DESK REVIEW: ANALYZING THE INCLUSION OF CIVIL SOCIETY PRIORITIES IN GLOBAL FUND HIV AND TB FUNDING REQUESTS – INCLUDING MATCHING FUNDS IN 8 ANGLOPHONE AFRICAN COUNTRIES

JULY 2018

TUNISIA

ALGERIA

LIBYA

EGYPT

LIBYAN DESERT

TRIPOLITANIA

Tripoli

Tunis

MALTA

Gulf

Sfax

Sousse

Bizerte

Annaba

Constantine

Batna

Biskra

El Oued

Touggourt

Ghardaïa

Ouargla

El Goléa

In Salah

Adrar

Reggane

Gueltas d'In Ziza

Tamanrasset

Mt. Tahat 9,573

HAGGAR MTS.

Djanet

Illizi

Ghadames

Sabha

Marzuq

Ghat

Qatrun

Al Qatrun

Toummo

Djado

AÏR (AZBINE)

NIGER

Ingal

Agadez

Agadem

Bilma

Surt

Suknah

Zillah

Maradah

Rabyanah

Al Jawf

Kufrah Oasis

TIBESTI MTS.

Bardai

Ounianga Kébir

Faya-Largeau

Fada

Bodele Depression

Koro Toro

CHAD

Mao

N'Djamena

Bokoro

Chari

Sarh

Koumra

SAHARA

SAHARA DESERT

EL DJOUF DESERT

MALI

Kidal

Ménaka

Gao

Araouane

Tombouctou (Timbuktu)

Mopti

Ségou

Nara

Nioro

Kayes

Bamako

BURKINA

Ouagadougou

Léo

Bolgatanga

Tamale

Bouaké

Séguéla

Man

Yamoussoukro

CÔTE D'IVOIRE (IVORY COAST)

GHANA

Kumasi

Accra

Sekondi

Axim

Abidjan

Sassandra

Tabou

Cape Palmas

Harper

Greenville

Monrovia

LIBERIA

GUINEA

Conakry

Kankan

Boké

SIERRA LEONE

Freetown

Tahoua

Niamey

Zinder

Sokoto

Kano

Hadejia

Gaya

Kaduna

Ilorin

Kandi

Ibadan

Lagos

NIGERIA

Abuja

Bauchi

Makurdi

Enugu

Benin City

Porto Novo

Lomé

TOGO

BENIN

N'Guigmi

Lake Chad

Garoua

CAMEROON

Yaoundé

Douala

Malabo

BIOKO

EQUATORIAL GUINEA

RIO MUNI

Libreville

Oyem

Port Gentil

GABON

Franceville (Masuku)

Mayumba

Pointe-Noire

CABINDA (Angola)

Bight of Benin

SÃO TOMÉ & PRÍNCIPE

Príncipe

São Tomé

Annobón (Pagalu) (Eq. Guinea)

GULF OF GUINEA

Niger

CENTRAL AFRICAN REPUBLIC

Bangui

Abéché

Oum Hadjer

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ACKNOWLEDGEMENT

ABOUT EANNASO

The Eastern Africa National Networks of AIDS Service Organization (EANNASO) is a membership regional network made up of eight national networks of AIDS Service organizations in seven countries: Burundi, Ethiopia, Kenya, Rwanda, Sudan, Tanzania (mainland and Zanzibar) and Uganda. EANNASO facilitates coordination, effective joint advocacy, networking and information sharing among its member networks in Eastern Africa, with a vision of an empowered civil society which can effectively contribute to promoting a life free from the HIV epidemic and its associated impacts in the East African region. Through driving a regional HIV prevention agenda that empowers national networks, we can effectively contribute to reducing new HIV infections by enhancing the voice of CSOs and strengthening both institutional and programmatic capacities.

In 2017, EANNASO's mandate as the Community Rights and Gender Strategic Initiative's Regional Platform for Communication and Coordination on HIV/AIDS, Tuberculosis and Malaria for Anglophone Africa was renewed for 2017-2019. EANNASO's Platform work is guided by four objectives:

- further the meaningful engagement of civil society and communities in Global Fund processes through bi-direction communication and the provision of accurate and accessible information;
- improve the overall impact of Global Fund programs and interventions through strengthened engagement of civil society and communities affected by HIV, TB and malaria;
- expand access to technical assistance (TA) for civil society and communities through greater coordination with the CRG-SI short-term TA component, as well as other TA providers and opportunities; and
- support strategic civil society and community capacity development initiatives through fostering spaces for engagement and collective participation in key decision-making processes, in particular as they relate to community, rights and gender.
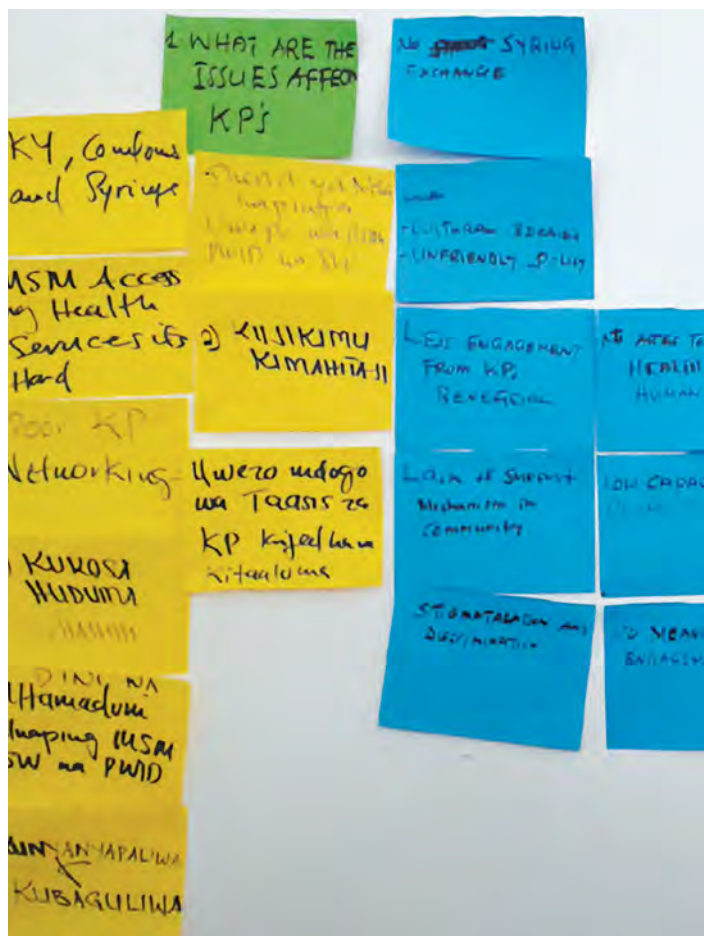
LIST OF ACRONYMS

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CS	Civil Society
EANNASO	East Africa National Networks of AIDS Service Organizations
FBO	Faith-Based Organization
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
KP	Key Populations
LGBT	Lesbian, Gay, Bisexual and Transgender
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MSM	Men Who Have Sex with Men
NGO	Non-Governmental Organization
NSP	National Strategic Plans
PAAR	Prioritized Above Allocation Funding Request
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PreP	Pre-exposure Prophylaxis
PWID	People Who Inject Drugs
RMNCH	Reproductive, Maternal, Newborn, Child Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
SW	Sex Workers
TB	Tuberculosis
TRP	Technical Review Panel
VMMC	Voluntary Male Medical Circumcision
ZGFCCM	Zanzibar Global Fund Country Coordinating Mechanism

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EXECUTIVE SUMMARY

The desk review seeks to understand how civil society priorities - particularly pertaining to community, rights and gender are included in Global Fund funding requests for HIV and tuberculosis including matching fund requests. The review looks at civil society priority charters and reports from consultations supported by EANNASO in eight countries: South Sudan, Zanzibar, Zambia, Zimbabwe, Ghana, Tanzania, Kenya and Nigeria. It compares these charters to the last available draft of funding request submissions to determine whether civil society priorities were included in the regular allocation, relegated to the prioritized above allocation request (PAAR) or left out altogether. The review also analyzes whether priorities were taken up in the matching funds requests (where relevant). Lastly, the desk review surveyed civil society and community respondents on their perceptions of their involvement in the process and factors that facilitated and hindered their involvement.

The desk review found variations in the degree to which civil society and community groups' priorities were included in funding requests. For example, Zambia was successful in integrating all of their community systems strengthening asks into the funding requests including funding for community-based monitoring and advocacy for enabling environments and social accountability for marginalized, left out/hard to reach populations and communities. For its part, civil society in Tanzania identified a number of key priorities for TB and TB/HIV which included providing support for community engagement around TB, including calls to strengthen and coordinate the community-led response and advocate for the inclusion of community indicators into the existing systems. Interventions to coordinate the community response were found in prioritized above allocation register.

