Integration of Sexual and Reproductive Health into HIV/AIDS Programming:

Guide for Submitting HIV/AIDS Component Proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 6 and Beyond

May 2006

"Existing AIDS services can be made more women-friendly by ensuring that they are responsive to women's needs and constraints....Women's access to services can also be increased by integrating reproductive health, family planning, and HIV/AIDS services. Integrating these services may also serve to destigmatize AIDS services."
— *Dr. Geeta Rao Gupta, International Center for Research on Women, June 2, 2005*

"Linking HIV/AIDS and sexual and reproductive health (SRH) programmes has the potential to significantly curtail the AIDS epidemic. Furthermore, it also addresses the unmet need and rights of women and men living with HIV/AIDS to SRH services."
— *World Health Organization, Linking Sexual and Reproductive Health and HIV/AIDS*

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EXECUTIVE SUMMARY

Sexual and reproductive health (SRH) is intricately connected with the AIDS epidemic that continues to ravage individuals and communities around the world. With over 40 million people infected with HIV, drastic measures must urgently be added to the prevention and treatment efforts already underway. In particular, women and girls continue to acquire HIV at disproportionately high rates, due to socio-economic disempowerment, gender-based violence, and other factors; SRH services particularly target this population, providing an entryway for HIV services, and vice versa. It is for these reasons that the Global AIDS Alliance and other nongovernmental organizations, service providers, and international agencies are advocating for a commitment to health programming that operationalizes the delivery of integrated SRH and HIV/AIDS programmes.

The Global Fund to Fight AIDS, Tuberculosis and Malaria, a unique multilateral partnership that has proven itself the most successful mechanism in the world for fighting these diseases, has recently announced the impending launch of Round 6 of its grant-making activities. In preparation for this round, *Integration of Sexual and Reproductive Health into HIV/AIDS Programming: Guide for Submitting HIV/AIDS Component Proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, Round 6 and Beyond* is designed to support SRH and HIV implementing organizations in countries eligible for Global Fund funding in submitting SRH-HIV proposals under the Global Fund's HIV/AIDS component for Round 6. Despite wide-ranging consensus that integrated SRH-HIV programming is severely lacking from the current HIV response, recent research by the International Planned Parenthood Federation (IPPF) among its Member Associations (MAs) around the world determined that lack of knowledge about the Global Fund and its processes is among the most important barriers to seeking SRH-HIV support from the Global Fund.

This *Guide* responds to the low number of SRH-related proposals included in Country Coordinated Proposals in previous Global Fund funding rounds, and to the expressed need of MAs to learn more about the nexus of SRH and HIV and about ways in which to get involved with the Global Fund and its in-country structures. The *Guide* is intended for all organizations working to implement SRH programming, applying also to those that are not IPPF MAs. The *Guide* highlights important links between SRH and HIV/AIDS. Finally, the *Guide* emphasizes the key components of a proposal to the Global Fund that would benefit SRH programming under the HIV component of funding. The sections throughout the *Guide* can stand alone and may be used as independent reference sections, or the *Guide* may be read in its entirety.

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ARV	antiretroviral
BCC	behavioural change communication
CBO	community based organization
CCM	County Coordinating Mechanism (of Global Fund)
CCP	Country Coordinated Proposal (for Global Fund)
FPAK	Family Planning Association of Kenya
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GAA	Global AIDS Alliance
GBV	gender-based violence
GIPA	greater involvement of people living with HIV
HIPC	Highly-indebted Poor Country
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICPD	International Conference on Population and Development
IDUs	injecting drug users
INGO	international nongovernmental organization
IPPF	International Planned Parenthood Federation
KECOFATUMA	Kenya Consortium of Organizations Fighting AIDS, Tuberculosis and Malaria
MA	Member Association (of IPPF)
MARP	most-at-risk population
MCH	maternal and child health
MCTC	mother-to-child HIV transmission
MDGs	Millennium Development Goals
MoH	Ministry of Health
MSM	men who have sex with men
NGO	nongovernmental organization
PLHIV	people living with HIV
PMCTC	prevention of mother-to-child HIV transmission
PR	Principal Recipient (of Global Fund grants)
PRS	Poverty Reduction Strategy
RCM	Regional Coordinating Mechanism
RO	Regional Organization
RTIs	reproductive tract infections
SR	Sub-recipient
SRH	sexual and reproductive health
STI	sexually transmitted infection
Sub-CCM	sub-national Coordinating Mechanism
SWAps	Sector Wide Approaches
TB	Tuberculosis
ToR	terms of reference
ToT	training of trainers
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	voluntary counselling and testing
WHO	World Health Organization

GLOSSARY

A. Global Fund-related terms

Board: The Global Fund's international Board includes representatives of donor and recipient governments, nongovernmental organizations, the private sector (including businesses and foundations), and affected communities. Key international development partners also participate, including the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank. The latter also serves as the Global Fund's trustee.

Secretariat: The Global Fund staff is responsible for day-to-day operations, including mobilizing resources from the public and private sectors, managing grants, providing financial, legal and administrative support, and reporting information on the Global Fund's activities to the Board and the public. The Global Fund Secretariat consists of about 170 persons based in Geneva, Switzerland.

Partnership Forum: Every two years, the Global Fund convenes a broad group of stakeholders in a Partnership Forum. In 2004, the first of these Partnership Forums met to allow stakeholders to provide important feedback and guidance to the Global Fund on its impact in fighting these diseases. This also serves as an opportunity for the Global Fund to inform stakeholders of progress and challenges.

