the establishment of RAI specific services.

The importance of gender to effective malaria responses is notoriously under-recognised despite the reality that gender roles and inequality are a significant influence on the malaria response. Men are more likely to be among mobile and migrant populations that enter high-risk areas for work and frequently demonstrate lower health seeking behaviours. At the same time, gender inequality limits access to health services among women and girls, including due to risk of violence widely recognised among mobile populations in humanitarian settings. Women in mobile and migrant groups are less likely to participate in paid work, primarily caring for dependents. Women are therefore a valuable group to engage as voluntary health workers given their direct caring role and connection members of high-risk communities. Involving women in non-domestic work, possibly with remuneration or incentive payments may also empower women with the potential for transformative gender policy.

Guidance on human rights and gender and malaria has improved since the RAI concept note was developed. This should be referred to in any extension of the scheme. Practical programming examples however may still be scarce and should be developed for the Asia-Pacific region and in relation to cross-border contexts. Specifically referring to CRG priorities in the objectives for future manifestations of the RAI initiative and in the Performance Framework may improve coverage of those issues.

APCASO

APCASO is a regional CSO network of 14 community-based (CBOs) and non-government organisations (NGOs) on HIV, health, and social justice, with a focus on advocacy and community capacity development in Asia and the Pacific.

We support and promote the role of CBOs and NGOs, who work with and represent key populations and communities most in need, in advancing a rights-based social development health agenda.

We envision just and inclusive societies that respect, fulfill and advance the rights of communities most in need - thereby hastening the end of AIDS, TB and malaria epidemics and other health challenges.

We work to strengthen advocacy and community systems toward effective social development and health responses, inclusive of HIV, in Asia and the Pacific.

APCRG

CRG, or "communities, rights and gender", refers to interventions that aim to ensure that country responses and programmes on HIV, TB, and malaria are community-focused, human rights-based, and gender transformative. To be effective, HIV, TB and malaria interventions must entrench principles of CRG.

The Asia-Pacific Platform on Communities, Rights and Gender (APCRG) is a communication and coordination platform for CSO groups, key population networks, non-government and CSOs that are involved in the response to fight HIV, TB and malaria. It is one of the six regional platforms that were established with the support of the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund) under the Community, Rights and Gender Special Initiative.

As the Platform, APCASO is working to:

- improve the knowledge of CSO and community-based organisation on the Global Fund and how to access technical assistance to improved the inclusion of CRG-related interventions in the HIV, TB and malaria programmes;
- coordinate with other technical assistance providers in the region;
- Improve understanding on the technical assistance and capacity gaps of CSO and CBOs to promote and/or implement CRG-related interventions; and
- Promote strategic CRG-related capacity building initiatives in the region.