Unsurprisingly, one trend that emerged was that priorities around key populations and human rights were often omitted from the funding request or relegated to the prioritized above allocation register. In addition, matching fund requests mostly did not reflect the priorities identified in the civil society priority charters. Despite this, a majority of civil society and community survey respondents believe that civil society priorities were included and they reported that in all key steps of the funding request process, civil society and community groups were either "moderately engaged" or "engaged". The exception to this was in the review by the Grant Approvals Committee, where civil society noted that they were "barely engaged" in that step of the process. In fact, respondents felt that this process deliberately left out civil society and left the decision making to high-level stakeholders.

The desk review identified the availability of technical support from EANNASO, UNAIDS and Global Fund's Community Rights and Gender Technical Assistance, clear guidelines and policies for engagement and support from government as some of the key factors facilitating engagement. In particular, the support from EANNASO in convening spaces for civil society to caucus, discuss entry points, agree upon priorities and chart advocacy strategies was identified as a strength in several country reports. Conversely, a lack of access to timely technical support, funding and evidence and data were among the factors hindering engagement.

The following are recommendations to ensure robust community and civil society engagement in Global Fund processes:

For Civil Society and Community Groups:

- Civil society and community groups should advocate for more space for indigenous civil society organizations (for e.g. through a quota systems)

- Civil society and community groups should be vocal in pushing to be involved and represented in all stages of Global Fund processes

- Civil society and community groups should advocate for evidence-based priorities that will benefit the response and not just their respective organizations

- Civil society should provide the writing team with prioritized and costed activities and interventions that align with the modular template

For Country Coordinating Mechanisms:

- Ensure community groups/ networks/ affected communities are part of the decision-making, planning, implementation and evaluation processes throughout the funding cycle. Ensure there is funding to enable community groups' and networks' engagement with the processes.

- Ensure adequate communication with civil society and community groups. This includes broadly seeking input, within reasonable timelines and laying out the process and opportunities for input transparently.

- Ensure that civil society and community groups' input is captured and included in the feedback provided at every stage of the process.

For Technical Support Providers:

- Provide funding to civil society and community groups to participate in meetings both in-person and virtually.

- Provide capacity building for civil society to understand, develop and use data for more effective advocacy.

- Provide capacity building for civil society to monitor the inclusion of their priorities in the grant (and during implementation)

- Provide technical assistance for gender-based analysis

- Provide capacity building for civil society to develop advocacy and negotiation skills, competencies to participate in Global Fund processes

One of the key limitations of this study was having to rely on available data. For example, each country produced a civil society charter using their own format. In some cases, these were prioritized lists of specific interventions tied to Global Fund modules, in others they were long lists of community asks. This made comparison between countries and with funding requests more challenging than if a standard template had been used .

Another challenge was that in some cases, specific costed budget information was not included in the funding request. Even if several interventions related to community, human rights and gender were included, they may have amounted to a relatively small dollar amount. Lastly, the study relied on the last available drafts of funding submissions. The submissions are reviewed and revised during the approval process and as such do not actually reflect what was actually approved in the final grant following those negotiations. These should be areas of further investigation.

INTRODUCTION

In recent years, there has been increased recognition of the need to include civil society voices in the design, implementation and oversight of Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) programs. The Global Fund's funding model requires countries to demonstrate that they have engaged civil society in ongoing, robust multi-stakeholder country dialogue to qualify for funding.

Although civil society organizations[1](CSOs) are increasingly called upon to participate in consultations to provide recommendations for funding priorities, meaningful engagement remains challenging. The Global Fund's strong focus on aligning fund requests with National Strategic Plans (NSP) poses a risk for the inclusion of civil society priorities, as these are not always adequately captured and reflected in NSPs.

Moreover, community groups, including networks of people living with HIV and affected by malaria and tuberculosis as well as key and vulnerable populations, face additional barriers exacerbated by stigma and discrimination. All over Africa, civil society organizations and community groups have come together to discuss and agree upon recommendations to ensure greater impact of Global Fund funded programs. As a result of this advocacy, there are several entry points for civil society to influence funding requests, for example by participating in consultations or reviewing drafts and yet there still is no guarantee that civil society priorities will actually make it into the funding requests.

Evidence[2] shows that there is a significant relationship between HIV prevalence and the responsiveness of concept notes/funding requests to civil society priorities. Looking at 8 countries in Southern Africa, a 2015 EANNASO study found that countries with lower HIV prevalence were more responsive to civil society priorities. While this does not imply causality, the correlation is certainly worthy of further investigation. In 2017, EANNASO supported civil society and community groups in 8 countries to engage in various stages of funding request development. This desk review examines whether and how civil society priorities have been included in HIV and tuberculosis funding requests-in particular as costed interventions, the prioritized above allocation register (PAAR) and (where relevant) in matching fund requests. It includes a country case study looking at Zanzibar's program continuation request and closes with a civil society assessment of how the process went, what hindered and/or facilitated engagement and guidelines for civil society participation and recommendations for technical support.

[1] CSOS INCLUDE A DIVERSE SET OF ORGANIZATIONS, RANGING FROM SMALL, INFORMAL, COMMUNITY-BASED ORGANIZATIONS TO THE LARGE, HIGH-PROFILE, INTERNATIONAL NON-GOVERNMENTAL ORGANIZATIONS WORKING THROUGH LOCAL PARTNERS.

[2] EANNASO. 2016. ASSESSING THE INCLUSION OF CIVIL SOCIETY PRIORITIES IN GLOBAL FUND CONCEPT NOTES: A DESK REVIEW OF CONCEPT NOTES SUBMITTED BY KENYA, MALAWI, SWAZILAND, TANZANIA, UGANDA, ZAMBIA, ZANZIBAR AND ZIMBABWE.

OBJECTIVES & METHODOLOGY

The desk review seeks to understand how civil society priorities particularly pertaining to community, rights and gender are included in Global Fund funding requests for HIV and tuberculosis and matching fund requests. The review looks at eight countries: South Sudan, Zanzibar, Zambia, Zimbabwe, Ghana, Tanzania, Kenya and Nigeria. The study aims to answer the following questions.

1. Have civil society priorities for community, rights and gender been incorporated in funding requests? If so, how?

2. Are aspects of community, rights and gender discussed in the country context sections of the proposals, but then omitted in the actual funding request section?

3. Have countries submitted requests for matching funds? Have they requested the suggested amount (or more/less)?

4. Additionally, have civil society priorities for adolescent girls and young women, key populations, removing human rights barriers and finding the missing cases of TB been incorporated into matching fund requests? If so, how?

5. Were civil society priorities included in the allocation requests, or in the prioritized above allocation request?

6. At which stages of the application process were civil society and community groups engaged?

7. What factors may have facilitated/hindered the inclusion of this engagement?

8. What are recommendations and key guidelines for CS and community groups as they continue to engage in Global Fund processes, throughout the funding cycle? What are the implications and recommendations for future technical support?

For this study, EANNASO used reports from civil society consultations held in each of the eight aforementioned countries. These countries were selected on the basis of available data as EANNASO had provided technical support to each of the consultations. These reports were not in a standard format as civil society expressed a desire to have more open conversations and not use restrictive formats.

Priorities were then summarized and compared against Global Fund funding requests and matching request submissions (or latest drafts available). In the case of Nigeria, the technical review panel review form was used in lieu of the funding requests. The Global Fund funding requests were sourced via relevant partners including CCM Secretariats, CCM members and civil society representatives. The funding requests were for integrated TB/HIV funding requests with the exception of South Sudan, who provided separate HIV and TB funding requests. Civil society priorities for malaria were excluded from the analysis. The desk review also includes analysis from a short online survey disseminated to key civil society and community stakeholders involved in these consultations. The survey received 31 responses.

LIMITATIONS

One of the key limitations of this study was having to rely on available data. For example, each country produced a civil society charter using their own format. In some cases, these were prioritized lists of specific interventions tied to Global Fund modules, in others they were long lists of community asks. This made comparison between countries and with funding requests more challenging than if a standard template had been used. Another challenge was that in some cases, specific costed budget information was not included in the funding request. Even if several interventions related to community, human rights and gender were included, they may have amounted to a relatively small dollar amount. Lastly, the study relied on the last available drafts of funding submissions. The submissions are reviewed and revised during the approval process and as such do not actually reflect what was actually approved in the final grant following those negotiations. These should be areas of further investigation.

SECTION I:
COUNTRY BY COUNTRY ANALYSIS

In 2017, the EANNASO provided technical support to civil society and community groups to engage in the development of funding requests in Anglophone African countries. EANNASO's involvement was different for each country. In some countries, EANNASO was instrumental in supporting the development of civil society priorities to feed into the NSP all the way through to the funding request. In other instances, support requests came later - when countries were already quite advanced in the drafting process. This section briefly summarizes the consultation process, analyses the inclusion of civil society priorities in funding requests and matching fund requests and provides observations around key successes and challenges.

ZAMBIA

Zambia has made significant progress towards halting and reversing the HIV and TB epidemics over the last decade.

