CIVIL SOCIETY SUCCESS ON THE GROUND
Community Systems Strengthening and Dual-track Financing: Nine Illustrative Case Studies
List of Terms & Abbreviations

Alliance International HIV/AIDS Alliance
ACER ART Community Education and Referral (Zambia)
ANCE Alliance Nationale Contre le SIDA (Senegal)
ART antiretroviral treatment
CBPO community-based organization
CCM Country Coordinating Mechanism
CHAZ Churches Health Association of Zambia
CISS Coordination of International Support to Somalis
CSS community systems strengthening
IDU injecting drug user
IDFID Department for International Development (UK)
DTF dual-track financing
HCT home-care team
HSS health systems strengthening
ICPC Integrated Care and Prevention Program (Cambodia)
IIEC information/education/communication
ICJA International Cooperation Agency
KHANA Khmer HIV/AIDS NGO Alliance
LGBT lesbian/gay/bisexual/transgender
M&E monitoring and evaluation
MSM men who have sex with men
NAF National AIDS Foundation (Mongolia)
NGO nongovernmental organization
OI opportunistic infections
OVC orphans and vulnerable children
PEPFAR President’s Emergency Plan for AIDS Relief (U.S.)
PLWHA people living with HIV/AIDS
PMTCT prevention of mother-to-child transmission
PR Principal Recipient
STI sexually-transmitted infection
TB tuberculosis
UNICEF United Nations Children’s Fund
UNFPA United Nations Population Fund
USAID United States Agency for International Development
VCT voluntary counseling and testing
ZNAN Zambia National AIDS Network

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organizations working to support community action on AIDS. These national partners help local community groups and other NGOs to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out at the UK-based international secretariat and across the Alliance.

In addition to community and country-based programs, the Alliance also has extensive regional programs and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice development, as well as policy analysis and advocacy.

This publication is based on an extensive literature review and interviews among staff at the Secretariat of the International HIV/AIDS Alliance (Brighton, UK) and the Global Fund Secretariat (Geneva, Switzerland). Staff from Alliance linking organizations in specific countries also provided information, observations and insights.

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THE GLOBAL FUND ENCOURAGES PROPOSALS DESIGNED TO REACH KEY AFFECTED POPULATIONS WHO OFTEN DON’T HAVE A STRONG VOICE, SUCH AS WOMEN, YOUNG GIRLS AND SEXUAL MINORITIES.
Programs to combat malaria aim to save the lives of those most vulnerable, particularly children under five and pregnant women, whose bodies are unable to effectively fight the disease.
Many would recognize that the Global Fund to Fight AIDS, Tuberculosis and Malaria is a continually developing institution, evolving as a result of feedback from its key stakeholders. The organization’s eighth funding round, launched in March 2008, and its impending Round 9 to be launched in October 2008 represent the culmination of a number of mechanisms to harness and enhance the role of civil society in the implementation of Global Fund grants. This publication has been designed to serve as a tool to support countries in understanding these mechanisms and what they mean practically at country level, including the types and kinds of partnerships as well as the possible interventions the Global Fund supports.

Through the use of country-level case studies, the publication highlights examples of substantial civil society involvement in all aspects of Global Fund processes from grant management to service delivery. The case studies are not intended to provide in-depth, step-by-step guidelines for interested organizations and stakeholders. Instead, they aim solely to show the range of innovative options that many civil society groups have already identified and implemented within their specific contexts.

This publication was coordinated jointly by the International HIV/AIDS Alliance and the Global Fund. The Open Society Institute provided financial support. Of the nine case studies, five (Cambodia, India, Mongolia, Senegal and Ukraine) focus specifically on the involvement of Alliance linking organizations in those countries. The other four (Peru, Somalia, Thailand and Zambia) consider civil society engagement as it would pertain to management and oversight of existing Global Fund grants.

Although these nine case studies examine grants for HIV/AIDS programs, the guidelines and policies discussed are applicable across the three diseases.
Civil society\(^1\) has been an important and vital partner to the Global Fund since the financing mechanism was first conceived. Civil society organizations contributed to the design and structure of the Global Fund, and subsequently they have encouraged governments to commit more resources to support its work.

Civil society has not just been an advocate for the Global Fund; it has also played an essential role in the oversight and implementation of Global Fund grants. A look at one key indicator demonstrates the strong role of this sector in implementation. As calculated by the Global Fund, year-end figures from 2006 show that 83 percent of programs with civil society Principal Recipients (PRs) received one of the two highest ratings (“A” or “B1”). Only two percent of such programs received a “C” rating, a lower proportion than programs without civil society PRs.

These results highlight the impact and importance of having civil society implementers. Moreover, they have achieved these successes through several different and innovative models. Some have implemented alongside governments in a mechanism now known as dual-track financing (DTF), under which the Global Fund strongly encourages countries to nominate at least one government and one non-government PR to lead program implementation. (Additional details about DTF may be found in the Glossary of Key Terms section.) Other examples of civil society engagement have included multiple-PR models (with more than one civil society PR), which is a form of DTF, and where civil society has acted as the sole PR. At least one of each of the above-mentioned PR models involving civil society is discussed in the case studies that follow.

It is not just as implementers that civil society has a major impact. Nongovernmental organizations (NGOs) regularly serve as sub-recipients and (where they exist) sub-sub-recipients. Experience indicates that local NGOs are especially effective in reaching those in need when it comes to actual hands-on service delivery. That is because many of them not only serve the community, but actually reflect the community too. Networks of people living with HIV/AIDS (PLWHA) are assuming key roles in treatment literacy and adherence, as well as continuing valuable and essential support for education and prevention initiatives. These networks fill an invaluable void in ensuring that social support and care interventions are effective and stretch to hard-to-reach communities, in particular vulnerable and marginalized populations.

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\(^1\) The Global Fund has adopted the United Nations definition of civil society: “The associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit-making activity (the private sector) or governing (the public sector). Of particular relevance to the United Nations are mass organizations (such as organizations of peasants, women or retired people), trade unions, professional associations, social movements, indigenous people’s organizations, religious and spiritual organizations and academic and public benefit nongovernmental organizations.”
Such local groups and networks are often small and lack the capacity to deliver the quantity and quality of services needed, especially as programs are scaled up. The Global Fund’s response is to support smaller implementing organizations to help them become stronger and more effective implementers, not just in the short term but over the long term too. To fulfill this goal, the Global Fund encourages the Country Coordinating Mechanism (CCM) members to identify national gaps and constraints to scale-up within the context of developing the capacities of community-based organizations (CBOs). These interventions, known as community systems strengthening (CSS), are increasingly becoming a core part of the Global Fund’s preferred strategy across its programs. More and more civil society groups are receiving not only financial support but also crucial technical support in areas including accounting and monitoring and evaluation (M&E). Such CSS activities are vital for the long-term sustainability of organizations providing essential prevention, treatment and care services.

In April 2007, the Board developed the following decision point to ensure that the role of civil society and the private sector in the work of the Global Fund is maximized:

“The Board believes that civil society and the private sector can, and should, play a critical role at all levels of the architecture and within every step of the processes of the Global Fund, at both the institutional and the country levels. This includes their critical roles in the development of policy and strategy, and in resource mobilization at the Global Fund Board level, and in the development of proposals and the implementation and oversight of grants at the country level. The Board further expresses its desire for strengthened and scaled-up civil society and private sector involvement at both the country and Board levels, while recognizing the respective strengths and roles of the two sectors.”

As noted previously and in the case studies that follow, the Global Fund has and will continue to support measures in proposals that are designed to increase civil society engagement and participation. The Global Fund is committed to doing so at all levels of its architecture, from being a member of a country CCM to supporting proposal development to directly servicing grant implementation. However, despite the strong leadership from the Global Fund to support the role of civil society stakeholders, not all governments recognize the valuable support civil society can bring to scale-up. Stakeholders, including governments, may not know how to reach out to or include civil society organizations or, in many cases, may be reluctant to include them due to the often wary or critical nature of the government-civil society interface.

In many countries, government reluctance to work with civil society has been a significant barrier to the effective design of proposals and, equally, to the managing of bottlenecks and challenges in grants. However, even those barriers are less significant overall than the lack of knowledge and awareness among civil society, particularly at the local level, of the possibilities available for support, funding and participation through the Global Fund. Civil society groups with the appropriate information and support can point to the clear Global Fund guidelines regarding the increased direct engagement of civil society.

For example, it is important for all members of a CCM – including civil society – to understand the call for Global Fund proposals, both in terms of the type of funding and the mechanism for approving funding. One particularly common occurrence is that CCM members believe there are funding ceilings applicable to each country, and thus the CCM designs and submits a less ambitious country proposal. By acting so cautiously, a CCM can seriously limit the amount of assistance that could theoretically be available to civil society partners (especially service deliverers) and people in need. However, according to the Global Fund Secretariat there are i) no funding ceilings and ii) the Secretariat is often disappointed by the size and ambitiousness of applications.

Ultimately, the responsibility for increasing civil society engagement lies within civil society itself. For example, if NGOs in some countries are not ready to serve as PRs, then they can work with CCMs to apply for increased funding for CSS to strengthen their capacities in the medium term. This will enable them to become stronger sub-recipients, and eventually capable PRs of Global Fund resources.

The case studies in this publication aim to increase awareness of the areas where civil society can engage across Global Fund processes. Each context is different, so countries must determine the most suitable solution for their national context. However, the relatively wide range of models is likely to offer something for all potentially interested stakeholders.

As civil society continues to engage in Global Fund processes – including proposal development and grant implementation – other stakeholders, including governments, will increasingly come to recognize the comparative advantage these organizations bring, in particular to reaching vulnerable and marginalized populations. The Global Fund can offer this leadership; however, it is also important for civil society organizations to coordinate and develop networks to increase their representation within these processes. The strength of the relationships they have with their governments will not be an organic process in every setting, and in some contexts will require time to nurture. These funding opportunities for civil society represent key opportunities to strengthen these relationships as well as to pave the path for sustainable responses to AIDS, TB and malaria in the long term.
This section includes detailed descriptions and explanations of some of the major concepts and terms discussed in the case studies. Readers who are not familiar with the Global Fund or its recent policy decisions are recommended to review this section prior to reading the case studies.

COMMUNITY SYSTEMS STRENGTHENING

**Community systems strengthening (CSS)** refers to the provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities. From the Global Fund’s perspective, most entities in need of such support are local NGOs that comprise and/or provide services to people living with HIV/AIDS (PLWHA), TB or malaria, members of vulnerable populations and individuals who otherwise have sub-standard access to vital health services. Both civil society and government can and do provide CSS currently in Global Fund grants.

CSS has been an element of most grant programs over the first seven rounds. It is only recently, however, that the Global Fund Secretariat and Board have signaled how and why it should be a priority across all disease components. In particular, the Board now recommends “the routine inclusion, in proposals for Global Fund financing, of requests for funding of relevant measures to strengthen community systems necessary for the effective implementation of Global Fund grants.” Applicants are therefore specifically encouraged to include CSS activities in their proposals where these interventions support increased demand for and access to service delivery at the local level for “key affected populations” – including women and girls, sexual minorities and people who are not reached with services due to stigma, discrimination and other social factors.

The Global Fund has identified three interconnected areas of need that can be addressed as part of efforts to strengthen community organization responses to HIV/AIDS: predictable financing, training and capacity building and coordination, alignment and advocacy. As specified in the Global Fund’s Round 8 Guidelines, released in March 2008, CSS initiatives may include (but are not limited to):
Capacity building of the core processes of CBOs through:
> physical infrastructure development – including obtaining and retaining office space, holding bank accounts, strengthening communications technology; or
> organizational systems development – including improvement in the financial management of CBOs (and identification and planning for recurrent costs); development of strategic planning, M&E, and information management capacities;
> Systematic partnership building at the local level to improve coordination, enhance impact, avoid duplication, build upon one another’s skills and abilities and maximize service delivery coverage for the three diseases; and/or
> Sustainable financing: creating an environment for more predictable resources over a longer period of time with which to work.

The Global Fund’s final stipulation was that inclusion of such initiatives is appropriate “provided that the support requested is demonstrated to be linked to improved service delivery and outcomes for the three diseases.”

DUAL-TRACK FINANCING

At its Fifteenth Meeting in 2007, the Global Fund Board approved a set of measures under the heading of “Strengthening the Role of Civil Society and the Private Sector in the Global Fund’s Work.” As part of this decision, the Board approved the recommended, routine use of dual-track financing (DTF), whereby both government and non-government PRs are included in proposals to the Global Fund. The new guidelines are not a requirement. However, they do include the following caveat: “If a proposal does not include both government and non-government PRs, it should contain an explanation of the reason for this.”

