icaso | until **we** end aids

Country Coordinating Mechanism: Key Affected Populations and People Living with the Diseases Engagement Initiative Pilot Evaluation Report – Summary, 2015

A. Introduction

The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) launched a **pilot initiative** in June 2013. The program, *"Strengthening and Systematizing Civil Society Engagement in the New Funding Model" (the Pilot)* provided top-up funding to Country Coordinating Mechanism (CCM) secretariats in ten countries. The funding, limited to between $25,000 and $50,000 USD, was meant as support for the greater engagement of key affected population networks and people living with HIV, malaria and/or tuberculosis in the New Funding Model (NFM) processes in 2013 and 2014. The funds were to enable and incentivize CCMs to ensure meaningful involvement of key affected population and people living with the diseases (PLWD) networks in country dialogue and concept note development, as well as in program planning and implementation, and to provide them with support from a third-party organization to advise and monitor the pilot program's progress. Ten CCMs were invited to participate.

Participating Country Coordinating Mechanisms (CCMs)	
Côte d'Ivoire	**The Philippines**
Democratic Republic of the Congo (DRC)	**Sri Lanka**
Guyana	**Swaziland**
Moldova	**Thailand**
Nigeria	**Uganda**

CCM Pilot Funding Amounts (1 year, USD; gray indicates funds not transferred as of October 15, 2014)				
Côte d'Ivoire: $50,000	**Guyana: $34,000**	**Nigeria: $50,000**	**Sri Lanka: $25,000**	**Thailand: $34,000**
DRC: $50,000	**Moldova: $26,000**	**The Philippines: $36,000**	**Swaziland: $34,000**	**Uganda: $50,000**

The Pilot was jointly developed and supervised by the CCM Hub and the Community, Rights and Gender Department (CRG Department) of the Global Fund Secretariat, guided by a four-step framework:

- Establish a CCM subcommittee of key affected population and PLWD members;
- Select a regional mentor organization to provide technical support to the subcommittee;
- Develop a two-year work plan for key affected population and PLWD engagement; and
- Implement the work plan.

CCMs and Regional Mentor Organizations as of October 15, 2014	
Côte d'Ivoire: African Council of AIDS Service Organizations (AfriCASO)	**The Philippines**: 7 sisters
DRC: International HIV/AIDS Alliance (The Alliance)	**Sri Lanka:** 7 Sisters
Guyana: Caribbean HIV & AIDS Alliance (The Alliance)	**Swaziland:** AIDS Accountability International
Moldova: East Europe & Central Asia Union for PLWH (ECUO)	**Thailand:** Sukhontha Kongsin (consultant)
Nigeria: International HIV/AIDS Alliance (The Alliance)	**Uganda:** East African Network of **AIDS** Service Organisations (EANNASO)

B. Background & Context

Key affected populations

Key affected populations vary across contexts. In the broadest sense, key affected populations experience significant disease burden, restricted access to services, and limitations on their human rights. Any group which meets the three criteria above can and should be considered a key affected population, and therefore deserving of tailored disease response programs.

Key Affected Populations, *as defined by the Global Fund**:

- Women & girls
- Men who have sex with men
- Transgender people
- People who use drugs
- Sex workers
- Prisoners
- Refugees and migrants
- People living with HIV
- Adolescents and young people
- Orphans and vulnerable children
- Populations of humanitarian concern

** http://www.theglobalfund.org/en/ccm/*

Conventional understanding of key affected populations tends to focus on HIV, for which men who have sex with men, transgender people, people who use drugs, and sex workers are the most commonly identified populations. Women and girls are also a large population which generally fit the above criteria, but whose inclusion in key affected population discussions varies across contexts. Key affected populations for tuberculosis and malaria manifest differently from an epidemiological and social perspective, often putting them in the shadow of the HIV key affected population discourse.

Effectively responding to the AIDS epidemic and to a certain extent tuberculosis and malaria, in every region, requires the prioritization of and investment in key affected populations. Key affected populations need to have adequate access to services, at least in proportion to the burden of disease they face. Often times, expanding access means confronting and removing legal and social barriers, and challenging high levels of stigma against key affected populations. Particularly in high overall prevalence settings, key affected populations have historically not been a priority in national AIDS programs, to the detriment of the overall response.

The Key Populations Action Plan, 2014-2017[1]

The *Key Populations Action Plan* was released in July 2014, one year after CCMs were invited to participate in the Pilot. This strategic document provides an excellent roadmap for the greater inclusion and impact of key affected populations within the NFM. However, the Pilot implementation did not benefit from the Action Plan given the different timings, and it remains unclear why the Pilot was not delayed until after the Key Population Action Plan was developed. It is the opinion of the evaluation team that the Pilot would have benefited substantially from being contextualized in a broader strategy for key affected population engagement.