The number of new HIV infections has fallen by 29.4%[3] (from 85,000 in 2004 to 60,000 in 2015). Although HIV prevalence has been declining, there are gender and age-related disparities in HIV burden. While prevalence has been recorded at 14.5% prevalence among women compared to 8.6% prevalence among men. This disparity is most pronounced among young people aged 20-24, where HIV prevalence is more than four times higher among women (8.6%) as compared to their male peers (2.1%)[4].

Criminalization, stigmatization and marginalization drive both higher rates of infection and lower uptake of services among key populations. For instance, the Zambia people living with HIV (PLHIV) Stigma Index shows that 68.5% of sex workers report being physically harassed or threatened due to their HIV status, compared to an average of 46.7% among the entire sample. [5]The National HIV and AIDS Strategic Framework 2017-2021 defines key populations as PLHIV, adolescent girls and young women, young men, inmates, migrants, people who inject drugs, sex workers, gay men and other men who have sex with men, transgender people, children and pregnant women living with HIV, displaced persons, persons with disabilities and people aged 50 years and older.

[3] DATA FROM HTTP://AIDSINFO.UNAIDS.ORG/ AND UNAIDS (2016). PREVENTION GAP REPORT. PAGE 221. ONLINE AT
    HTTP://WWW.UNAIDS.ORG/SITES/DEFAULT/FILES/MEDIA_ASSET/2016-PREVENTION-GAP-REPORT_EN.PDF
[4] ZAMHPIA 2015-2016 FACT SHEET. ONLINE AT HTTPS://PHIA.ICAP.COLUMBIA.EDU/WP-CONTENT/UPLOADS/2016/09/ZAMBIA-FACTSHEET.FIN_.PDF
[5] ZAMBIA NETWORK OF PEOPLE LIVING WITH HIV (ZNP+) (2012). THE PEOPLE LIVING WITH HIV STIGMA INDEX: ZAMBIA. PAGE 38. ONLINE AT
    HTTP://WWW.STIGMAINDEX.ORG/SITES/DEFAULT/FILES/REPORTS/ZAMBIA%20PEOPLE%20LIVING%20WITH%20HIV%20STIGMA%20INDEX%20REPORT%20%202009%20PUBLISHED%202012.PDF

Tuberculosis incidence has fallen by 40%[6] (from 650/100,000 population in 2003, to 391/100,000 population in 2015). The country's first National TB Prevalence Survey (2013– 2014) found that the prevalence of TB in Zambia is higher than previously estimated. In Zambia, the TB program has identified prisoners, mining communities, the urban poor, children, people living in farm blocks, PLHIV and people with diabetes as key populations for the TB response. Table 1 below shows the amount the country could apply for per component:

Zambia: Full Review		
ALLOCATION AMOUNT	HIV	184,377,140
	Tuberculosis	10,008,862
MATCHING FUNDS	HIV: Adolescent girls and young women	4,000,000

Table 1: Funding allocation amounts in the allocation letter

The civil society consultations' main objective was to ensure that civil society, including community groups, were provided with space and voice through their own representation to identify key national priorities and have them included in the funding request. Civil society participants were drawn from 15 civil society constituencies including members of key and vulnerable populations such as people living with HIV, TB, sex workers, lesbian, gay, bisexual and transgender individuals, youth, people who use drugs, women and prisoners. A civil society meeting, hosted by the PLHIV constituency, was held in February 14, 2017 where civil society refined the tool that they would use to determine what they saw as gaps in the response. This meeting was followed by a series of 4 provincial consultations conducted during the week of February 27 – March 3, 2017 in the Copperbelt, Northern, Southern and Western provinces involving 130 people and representing 15 constituency groupings. Finally, 164 people were consulted during the adolescents, youth and women consultations March 9 and 17, 2017.

Zambia's civil society produced a document with priority interventions categorized according to the areas in the modular template. The majority of the interventions were included in the allocation budget in the funding request, with some interventions being placed in the PAAR and a few interventions being completely left off.

For example, civil society was successful in getting decentralized and differentiated HIV testing services into the community. As well as a differentiated care model which includes the decentralization of ART.

[6] WHO (2016) GLOBAL TB REPORT. PAGE 168 (ZAMBIA PROFILE). HTTP://APPS.WHO.INT/IRIS/BITSTREAM/10665/250441/1/9789241565394-ENG.PDF?UA=1

That said, interventions that required strengthening community-based support services for PLHIV and strengthening treatment adherence and literacy were relegated to the PAAR. In the area of combination prevention, interventions related to demand creation for Voluntary Male Medical Circumcision (VMMC) were included in both the funding request and the PAAR, but key interventions to strengthen awareness of PrEP and PEP were notably absent as were interventions to promote the dignity and well-being of PLHIV. In terms of key and vulnerable populations, the funding request allocated funds to differentiated delivery of peer-led comprehensive health and empowerment programs, combining community empowerment, addressing violence, distributing condoms and lubricants, taking a harm reduction approach, providing integrated HIV/TB/STI health services, offering legal support, and making creative use of information communication technology.

Notably, all of the civil society priorities related to community systems strengthening were included in the funding request. These included interventions such as:

- Supporting advocacy for enabling environments and social accountability for marginalized, left out/hard to reach populations and communities.

- Enhancing community structures' monitoring of interventions, including for human rights violations of vulnerable populations

- Strengthening the capacity of community structures to deliver inclusive and gender responsive HIV/STI/TB/GBV/SRHR/malaria responses, to meet specific needs of key and vulnerable populations.

- A capacity assessment of CBOs, NGOs, FBOs and community groups in 30 target districts, documenting and identifying providers to provide capacity development support to improve service delivery to expand community-led service delivery.

- Developing community monitoring basic guidelines and tools to monitor implementation (by local authorities) of prioritized plans and interventions agreed upon with local authorities and orienting community representatives and leadership and supporting them to implement activities using the monitoring tools.

An amount of $6,140,084 or 3% of the grant was dedicated specifically to interventions targeting adolescent girls and young women. These interventions include: behavioral change; HIV testing services for adolescents and youth (AGYW), in and out of school; linkages of HIV, RMNCH; and TB programs for adolescents, girls, and young women, other intervention(s) for adolescent and youth, community mobilization and norms change, gender-based violence prevention and treatment programs for adolescents and youth.

In relation to TB and MDR-TB, the funding request included civil society priorities related to Intensifying TB case finding to people in communities, mining, prisons and other closed settings by using CSOs to prioritize high TB prevalence areas as well as investments for community health volunteers to support treatment adherence for MDR-TB. However, community contact tracing for both TB and MDR-TB were also placed in the PAAR. The funding request also included civil society priorities to support targeted and intensified TB case finding and prevention interventions among key populations , including prisoners, miners, PLHIV, children, adolescents, TB contacts, healthcare workers, diabetics, and high-density urban residents. In the mining areas, the National Tuberculosis and Leprosy Program the funding request proposed to build the capacity of mining hospitals/clinics for periodic screening of workers for TB, their families and introduce contact screening.

Zambia submitted a matching fund requests for 4 million dollars for adolescent girls and young women (the maximum amount). The proposed intervention is to scale up the AGAPE project which provides cash transfers and direct payments of school fees to 3,000 AGYW between the ages of 10 and 24 to keep them in school and prevent pregnancies and early marriages. These priorities were not listed in the civil society priority document.

OBSERVATIONS:

Overall, Zambian civil society priorities were well reflected in the funding request although they represent a very small amount of funding. The Zambian civil society priorities document focused on a few specific priorities that were categorized by intervention in keeping with the modular template. This may have aided the inclusion of civil society and community priorities.
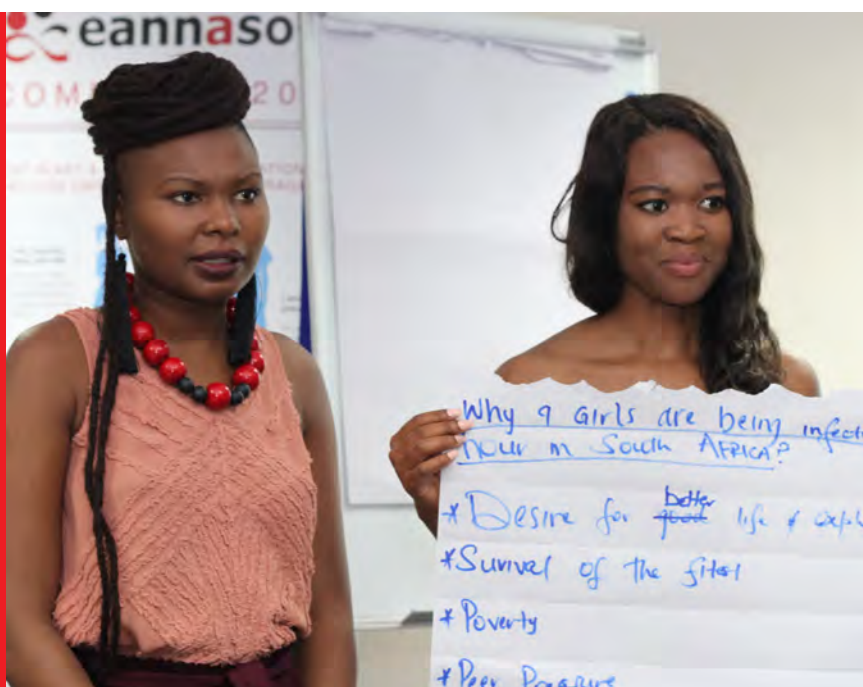
TANZANIA

The HIV prevalence has steadily declined over the past decade from 7% in 2003 to 5.3% in 2012[7]. There is an ongoing nation-wide population-based HIV impact survey that is expected to provide more current estimates for the epidemic.