According to the Board’s decision, the “possible benefits of DTF” include:

> increased absorption capacity (from taking full advantage of implementation capacity of all domestic sectors, both governmental and non-governmental);
> accelerated implementation and performance of grants; and
> the strengthening of weaker sectors.

PRINCIPAL RECIPIENT

The term Principal Recipient (PR) means principal implementer/manager of program interventions. The PR is responsible to the Global Fund for reporting on programmatic and financial performance during the program term. In country, the role is to oversee and ensure timely, outcome-focused service delivery by other key implementing partners under the Global Fund grant.

SUB-RECIPIENT

Sub-recipients are program implementers that deliver services under the leadership and management of the PR. Sub-recipients have a direct contractual relationship with the PR and can be selected from a broad range of possible implementing partners, including:

> NGOs and CBOs
> networks of PLWHA
> the private sector
> faith-based organizations (FBOs)
> academic/educational institutions
> government (including ministries of health, as well as other ministries involved in a multisectoral response to the diseases, such as education, agriculture, youth, women’s affairs, information, etc.); and
> multi-/bilateral development partners (but ideally only where no national recipient is available).

SEXUAL AND REPRODUCTIVE HEALTH INTEGRATION

In the context of the Global Fund, sexual and reproductive health integration usually refers to efforts to more fully coordinate and integrate reproductive health and HIV/AIDS services. Many grant implementers already consider this a priority when soliciting proposals and selecting sub-grantees. However, it is only in the past couple of years that the Global Fund Board has taken steps that greatly increase the ability and inclination of CCMs to submit proposals that specifically outline sexual and reproductive health integration strategies. The most important are the following:

> The passage of a gender decision point, which places gender as a high priority for efforts to address HIV/AIDS, tuberculosis and malaria. It defines gender broadly to include not only women and girls but also sexual minorities, including people who identify as male, female, and transgender.
> A heightened recognition of the importance of funding health systems strengthening (HSS) initiatives. The primary principle of HSS is that activities should have a positive impact on the entire health system. Under Global Fund guidelines, such activities may relate specifically to any one of the three diseases – and if so, they should be included within the disease component under which a proposal is submitted. If, however, the activities are not specific to one of the diseases but are likely to benefit more than one, then they may also be included in a proposal as a separate cross-cutting initiative.
> Stronger efforts to push CCMs to include more members of vulnerable groups and to guarantee that they can participate meaningfully.
KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
> community systems strengthening
> care and support
> prevention programs for vulnerable populations

ORGANIZATION INVOLVED
Khmer HIV/AIDS NGO Alliance

COUNTRY BACKGROUND
POPULATION
14 million

INCOME LEVEL CLASSIFICATION
Low income (as per latest World Bank data)

ADULT HIV PREVALENCE
0.9% (as per 2007 estimates from Cambodia’s National Center for HIV/AIDS, Dermatology and STDs)

POPULATIONS MOST AT RISK
Sex workers, IDUs, MSM

NOTABLE TRENDS
Overall HIV prevalence in Cambodia has declined over the past few years, from an estimated high exceeding 3% in the late 1990s to less than 1% in 2007. The decline is attributed to strong awareness-raising and prevention efforts by the government with support from bilateral and multilateral donors and civil society. Prevention efforts are thought to have been least successful among the most stigmatized populations, including IDUs and MSM. KHANA estimated in 2006, for example, that between 37% and 45% of IDUs in Cambodia were HIV-positive. Recent trends also indicate that half of new infections are among married women.

IN CAMBODIA, PREVENTION EFFORTS TO NEIGHBORHOODS ON THE OUTSKIRTS OF PHNOM PENH BRING BEHAVIOR CHANGE EDUCATION TO VULNERABLE GROUPS SUCH AS MSM.
IDENTIFYING PARTNERS AND STRENGTHENING NGOS’ APPLICATION PROCESSES

The typical process for KHANA is as follows:

1. As it seeks to identify potential new community-based partners, KHANA holds meetings across the country to which local civil society groups are invited. Some have previously worked on HIV issues; others have not but have expressed an interest in becoming involved. The organizations are selected according to experience in community mobilization, organizational capacity and demonstrated commitment to participatory development and service provision.

2. Members of CBOs and NGOs are then trained in the basics of HIV and sexually-transmitted infection (STI) prevention and treatment and in carrying out community needs assessments.

3. Once the needs assessments have been completed, KHANA then supports these organizations to develop a proposal for a project based on the assessment.

4. After review by a proposal review committee, the CBO or NGO may be supported by KHANA using funds available, for example as a Global Fund sub-recipient.

Once a partnership has been developed with a community group, and a grant is awarded, it is usual for this relationship to continue over many years as the NGO or CBO refines its project to meet the changing needs of the community and KHANA continues to provide technical support. During the development of proposals for Global Fund-supported programs, KHANA either mobilizes new partners using the process described above or else identifies existing partners whose capacity and focus are relevant for the priorities of that Global Fund round (as defined by the CCM). In addition to these specific application-oriented processes, KHANA is also involved in other activities that increase awareness among local civil society groups as to the availability of and ways to acquire additional resources.
KHANA’s Integrated Care and Prevention Program (ICP) supports PLWHA and affected families through the provision of comprehensive home-based care services. These services are provided by KHANA’s partners through home-care teams (HCTs). Each team consists of representatives from KHANA’s partner NGO, a representative from the local health center and volunteers. During home visits, the teams provide basic medical treatment and referrals to vital health services including opportunistic infections (OI), STI and tuberculosis (TB) treatment, as well as access to prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT) and antiretroviral treatment (ART) services. They also provide psychosocial support, prevention education, food and nutritional support, school materials and encouragement for orphans and vulnerable children (OVC) to complete basic education and facilitate access to income-generation opportunities.

HCTs encourage people living with HIV to access local self-help groups for mutual support. Additionally, the ICP program reaches out to the general population through community education activities and provides capacity-building opportunities for the government partners and PLWHA networks that work with KHANA.

Ongoing Technical Assistance to Selected Partners

Technical assistance continues to be an important and ongoing part of KHANA’s support after partner NGOs are on board. Such support focuses on both programmatic and organizational development: technical assistance is provided in the form of training workshops on a variety of themes such as home-based care for PLWHA, strategies for supporting OVC in local communities, M&E, financial management and fundraising.

Each partner organization faces a different set of challenges and has identified unique capacity-building needs. Therefore KHANA seeks to be as hands-on as possible when providing technical support. Staff provide one-to-one technical support during regular field visits to partner organizations with the goal of building the capacity of those organizations in specific technical and organizational areas according to individual partners’ needs. These visits also offer an opportunity for KHANA to monitor program activities. The network organizes (and encourages participation in) exchange visits among partners. Such direct engagement increases the sharing of useful and effective ideas and strategies.

KHANA has long recognized that building local partner M&E capacity must be a crucial component of its technical assistance efforts. This core element of comprehensive CSS has the dual effect of improving the quality and scope of service delivery among those in need while at the same time helping ensure longer-term sustainability. The process ensures partners are able to meet key requirements of other current and potential donors. Members of the KHANA M&E team help the partners to collect and present data according to set indicators and targets. Partners report quarterly, and reported data is collated in the KHANA central Monitoring and Reporting System database. Data can then be presented according to the requirements of each donor in a clear and timely manner.

The benefit of KHANA’s strong community systems means that in addition to supporting communities, KHANA has played an increasingly important role at the national level by taking part in policy development and inputting into the national strategic plans for the country. Through its understanding of and ability to represent the needs of people living with HIV and of vulnerable populations, KHANA is able to represent them or act as a bridge. This helps ensure that the views and voices of community are heard at the decision-making table and, hopefully, listened to.
GLOBAL FUND INVOLVEMENT

KHANA staff have worked with government and CCM officials planning and drafting all Global Fund proposals. The organization obtained funds as a sub-recipient for two HIV/AIDS grants (Rounds 1 and 5) and will again through Round 7, contingent upon the grant being signed.

For Round 1, KHANA focused primarily on what their areas of success at the time: home-based care (also known as community-based care) for PLWHA and OVC. Both of those have remained core priorities for KHANA through subsequent grant proposals. At the same time, the organization has recognized and responded to other urgent priorities as they have become apparent.

The HIV epidemic in Cambodia has continued to disproportionately strike members of certain vulnerable sub-populations, notably injecting drug users (IDUs), men who have sex with men (MSM) and sex workers. KHANA has encouraged the CCM and other leading in-country Global Fund stakeholders to provide more targeted assistance for members of these groups. For example, in the lead up to the Round 6 HIV/AIDS proposal, KHANA prepared a report highlighting the results of assessments that showed how stigma, discrimination, and lack of access to essential services were driving a new and little-recognized HIV epidemic among IDUs. That report and KHANA’s direct involvement in proposal preparation contributed to the inclusion of measures and target indicators aimed at HIV prevention and care among IDUs.

Cambodia’s Round 6 HIV/AIDS proposal ultimately was not approved. KHANA and its partner allies nevertheless determined to advocate for similar measures and indicators focusing on drug users for the Round 7 proposal. KHANA has broadened its efforts on behalf of vulnerable populations by recommending a project focusing on prevention for MSM. In the end, KHANA’s four main projects for the Round 7 proposal (which will be implemented contingent upon signing) included those two new focus areas – prevention among IDUs and MSM – and two longstanding areas – home-based care for PLWHA and OVC risk reduction – where it had demonstrated effectiveness.

For IDUs, KHANA included the following priority activities in the Round 7 proposal:

> supporting NGOs to implement drug-related HIV activities in seven provinces;
> initiating ten projects for risk reduction with amphetamine users that include outreach, peer education, life skills development, HIV/AIDS/STI education, condom distribution, assisted referral to STI/VCT/HIV care, and referral to drug treatment/rehabilitation;
> initiating five harm reduction projects for IDUs over three years. Such projects would include similar services to those for amphetamine users (noted in the bullet point above) as well as needle and syringe exchange;
> expanding socioeconomic support for IDUs through drop-in centers, income-generating activities, community-based support through teams for families and individuals and self-help groups; and
> creating NGO-led rehabilitation and detoxification services at two sites by the end of three years, each of which would also provide opioid substitution therapy.

For MSM, KHANA included the following in the Round 7 proposal:

> supporting seven NGOs to implement comprehensive MSM/HIV prevention and care in four provinces;
> expanding socioeconomic support by supporting NGOs to provide MSM-specific drop-in centers or “safe spaces”;
> initiating HIV prevention activities with a particular focus on increasing condom use rates and improving reduction in STIs transmission and better health-seeking behavior in relation to STIs. Specific efforts in this area include expanded outreach and peer education, life skills development, condom distribution, assisted referral to STIs and VCT sites, and integrating drop-in centers with STIs clinics;
> ensuring full access to non-discriminatory care for HIV-positive MSM. Specific efforts would include assisted referral to appropriate services for HIV care, including ART and treatment for opportunistic infections; and
> supporting the development of the first national MSM network.
Through its many years of work with local NGOs, KHANA has observed how important it is for applicants to recognize the amount of additional systems, restructuring and expertise that are required to make an application to be a PR. They need to discuss with the CCM which elements of the PR or sub-recipient role are manageable and decide if the expectations of the CCM are appropriate or might take them beyond current capacity. However, a desire to become a recipient can provide a clear set of goals in terms of developing internal capacity to take on GF responsibilities in the future. One of the key objectives of the recent focus of the Global Fund on investing in CSS is to enable CBOs, civil society organizations, networks and NGOs to build their capacity to play a greater and more competent role in scaling up services that help to reverse HIV, TB and malaria epidemics.

The availability of Global Fund financing has enabled KHANA, its partners and the government to scale up responses across the country. Such expanded programs have contributed to the overall decline in HIV prevalence. Continued success will depend on expanding and sustaining direct engagement with CBOs that have proved effective in supporting, if not leading, the HIV prevention and care efforts in Cambodia.

Other notable lessons learned from KHANA’s experience in Cambodia include the following:

- Ongoing partnership-building with key government agencies can provide an entry point for meaningful engagement in Global Fund processes. KHANA has been proactive in engaging in technical working groups and other forums at the national level where there is an opportunity to establish mutually-respectful working relationships with government counterparts and feed into national strategies and policies. By making itself visible and establishing its reputation and expertise in this way, KHANA is well positioned to influence the agenda when Global Fund priorities and programs are being discussed.