The New Funding Model (NFM)

The launch of the NFM in 2013[2] provided a critical opportunity to review and revise how the Global Fund works. In the interest of maximizing the impact of grants, and in response to widespread calls for change, the Global Fund has emphasized "the critical importance of ensuring full and meaningful engagement of civil society, especially key affected populations and people living with diseases throughout the NFM process at country level."[3] In practical terms this means greater participation

[1] The Global Fund, 2014. *Key Populations Action Plan, 2014-2017*. http://www.theglobalfund.org/en/publications/2014-07-25_Key_Populations_Action_Plan_2014-2017/

[2] The NFM was launched in 2013 with a selection of early applicants, and then fully rolled out to all countries in 2014.

[3] From the concept note for the Pilot: *Strengthening and Systematizing Civil Society Engagement in the NFM*

of key affected populations and PLWDs in country dialogue,[4] concept note[5] development, CCMs, and grant implementation and monitoring. A key feature of the NFM administrative changes is the revised CCM Eligibility and Performance Assessments (EPA).[6] All CCMs underwent assessment between 2013 and 2014, and will continue to be assessed on a yearly-basis henceforth. Of particular significance to this Pilot is Requirement 4 of the Eligibility Requirements, which obliges that *"… all CCMs to show evidence of membership of people that are both living with and representing people living with HIV, and of people affected by and representing people affected by Tuberculosis and Malaria, as well as people from and representing Key Affected Populations*." This requirement went into effect in January 2015.

Country Coordinating Mechanisms (CCMs)

Global Fund grants are applied for and overseen at the country-level by CCMs, which are made up of members of the private and public sectors, and include governments, international organizations, NGOs, civil society, academic institutions, private businesses and people living with the diseases.[7] As part of the NFM, beginning in 2015, all CCMs will be required to have representatives of key affected populations in addition to people living with the diseases.[8] The CCM is primarily responsible for engaging PLWD and key affected population networks and organizations in concept note development, through to grant implementation. Ensuring broad participation and meaningful engagement remain challenging for many CCMs for various reasons, including financial constraints.

C. Evaluating the Pilot

The evaluation of the Pilot began in November 2013, after some initial steps had been taken in most participating countries, but before any engagement activities started. The evaluation concluded in September 2014, with six of the 10 participating countries having embarked on Year 1 activities, although none had completed the activities in their work plans, where these existed. ICASO – a Toronto-based global health advocacy organization – partnered with the USAID-funded Health Policy Project (HPP) to conduct the evaluation. HPP provided in-kind support to the evaluation through in-country consultants, review of evaluation materials, including interview guides, technical advice and ongoing review of project process, as well as offered direct support through in-person key informant interviews in each of the countries visited.

Rather than seeking to examine *impact,* the evaluation sought to gain an understanding of the most efficient and effective steps needed in launching the program, and to some degree, how to sustain such a program in its early stages. Focused on the initiation process, the evaluation did not assess progress made towards achieving program objectives, which was considered beyond the remit of the assessment.

However, it is worth noting that the objectives of the pilot are to:

1. Systematize and strengthen ongoing key affected population and PLWD engagement before, during, and after Country Dialogue and Concept Note development, and to ensure continued and meaningful engagement throughout the grant cycle;
2. Empower key affected populations and PLWD CCM member(s) to engage their constituencies in robust and inclusive NFM processes;

---

[4] Country dialogue: an ongoing, multi-stakeholder process in which disease burden and response is assessed, priorities are established, and strategies are developed.

[5] Concept notes are the term for national and regional proposals to the Global Fund in the NFM. They are developed, submitted, and revised under the supervision of the CCM.

[6] For more information on CCM eligibility requirements and guidelines: http://www.theglobalfund.org/en/ccm/guidelines/

[7] The Global Fund. Country Coordinating Mechanisms. http://theglobalfund.org/en/ccm/

[8] The Global Fund. Guidelines and Requirements for Country Coordinating Mechanisms. http://www.theglobalfund.org/en/ccm/guidelines/

3. Strengthen in-country key affected populations network capacities to engage with the NFM process through adequate technical assistance and regional key affected population and PLWD network support; and
4. Establish an oversight mechanism by engaging credible regional organizations to monitor the process.

Additional top-up funds were approved by the Global Fund Secretariat to be dedicated by the activities linked to the objectives, while independent regional monitoring organizations would support and monitor this work and would be contracted directly with the Global Fund Secretariat as a technical assistance and oversight provider. [9] Using a "lessons learned" approach, the key findings and recommendations aim to offer a formative perspective on how to most efficiently initiate and implement such a program in the future. In addition, the findings and recommendations offer an instructive analysis of what can be done to ensure efficient roll-out and inclusivity with regard CCM key affected population and PLWD engagement.