The HIV prevalence in Tanzania is characterized by significant heterogeneity across age, gender, social-economic status and geographical location. HIV prevalence is higher among the key populations including men who have sex with men, people who inject drugs and sex workers, whose prevalence rates are estimated at 25%, 36% and 26%, respectively based on Consensus Estimates on Key Population Size and HIV prevalence in Tanzania. Data suggests that HIV infection rates begin to rise much earlier in girls than boys, creating a need to provide age-tailored prevention services to adolescent girls. Significant strides have been made to address vertical transmission of HIV with near universal antiretroviral therapy (ART) coverage of HIV-infected pregnant women.

The country conducted a Legal Environment Assessment in 2015 which reviewed laws, policies and practices which maintain structural conditions that leave populations without access to HIV services. HIV-related discrimination (in the workplace, health care setting, community, etc.) is often deeply interwoven with other forms of discrimination.

Tanzania ranks 6th globally in terms of its TB and TB/HIV burdens. The prevalence of TB is estimated by the World Health Organization (WHO) to be 528 per 100,000, with treatment coverage of only 37%, making it particularly critical for the National TB Program to identify and treat the missing TB cases. Table 2 below shows the amounts the country could apply for per component.

Tanzania: Full Review		
ALLOCATION AMOUNT	HIV	408,487,081
	Tuberculosis	25,849,887
MATCHING FUNDS	HIV: AGYW	8,000,000
	TB: Finding Missing TB Cases	6,000,000

Table 2: Funding allocation amounts in the allocation letter

[7] TANZANIA AIDS AND MALARIA INDICATOR SURVEY, 2012 WWW.NBS.GO.TZ

A total of 14 non-state actor sub constituencies engaged in non-state actor dialogue through structured meetings held between 22 and 29 March 2017 in Dar es Salaam. These meetings included members of the Tanzania National Coordination Mechanism constituencies represented by participants represented men and women (including people living with HIV), people affected by TB and malaria, key and vulnerable populations, youth, local NGOs, international NGOs, Christian and Muslim faith-based organizations, the formal and informal private sector, the media and academia.

The purpose of the non-state actor dialogues was to provide space for diverse sub-constituencies to engage in priority setting for the funding request. The resulting document listed gaps and proposed solutions however, it was not organized by module but rather focused on key component areas. These areas were: enabling environment and advocacy, community networks, linkages and partnerships and coordination, resources and capacity building, community activities and service delivery, organizational and leadership strengthening and monitoring and evaluation. It is worth noting that the priority charter did not include much in the way of specific interventions for key and vulnerable populations.

On key and vulnerable populations the suggested interventions were: to engage with the government for more dialogue on key and vulnerable populations and empower faith-based organizations in revitalizing abstinence, being faithful and the postponement of sex until marriage as models of preventions among key population youths. This priority was not reflected in the funding request.

The civil society priorities also identified a need for human rights and gender-based violence education for the community. The funding request included referrals and linkages to human rights protection services, gender-based violence related services for MSM and sex workers and their clients. The funding request also addressed civil society and community priorities related to legal literacy, including patients' rights, literacy trainings for PLHIV, key and vulnerable groups and training health care providers on human rights and medical ethics related to HIV. The request also supports the priority of advocating for policy change to reduce the age of consent for HIV testing – although only partially- as the funding request sets the age limit at 15, not 10 as suggested by civil society.

In addition, technical and financial support was included to enable umbrella organizations such as the Association of Tanzania Employers, the Tanzania Informal Employment Networks on AIDS Initiative, the National Council of People Living with HIV Technical Working Committee for the Government Ministries, Department and Agencies to effectively coordinate their constituencies in 10 regions with higher prevalence.

The funding request also responded to requests to extend facility and community-based HIV care and support services to ensure the continuum of care as well as rolling out community-based approaches for care to prevent missed appointments or loss to follow up.

In relation to adolescent girls and young women, civil society prioritized the engagement of community, traditional and religious leaders to address gender and cultural inequalities that influence vulnerability to HIV infection among AGYW.

Civil society identified a number of key priorities for TB and TB/HIV. This included providing support for community engagement around TB, including calls to strengthen and coordinate the community-led response and advocate for the inclusion of community indicators into the existing systems. Interventions to coordinate the community response were found in PAAR.

Tanzania was eligible for $8 million in matching funds to accelerate HIV prevention for adolescent girls and young women. A request totaling $8 million was submitted which includes the following

interventions: behavior change communication; comprehensive condom programming; gender-based violence treatment and prevention; HIV testing services; linkages to HIV, RMNCH and TB programs and keeping girls in school and economic empowerment. The fund request also budgeted for monitoring and evaluation. In contrast, civil society's priorities related to AGYW were the engagement of community, traditional and religious leaders to address gender and cultural inequalities that influence vulnerability to HIV infection among AGYW.

Tanzania was also eligible for $6.6 million in matching funds for finding the missing TB cases. Community, rights and gender related requests were included in the request. This included community TB care (transporting sputum feedback via motorbike), roll out of management of childhood illness through distance learning for key population and children, systematic screening of communities and high risk groups and procuring additional GeneXpert cartridges to intensify TB case finding among people living with HIV, prisoners and people who use drugs. None of these interventions had be included in the priorities identified by civil society.

OBSERVATIONS:

The civil society priorities for key populations were not always very specific and in some cases not based on evidence of what is effective. As a result, many civil society priorities were excluded altogether. For example, the civil society priorities make no mention of condoms and lubricants for key populations although they do appear in the funding request. This demonstrates a need to further build civil society capacity to identify evidence-based interventions and activities. It also suggest that there is value in supporting civil society to narrow down and be strategic about selecting their priorities.

ZANZIBAR

HIV prevalence in the general population is 1% with women and girls accounting for 60%[8] of all PLHIV. The Integrated Biological and Behavioral Surveillance Surveys conducted in 2011/2012 among key populations revealed a HIV prevalence of 11.3% for people who inject drugs, 19.3% for sex workers and 2.6% for MSM.

Zanzibar is one of the few states in Africa where the number of people newly placed on ART in 2016 (more than 690), surpassed the estimated rate of new infections (420 – Spectrum 2016).

In regards to tuberculosis, the National TB Prevalence Survey report of Sept 2013 in the United Republic of Tanzania estimated a prevalence rate of 124 per 100,000 population. The proportion of all notified smear positive TB patients in the period 2004-2013 was 63.1% males and 36.9% females demonstrating a gender disparity in TB notification. Table 3 shows below shows the amounts the country could apply for per component:

Zanzibar: Full Review		
ALLOCATION AMOUNT	HIV	3,992,509
	Tuberculosis	1,866,654

Table 3: Funding allocation amounts in the allocation letter

A series of consultative meetings with key populations and civil society were held from February 2-4, 2017. Two meetings were held during this 3-day period; the first day was with key populations groups; the second day with key populations and civil society organizations working to combat HIV, TB and Malaria.   At the end of Day 1, key populations discussed issues most affecting their communities and generated a list of priority interventions which was carried forward to Day 2 when meeting with other civil society organizations.

During the course of these meetings, participants discussed social, economic, structural and health issues affecting their communities, prioritized interventions or activities to prevent or mitigate effects of HIV, TB and Malaria in their communities, summarized lessons learned from this consultative meeting and elected a taskforce of civil society and key populations representatives to ensure priorities would be carried into Global Fund grants and National Strategic Plans.

[8] TANZANIA HIV/AIDS AND MALARIA INDICATOR SURVEY 2012

Civil society priorities related to prevention programs for key populations including men who have sex with men, sex workers and people who inject drugs were well included into the funding request. These include: HIV testing and screening, condom distribution, peer-led community based outreach services; size estimation and integrated biological and behavioral surveys. Interventions that were excluded were pre-exposure prophylaxis as well community-based needle and syringe programs.

In addition, the funding request supports interventions that address and mitigate stigma and discrimination against people living with HIV, men who have sex with men, people who inject drugs and sex workers. However, it excluded other interventions that had been identified by civil society such as interventions to counter self-stigma, undertaking a stigma index and sensitizing religious and community leaders. This also includes addressing stigma and discrimination in health care settings.