- Building complementarity with government based on comparative strengths can help establish a role for civil society in implementing Global Fund programs. In Cambodia, for example, approaches such as the continuum of care for PLWHAs have been built on the complementarity of public sector and civil society. While the Ministry of Health has focused on facility-based clinical services, KHANA and its partners have worked in the community to provide home care, referral, positive prevention, psychosocial support, adherence follow-up and socioeconomic support including livelihoods, education, nutrition and protection of OVC.

- Civil society organizations, which can link experience at the community level to the national level, can play a significant role in voicing the needs of vulnerable people during Global Fund processes. KHANA has been able to bring learning from its partners at the community level to the national level, where it has already established its voice and influence. For example, KHANA has encouraged the inclusion of activities targeting IDUs and MSM in Global Fund proposals based on its partners’ experience of working closely with these relatively hard-to-reach groups.

- Civil society needs to build on existing coordination mechanisms so that NGOs can bring a unified voice to Global Fund processes. In Cambodia, the NGO sector is large and diverse, which can have both positive and negative repercussions. To reduce the negative impacts, intermediary organizations like KHANA can play a role in helping improve coordination among civil society.
KHANA ENGAGES BUDDHIST MONKS IN EFFORTS TO PROVIDE SOLIDARITY AND A SUPPORTIVE ENVIRONMENT FOR PLWHA.
Country Background

Population
1.1 billion

Income Level Classification
Low income (as per latest World Bank data)

Adult HIV Prevalence
0.36% (as per latest UNAIDS data)

Populations Most at Risk
IDUs, sex workers, MSM, transgender individuals, internal migrants (commonly referred to in India as "single migrants").

Notable Trends
The estimated number of PLWHA in India was reduced significantly in 2007 under new UNAIDS methodology. Even so, the new estimate (2.5 million) remains the highest in Asia, although prevalence is far lower than in many other nations in the region due to the sheer size of India’s population. The HIV epidemic in India also varies substantially by region. In the north east, for example – most notably in the states of Manipur and Nagaland – HIV is concentrated among IDUs; elsewhere the main transmission route is unprotected sex. There is a wide range of responses across the 35 states of India. Awareness is higher in southern states where the epidemic has been most visible as well as where the response has been strongest.
BACKGROUND, ACTIVITIES AND STRATEGIES OF FOCUS ORGANIZATION

Established in 1999, the India HIV/AIDS Alliance is a partnership of organizations supporting effective, sustainable and comprehensive responses to HIV and meeting the challenges of AIDS in India. Supported by a national secretariat in Delhi, it comprises linking organizations, state partners and their networks of more than 110 community-focused organizations in six states: Andhra Pradesh, Delhi, Maharashtra, Manipur, Punjab and Tamil Nadu.

In 2007, the Alliance in India supported more than 120 community-based projects to prevent HIV infection, improve access to HIV treatment, care and support and lessen the impact of HIV/AIDS, including reducing stigma and discrimination. Particular emphasis was placed on working with and for the most vulnerable and marginalized communities, such as sex workers, MSM, IDUs, and adults and children living with HIV.

In 2007, the Alliance and its partners served an estimated 146,000 people, including some 43,000 sex workers; 28,000 PLWHA; 26,000 affected family members; 25,000 MSM and hijra/transgender community; 22,000 children affected by HIV/AIDS and 2,400 IDUs.

COMMUNITY SYSTEMS STRENGTHENING THROUGH SEXUAL AND REPRODUCTIVE HEALTH ACTIVITIES

The India HIV/AIDS Alliance sexual and reproductive health and HIV/AIDS integration program is the most recent of the three core programming streams. Initiated in 2006 with support from the Department of International Development (DFID), it was implemented across six states (the five states in which the Alliance continues to work as well as Orissa). The services were provided through four Alliance linking organizations, one lead state partner organization and 16 implementing NGO partners.

The overall goal of the program was to respond effectively to the “feminization” of the HIV epidemic in India. Moreover, it was designed to fit within the longer-term strategic context of the National AIDS Control Program’s new strategic framework. In practice this means that the Alliance’s primary objective is to strengthen and develop community-centered approaches to meet the sexual and reproductive health and HIV-related needs of women in low-income settings.

The Alliance in India developed information, education and communication (IEC) materials regarding sexual and reproductive health and HIV. These materials include information about HIV transmission and care, reproductive health, care during pregnancy, childcare, personal hygiene, condom usage, STIs and nutrition. The IEC materials, backed up by a rigorous system of training, were provided directly to Alliance implementing partners to support outreach workers and other community workers and volunteers. Those individuals organized sessions with community members and disseminated appropriate information related to sexual and reproductive health. Such capacity-building efforts constitute significant CSS activity.

In late 2007, the Alliance in India reported the following outcomes (as of mid-2007) of its sexual and reproductive health/HIV integration program:

> nearly 1,000 support groups of vulnerable women were formed and are meeting regularly;
> more than 100 women PLWHA groups were created;
> more than 20,000 information and discussion sessions were conducted in group meetings. Topics ranged from condom negotiation, ART, STIs, contraception and pregnancy to legal and policy issues;
> approximately 14,000 home visits were conducted by outreach workers offering sexual and reproductive health/HIV information;
> more than 2,000 referrals were made to STI and reproductive health services; and
> nearly 200 women were supported by NGOs in obtaining legal advice; more than half received free legal support services.

The focus, strategies, results and impact of this DFID program were so promising – and were achieved within a very short period of time (the project was only funded for 14 months) – that the Alliance decided that sexual and reproductive health/ HIV integration would be a strategic priority for the next three years. Based on demand from the communities and findings of various end-of-project reports, the Alliance decided to broaden the definition of sexual and reproductive health to include males at risk and ensure greater male involvement. This umbrella category includes: single migrant men living in urban slums; HIV-positive men; MSM and hijra/transgender community and male IDUs. The Alliance is keen to offer targeted sexual and reproductive health/HIV services to such individuals. This is because they tend to be particularly difficult to reach; are disproportionately vulnerable to contracting HIV; have little awareness of sexual and reproductive health/HIV issues; have limited access to appropriate services and/or face significant stigma and discrimination that restricts their ability or inclination to seek social and health services.
However, a major challenge to the expansion of the sexual and reproductive health/HIV integration program for marginalized male populations is the lack of comprehensive information about them and their unmet sexual and reproductive health needs. In order to address this challenge, the Alliance supported a comprehensive survey among representatives of male marginalized groups in 2007. Key areas of focus included awareness of HIV and STI risk behaviors (and inclination or ability to take preventive measures based on awareness), access to and use of condoms and uptake of available NGO and government services. Across all groups, the initial results demonstrated that there are gaps in the health system as far as men are concerned – and that the public health machinery has become disproportionately focused on women. Consequently, even when men make a decision to participate in and access services, there tends to be a limited scope or enabling environment for them to do so.

These findings are expected to guide the development of new Alliance programming on comprehensive sexual and reproductive health for males, including convergence with HIV.

OTHER COMMUNITY SYSTEMS STRENGTHENING EXAMPLES

The current focus on sexual and reproductive health/HIV integration is high-profile, but it is not the only pathway through which the Alliance in India facilitates CSS. Another important – and complementary – focus is on populations considered most vulnerable to HIV transmission, so-called key populations, including MSM, IDUs and sex workers.

The India HIV/AIDS Alliance has developed several CSS implementation models for working with these populations, all within the context of “focused prevention”. Focused prevention relies on supporting the behavior change of communities at risk (key populations) through providing peer education and supporting services in a selected area. The goal is to saturate the specific geographic area so that all (or nearly all) residents have access to HIV prevention and care information and resources.

One such effort was initiated recently in the state of Andhra Pradesh, one of five Indian states where the Alliance currently works. The effort is part of a larger community-driven prevention program supported by the Bill & Melinda Gates Foundation’s Avahan initiative, which currently reaches more than 50,000 key population community members in that state.

The model emphasized the Alliance working with community members in selected areas to develop a strategy that would address the challenges faced by them and their peers in terms of police harassment and stigma and discrimination as well as access to essential social and health services. The result was the evolution of the Core Advocacy Group concept, a model for involving community members at all levels in building their skills and empowering them to take responsibility for addressing these challenges. The model places priority on leadership from members of the affected communities themselves and has been introduced not only to Alliance implementing NGO partners but also to other groups working on similar issues.

GLOBAL FUND INVOLVEMENT

The Alliance is already serving – with distinction – as one of two civil society PRs for the India Round 6 HIV/AIDS grant. Its engagement at that level is a solid example of the utility and effectiveness of the DTF model, which was adopted in India long before it was specifically encouraged by the Global Fund.

The Round 6 grant focuses on scaling up care and support services for children living with and/or affected by HIV. As PR, the Alliance focuses on CSS: building the capacity of local NGOs to provide community-based services efficiently, consistently and at the high standards required by the Global Fund. The official start date of the Round 6 grant was 1st June 2007. By the end of the year, the India HIV/AIDS Alliance had initiated the following activities, most of which focused on project start-up (itself a vital part of CSS):

- staff recruitment and initial training/orientation at the national level for Alliance sub-recipients;
- setting up detailed M&E and financial systems;
- writing project operational guidelines;
- conducting child-profiling/mapping and participatory situation analysis at all field sites; and
- technical support and monitoring visits to sub-recipients by the Alliance, as well as joint visits with sub-recipients to implementing NGOs (known as sub-sub-recipients) to oversee staff capacity building and outline project compliance guidelines.

More recently, the Alliance in India has been asked to serve as PR of a proposal submitted for a Round 8 HIV/AIDS grant. The request was based on Alliance experience as PR in Round 6, its work supporting sexual and reproductive health/HIV integration and its history of building the capacity of community groups (including NGOs) to effectively respond to the epidemic in India. The Round 8 proposal focuses on CSS for sexual minorities as a key part of efforts to increase access to HIV prevention and care services among MSM and members of the hijra/transgender communities. The proposal seeks to achieve these and other goals by strengthening the management of relevant health system resources and increasing the involvement of community-based groups.

2 Additional information about the Avahan initiative may be found on the Gates Foundation website: www.gatesfoundation.org/GlobalHealth/Pri_Diseases/HIV/AIDS/HIVProgramsPartnerships/Avahan/
As specified in the Round 8 proposal, some of the major capacity-building needs of sexual minority groups include institution-building of CBOs, project cycle management and financial management. Also deemed important are efforts to address relevant non-HIV needs of community members, such as mental health, trauma and violence response and family crisis-support programs. Notable activities in the Round 8 proposal include community mobilization and organization in the form of CBOs, capacity building of organizations, sensitization training and quality assurance for service providers, and advocacy for legal and social reforms. The proposal also includes lesser-studied areas such as spouse and partner coverage, linkages and services for MSM and hijras/transgenders living with HIV and HIV prevention for married men as learning and advocacy initiatives.

The Global Fund had yet to announce its Round 8 decisions at the time research for this case study was collected. Moreover, program implementation of the Round 6 grant is now new – the official start date was in mid-2007 – that outcomes, impacts and observations are somewhat limited. However, by early 2008 the following two challenges and obstacles had been identified by India HIV/AIDS Alliance staff as being especially noteworthy:

1. WORKING WITH GOVERNMENT: AN EVOLVING RELATIONSHIP

The national government’s strong and significant role in the CCM is a critical factor governing participation by and from civil society. The sector’s participation has been further influenced by the continued vacancies of several CCM seats reserved for civil society. As a co-PR, the Alliance has “special invitee” status only on the CCM. In that role as observer, it is not permitted to vote and can only contribute informally to discussions and questions upon request of the CCM membership or office bearers (including occasional presentations to the CCM on results and performance).

The result is a situation where civil society is poorly represented and implementing organizations such as the Alliance cannot contribute. This situation, coupled with many government agencies’ critical view of the capacities and governance of civil society organizations in general, has had a negative impact on the ability of civil society to be considered equal and/or significant players to date for the Global Fund. The result continues to be missed opportunities for effective communication and engagement.

2. LACK OF CAPACITY AND AWARENESS IN THE CIVIL SOCIETY SECTOR

The CCM received a reported 700 responses to its call for proposals, the majority of which came from NGOs seeking to serve either as PRs or sub-recipients for Round 6. Of those, only about 20 (less than three percent) came close to meeting the necessary criteria. Such results point to the lack of awareness among local civil society groups as to the relevant Global Fund processes and expectations. They also highlight crucial gaps in capacity within the sector. In advance of upcoming rounds, the Alliance has partnered with several other civil society players, including the other non-governmental PR (Population Foundation of India), to try to address this lack of awareness. The groups involved are leading a series of meetings with civil society organizations across the country to outline the process and expectations of being a PR or an sub-recipient – and to share experiences of organizations that have already held such roles. There has also been some participation from government agencies in this effort, including the National AIDS Control Organization.