D. Key findings and recommendations

While the Pilot was not clear on what elements would constitute its successful implementation, those interviewed for this evaluation – some 80 people representing key affected population network leaders, PLWD representatives, CCM secretariat staff, CCM members, and others – provided good insights into what they thought success may look like:

- **"… having a regular feedback process where key affected populations can see what was taken and what was left out."**
- **"… strengthened key affected population networks that are providing services to key affected populations so that they can attract funding directly and be self-dependent."**
- **"… stronger tuberculosis and malaria networks."**
- **"… having to rely less and less on the Global Fund for key affected population engagement – that we institutionalize it!"**

Despite the challenges associated with the Pilot implementation the most important finding is that **the model appears to be appropriate, with some changes suggested, and that the requisite stakeholders were generally receptive to this approach.** A revised model is recommended to be rolled out beyond the ten pilot countries. As for performance of the Pilot, the evaluators found limited central coordination to be a significant barrier to efficient implementation. To have impact, this program will need a dedicated focal point at the Global Fund Secretariat **and additional human resources to be located in the CCMs Hub or CRG Department.**

Summary of Key Findings

- The Global Fund's Pilot investment to increase key affected population voices on the CCM was welcomed, but perceived as insufficient.
- The Global Fund's Pilot initiation was sluggish and did not include sufficient orientation for key stakeholders.
- Insufficient human-resource allocation to the Pilot at the Global Fund Secretariat led to weak internal coordination of the Pilot.
- Capacity building focused almost exclusively on the nascent (and socially/legally marginalized) networks of sex workers, men who have sex with men, transgender, and

[9] Throughout the course of the Pilot development and implementation "regional mentor organizations" have also been referred to as "regional entities" and "mentor organizations."

injecting drug users; the pilot missed the opportunity to build sensitivity and acceptance of these communities' needs and contributions among other CCM members.
- The establishment of CCM Subcommittees of community groups to supervise implementation of the Pilot assumed sufficient existing representation of the intended communities with which to form a subcommittee; in many cases there was no key affected population representation.

Summary of Key Recommendations
- Situate a scaled up and more formalized program (no more "piloting") within the Global Fund's *Key Populations Action Plan.*
- Ensure transparency at all stages of the program implementation and evaluation.
- Establish a focal point at the Global Fund Secretariat to oversee and coordinate the Pilot, with regular reporting back to the Global Fund Secretariat and Board and country CCMs.
- Allocate greater human resources to the coordination and roll out of community engagement for those most affected and marginalized by their country's legal codes.
- Provide orientation to country teams, CCMs, and communities of men who have sex with men, transgender, sex worker and people who use drugs on the Global Fund's mandate to support HIV programming among all populations in countries – particularly those with disproportionate HIV burdens.

E. Conclusion

The Pilot represents an important step towards more meaningful engagement of key affected populations and should not be retreated from or discarded because of implementation challenges. The experience of the Pilot so far should be acknowledged, lessons learned taken into account, and the model revised accordingly, given that the core of the model and the general approach used for the Pilot were found to be appropriate and to hold substantial potential for enhancing engagement of key affected populations in the NFM. Additional resources should be allocated to the CCM Hub (specific to each CCM) and CRG Department to support the appropriate staffing and stewardship of this and other programs.

The Pilot's shortcomings to-date can in many ways be blamed on the absence of a strategic approach. The core problem, a lack of preparation and guidance, would likely have been mitigated had the Pilot been implemented in the context of a larger strategy. The Pilot, and the key affected populations in the ten countries, may have been better served if the Pilot had been postponed until after the *Action Plan* was fully developed, for a more holistic, strategic approach. The *Key Populations Action Plan 2014-2017* still presents an excellent opportunity to locate the Pilot and other efforts, within a broader strategy to invest more strategically in the engagement of key affected populations and PLWDs.

Finally, global, regional, and national key affected population and PLWD networks have a significant investment in the success of this initiative. As such, the Global Fund should partner with them on the revision and further implementation of the Pilot program. An early step in this is to make sure that the findings presented in this report are shared broadly, and a process for feedback is put in place. Although with the submission of this report ICASO has fulfilled its obligations under the contract, it offers its support to collect feedback from key stakeholders and present this in a systematic manner to the Global Fund Board and Secretariat. All stakeholders should be made aware of the findings of the evaluation, and invited to help improve this and other key affected population engagement efforts.

The full report is available upon request by writing to icaso@icaso.org.