None of civil society's priorities pertaining to human rights were included in the funding request. These include operational research on socio-cultural norms, attitudes and behavior towards MSM, PLHIV and FSWs, review of existing policies, laws and regulations on key populations to identify and recommend areas of improvement, sensitization for law enforcers on human rights and capacity building for women, youth, PLHIV and key populations so they are aware of their rights.

Civil society was partially successful in ensuring that prevention of vertical transmission of HIV (commonly referred to mother-to-child transmission) was included in the funding request.

Civil society priorities in the area of AGYW were not included in the funding request. Namely, target adolescents and youth with audience appropriate sexual and reproductive health education, including on gender-based violence and rights. For those in school, priorities included school-based interventions for all adolescents and youth addressing gender equality, the prevention of gender-based violence & comprehensive sexual and reproductive education.

In the area of tuberculosis, priorities around community TB education and literacy were not included into the funding request.

OBSERVATIONS:

Zanzibar performed moderately well in getting civil society priorities included into the concept note. The priority interventions were clearly articulated and civil society was diligent in ensuring that their voices were heard, despite being told that there was limited room to add or modify interventions. This is because Zanzibar submitted a program continuation request: programs deemed by the Technical Review Panel to be well performing and not requiring significant program change. A short-case study on the Zanzibar experience is provided in Section 2.

SOUTH SUDAN

Ongoing conflict in South Sudan has resulted in thousands of people seeking refugee status in neighboring countries, an increase in the number of persons internally displaced and an increase in migrant populations as people move in and out of the country as the threat of violence fluctuates. This situation has been exacerbated by the fledgling health system and inconsistent and insufficient access to health services.

UNAIDS estimated the HIV prevalence in South Sudan at 2.71% in 2016 and the number of PLHIV in South Sudan by end of 2016 at about 198,503 with pockets of higher prevalence among key populations. The 2014 mode of transmission report (South Sudan GARP report 2016) estimated that most of the new HIV infections are in clients of sex workers (42.6%), children born to mothers living with HIV(15.7%), men and women involved in casual sexual relationships (14.5%), and sex workers (11.2%). Overcrowded and poorly lit living conditions may have a direct implication on the incidence of gender-based violence and trade of sex for money or food. The prevalence of condom use in the country is less than 5% with variations across states.[9] In a society where polygamous unions are common, this puts a large number of women and children at risk of HIV infection

Tuberculosis is a major public health problem in South Sudan. According to the WHO, TB prevalence was 257 per 100,000 population in 2012 (WHO), while 16,000 individuals were newly affected, indicating an incidence of 146 new TB cases per 100,000 population. Table 4 below shows the amounts the country could apply for per component.

South Sudan: Full Review		
ALLOCATION AMOUNT	HIV	29,015,250
	Tuberculosis	9,000,000

Table 4: Funding allocation amounts in the allocation letter

Documents provided to EANNASO by civil society in South Sudan did not describe the process that civil society undertook or the composition of the consultations. The priorities, which pertained exclusively to HIV, were categorized by theme and each theme included a description of the gap or problem to be addressed. Additionally, the versions of the HIV and TB funding requests that were sent to EANNASO appeared to be earlier drafts and may not be fully reflective of the degree to which civil society priorities were costed and included.

[9] UNDP, SOUTH SUDAN, 2010

In relation to HIV, priorities around Social and Behavioral Change programming were included in the funding request. Activities in the funding request ranged from individual to small group counselling to community and media activities. Priorities around condoms were only partially taken up. The priorities charter emphasized condoms as part of programs for the general population and male and female condoms for youth. The funding request included condoms as part of programs for sex workers and their clients and men who have sex with men.

Strengthening adherence through support mechanisms such as Mother to Mother support groups was a partial response to civil society's request to effectively cushion and empower PLHIV. Civil society also requested support for civil society to provide treatment and prevention and to integrate community responses that promote the uptake of biomedical prevention and treatment services. This request was partially addressed in the funding request with an intervention to train community-based organizations and PLHIV to bridge the gap in serving the community through counseling, support, client tracing, health education and the distribution of drugs. Priorities related to PMTCT were only partially addressed, with an intervention to scale up PMTCT services and early infant diagnosis but no mention of community-based innovations to facilitate community reach given great distances to health facilities, insecurity and high levels of poverty in the country.

The funding request also included interventions to reduce stigma, denial and discrimination at the individual, interpersonal, community and institutional levels.

Interventions that received no mention in the funding request include:

- Interventions to gather quantitative and national and context specific data on key and affected populations.
- Scale up of voluntary male medical circumcision
- ART provision for key and vulnerable populations and populations of humanitarian concern
- Addressing social cultural norms, practices and behavior, namely male dominated-gender norms, gender inequalities, sexual and gender-based violence and harmful social and cultural norms and practices
- Providing young women and girls key information and freedom to make informed decisions about their sexual health and to protect themselves from HIV.

No priorities related to TB were provided to EANNASO.

OBSERVATIONS:

Many civil society priorities were excluded from the funding request. That said, the funding request was incomplete- therefore subsequent iterations may have included more interventions that responded to civil society asks. In addition, South Sudan is characterized as a "challenging operating environment[10]" thus facing additional barriers beyond the usual challenges facing civil society and community groups.

[10] THE GLOBAL FUND DESCRIBES CHALLENGING OPERATING ENVIRONMENTS AS COUNTRIES OR REGIONS CHARACTERIZED BY WEAK GOVERNANCE, POOR ACCESS TO HEALTH SERVICES, AND MANMADE OR NATURAL CRISES

ZIMBABWE

HIV prevalence has decreased by 28% over the last decade[11]. Zimbabwe has an estimated 1.4 million people living with HIV (PLHIV), 1.2 million of whom are between the ages of 15 and 64[12]. Adult HIV prevalence has steadily decreased over the last ten years, declining from 18.1% in 2005 to 13.8% in 2015[13]. Women continue to bear disproportionate burden and also account for a greater share of new infections-with a dramatic burden among adolescent girls and young women. Preliminary results from the modes of transmission study show nearly 4,000 new HIV infections a year among female sex workers with a prevalence around 57.1% and nearly 2,000 new infections each year among (MSM) with a prevalence of about 23.5%.

For its part, TB incidence has dropped by nearly 60% over last 10 years[14]. TB incidence has sustained a downward trajectory from as high as 799/100,000 population in 2005 to 242/100,000 population in 2015. TB mortality excluding HIV has declined by 50%[15]. Table 25 below shows the amounts the country could apply for per component.

Zimbabwe: Full Review		
ALLOCATION AMOUNT	HIV	406,518,928
	Tuberculosis	23,775,807
MATCHING FUNDS	HIV: Key populations impact	10,000,000
	HIV: AGYW	8,000,000

Table 5: Funding allocation amounts in the allocation letter

The consultation process kicked off with a national four-day advocacy training with CCM CSO representatives, the advocacy core team and provincial CSO representatives. The workshop sought to ensure that civil society had a solid understanding of key opportunities to influence Global Fund processes, the midterm review of the National Strategic Plan as well as the new Prevention Strategy. It also aimed to identify key barriers and challenges in the TB/HIV response, develop a shared assessment of priority

[11] DRAFT MODES OF TRANSMISSION STUDY
[12] ZIMBABWE DHS 2015
[13] ZIMBABWE DHH 2015
[14] THE EPIDEMIOLOGICAL REVIEW OF TB DISEASE AND SURVEILLANCE (MAY 2016)
[15] MODES OF TRANSMISSION STUDY 2015

interventions and develop an action plan to ensure the implementation of priorities identified during the training. Once the priorities were agreed upon, a series of 3 regional civil society consultations were held from December 2016 to February 2017 to ensure broad-based consensus on the priorities to be included in the NSP and the funding request and to agree on who would sit on the CSO writing team. The team included a diverse group of individuals representing, people living with HIV, youth, women and key populations.

HIV

Priorities that were captured in the funding request include:

- Interventions to address stigma, discrimination and violence against sex workers. These services will be combined with legal support and legal literacy, and service to prevent and respond to sexual, physical and gender-based violence.

- Interventions that address stigma, discrimination and violence against MSM through legal support and legal/patients-rights' literacy trainings reduce human rights-related barriers to HIV services for MSM

- New comprehensive sexuality education curriculum

- Post-test counselling for HIV negative women, safe delivery and related commodities, and links to the school program.

- School and tertiary activities focusing on delivering peer-driven approaches to address issues around gender, power, violence and linkages to services

- Addressing social norms within communities

- Positive health dignity and prevention activities

Priorities that were included in the PAAR:

- Funding is requested for institutional capacity building, planning and leadership development to support organizational

and systems development, M&E, financial management, human resources and leadership of sectoral coordinating bodies, networks of people living with HIV, structures for workplace based interventions and community based organizations.

- Positive health dignity and prevention activities.

- Primary gender-based violence prevention programs to protect vulnerable women and girls.