LESSONS LEARNED

The following are three of the numerous lessons learned by the Alliance from its work in India over the past several years:

> Effective DTF can occur even in environments where the government remains somewhat suspicious of the civil society sector. Proof of this comes from the Alliance’s strong performance as co-PR for the Round 6 HIV/AIDS grant. Such useful work has helped prompt the government to recognize the value of civil society not only in Global Fund processes, but also more broadly.

> It may seem as though CSS would have a limited effect in large and populous countries with thousands of local civil society groups of greatly varying quality, experience and interests. The Alliance in India has shown that a useful strategy in such a situation is to keep the focus limited to a few targeted areas and districts at first. The effective CSS model that emerges from that strategy can then be adapted and expanded elsewhere in the country. In many cases, as with the Bill & Melinda Gates Foundation Avahan initiative, partnerships can be formed with other international, national and local civil society groups to fund, design and implement such models elsewhere.

> Effective sexual and reproductive health/HIV integration requires the involvement of men as well as women. Services in particular need to be expanded to men and sexual minorities, since women are targeted in many reproductive and child health projects of government. Programs and strategies targeted at men – who in some environments remain underserved – are often best designed and implemented by civil society. The most appropriate efforts are those that seek guidance and engagement from community groups with relevant experience and an interest in reaching out to men.
Mongolia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
- community systems strengthening
- sexual and reproductive health integration

ORGANIZATION INVOLVED
National AIDS Foundation

COUNTRY BACKGROUND

POPULATION
2.7 million

INCOME LEVEL CLASSIFICATION
Low income (as per latest World Bank data)

ADULT HIV PREVALENCE
Less than 0.1% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK
MSM, sex workers

NOTABLE TRENDS
The total number of PLWHA in Mongolia is estimated to be about 1,000. However, although HIV cases are rare to date, numerous social, health and economic indicators point to the possibility of substantial increases in the future. Among those factors are:

- rising rates of STIs, poverty, unemployment, and alcohol and substance abuse;
- growing numbers of sex workers and street children;
- a young population (50% of Mongolians are below the age of 23);
- increasing internal and external migration;
- surging HIV epidemics in neighboring nations;
- limited access to health services for vulnerable populations; and
- high levels of HIV-related stigma and discrimination.

CBOs HELP TO RELIEVE THE PRESSURE ON HOSPITALS AND CLINICS BY PROVIDING BASIC HEALTH CARE AND EXTENDING MEDICAL SERVICES THROUGHOUT THE COMMUNITY.
Established in 1998, the National AIDS Foundation (NAF) is the Mongolian linking organization of the International HIV/AIDS Alliance. It is also a member of Mongolia’s National AIDS Committee. NAF’s main activities over the years have included providing financial and technical support to local NGOs, conducting research and needs assessments, documenting the work of its local partners and identifying best practices and participating in policy-making and advocacy aimed at improving the national HIV/AIDS response.

Mongolia is the Global Fund’s smallest program. It is also unusual in that the (relatively) few recorded cases of HIV in the country means that treatment needs – which dominate grants in many other nations – are quite low. The Global Fund’s efforts in Mongolia are therefore focused on prevention, especially among vulnerable populations, and on reducing stigma and discrimination.

Mongolia has been awarded HIV/AIDS grants from the Global Fund in Rounds 2, 5 and 7 - provisionally with regard to the most recent. (As of May 2008, the Round 7 grant had yet to be signed. The total request over five years was for US$ 2.95 million) The Ministry of Health is sole PR for all three grants, with NAF acting as one of the main sub-recipients in each case. NAF also sits on the CCM, thereby guaranteeing a strong and engaged civil society presence. The organization has worked closely with – and maintains good relations with – the Ministry of Health and other relevant government agencies. Its work in recent years as a sub-recipient is considered not only competent but efficient and innovative.

As one of the main sub-recipients, NAF has been developing its own organizational capacity including financial management, onward granting, and M&E, all with the support of the Alliance. The Global Fund’s new emphasis on DTF and CSS implies further capacity building of civil society organizations, particularly those acting as sub-recipients. NAF is a good example of a sub-recipient with the potential to achieve the qualities needed to be a co-PR in the future. The possible step up in responsibility would undoubtedly bring new challenges; however, the early signs are that NAF is gaining the expertise and experience to effectively serve as co-PR.
SEXUAL AND REPRODUCTIVE HEALTH WITHIN GLOBAL FUND WORK

All three HIV/AIDS grants contain several specific sexual and reproductive health indicators. The Round 2 grant, for example, included indicators aimed at reducing syphilis prevalence and improving STI diagnosis and treatment. Additional indicators and targets — including some focusing on specific vulnerable populations — were included in subsequent grants. The Global Fund’s partners have therefore from the very beginning seized the opportunity to facilitate greater integration of sexual and reproductive health and HIV services.

As a sub-recipient, NAF is a crucial part of this ongoing integration. Its work through the Global Fund is also a consistent source of CSS across Mongolia. NAF has funded and provided technical assistance to local NGOs offering a wide range of HIV prevention and sexual and reproductive health-related services including condom promotion, mobile VCT, drop-in centers, legal support, basic medical care and referrals, peer education (focusing on both HIV and sexual and reproductive health issues) and community outreach. NAF selects, funds and supports NGOs that are able and willing to reach some or all of the following key populations: sex workers, MSM, mobile traders, migrant workers (including miners working in the country illegally), IDUs and vulnerable children.

The Round 7 proposal represented the most far-reaching effort to increase Global Fund support for sexual and reproductive health and, by extension, improve sexual and reproductive health/HIV integration. Even more so than in previous proposals, it also allocated significant resources to building capacity among local groups to deliver such services. Local NGOs will receive ongoing training, including through regular field visits from NAF and other stakeholders. The training will focus on (among other areas) accounting and bookkeeping, M&E, and HIV prevention and care. This example of Global Fund–supported CSS was strongly backed by NAF and the Alliance.

NAF, moreover, was directly involved in drafting the Round 7 proposal. The elements of sexual and reproductive health integration to be addressed and supported include the following:

- linking and adapting outreach and peer education programs with sexual and reproductive health education for sex workers;
- including treatment and counseling for STIs in all VCT services;
- training and educating as to the utility of condoms as dual protection;
- increasing referrals, for example, by considering prenatal clinics to be major entry points to sexual and reproductive health/HIV services; and
- seeking to meet standards set by WHO and UNAIDS on issues such as one-stop care services for prenatal care, controlling syphilis to help decrease HIV transmission risk, private-sector quality improvement and laboratory quality control and transport.

In the lead up to Round 7, NAF also identified strategies and activities to reach and improve services among key vulnerable populations. The organization specifically identified its intent to support partners in providing mobile STI and VCT services to both sex workers and MSM, for example. It also planned to train outreach workers to provide information, education and skills to illegal miners with the goal of establishing five total sites and reaching 25,000 people by the final year of the grant. Separately, it called for training staff to provide a range of crucial care interventions — including VCT, STI diagnosis and treatment and counseling — for illegal miners via mobile services for six months every year.

The following were among the other notable integrated HIV/sexual and reproductive health prevention activities included in the Round 7 proposal:

- organizing education workshops and sessions on HIV and STIs for sex workers detained at facilities in Ulaan Bataar. Detention center staff would also be a focus of education outreach. These efforts would include the development of training manuals for NGO staff overseeing the sessions; and
- offering education and training on HIV prevention and communication skills to police officers who are in regular contact with members of vulnerable groups. Such efforts would focus on six districts of Ulaan Bataar.
CHALLENGES TO SEXUAL AND REPRODUCTIVE HEALTH/HIV INTEGRATION

NAF itself has identified several challenges to the effective implementation and sustainability of programs and strategies to increase sexual and reproductive health/HIV integration. The two main broad challenges include:

> inadequate human, financial, technical and M&E capacity among local NGOs, many of which have traditionally focused on more specific, segmented elements of care; and

> lack of knowledge and understanding about sexual and reproductive health/HIV integration, including why it might improve health delivery.

The organization plans to address such challenges by expanding the scope and scale of technical assistance it offers NGO partners. It has received assistance from the Alliance to help develop appropriate training models in advance. CSS is and will continue to be directly enhanced by the flow of ideas, information and resources from the Alliance to NAF to local partners. In return, the local partners will act as the eyes and ears at the grassroots level so that NAF and the Alliance receive guidance and suggestions as to the most important priorities.

LESSONS LEARNED

The following are three of the more notable lessons learned from NAF’s work in Mongolia over the past several years:

> Civil society organizations often lead the way in identifying and implementing innovative strategies and initiatives that are included in Global Fund programs. Civil society’s ability to influence Global Fund proposals is best achieved when one or more organizations, such as NAF, are directly involved in drafting Global Fund applications. Among NAF’s most important influences has been to focus attention and resources on sexual and reproductive health integration, which was a little-known and poorly-funded health objective prior to the Global Fund’s engagement.

> HIV-related stigma and discrimination are persistent, widespread and debilitating obstacles to public health, even in countries with low HIV prevalence. These point to the continued urgent need to expand and improve HIV education and awareness initiatives in such environments. The effectiveness of such initiatives is enhanced when civil society and government collaborate closely.

> NAF’s experience in Mongolia perfectly illustrates how CSS can be implemented among organizations and partners of widely varying sizes and expertise. NAF itself is a beneficiary of CSS from its international partner, the Alliance, and it in turn serves the same role with many smaller NGOs across the country. Such a multi-layered structure is often particularly effective at the grass-roots level because national and local organizations are far more likely than international ones (or bilateral donors) to provide training and information in ways that are culturally, economically and politically appropriate.
**Peru**

**KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT**
- civil society as sole Global Fund Principal Recipient
- community systems strengthening

**ORGANIZATION INVOLVED**
CARE Peru

**COUNTRY BACKGROUND**

**POPULATION**
28 million

**INCOME LEVEL CLASSIFICATION**
Lower-middle income (as per latest World Bank data)

**ADULT HIV PREVALENCE**
0.6% (as per latest UNAIDS data)

**POPULATIONS MOST AT RISK**
Sex workers, MSM

**NOTABLE TRENDS**
HIV prevalence is several times higher among key vulnerable groups - an estimated 10% among MSM and more than 2% among female sex workers, for example - yet HIV prevention and education services reportedly reach fewer than half of individuals in such groups. TB is another important factor, because Peru reportedly has the continent’s second-largest burden of that disease, which is the single most common killer of HIV-positive people worldwide.

**IN PERU, THE GOVERNMENT AND CIVIL SOCIETY HAVE COME TOGETHER TO PREPARE A MULTISECTORAL NATIONAL STRATEGY TO FIGHT HIV/AIDS, WHICH INCLUDES MEASURES TO PREVENT MOTHER-TO-CHILD TRANSMISSION OF HIV.**
THE “NO-GOVERNMENT” MODEL: AN NGO AS SOLE PRINCIPAL RECIPIENT

As of March 2008, the Global Fund had approved a total of five grants for Peru, three for HIV/AIDS and two for TB. Uniquely, no government agency is involved as PR: all grants are overseen and implemented by the same civil society organization, CARE Peru. (The organization is affiliated with CARE International, but is formally separate and operates independently with local staff.)

Peru’s case is unusual for the Global Fund because the government did not insist on one or more of its agencies serving as PR. That made it easier for the CCM to appropriately honor and respond to the results of the public tenders associated with each grant. In all five cases, CARE Peru’s proposals were evaluated as the strongest by an independent review committee.

These decisions were not only accepted, but generally welcomed. From the chair downwards, government representatives of the CCM have noted the importance and value of civil society involvement in all Global Fund processes and programs.

To some extent the government’s attitude reflects the historic strength of and respect for civil society that is seen throughout much of Latin America. More directly in the case of HIV and TB, however, it results from the belief that effective prevention and treatment activities should not be just community-based but also community-run. In particular, NGOs are believed to have greater success, once properly supported, in identifying and reaching the most vulnerable populations. Many individuals in those groups tend to be wary of government structures because they engage in behavior that is either illegal or highly stigmatized (or both).

The CCM and the government have openly signalled their backing for such an overall decentralized strategy by selecting a civil society PR and publicly announcing how and why the two sectors (public and non-governmental) are expected to cooperate in terms of HIV and TB service provision.