- Capacity building for community-based organization , centering on program delivery on community engagement tools on the three diseases (i.e. prevention and treatment literacy

- Addressing stigma, discrimination and violence against people in prisons and other closed settings, transgender people, people with disabilities, MSM and sex workers

TUBERCULOSIS:

Priorities that were captured in the funding request include:
- Advocacy, communication and social mobilization (ACSM) to leverage community responses for drug sensitive TB to empower communities to better provide treatment adherence, palliative care and psycho-social support for DRTB in a non-stigmatizing manner

Priorities that were captured in the PAAR:
- Community responses for drug sensitive TB to empower communities to better provide treatment adherence, palliative care and psycho-social support for DRTB in a non-stigmatizing manner.

MATCHING FUNDS:

Zimbabwe requested $9.9 million out of a possible $10 million for key populations. It included civil society priorities to establish a technical support unit (TSU) to deploy long-term capacity building and technical assistance to key populations' organizations in order to support the scale up of quality service delivery.

Zimbabwe requested $7.98 million out of a possible $8 million for adolescent girls and young women. The matching fund request included civil society priorities around gender-based violence and PreP.

OBSERVATIONS:

Civil society noted in their lessons learned report from the process that civil society priorities around key populations were not sufficiently taken up as evidenced by the fact that many interventions for key populations were relegated to the PAAR.

GHANA

According to UNAIDS, Ghana maintains a relatively low prevalence rate at 1.6%. However, only an estimated 36 percent of people living with HIV were on antiretroviral therapy as of the end of 2016. Women consistently test positive for HIV at higher rates than men. Surveillance among sex workers show persistently high rates of infection compared to the general population, although prevalence has been declining. Bio-behavioral data on HIV prevalence in MSM also shows disproportionately higher prevalence.

WHO estimates from 2013 put TB prevalence at 92 per 100,000 population. Key populations for TB in Ghana are PLHIV, prison inmates, children, miners, diabetics, pregnant women and the elderly. These populations are scattered geographically in both TB high incidence districts and non-high incidence districts among the general population. Table 6 below shows the amounts the country could apply for per component:

Ghana – tailored to material change		
ALLOCATION AMOUNT	HIV	66,436,395
	Tuberculosis	16,012,823
MATCHING FUNDS	HIV: Key populations impact	3,600,000
	HIV: remove HR barriers	2,300,000

Table 6: Funding allocation amounts in the allocation letter

A four member management comprised of members of the lead organisation was created to lead the implementation of the project to develop a non-state actor charter. A mapping was conducted that identified approximately fifty organisations made up of CSO, key populations, the private sector, faith-based organisations, youth groups, community traditional leaders, and the media. A consultative meeting was held in May 2017 to solicit input into the priority issues and interventions for inclusion in the Global Fund request. The purpose of the meeting was, among other things, to strengthen the capacity of CSOs and community groups to dialogue and engage and input into the funding request development process, as well as be part of the implementation of the HIV, TB and Malaria grants. Another important aim of the meeting was to ensure that interventions for key populations were included in the funding request.
The funding request obtained by EANNASO did not contain details of the PAAR.

HIV

Priorities captured in the request include:
- Involve women's organizations in playing an active role in HIV advocacy at the all levels
- Ensure that barriers to HIV/AIDS treatment access are addressed by introducing an HIV prevention program for non-paying partners of sex workers akin to that for KPs; strengthen peer led interventions to ensure effective linkage and retention in care integrate HIV care in routine out-patient clinics at the new ART sites in the PMTCT expansion plan articulated earlier; (sensitization of health facility workers on appropriate attitudes towards patients irrespective of their sexual orientation, gender, HIV status and medical condition; training of cadre of health staff as case managers to enhance key population access to services and periodic communication from the Ministry of Health to all staff reminding them of the ethics of their professions.
- Persons living with HIV and key populations, and their networks involved in community mobilization, care and support will play prominent leadership roles in the implementation of this grant

Priorities excluded:
- Support to civil society organizations to enhance their capacity to become principal and sub-recipients of the Global Fund.
- Creating conducive environment for human rights support to lesbian, gay, bisexual, transgender and intersex individuals
- Research geared towards mainstreaming gender in KP programming
- Allocate resources for HIV prevention in particular for the young people
- Integration of maternal newborn and child health into Global Fund program implementation

TB

Priorities captured in the request include:

- intensified case finding at all levels of the health system in priority districts and extend the new diagnostic algorithm to high risk populations
- TB stigma reduction activities

MATCHING FUNDS:

Ghana was also eligible for matching funds for key populations impact and to remove human rights barriers. A matching funds request could not be obtained for the purpose of this study.

OBSERVATIONS:

Although many priorities for HIV were excluded, civil society were successful in ensuring that some of their priorities were taken into account in the funding request. According to civil society involved in the process, having civil society as part of the writing team and having civil society speak with one cohesive voice were factors that facilitated their advocacy.

NIGERIA

Nigeria continues to have high HIV and TB burdens. Even though the country has achieved a steady decline in HIV prevalence from 5.8% (2001) to 3.0% (2014), it is still ranked second for global HIV burden with almost 3.1 million people living with HIV, due to the heterogeneity of the HIV epidemic in Nigeria.

Even though Nigeria sustained drug-resistant and drug-susceptible TB treatment success rates of 77% (2013) and 87% (2015) respectively, the vast majority of TB cases (85% susceptible and 96% drug resistant) go undetected. Globally, the country is ranked fourth for new TB cases, with total incidence of 586,000 in 2015. Table 7 below shows the amounts the country could apply for per component:

Nigeria: Full Review		
ALLOCATION AMOUNT	HIV	239,781,871
	Tuberculosis	107,495,151
MATCHING FUNDS	TB: Finding Missing TB Cases	14,000,000

Table 7: Funding allocation amounts in the allocation letter

In May 2017, a group of civil society leaders responded to the call of CISHAN and the KAP Secretariat to contribute to the funding request from Nigeria. With financial and technical support from EANNASO, the organisers invited 15 CSO leaders at Summit Villas Hotel in Abuja. The civil society leaders were invited to form a community review panel on the basis of their knowledge, experience with Global Fund processes and positions within communities affected or at-risk of acquiring HIV or TB. Constituents represented each of the following: people who inject drugs, sex workers, men who have sex with men, LGBT, TB, women and girls, youth and adolescents and the faith sector. A key aim of the meeting was to consolidate CSO priorities and ensure that they were captured in ongoing writing efforts. During, the two-day meeting the panel was asked to make comments to the draft funding request which had been drafted on May 8th, 2017

Nigeria's TRP review form (not the submitted fund request) was used to analyze the inclusion of civil society priorities. Many of civil society's priorities were excluded from the funding request. Below are some of the TRPs comments:

- Prevention programs for key populations (sex workers and their partners, men who have sex with men and people who inject drugs) lack detailed interventions to convince the TRP of feasibility of implementation

- Prevention programs for key populations (sex workers and their partners, men who have sex with men and people who inject drugs) lack detailed interventions

- The minimum package for people who inject drugs does not include core harm reduction activities.

- There is a lack of detail on how to reach adolescents and youth, the range of comprehensive sexuality services they should be able to access, approaches to working with other programs to ensure delivery of and access to such services.

MATCHING FUNDS:

According to the TRP review form, the funding request does not adequately address how missing TB cases will be found and initiated on appropriate and successful treatment.

OBSERVATIONS:

The Nigerian funding request was not recommended to move forward due to having too many weaknesses and gaps. The funding request did not provide specific, evidence-based interventions to address community, rights and gender-related priorities. A new funding request will be submitted for approval.

KENYA

In 2015, Kenya had approximately 1,517,707 people living with HIV (775,939 women, 643,598 men and 98,170 children)[16].

The burden of HIV is disproportionate across counties with 65% of PLHIV in 11 counties. Prevalence among adults (15-49 years) is estimated at 5.9% (women, 6.5% and men, 4.7%). HIV prevalence among key populations is higher than the national averages: sex workers, 29.3%; men who have sex with men, 18.2% and people who inject drugs , 18.3%.[17] This data demonstrated a generalized epidemic with age, sex and geographical variations and high concentration among key populations.

Tuberculosis is the 4th leading cause of mortality in Kenya[18]. Kenya is also classified as a TB, TB/HIV and MDR-TB high burden country[19]. The burden of TB is nearly twice the WHO estimates; 558 vs 298/100,000 population[20]. Thus, of the estimated 138,000 prevalent cases in 2016, 40% were missed (Global TB Report 2016). Table 8 below shows the amounts the country could apply for per component:

Kenya: Full Review		
ALLOCATION AMOUNT	HIV	246,899,292
	Tuberculosis	45,507,072
MATCHING FUNDS	HIV: Key populations impact	10,000,000
	HIV: AGYW	5,000,000
	HIV: remove HR barriers	2,800,000
	TB: Finding Missing TB Cases	6,000,000

Table 8: Funding allocation amounts in the allocation letter

[16] KENYA AIDS PROGRESS REPORT 2016
[17] KENYA AIDS PROGRESS REPORT, 2016
[18] KENYA HEALTH POLICY (2014-2030) – PAGE 9
[19] WHO GLOBAL TB REPORT 2016 – PAGE 63
[20] KENYA TB PREVALENCE SURVEY 2017 – PAGE 10

There was no priority document to review for Kenya however, the desk review looked at a meeting report from a meeting called "Facilitating Meaningful Engagement". In the report, civil society provided the following observations:

Kenyan grants from the Global Fund have historically been commodity heavy. This has meant that quite a large proportion of the grant is being utilized for the procurement of biomedical commodities and health equipment, including diagnostics. This leaves small percentages for the implementation of structural and behavioral interventions. During the Funding Request writing, an appeal by communities for an increased resource split with CSOs and communities was not taken well by the Government partners.