COMMUNITY SYSTEMS STRENGTHENING AS CORE PRIORITY

CSS is an integral part of all five Global Fund grant programs in Peru, with specific focus on groups run by people living with and/or directly affected by one or both of the diseases. For example, each program objective outlined in the HIV/AIDS grants is tackled by a consortium of NGOs working together. Through its sub-recipients — which include both civil society groups and government entities — CARE provides these local groups with financial and technical support over a wide range of areas, such as:

> improving basic management skills (including helping legalize PLWHA groups as NGOs);
> training PLWHA groups and advocates on how to effectively work and advocate within the public health system;
> training MSM and sex workers to serve as peer educators and counselors in all issues related to HIV prevention and treatment. Particular attention is paid to giving them the skills and confidence to promote condom usage, STI screening and care and treatment adherence. The educators also assist their peers in navigating care systems; and
> helping PLWHA networks set up income-generating microenterprises as part of an effort to improve the livelihoods of HIV-positive people.

The peer educator approach now used in all HIV/AIDS grants was modelled on the one pioneered in the TB programs. Through the TB grants, CARE sub-recipients create and support local TB organizations at the community level. These groups encourage testing, educate patients and their families on adherence and prevention and deliver services directly if needed. Many, for example, conduct home visits to bring medicines to patients. A major priority of CARE is to help ensure that these organizations are able to continue their activities once Global Fund support ends. Training is therefore offered in financial management, applying for grants and forming partnerships with government agencies and other NGOs.

LESSONS LEARNED

The following are among the noteworthy lessons learned from the Global Fund’s experience to date in Peru:

> Governments do not need to be directly involved in the design and management of Global Fund programs for them to be efficient and effective. None of the five Global Fund programs approved for Peru have PRs from the public sector. That does not stem from any particular perceived or real lack of capacity among government agencies; instead, it is based on agreement among all stakeholders (including those in government) that civil society would likely do a better job.

> Global Fund programs may be implemented more smoothly when each sector’s responsibilities are clear from the very beginning. Civil society and the government are both involved in HIV and TB service provision in Peru through the Global Fund. Yet potential confusion and mistrust regarding funding and roles have largely been avoided because all stakeholders have always been aware of what can be expected of them in their focus areas.

> The peer educator approach can be an important part of effective strategies to increase uptake of vital prevention, care and treatment services. As seen in Peru, such an approach can work across all disease components if tailored and implemented properly.
Senegal

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
- dual-track financing
- community systems strengthening

ORGANIZATIONS INVOLVED
- Alliance Nationale Contre le SIDA (Senegalese National HIV/AIDS Alliance), or ANCS
- Observatoire de la réponse au VIH/SIDA au Sénégal (Watchdog of the response to HIV/AIDS in Senegal), or Observatoire

COUNTRY BACKGROUND
POPULATION
12 million

INCOME LEVEL CLASSIFICATION
Low income (as per latest World Bank data)

ADULT HIV PREVALENCE
0.9% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK
Sex workers, migrant laborers, MSM

NOTABLE TRENDS
HIV prevalence in Senegal has long been among the lowest of all countries in sub-Saharan Africa. Its success in holding back the epidemic stems from the government’s early and relatively consistent efforts to raise awareness and provide HIV and STI prevention information and materials (including condoms) throughout the country. The government also implemented one of the first national initiatives in the region to provide ART. Civil society has played a vital role in supporting the government’s comprehensive efforts and advocating for improvements when deemed necessary.

JAMRA IS A PRIMARY SCHOOL FOR CHILDREN WHOSE LIVES ARE AFFECTED BY HIV/AIDS, DRUGS OR POVERTY.
Founded in 1995, Alliance Nationale Contre le SIDA (ANCS) is the linking organization in Senegal for the International HIV/AIDS Alliance. It receives financial and technical support from the Alliance on a regular basis and has provided similar assistance to numerous NGOs engaged in the HIV/AIDS response at the local level.

ANCS is one of five NGOs comprising the Observatoire, an informal network whose members first met in 2003. The Observatoire’s important and decisive impact on the HIV/AIDS response in Senegal is based on the fact that not only did it identify problems, but it also proposed solutions. Its members also agreed from the very beginning that government and civil society must consider themselves partners, not adversaries, in all elements of a comprehensive response. DTF in the Global Fund context was a crucial outcome of these efforts.

The impetus behind the Observatoire’s establishment was growing recognition that key government agencies – notably the National AIDS Council – were having difficulty managing projects funded by the World Bank and the Global Fund (through Round 1). Also, NGOs were discouraged that civil society was not being consulted and thus could have little impact on decision-making.

Observatoire members decided that they needed clear evidence for their concerns to be taken seriously. They agreed to conduct research on Senegal’s response to HIV/AIDS and use the information to identify solutions and advocate for appropriate policy and management change. The result was a paper presented at a highly-publicized press conference in January 2005. Among the findings – all of which pointed to the possibility of a more extensive epidemic – were the following:

- surveys of pregnant women indicated that HIV infection rates had risen recently in more than half of Senegal’s 12 regions;
- access to HIV testing and ART remained limited, despite government commitment to reach all in need; and
- few programs were in place to provide services for OVC and members of some vulnerable populations, including MSM.

More specifically, the report concluded that the National AIDS Council had not developed clear, transparent guidelines for managing Global Fund and World Bank assistance. The quality and effectiveness of newly-funded, established programs were also questioned. Moreover, the civil society sector was found to be insufficiently represented on the Global Fund CCM and, more broadly, limited in its ability to participate in the national response. The report included several recommendations, most of which focused on increased transparency and restructuring so that program activities could be more closely reviewed and influenced by non-governmental stakeholders.

The Observatoire’s report reinforced similar concerns at the Global Fund Secretariat that the targets identified in the grant would not and could not be met. In April 2005, the Global Fund Board threatened to withdraw the grant if administration and implementation problems were not addressed within three months.

The threat prompted government officials to engage directly with key civil society organizations. The main result of the discussions was an agreement to split the Global Fund grant into separate government and civil society components and to appoint an NGO to serve as PR for the civil society component beginning with Phase 2. This early example of DTF was confirmed when ANCS, by consensus the best prepared of local NGOs, was appointed to be co-PR.
ACTIVITIES AND STRATEGIES OF ANCS

ANCS worked with six sub-recipients through the Round 1 grant. They provide the following services at the community level: support and referrals for PMTCT services; community mobilization; care and support for PLWHA; care and support for OVC; prevention among sex workers and MSM and VCT services. As part of an effort to ensure integrated care, all services are provided in partnership with government agencies at the local level. For example, sub-recipients offer adherence and social support to PLWHA receiving ART at public-sector health facilities.

ANCS also keeps in mind one major issue highlighted in the Observatoire’s report – that the government was not as transparent as it should be. Thus, ANCS pays close attention to ensuring transparency in all its activities. It set up an advisory committee comprising representatives from civil society networks, UN agencies, CCM members and government agencies to focus on strengthening transparency and ownership of the program. Now, for example, sub-recipients are selected by merit in an open process that begins with a nationwide call for proposals via the media. An independent committee then reviews applications and selects the most promising ones.

Strong support of CSS by ANCS is exemplified by the scale and scope of technical assistance it provides to sub-recipients. The first step is usually a capacity analysis to determine what each sub-recipient needs most. All have at the very least received in-depth training on finance and accounting and – given the Global Fund’s strict requirements – on M&E activities. Additional assistance has been offered in areas ranging from human resources management to quality control. ANCS also makes it a priority to review sub-recipient systems and progress on an ongoing basis through regular site visits. It steps in with advice and support if and when problems are identified.

The PR’s close working relationship with its sub-recipient partners has greatly assisted the latter in efforts to achieve longer-term sustainability. Among the most notable CSS impact to date has been the fact that sub-recipients have used the same systems when dealing with other donors, including USAID.

KEY SUCCESSES, OUTCOMES AND CHALLENGES

The DTF arrangement has been remarkably successful in Senegal. The majority of sub-recipients supported by ANCS in the Round 1 grant have exceeded their targets, and the others have at least met them. The Global Fund’s own evaluation of Senegal’s grant was mostly positive, with implicit support for ANCS’s performance as PR. The success of the DTF structure prompted the CCM to replicate it – with the National AIDS Council and ANCS serving as PRs for the government and civil society components, respectively – in Senegal’s successful Round 6 HIV/AIDS proposal. A total of US$ 4.47 million was approved for Phase 1 of that second grant.

With such success comes a major challenge, however. ANCS recognizes that maintaining its high level of performance throughout the Round 6 grant may be difficult because the number of sub-recipients it oversees is expected to at least double (from six). The organization has itself sought capacity-building support from the Alliance as it prepares to scale up its engagement.

The work of ANCS and, by extension, the watchdog activities of the Observatoire have also ensured that civil society is more fully and meaningfully involved in all aspects of the national response to HIV/AIDS. One important example of the positive impact of such engagement is that most of the recommendations in the Observatoire’s landmark report have subsequently been adopted. As a result, most observers agree that access to HIV testing and treatment have improved; programs have been initiated with the goal of reaching more MSM and other vulnerable populations and more aggressive efforts have been undertaken to reduce HIV-related stigma and discrimination.
LESSONS LEARNED

The following are among the lessons learned from the ongoing and direct efforts by the Observatoire and ANCS to improve the HIV/AIDS response in Senegal:

- Civil society organizations can more effectively influence government policy if they build coalitions and work together;
- National responses can be greatly improved when civil society effectively recognizes and exploits its crucial "watchdog" function. Such efforts are best approached with the goal of proposing solutions and soliciting the support of funders;
- Local NGOs can manage funds and programs carefully, efficiently and effectively. The performance to date of ANCS sub-recipients offers proof that targeted support reaps major benefits;
- Ongoing reviews of sub-recipients’ performance can help identify gaps and problems early on and enable them to be fixed promptly. This can help ensure that targets and goals are ultimately met; and
- Close collaboration and partnerships between government and civil society can be a successful model. The model works when government recognizes the inherent value of civil society engagement and NGOs have the capacity to deliver quality outcomes.
Somalia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
- community systems strengthening
- non-Country Coordinating Mechanism proposal

ORGANIZATION INVOLVED
Coordination of International Support to Somalis (CISS)

COUNTRY BACKGROUND
POPULATION
8.3 million

INCOME LEVEL CLASSIFICATION
Low income (as per latest World Bank data)

ADULT HIV PREVALENCE
0.9% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK
Internally-displaced people and other mobile populations, young people

NOTABLE TRENDS
The lack of reliable data from Somalia regarding all health issues – not just HIV – greatly limits the ability to identify epidemiological trends. Most observers believe there is a significant TB/HIV co-infection problem, given that Somalia is one of the world’s high-burden TB countries.

INCREASED LITERACY AND EDUCATION FOR CHILDREN, PARTICULARLY GIRLS, IS DIRECTLY LINKED TO IMPROVED HEALTHCARE.
OVERARCHING OBSTACLE: ABSENCE OF CENTRALIZED AUTHORITY

Somalia has been considered a “failed state” since the early 1990s, when the most recent national government fell amid tribal and clan-based conflict. The international community has worked to help re-establish central authority, but various efforts over the years have not proved successful. The country instead has been divided into three separate regions, each of which has its own administrative bodies. However, the governments of two of the regions, Puntland and Somaliland, are not recognized abroad, and neither they nor the national government based in Mogadishu in the south have more than a tenuous reach throughout their territory. The situation currently is most challenging in the south, where persistent conflict, poverty, and hunger have forced hundreds of thousands of Somalis to flee their homes. The majority remain in camps for internally-displaced people run by the UN and other international organizations.

Although conditions are marginally better in Puntland and Somaliland, the political chaos over the years has been accompanied by near-total collapses in Somalia’s nationwide economy and its education and health systems. Illiteracy rates have continued to rise while life expectancy worsens. Awareness about HIV is extremely low, which – as it does in most other societies – contributes to high levels of HIV-related stigma and discrimination. Another important factor behind such high levels is a deeply conservative culture that often stigmatizes and ostracizes individuals who contract HIV due to the real or perceived behaviors leading to transmission.

BACKGROUND TO GLOBAL FUND INVOLVEMENT

Although Somalia is considered a failed state, the experience of the Global Fund is that such states should not necessarily be equated with poor performance in implementation. Applications from Somalia have been approved and funded – including one that focuses on HIV/AIDS through Round 4.