Faced with limited capacity and technical know-how on issues that matter to affected communities such as community systems strengthening, gender inequality, stigma and discrimination from among the government partners, negotiations for prioritization and resources for such interventions was very difficult. The Global Fund country team had to come in to intervene.

Lastly, because most of the negotiation forums, including the CCM meetings take place in Nairobi, bringing in national representation to the Global Fund writing process and grant-making negotiations from outside the capital proved very expensive to the consultation organizing partners.

SECTION II:
ILLUSTRATIVE CASE STUDY: CIVIL SOCIETY AND COMMUNITY PARTICIPATION IN ZANZIBAR'S PROGRAM CONTINUATION FUNDING REQUEST

Case study from Zanzibar's funding request development and submission

Zanzibar provides an interesting example as the only program continuation request of the group. The Zanzibar Global Fund CCM (ZGFCCM) established a Funding Request Task Force to prepare and implement a roadmap for fulfilling all the requirements for submitting funding requests to the Global Fund by March 20, 2017. To ensure community engagement throughout the process, Eastern Africa National Networks for AIDS Service Organizations was contracted by ZGFCCM to conduct consultative meetings and processes with key population and civil society organizations to identify and ensure priority areas and interventions were included in the program continuation grant. During this stage, EANNASO supported two consultative meetings (February and March 2017), the civil society and key population taskforce and a local consultant to oversee and document civil society and key population involvement throughout the funding request development and submission process.

A series of **consultative meetings** with key populations and civil society were held from February 2-4, 2017. Two meetings were held during this 3-day period; the first day was with key populations groups; the second day with key populations and civil society organizations working to fight HIV, TB and Malaria. At the end of Day 1, key populations discussed issues most affecting their communities and generated a list of priority interventions which was carried forward to Day 2 when meeting with other civil society organizations. During the course of these meetings, participants discussed social, economic, structural and health issues affecting their communities, prioritized interventions or activities to prevent or mitigate effects of HIV, TB and Malaria in their communities, summarized lessons learned from this consultative meeting and elected a taskforce of civil society and key populations representatives to ensure priorities are carried into Global Fund grants and National Strategic Plans.

The **Taskforce of civil society groups** was assigned the following mandate:

1. improve communications channels among CS and KP groups focusing on human rights, HIV, TB and Malaria

2. ensure full and equal participation of CS and KP groups during funding request development

3. act as a bridge between CSOs and KPs with the FR writing teams. This would require lobbying, being vocal and fighting for CS/KP priorities, issues and space to engage in decisions that affect them, their rights or related services4) remain independent, neutral and free from conflict-of-interest

4. give feedback to ZGFCCM on CS/KP involvement in the FR and grant process. This would require the Task Force to request to participate in ZGFCCM meetings as an observer in order to give feedback.

5. The Taskforce was comprised of 4 seats for KPs (including MSM, sex workers and people who use drugs), 2 seats for CSOs, 1 seat for Government. It was agreed that members representing Malaria and TB organizations would be added later. ZGFCCM members could be involved in the Task Force since they represent a specific civil society constituency. Elections were held and seven (7) representatives chosen for the CS/KP Task Force; of which 3 are members of the ZGFCCM representing PLHIV, key population and NGO and 2 of them were on HIV writing team.

The first meeting of the Task Force was held after the consultation meeting. The Taskforce agreed to be up and running by February 10, develop a workplan, seek representatives from Malaria and TB organizations, meet quarterly with extraordinary meetings for urgent issues. They also agreed that the Secretariat would send a draft terms of reference to the Task Force to finalize for operations to begin.

Following this meeting, a consultative meeting was held with key stakeholders on March 11, 2017. A total of 62 participants attended the meeting representing CSOs, public and private sectors, grant programs and key populations. The aim of the meeting was to:

1. Share the draft funding requests (HIV and TB; Malaria) with stakeholders for feedback and input.

2. Recommend priorities and interventions to be included in the two proposals considering issues related to a) gender and human rights, b) key and most vulnerable populations, c) community involvement and d) health systems strengthening.

After each program presented their Self-Assessment Findings, discussions followed with group work to build on what programs are currently doing. From group presentations and discussion, a summary list of priority interventions was compiled and submitted to ZGFCCM and grant writing teams.

An extraordinary meeting was held March 15, 2017, to allow the ZGFCCM to present, discuss and ratify the funding requests were ratified by ZGFCCM.   The report/priority list from the Stakeholders' Meeting had not been circulated with other meeting documents and encountered great difficulty getting 5 copies of summary list of priorities to give to CS/KP taskforce members and writing team consultants. Efforts to get CS/KP priorities, explanations and input "on the record" were curtailed by responses of "it will be addressed during grant-making", "this is program continuation so no new activities" or restricting input and discussion with time limits. Nevertheless, most of the priorities appeared in the meeting minutes which were sent to Global Fund with the funding request. Informal discussions with writing team consultants continued during and after the meeting to see how priority words or statements could appear in the funding request so they would not be omitted during the grant-making process.

SECTION III:
RESULTS FROM CIVIL SOCIETY AND KEY POPULATION SURVEY ON INVOLVEMENT IN GLOBAL FUND PROCESSES

Civil society perceptions about the their level of engagement and influence

The Global Fund application is a multi-step process. The Global has mandated that country dialogue should be an ongoing feature that begins prior to the development of the fund request and extends right through the implementation of the grant. Country dialogue is meant to be an open and inclusive conversation with those who respond to and are living with or affected by the three diseases. It is illustrated in figure 9 .

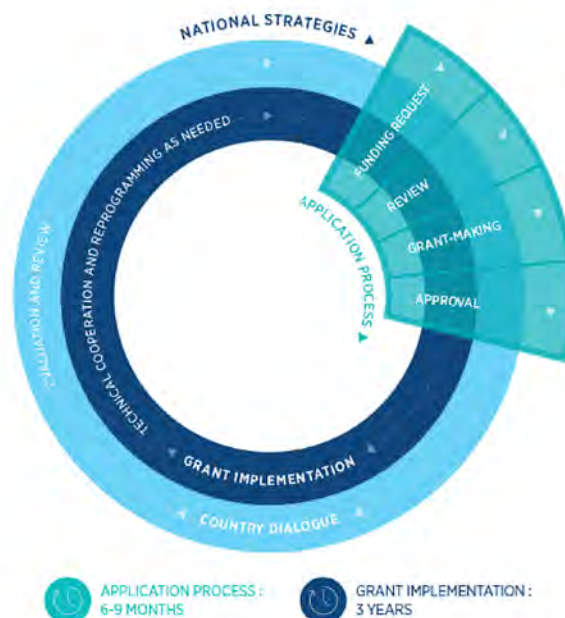The Global Fund to Fight AIDS, TB, Malaria - https://www.theglobalfund.org/en/funding-model/funding-process-steps/

Figure 9. Global Fund Application Process

The survey included responses from a cross-section of organizations involved in the Global Fund funding request development across Anglophone Africa (including the 8 countries in the analysis). The following captures their views on their involvement, key factors that facilitated and hindered involvement at each stage as well as recommendations for technical support and guidelines for how to improve civil society engagement.

In your opinion, have civil society priorities for human rights, key populations, adolescent girls young women and finding missing TB cases been reflected in the funding request (including the matching fund requests)?
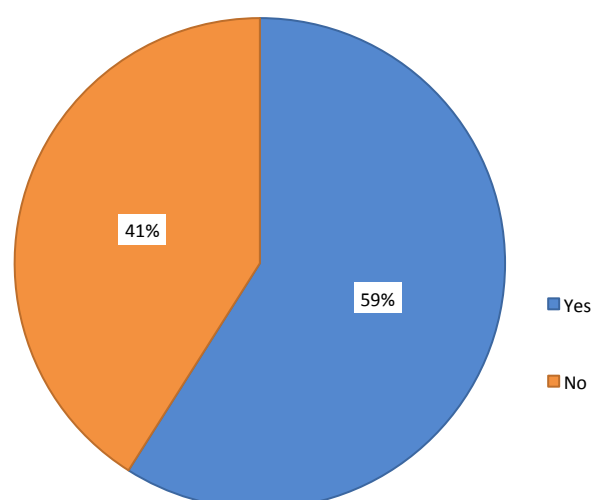

Figure 10. Civil Society responses on the inclusions of their priorities

The survey asked participants whether they believed that civil society priorities were included in the funding requests. Of the respondents, 59% said "yes" and 41% said "no". Although the majority of civil society and key populations actors believed that civil society priorities were included in the funding requests, some expressed that they believed that these priorities were treated as an afterthought. According to Chamunorwa Mashoko of the Advocacy Core Team in Zimbabwe: "civil society felt strongly that their priorities were an afterthought as the HIV response reflects about 90% biomedical interventions. The process is skewed towards keeping civil society under capacitated". He goes on to say: "The views of the general civil society are not fully captured as those who lead consultative meetings are underfunded or not supported at all".

At which stages were civil society and community groups engaged in the Global Fund funding request development process?
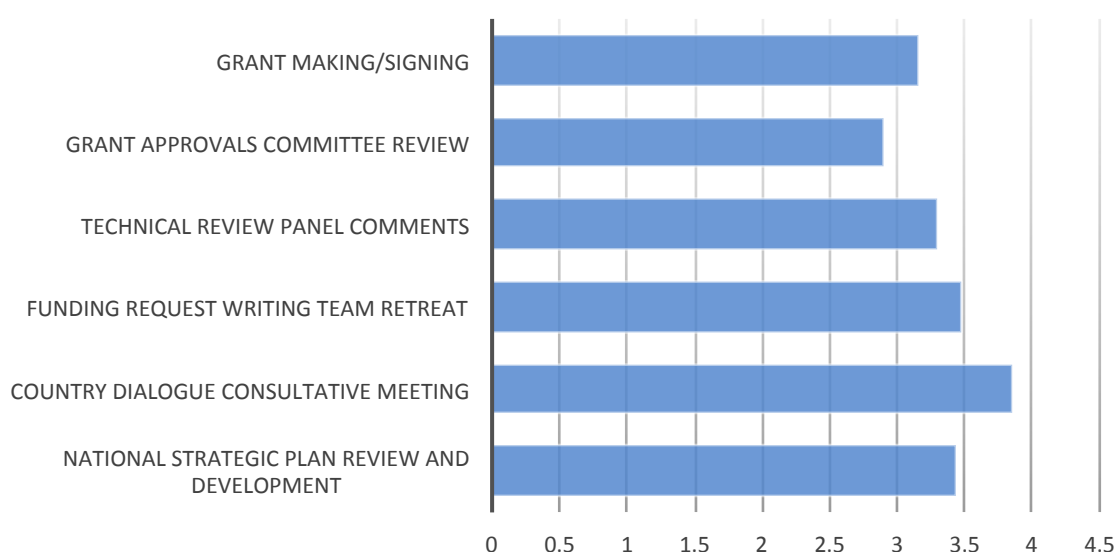

Figure 11. Civil society engagement by stage

The survey asked respondents to rank civil society engagement according to a 5 point scale where 1= did not engage, 2=barely engaged, 3=moderately engaged, 4=engaged, 5=strongly engaged. The survey found that in all key steps of the funding request process, civil society and community groups were either "moderately engaged" or "engaged". The exception to this was in the review by the Grant Approvals Committee, where civil society noted that they were "barely engaged" in that step of the process. Many of the respondents felt that this process deliberately left out civil society and left the decision making to high-level stakeholders. The country dialogue consultative meetings were the stage at which civil society and community groups reported being most engaged.

Factors that facilitated/hindered civil society and community involvement

Respondents were polled about factors that either facilitated or hindered civil society and community involvement at each stage of the process. A number of key themes emerged as factors facilitating involvement. They are summarized below:

- Civil society advocacy to be engaged and being present and participating when opportunities to arose

- Having civil society set the agenda, lead the process and contribute to various committees

- Having defined priorities and costed activities

- Ensuring that invitations to civil society and community actors are circulated broadly with enough time to ensure meaningful engagement

- Having clear guidelines and policies from the Global Fund to facilitate engagement (e.g guidance notes on gender, human rights, community systems, etc.)

- Funding from the Global Fund and other donor sources

- Technical support from EANNASO, UNAIDS and Global Fund's Community Rights and Gender Technical Assistance program

- Coordination and support by the CCM who identified stakeholders to engage in the process

- Willingness of the government to engage

Conversely, key themes emerged as factors hindering engagement. They are as summarized below:

- Lack of funding and capacity to include civil society, particularly key populations, youth and grassroots organizations

- Civil and community was not aware of opportunities to engage

- Civil society and communities did not have defined priorities and costed activities

- Failure on the part of the CCM to broadly include civil society (handpicking CSOs)

- Lack of cohesion civil society and community representatives pushing organizational agendas rather than national issues

- Political crisis (violence)

- Civil society voices overshadowed by government, National AIDS Commission, United Nations agencies and International NGOs

- Civil society and/or key populations comments not captured and taken into consideration

- Tight timelines and delays in accessing information

- Lack of evidence and civil society data

- Lack of transparency around the process

Conclusions and recommendations to improve civil society and community groups engagement in Global Fund processes, (particularly around community, rights and gender)

The desk review found variations in the degree to which civil society and community groups' priorities were included in funding requests. For example, Zambia was successful in integrating all of their community systems strengthening asks into the funding requests including funding for community-based monitoring and advocacy for enabling environments and social accountability for marginalized, left out/hard to reach populations and communities. For its part, civil society in Tanzania identified a number of key priorities for TB and TB/HIV which included providing support for community engagement around TB, including calls to strengthen and coordinate the community-led response and advocate for the inclusion of community indicators into the existing systems. Interventions to coordinate the community response were found in PAAR.

Unsurprisingly, one trend that emerged was that priorities around key populations and human rights were often omitted from the funding request or relegated to the prioritized above allocation register. In addition, matching fund requests mostly did not reflect the priorities identified in the civil society priority charters. Despite this, a majority of civil society and community survey respondents believe civil society priorities were included and reported that in all key steps of the funding request process, civil society and community groups were either "moderately engaged" or "engaged". The exception to this was in the review by the Grant Approvals Committee, where civil society noted that they were "barely engaged" in that step of the process. In fact, respondents felt that this process deliberately left out civil society and left the decision making to high-level stakeholders.

The desk review identified the availability of technical support from EANNASO, UNAIDS and Global Fund's Community Rights and Gender Technical Assistance, clear guidelines and policies for engagement and support from government as some of the key factors facilitating engagement. In particular, the support from EANNASO in convening spaces for civil society to caucus, discuss entry points, agree upon priorities and chart advocacy strategies was identified as a strength in several country reports. Conversely, a lack of access to timely technical support, funding and evidence and data were among the factors hindering engagement. Recommendations to improve engagement are described below:

For Civil Society and Community Groups:

- Civil society and community groups should advocate for more space for indigenous civil society organizations (for e.g. through a quota systems)

- Civil society and community groups should be vocal in pushing to be involved and represented in all stages of Global Fund processes

- Civil society and community groups should advocate for evidence-based priorities that will benefit the response and not just their respective organizations

- Civil society should provide the writing team with prioritized and costed activities and interventions that align with the modular template

For Country Coordinating Mechanisms:

- Ensure community groups/ networks/ affected communities are part of the decision-making, planning, implementation and evaluation processes throughout the funding cycle. Ensure there is funding to enable community groups' and networks' engagement with the processes.

- Ensure adequate communication with civil society and community groups. This includes broadly seeking input, within reasonable timelines and laying out the process and opportunities for input transparently.

- Ensure that civil society and community groups' input is captured and included in the feedback provided at every stage of the process.

For Technical Support Providers:

- Provide funding to civil society and community groups to participate in meetings both in-person and virtually.

- Provide capacity building for civil society to understand, develop and use data for more effective advocacy.

- Provide capacity building for civil society to monitor the inclusion of their priorities in the grant (and during implementation)

- Provide technical assistance for gender-based analysis.

- Provide capacity building for civil society to develop advocacy and negotiation skills, and competencies to participate in Global Fund processes.

NOTES

eannaso

Regional Platform
for Communication and Coordination
on HIV/AIDS, Tuberculosis and Malaria
For Anglophone Africa

The Eastern Africa National Networks of AIDS and Health Service Organizations (EANNASO) is a regional network bringing together civil society and community voices to inform policies and improve the programming of HIV, TB, malaria and other health issues present in our communities.

As of September 2017, EANNASO was re-selected by the Global Fund Community Rights and Gender Strategic Initiative (CRG SI) to host the Regional Communication and Coordination Platform for Anglophone Africa for the period of December 2017 to December 2019 covering 25 Anglophone African countries.

The regional platform for communication and coordination has a key role in engaging civil society organizations and community networks in Global Fund processes. It is responsible to foster regional dialogue, exchange knowledge and good practices among civil society and community actors and networks, as well as to disseminate information on technical assistance opportunities across all Anglophone countries where the Global Fund has grants countries.

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