The Global Fund’s inherent flexibility has been the major underlying reason for its ability and inclination to provide support in challenging environments. For instance, it is true that the Global Fund generally encourages national governments to be directly involved in establishing a CCM and overseeing Global Fund activities, including grant applications, through that body. No central government exists in Somalia; therefore, forming one government-level CCM was impossible with three separate governing authorities. A group of international organizations (including UN agencies) formed the Coordination of International Support to Somalis (CISS) to submit non-CCM proposals to the Global Fund. This option was acceptable because the Global Fund’s guidelines specifically state that it will consider such proposals from nations where a viable central government does not exist.

CISS is an unusual model for numerous reasons. Not only is it not considered a CCM, but originally it was composed entirely of representatives of international organizations. At the time that CISS was being formed its members believed that no local organizations – civil society or public sector – had the capacity to or were prepared to represent themselves. Original CISS members also were concerned that including local representatives would exacerbate competing interests throughout the highly-charged domestic political environment. Because of the importance it places on national ownership, the Global Fund Secretariat was not satisfied with that decision. It strongly urged CISS members to devise a solution to ensure that Somalis were directly represented. In the wake of negotiations with authorities of the three separate regions, the coalition agreed to include at least one representative from each region.

Another unusual feature is that CISS is not based in Somalia but in neighboring Kenya (in Nairobi). That decision was based on security concerns and on close consideration of the political complications of seeking to work across all three regions of Somalia. CISS members recognized that a potential base in Somalia would mean having to choose one of the three regions. The two regions not chosen might then have barred all or some forms of Global Fund assistance in response.

The lack of local capacity is also the reason that an international agency, the United Nations Children’s Fund (UNICEF), was selected as PR for the HIV/AIDS grant, Implementing the Strategic Framework of Prevention and Control of HIV/AIDS and STIs within Somali Populations. The total funding request was for US$ 24.9 million.

UNICEF manages the grant from Nairobi, although it retains a persistent presence in Somalia through focal points in all three regions, in conjunction with regular site visits by key staff. To the fullest extent possible, the agency and its implementing partners seek to coordinate and integrate similar activities within the framework of the different HIV/AIDS strategies and programs devised by authorities in the three regions. One success has been the establishment and utilization in all three regions of a single M&E framework with common reporting tools.
COMMUNITY SYSTEMS STRENGTHENING THROUGH THE GLOBAL FUND

CSS is one of the major, if not the most important, Global Fund activities undertaken to date through the Round 4 HIV/AIDS program in Somalia. The rationale was lack of awareness and capacity among local NGOs to even apply for Global Fund grants, let alone provide appropriate services. The first year of the grant was almost exclusively oriented toward intensive training of civil society groups (and, to some extent, public sector entities) in all aspects of organizational administration and service provision. The priority skills included basic M&E skills, blood safety measures, VCT, and anti-stigma and behavior-change strategies. As of February 2008, approximately 20 NGOs had been accredited (deemed prepared to serve as sub-recipients).

UNICEF has been assisted in these CSS efforts by other international NGOs, including Oxfam. That organization’s local branch has received Global Fund support for a project in which local “trainee consultants” are given three months of training in organization development and then “attached” to selected NGOs for six months, during which time they in turn train that group’s staff and serve as mentors. Such a CSS model is particularly effective because the ultimate hands-on training of NGOs is provided by local experts.

According to a Global Fund scorecard prepared and released in 2007, the program “has achieved some significant results.” Among the most notable in terms of exceeding targets were the following:

- 580 people receiving VCT services (290 percent of target);
- 227 PLWHA had received adequate treatment and/or prophylaxis for OIs (151 percent of target);
- 70 PLWHA in need had received ART (77 percent of target); and
- 9,782 people had been reached by CBOs each year with HIV prevention, treatment and care services (217 percent of target).

Global Fund staff also note that reporting (M&E) is of particularly high quality among sub-recipients in Somalia. That achievement would seem to be a direct result of the concentrated and extensive focus on CSS from the very start of the grant.

CURRENT AND POTENTIAL CHALLENGES TO GLOBAL FUND ACTIVITIES

The successes demonstrated to date in Somalia should not be underestimated, but it is important to note that significant challenges remain for all stakeholders involved in the HIV/AIDS response. Among them are the following:

- Whether viewed collectively or by individual regions, Somalia is one of the poorest societies in the world. Few domestic resources are therefore available to contribute to an effective HIV/AIDS response. The lack of resources and capacity within governing bodies could prove problematic for the long-term sustainability of HIV/AIDS and other key health programs.
- Very little is known about the HIV epidemic in Somalia. Most observers believe HIV prevalence remains relatively low, especially in comparison with some neighboring countries, but no reliable data currently exist. Collecting such information country-wide will always be difficult with the existing political structure as well as with the ongoing conflict in certain regions.
- Direct and consistent engagement by Somalis in decision-making is hindered by the fact that both CISS and the PR are based in Kenya.
- Reports to date indicate that although prevention activities are expanding into all parts of the country, they have reached only a small number of people in key high-risk groups (including sex workers, IDUs and army personnel). Comprehensive prevention efforts have also been hindered by the slow progress of condom distribution. One reason cited for that shortfall is concern on the part of PR staff of potential reprisals against service providers by socially-conservative opponents of such interventions.
- CISS, the PR and their local implementing partners have had little success in getting PLWHA involved in any capacity building, let alone in taking leadership roles. They point to persistently strong HIV-related stigma and discrimination, including examples in which HIV-positive individuals have been shunned by or experienced physical abuse from family members, friends and other community members.
LESSONS LEARNED

The following are two complementary and important overall lessons to be learned from the mostly-positive impact and outcomes of the Global Fund’s HIV/AIDS grant in Somalia:

- The Global Fund’s guidelines are flexible and adaptable enough for it to be directly engaged in even the most complex, resource-constrained and politically challenging environments.
- Local civil society groups can be effective service providers and partners in challenging environments as well, provided i) they receive appropriate, targeted support as early as possible, and ii) they themselves demonstrate a strong degree of commitment and coordination.
PEER EDUCATION AND CLEAN NEEDLE EXCHANGE PROGRAMS FOR IDUs HAVE MADE SIGNIFICANT INROADS IN THE SPREAD OF NEW INFECTIONS IN THAILAND.

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
> leadership by vulnerable population
> non-Country Coordinating Mechanism proposal
> community systems strengthening

ORGANIZATION INVOLVED
Raks Thai Foundation

COUNTRY BACKGROUND
POPULATION
65 million
INCOME LEVEL CLASSIFICATION
Lower-middle income (as per latest World Bank data)
ADULT HIV PREVALENCE
1.4% (as per latest UNAIDS data)
POPULATIONS MOST AT RISK
IDUs, sex workers, MSM
NOTABLE TRENDS
In the 1980s, Thailand was one of the first Asian countries to face a severe HIV epidemic. In the following decade, its government was also one of the first among high-burden countries – not only in the region, but worldwide – to initiate comprehensive prevention and treatment programs. Those steps were successful in stabilizing the epidemic, although the intensity and quality of the government’s prevention efforts in recent years have been criticized as inadequate.
Injecting Drug Users: The Most Vulnerable of the Vulnerable

HIV prevalence in Thailand continues to be several times higher among the most vulnerable groups than the general population. Individuals most at risk are IDUs, MSM and sex workers, of which Thailand has a particularly large number, due to its domestic sex industry. In 2000, the health minister estimated that nearly half of IDUs were HIV-positive. That share is thought to have declined, but more recent estimates—that perhaps one-third of active IDUs are living with HIV—offer clear signs of a still-raging epidemic.

The stigma and discrimination experienced by Thailand’s IDUs, estimated to number at least 200,000, were starkly displayed during a high-profile anti-drugs campaign launched by the government in 2003. Over the course of several months, police detained tens of thousands of people and killed as many as 3,000 of them, almost all extra-judicially. The government claimed that those killed were drug dealers, but many independent observers said the majority were simply users. The resulting international uproar prompted the government to scale back the campaign, but calls for re-escalation continue to be made from time to time by various officials.

The Thai government’s indifference toward IDUs has long been evident in terms of HIV services also. Even though authorities recognized that IDUs were a particularly vulnerable population by 2000, they had not implemented measures to address the specific HIV prevention and care needs of drug users. Instead drug-related policies focused on punishment by emphasizing incarceration, mandatory drug treatment and violations of confidentiality. Given such conditions, it was not surprising that most IDUs were unable or unwilling to seek access to vital HIV services. Moreover, the risks of contracting HIV remained high because no syringe exchange or substitution treatment programs existed in Thailand, even though a handful of pilot projects had been evaluated as successful and effective.

Background to Global Fund Involvement

According to the experiences of some of the NGOs, the government’s attitudes toward IDUs carried over to the CCM, the majority of whose members are from government agencies. For example, a group of civil society organizations—including the Raks Thai Foundation—was stymied when it approached the CCM with proposals to integrate the needs of IDUs into Thailand’s first Global Fund HIV/AIDS grant application. CCM members reportedly said that working with IDUs would be “too complicated”. A second effort was similarly rebuffed, with some CCM members stating that a proposal to the Global Fund with specific targets and services for IDUs was “not necessary” and would “not merit funding”.

Raks Thai and its civil society allies, including organizations of drug users, therefore decided to bypass the CCM and submit their own proposal. The main reason for this was based on the CCM refusal to consider their proposal, which the Global Fund guidelines specifically mention as an appropriate rationale for submitting a non-CCM proposal (see box on following page).

In its proposal, Raks Thai listed the following other reasons for not submitting a proposal through the CCM:

> The government of Thailand and Thai society [do] not currently recognize the value of harm reduction [to reduce HIV transmission risk among IDUs].
> Although there are public health officials in government positions who support harm reduction, they are currently unable to express this support publicly given the current policy environment.
> Harm reduction programming is urgently needed in Thailand. However, in light of the current official drug policies, it is drug users themselves who are in the best position to deliver harm reduction programming. Their peers may be reluctant to participate in similar government-initiated programs because participation could be perceived to carry the risk of harassment, arrest, and mandatory treatment and HIV testing. They also fear for their privacy, given that health-care facilities and the police regularly share information about drug users.
> The [applicant] does, however, firmly believe that the Thai government will permit the proposed pilot project to proceed. That is because the government had officially recognized drug use as a health issue; it had previously allowed pilot studies of harm reduction programs, including syringe exchange and methadone maintenance; the project is consistent with several of the stated objectives in the current National HIV/AIDS Plan; and the proposed project has the support of recognized NGOs and academic partners who will independently and rigorously monitor and evaluate the project.
The proposal, *Preventing HIV/AIDS and Increasing Care and Support for Injecting Drug Users in Thailand*, was approved in Round 3. It was a small grant, with just US$ 1.3 million requested over three years (in comparison with the standard five-year grant). Three civil society implementing partners were involved: the Thai Drug Users’ Network, the Thai Treatment Action Group and Alden House.

The main objectives of the grant, listed below, were designed to fill a gap left by the Thai government’s reluctance to engage fully in HIV prevention and treatment services for IDUs:

- dissemination among IDUs of education and awareness information regarding how to prevent HIV infection and other health-related harms;
- increasing uptake of health-care services among IDUs by providing information on where and how to get such services;
- increasing uptake of VCT among IDUs;
- reducing AIDS deaths among IDUs;
- increasing the capacity of policy-makers to create public health policies specific to injection drug use and HIV/AIDS; and
- increasing awareness and capacity among health-care providers, police and prison staff as to how and why to provide and support comprehensive HIV prevention, care, treatment and support to IDUs.

The grant offers a rich example of CSS aimed specifically at members of vulnerable populations. Through capacity-building activities, grant implementers focused on training peer leaders within IDU communities. Those participating could be either current or former drug users. Approximately 50 peer leaders were trained under a model that involved formal partnerships among, and regular input from i) public health experts and health researchers from Thailand and abroad and ii) four dynamic and effective drug users’ organizations from abroad.

After being trained, the individuals provided peer-based outreach, education, and counseling and referral in four communities, including in local prisons and youth detention centers. Their activities were organized and coordinated through harm reduction centers (small office spaces with drop-in centers) established with grant funds. Support for HIV testing and ART adherence were two of the more specialized activities in which they were trained. Grant implementers and their partners also provided regular training updates for all participants.
LESSONS LEARNED

The following are among the notable lessons learned from this unique Global Fund program in Thailand:

> The Global Fund guidelines on non-CCM proposals are taken seriously by the Global Fund Board and proposal review committees (such as the Technical Review Panel). Although the Global Fund does prefer proposals to come from CCMs, there are exceptional cases based on set criteria for accepting non-CCM proposals. Assuming they meet the relevant criteria, non-CCM proposals are considered carefully and potentially funded.

> Civil society organizations, notably those comprising members of vulnerable communities, need not necessarily be large or experienced for their non-CCM proposals to be considered. As proved by the Raks Thai Foundation in its successful proposal, it is more important that they be able to identify significant obstacles to the delivery of services to those in need, have developed a plan to respond and can demonstrate a commitment to carry out their objectives.

> Funding from the Global Fund can be used for capacity-building activities within the applicant organization. This is especially important when a non-CCM application is made, because in such instances government expertise and resources are less likely to be available to implementers.

> Local and international NGOs are often willing and able to help their civil society compatriots in drafting proposals (non-CCM and otherwise); training staff and volunteers and helping build implementation capacity. Such assistance played a critical role in all aspects of the civil society-led, non-CCM grant in Thailand.

According to Global Fund guidelines, proposals from non-CCMs are eligible if they satisfactorily explain that they originate from:

> countries without a legitimate government (such as governments not recognized by the UN); or

> countries in conflict, facing natural disasters, or in complex emergency situations; or

> countries that suppress or have not established partnerships with civil society and NGOs.

In the first two criteria, non-CCM proposals are eligible because it is likely that CCMs have not been established. That is the case with Somalia.

The third criterion is more pertinent to countries where CCMs do exist, as in Thailand. As the Global Fund guidelines further state, non-CCM proposals are eligible when a CCM “unreasonably fails to consider a proposal that has been submitted though the CCM’s advised processes for proposal consideration.” Such a failure on the part of the CCM may be related to the fact that it “i) did not review the proposal; ii) did not review it within a reasonable timeframe; or iii) unreasonably refused to include it (or some part) in the CCM’s own proposal to the Global Fund.”

The successful non-CCM proposal from Thailand included extensive documentation, as required, that convinced grant evaluators that the CCM had in fact unreasonably refused to include proposals related to prevention and care among IDUs.
KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
- community systems strengthening
- leadership by vulnerable populations

ORGANIZATIONS INVOLVED
- International HIV/AIDS Alliance in Ukraine
- All-Ukrainian Network of People Living with HIV

COUNTRY BACKGROUND
POPULATION
46 million

INCOME LEVEL CLASSIFICATION
Lower-middle income (as per latest World Bank data)

ADULT HIV PREVALENCE
1.4% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK
IDUs, sex workers, MSM, prisoners, street children

NOTABLE TRENDS
Ukraine is home to the highest HIV rate in Europe and one of the world’s fastest-growing epidemics in recent years. One of the main reasons the epidemic has yet to show signs of stabilizing is that prevention programs still reach only relatively small proportions of the most at-risk populations, notably IDUs, sex workers and MSM. As in most other countries of the former Soviet Union, the epidemic in Ukraine has long been concentrated among IDUs. Although their share of new infections has dropped below 50% recently, they are still by far the most heavily-affected group.

IN UKRAINE, VOLUNTEERS AND PROFESSIONAL COUNSELORS ATTEND A WORKSHOP ON MOTIVATIONAL COUNSELING WHICH INCORPORATE TRUST-BUILDING EXERCISES.
BACKGROUND AND OBJECTIVES OF FOCUS ORGANIZATIONS: CSS AT THE CORE

Established in 2000, the International HIV/AIDS Alliance in Ukraine is in some respects the largest NGO in Ukraine. Its current size stems primarily from the appointment, in March 2004, of the UK-based International HIV/AIDS Alliance as PR of the country’s Round 1 HIV/AIDS grant. (The Alliance in Ukraine is implementing the Global Fund program on behalf of its parent organization.) The Alliance had not sought the PR responsibility when the grant proposal was first submitted; it became directly involved only after the Global Fund Board suspended the grant in January 2004 amid concerns over the original PRs’ mis-management and slow disbursement of funds.

The Alliance in Ukraine also serves as co-PR of the Round 6 HIV/AIDS grant, sharing responsibilities with another civil society group, the All-Ukrainian Network of People Living with HIV (the Network). Through its work with the Global Fund and the USAID SUNRISE project, the Alliance has provided financial and technical support to about 150 NGOs and national institutions, enabling them to deliver appropriate and high-quality services and information. The full range of technical support includes treatment awareness, project design, service provision to vulnerable communities, budget planning, strategic planning, M&E, financial management, development of information and resource materials, partnership building, advocacy and resource mobilization.

The Alliance’s effective oversight of the Round 1 grant has been particularly notable given the difficult circumstances under which it became involved. It succeeded in speeding up overall implementation to efficient levels, achieved more widespread and rapid scale-up of ART enrollment and identified and removed many of the obstacles hampering effective introduction of substitution treatment. One important factor behind the Alliance’s success in Ukraine has been that it has from the beginning been able to rely on the expertise of the Alliance Secretariat in the UK. The technical and capacity-building support provided by the Secretariat proved invaluable in enabling the Ukraine linking organization to step into the PR role relatively quickly and efficiently.

The Network is a homegrown entity that was started a decade ago by a small group of PLWHA, many of whom had experience in self-help groups. At the time, there was almost a complete lack of treatment and care services available for HIV-positive people. Most of the rapidly-growing number of PLWHA were isolated and alone, vulnerable to legal, social and economic discrimination. Ignorance about HIV was widespread and the few prevention services available rarely targeted the most at-risk individuals (then, as now, IDUs). The Network grew to become the primary advocacy and support group for PLWHA in Ukraine. It has reached some 20,000 PLWHA across the country through community centers where local volunteers and members provide care and support services to their HIV-positive peers.

With the assistance of several international NGOs, the Network has gained the ability to provide direct technical support and training for PLWHA, social workers and counselors on how to manage the local centers and deliver comprehensive services at the community level. The Global Fund has also played a direct role in such CSS activities. Not only is the Network co-PR of the Round 6 HIV/AIDS grant, but it is a sub-recipient for the Round 1 grant. It therefore has long received financial and technical support through the Global Fund to help strengthen and expand its activities on the ground.

GLOBAL FUND ROUND 6: DUAL CIVIL SOCIETY PRINCIPAL RECIPIENTS

In the wake of the problems with the Round 1 grant, the original Ukrainian CCM was disbanded and replaced with a new one, the National Coordination Council, in 2005. The following year, the council led the development of a successful Round 6 HIV/AIDS proposal that included a maximum amount of US$ 151 million over five years, the largest grant ever approved for Eastern Europe.

The newer grant is even more unusual than its Round 1 predecessor because it not only has two PRs, but both are civil society organizations. This is not an example of DTF per se (because no government body is involved). It is more accurately viewed as a multiple-PR model in which an experienced organization (the Alliance) simultaneously shares responsibility with and helps build the grant-management capacity of another group with which it has long been partnered (the Network). This is a formal arrangement where, as part of the program, the Network has been contracted with the Alliance to provide technical assistance in developing its procedures so that it can effectively meet its PR responsibilities. The lesson learned by this structure is that the Global Fund is willing to consider numerous options in order to help raise committed local NGOs to leadership positions.

The Alliance oversees most prevention and M&E activities funded through the Round 6 grant. The Network, alternatively, focuses on treatment, care and support and building supportive environments. The PRs’ responsibilities overlap to some extent in certain areas, given that prevention and care are not mutually exclusive. For example, the provision of substitution treatment for IDUs is both a vital (particularly in Ukraine) HIV prevention service and also an important treatment one because it is often the first step towards IDUs accessing regular care and support.

ROUND 6 STRATEGIC PRIORITIES, OBJECTIVES AND SERVICE DELIVERY AREAS

Staff from the Alliance and the Network were among the civil society stakeholders involved in developing the proposal for the Round 6 HIV/AIDS grant.
Nearly all local and international NGOs – as well as independent observers – agree that Ukraine’s HIV epidemic can only be addressed effectively when IDUs have more extensive and consistent access to a full range of harm reduction services. Many of those interventions, including syringe exchange and opiate substitution treatment, remain controversial, however. Opponents of substitution treatment, for example, believe that providing drug users with orally-ingested medicine to wean them off of injecting heroin is merely an example of swapping one addictive drug for another. They either do not see or do not care about the most important impact: the dramatic reduction in HIV transmission risk.

Advocates’ efforts to increase access to substitution treatment in Ukraine have spanned more than a decade. Their efforts have not been in vain, as similar efforts have been in neighboring Russia, where methadone and similar medicines used in substitution treatment remain banned for any purpose. However, powerful drug-control officials in Ukraine have thrown up one roadblock after another, even after the government formally acknowledged the internationally-recognized effectiveness of substitution treatment in reducing HIV transmission and treating opiate addiction.

The debate has been going on for nearly five years. As far back as December 2003, the Alliance in Ukraine’s executive director, Andriy Klepikov, emphasized the need for substitution treatment during hearings in the Ukrainian parliament. Four months later, the prime minister signed a new National HIV/AIDS Program that specifically provided for substitution treatment implementation.

No further action was taken for a full year. Finally, in April 2005 the health minister issued the first order on implementation of substitution treatment programs in six Ukrainian cities. However, law enforcement authorities launched a campaign to ban the medical use of methadone, the cheapest and most widely-used (internationally) substitution treatment medicine.

Advocates, including the Alliance and the Network, used Global Fund assistance to help successfully counter the banning effort. Even so, the number of IDUs able to access either methadone or its less controversial counterpart, buprenorphine, remained limited. Part of the problem was lack of funds; other obstacles included various customs and drug-scheduling regulations that effectively limited supply.

Advocates continued to meet with government officials and parliamentarians to explain the evidence-based rationale for substitution treatment and urge them to facilitate its access as a vital public health intervention. Finally, the Ukrainian government in November 2007 included funds in the national budget to treat patients with substitution treatment. The following month, the president issued a decree aimed at eliminating existing barriers to the scale-up of substitution treatment. The first batch of methadone to be used for substitution treatment arrived by the end of the year.

The most recent outcome is likely to have the most far-reaching positive impact on drug users’ health. In January 2008, an amended version of the national drug law took effect. It not only stresses the concept of drug-related harm reduction as one of the key strategies of the government drug policy, but also cancels the government’s monopoly on the use of narcotic drugs for medical purposes. That means civil society groups are now allowed to implement substitution treatment programs on their own. The new law is a major triumph for civil society stakeholders in Ukraine and the culmination of many years’ effort.
Because the grant is so large and ambitious, they created a system in which the following four main strategic priorities constituted the overall guidelines of the grant:

- coordinating services to increase efficiency;
- expanding prevention services for the most at-risk populations;
- scaling up treatment, care and support for most affected populations to redress inequities; and
- sustaining and enhancing the key achievements of the Round 1 program.

These four main strategic priorities were the basis from which five key objectives were determined. In turn, 15 service delivery areas were identified from those five objectives.

- **IDUs** are at the center of one key objective and several service delivery areas, all of which are overseen by the two PRs. The basic package of services for IDUs around the country is being enhanced by establishing drop-in centers and improving access to social and vocational support, mobile HIV testing, TB detection, STI detection and treatment and structured referral to treatment, care and support. Much of this work is being done through a community outreach model that is driven by local NGOs, particularly those comprising drug users themselves. The capacity of local organizations is being strengthened through the formation of peer groups, with special focus on underserved small towns and villages. These new groups are expected to be among the most important advocates for policy change at the local and national levels, especially with regard to HIV prevention and treatment among IDUs.

Other service delivery areas focus specifically on the three other populations considered to be the most vulnerable in Ukraine:

- **Grant funds** are being used by local organizations to create and sustain self-help groups for **MSM**, an often-neglected but highly-stigmatized population. Financial and technical support are also being provided to strengthen the capacity and reach of a newly formed lesbian/gay/bisexual/transgender (LGBT) coalition. Leaders of this coalition, which is modelled to some extent on the Network, are seeking to boost their ability to conduct effective advocacy on behalf of MSM at local and national levels. The main advocacy goals include reducing stigma and discrimination and helping to improve access by MSM to essential HIV prevention and care services.

- **Communities of female sex workers and the NGOs that work with them** are being strengthened through training and the formation of peer groups to conduct effective outreach. As with the MSM and IDU communities, one key goal is to increase sex workers’ direct participation in HIV-related service delivery to their peers. This involves soliciting input from and training sex workers in areas including project design, planning, implementation and M&E.

- **Prevention services for prisoners** are being scaled up, with a goal of reaching some 50,000 inmates by the end of the grant. Prison staff and local NGOs are providing prisoners with information about HIV transmission and care as well as about TB (which is a huge health problem in Ukraine’s penitentiaries). Projects are also being designed to provide basic commodities, including condoms and bleach (to help clean injecting materials). In a possible indication of a long-term strategy, at least one prison pilot substitution treatment project is being developed.

All of these service delivery activities include substantial CSS elements, given the high priority placed on involving local civil society groups. To facilitate this overall effort, the grant proposal calls for the establishment of two regional resource centers to provide wide-ranging technical assistance to NGO sub-grantees. These centers are intended to bolster the capacity of civil society to contribute to the national response to HIV/AIDS by offering individual counseling and advice on technical, legal and organization development issues; financial management schemes; strategic planning and advocacy for promoting efficient models and civil society mobilization.

**LESSONS LEARNED**

As of March 2008, the Round 6 grant had been operating for less than a year; thus it is not yet possible to draw firm conclusions about its impact. It is possible, however, to list a few important observations related to the process to date:

- **Civil society groups** are often willing, able and committed to support each other in ensuring the success of Global Fund grants. In Ukraine and elsewhere, bonds between nongovernmental groups are generally stronger than those between NGOs and government bodies due to more closely-shared objectives and operating mechanisms. Therefore, CSS is manageable and effective even when both the provider and recipient of technical support have similar high-level responsibilities.

- The enthusiasm, motivation and commitment of members of vulnerable communities should not be underestimated. Even if on paper they may not have the appropriate capacity or expertise to manage programs and services, they should be given special attention because of their potential and likelihood of remaining engaged and identifying new strategies. In Ukraine, the direct engagement of HIV-positive individuals through the Network has greatly invigorated HIV prevention and treatment initiatives begun by the Alliance and other stakeholders.

- **Even if government-controlled, CCMs** are often willing to support civil society taking the lead in Global Fund projects. This is especially true if the organizations specifically stress that their activities are in line with the national HIV/AIDS programs and they present themselves as collaborators, not adversaries. The Alliance in Ukraine offers a good example of how to walk that line deftly and appropriately - as both partner to the government and advocate seeking to encourage policy change.
Zambia

KEY ELEMENTS OF CIVIL SOCIETY ENGAGEMENT
> dual-track financing with multiple PRs
> community systems strengthening

ORGANIZATIONS INVOLVED
> Zambian National AIDS Network
> Churches Health Association of Zambia

COUNTRY BACKGROUND

POPULATION
12 million

INCOME LEVEL CLASSIFICATION
Low income (as per latest World Bank data)

ADULT HIV PREVALENCE
17% (as per latest UNAIDS data)

POPULATIONS MOST AT RISK
Everyone (generalized epidemic)

NOTABLE TRENDS
With nearly one in five people between the ages of 15 and 49 living with HIV, Zambia’s epidemic is one of the most generalized in the world. Nearly all individuals are at risk of contracting HIV, which has spread for the most part through unprotected sex and mother-to-child transmission. External assistance, particularly from the Global Fund and the President’s Emergency Plan of AIDS Relief (PEPFAR), has helped increase access to treatment and bolster prevention programs.

A PEER EDUCATOR IN ZAMBIA LEADS A SESSION WHICH IS PART OF A CAMPAIGN ENTITLED “YOUNG, HAPPY, HEALTHY AND SAFE” WHICH PROVIDES INFORMATION ABOUT AND RAISES AWARENESS OF HIV/AIDS.
GLOBAL FUND INVOLVEMENT

Zambia’s CCM successfully applied to the Global Fund HIV/AIDS component for Rounds 1 and 4. From the very beginning, it considered civil society to be an equal partner to the government, specifically in terms of grant management and implementation. For both Rounds 1 and 4, the CCM’s proposal called for four PRs, two from the government sector (the Ministries of Finance and Health) and two from the civil society sector (the Zambian National AIDS Network (ZNAN); and the Churches Health Association of Zambia (CHAZ)).

The Zambian example is unusual because the multiple-PR model was adopted so early in the Global Fund’s history – with the very first round of grants. The CCM was the key driving force behind that model. It was determined to take whatever appropriate steps were necessary to address its national HIV epidemic effectively and quickly, and it concluded that getting money to community-based NGO implementers through civil society itself would be the most effective means for the specific Zambian context.

The model also stemmed from the CCM’s recognition that the most efficient strategy would be to hold different stakeholders responsible for different aspects of implementation. The four PRs were selected for their ability to implement programs, manage resources efficiently and effectively, harness community support and ensure accountability. Each PR was given responsibility for different parts of the grant (although some responsibilities overlap in part).

ZNAN and CHAZ, the two civil society PRs, oversee all civil society sub-recipients and program activities. The two ministries focus on overall coordination, as well as large-scale logistical activities in which public-sector negotiations are ongoing (such as ARV procurement).

ONE CIVIL SOCIETY PRINCIPAL RECIPIENT’S RANGE OF FUNDED ACTIVITIES

One notable outcome from the multiple-PR model is that more than one stakeholder nearly always means that a greater number and wider range of activities and options will be considered. That point is illustrated by the type of activities funded in Round 4 by ZNAN, for example.

Improving access to HIV treatment is one of the two main responsibilities ZNAN has as PR. (The other refers more directly to prevention education and service provision.) The organization realized that several different strategies could be used to fully achieve the one HIV treatment objective. In some cases, the organization emphasized existing best practice, while in others it developed new projects.

One best practice identified by ZNAN is an innovative and successful community-engagement project that exemplifies CSS. That project, known as ART Community Education and Referral (ACER), was launched by the International HIV/AIDS Alliance and has been implemented in partnership with numerous local NGOs and community groups (see box, next page). ACER focuses on training and employing PLWHA to help support those in need and link them with appropriate treatment services. ZNAN supported the project through the Global Fund to expand from four sites to more than ten.

ZNAN has also sought to increase the involvement of the private sector in the country’s HIV/AIDS response. The organization signalled this priority immediately after the Round 4 grant was signed. It announced through the media (including newspapers and radio) that it would be supporting the development and expansion of HIV/AIDS workplace programs through the Global Fund. The announcement included a public call for proposals – with relevant criteria clearly outlined – from private companies and organizations involved or interested in setting up such programs.

After reviewing all submissions, ZNAN chose the Zambian AIDS Business Coalition to be the main sub-grantee for that private-sector initiative. The PR assessed the coalition’s capacity needs and provided support where necessary, including staff training, improved transportation options and upgraded technology (including better computer access). This type of capacity-building support is similar to – and ultimately complements – the CSS activities offered by ZNAN to civil society sub-grantees in its role as PR.
The Global Fund in Zambia recently agreed to support the innovative project ACER, begun by the International HIV/AIDS Alliance in 2004. The decision by ZNAN, one of the PRs of a large HIV/AIDS grant, was in recognition of the success of the project and the expectation that it would expand. It also serves as an indication of the type and scope of projects that are funded through the Global Fund.

The underlying idea behind ACER was to explore how an integrated community-engagement approach can support the government ART program, increase uptake of HIV testing and ART and contribute to better HIV prevention and health-seeking behavior. To that end, ACER focuses on linking existing community organizations – including home-based care providers, church groups, traditional healers and PLWHA groups – with government health services. Those partner groups provide community education on ART, VCT, HIV prevention and stigma reduction. They also help develop and sustain a two-way referral system between the community and the health system (including other treatment supporters), thereby helping ensure that individuals are followed up and supported when they return to the community.

Another key element of ACER is the direct involvement of PLWHA in all stages of its design and implementation. For example, based on the belief that peer support is a highly-effective strategy in reaching people in need, the project trains people openly living with HIV as treatment support workers. They promote uptake of treatment, support treatment adherence and help enhance prevention efforts in community and clinic settings. All treatment support workers are full-time employees, which not only guarantees them and their families a livelihood but also creates a committed and experienced staff.

In addition, the Network of Zambian People Living with HIV AIDS (NZP+) was involved in the two formative assessments, known as “community consultations” held prior to the project’s launch. Those consultations were essential for project designers to recognize and understand individual and community perceptions as well as residents’ knowledge and experiences of HIV/AIDS and its related treatment. NZP+ and its HIV-positive members continue to be key partners in the ongoing implementation of this model.

As of the beginning of 2008, the project was reaching more than 120,000 people at a total of four sites in Zambia, two each in Ndola and Lusaka. With recently-announced Global Fund assistance, totaling at least US$ 1 million, the project will be scaled up to 13 districts. That will lead to a large increase in the number of treatment support workers; perhaps as many as 500 will ultimately be needed.

The project’s success in helping increase uptake in VCT and treatment services has also prompted the Zambian Ministry of Health to use the ACER community-engagement approach in the scale-up of its treatment services. And finally, there are significant and noteworthy CSS elements to the project. For example, local partner organizations are learning from their involvement in the ACER project and utilizing their new skills to build capacity for other activities.
IMPACT AND LESSONS LEARNED

Serving as a PR, even for only part of a grant, is a major responsibility for any entity. The challenges are arguably greater for civil society groups because they are nearly always smaller and have less direct access to resources than government agencies. ZNAN, however, has been relatively successful to date:

> According to a 2007 grant scorecard issued by the Global Fund, ZNAN progress has been mostly positive. It was noted in particular that the program “has performed well in its key activity of putting HIV/AIDS patients on ART (579 patients, 125 percent of target). There are also good results for people receiving sensitization and education on ART (90 percent of target) and health- and home-based care facilities receiving support (114 percent of target).”

> The number of patients on ART had more than doubled less than one year after the release of the 2007 Global Fund scorecard. According to ZNAN, in April 2008 nearly 1,420 patients were on ART through the program.

The most notable lesson learned from the experience in Zambia is that a multiple-PR model can indeed be effectively structured and implemented. The success to date serves as a clear counterweight to critics’ arguments that such a model is unwieldy to administer and creates a competitive environment among the various PRs. As has become clear in Zambia, such potential problems can be avoided when:

> civil society’s voice and influence in the CCM are strong and respected by all stakeholders;
> the CCM as a whole recognizes the comparative advantage of each of the sectors (public, civil society and private) in specific elements of service delivery;
> each PR’s responsibilities are identified and highlighted from the very beginning; and
> the program continues to be implemented in a spirit of mutual respect and cooperation among all PRs involved.
List of Terms & Abbreviations

**Alliance** International HIV/AIDS Alliance

**ACER** ART Community Education and Referral (Zambia)

**ANCS** Alliance Nationale Contre le SIDA (Senegal)

**ART** antiretroviral treatment

**CBD** community-based organization

**CCM** Country Coordinating Mechanism

**CHAZ** Churches Health Association of Zambia

**CISS** Coordination of International Support to Somalis

**CSS** community systems strengthening

**IDU** injecting drug user

**DFID** Department for International Development (UK)

**DTF** dual-track financing

**HCT** home-care team

**HSS** health systems strengthening

**ICP** Integrated Care and Prevention Program (Cambodia)

**IDU** injecting drug user

**IEC** information/education/communication

**JICA** Japan International Cooperation Agency

**KHANA** Khmer HIV/AIDS NGO Alliance

**LGBT** lesbian/gay/bisexual/transgender

**M&E** monitoring and evaluation

**MSM** men who have sex with men

**NAF** National AIDS Foundation (Mongolia)

**NGO** nongovernmental organization

**OI** opportunistic infections

**OVC** orphans and vulnerable children

**PEPFAR** President’s Emergency Plan for AIDS Relief (U.S.)

**PLWHA** people living with HIV/AIDS

**PMTCT** prevention of mother-to-child transmission

**PR** Principal Recipient

**STI** sexually-transmitted infection

**TB** tuberculosis

**UNICEF** United Nations Children’s Fund

**UNFPA** United Nations Population Fund

**USAID** United States Agency for International Development

**VCT** voluntary counseling and testing

**ZNAN** Zambia National AIDS Network

Established in 1993, the International HIV/AIDS Alliance (the Alliance) is a global partnership of nationally-based organizations working to support community action on AIDS. These national partners help local community groups and other NGOs to take action on AIDS, and are supported by technical expertise, policy work and fundraising carried out at the UK-based international secretariat and across the Alliance.

In addition to community and country-based programs, the Alliance also has extensive regional programs and works on a range of international activities such as support for South-South cooperation, operations research, training and good practice development, as well as policy analysis and advocacy.

This publication is based on an extensive literature review and interviews among staff at the Secretariat of the International HIV/AIDS Alliance (Brighton, UK) and the Global Fund Secretariat (Geneva, Switzerland). Staff from Alliance linking organizations in specific countries also provided information, observations and insights.

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