Country Coordinating Mechanisms (CCMs): Country-level partnerships that develop and submit grant proposals—Country Coordinated Proposals (CCPs)—to the Global Fund, monitor their implementation, and coordinate with other donors and domestic programs. CCMs are intended to be multisectoral, involving broad representation from government agencies, nongovernmental organizations, community- and faith-based groups, private sector institutions, individuals living with HIV, TB or malaria, and bilateral and multilateral agencies.

Principal Recipient (PR): A local entity nominated by the CCM and confirmed by the Global Fund to be legally responsible for grant proceeds and implementation in a recipient country. Once the Board approves a proposal, the Secretariat negotiates a two-year grant agreement in which disbursement of funds to the PR is based on the achievement of measurable results. There may be multiple public and/or private PRs in a country.

Sub-recipients (SRs): Entities chosen by the PR to implement parts of the grant. SRs often do not have the capacity to take on the responsibility of a PR, but are usually more involved in grassroots, community-level work.

Technical Review Panel (TRP): An independent panel of disease-specific and cross-cutting health and development experts that provides a rigorous review of the technical merit of Country Coordinated Proposals (CCPs). The TRP may recommend to the Board that the CCP be funded without condition, approved conditionally, resubmitted or not approved. To date, the TRP has recommended funding for 40% of the CCPs submitted.

Local Fund Agent (LFA): Independent organizations hired by the Secretariat to assess the PR's capacity to administer funds and provide ongoing oversight and verification of reported data on financial and programmatic progress.

B. SRH-related terms

Gender-based violence: Gender-based violence describes violence against men and transgendered people as well as women. It consists of all forms of violence targeted at an individual because of his or her gender, including but not limited to domestic violence, rape and sexual assault, community violence, and emotional or psychological abuse.

Voluntary counselling and testing: HIV Voluntary Counselling and Testing (VCT) forms the gateway to HIV prevention, care, treatment and support for persons in need. All HIV testing of individuals must be confidential, be conducted only with informed consent (meaning that it is both informed and voluntary) and be accompanied by counselling.

A routine offer of HIV testing should be made by health care providers to all patients in health care settings where HIV is prevalent, where a person shows signs or symptoms consistent with HIV-related disease, to clients receiving STI services, and in the context of antenatal care to facilitate prevention of mother-to-child transmission. Patients retain the right to refuse HIV testing.

At the same time, client-initiated HIV testing for all people who want to learn their HIV status through voluntary counselling and testing remains critical to the effectiveness of HIV prevention. Promotion of knowledge of HIV status among any population that may have been exposed to HIV is essential.

Risk and Vulnerability: HIV infection is associated with specific risks, including behaviours such as unprotected sexual intercourse or forced or coerced sex. Vulnerability to HIV is a measure of an individual's or community's inability to control their risk of infection. In many settings, women—and in particular young women—are especially vulnerable to HIV infection, as they may be less able than men to avoid non-consensual or coercive sexual relations, and are often unable to negotiate condom use.

Key Populations: Key populations are those where risk and vulnerability converge. HIV epidemics can be limited by concentrating prevention efforts among key populations. The concept of key populations also recognizes that these can play an important role in responding to HIV. Key populations vary in different places, depending upon the context and nature of the local epidemic. In most places, they include married women; adolescents; men who have sex with men; sex workers, their clients and regular sexual partners; and injecting drug users.

Dual Protection: Many sexually active people need dual protection: protection against unintended pregnancy and protection against STIs, including HIV. Those contraceptives that offer the best pregnancy prevention—such as an intrauterine device or oral contraceptives—do not protect against STIs. Thus, simultaneous condom use for infection prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently; however, they are associated with higher pregnancy rates than condoms used together with another contraceptive method.

Chapter 1 – Introduction

1. 1. Why these Guidelines

These Guidelines respond to the low number of SRH-related proposals included in Country Coordinated Proposals in the five previous Global Fund funding rounds. *Models of Care* Country Coordinating Mechanisms Research[1] (2005), a collaborative project between IPPF and German Technical Cooperation (GTZ), is the only study to date of SRH in the context of the Global Fund. Important findings from this research include that:

- 15 Member Associations reported that there had been a call for proposals on sexual and reproductive health issues, while 30 Member Associations stated that there had not been and 9 Member Associations did not know.
- 2 Member Associations (Tonga and Tuvalu)[2] reported successful SRH proposals.
- 7 Member Associations reported that their SRH proposals had been unsuccessful.
- 11 Member Associations did not know whether or not their proposals had been successful.
- Family Planning Association of Turkey (FPAT) noted that there had been a call for proposals on SRH, but the organization's Executive Board rejected the funding, as the CCM's proposal was related to sex workers, a target group with which the Association has no experience of working.[3]

Bulgaria, China, Columbia, Dominican Republic, Ethiopia, Madagascar, Morocco, Namibia, Niger, South Africa, Sudan, The Gambia, Togo, Tonga, Tuvalu, and Yemen have had successful SRH-HIV Global Fund proposals. Furthermore, Tanzania (joint proposal with World Vision) and Tonga have had successful AIDS and malaria proposals. The CCMs of many of these countries did not, at the time their SRH proposals were submitted to the Global Fund, include IPPF MAs.

SRH-related HIV proposals submitted to the Global Fund by Burkina Faso, Fiji, Georgia, Guatemala, Indonesia, Iran, Kenya, Lesotho, Malawi, Nepal, Pakistan, São Tomé, and Sri Lanka have been unsuccessful.

See **Annex 1** for a list of countries that have had:
- proposals approved by the Global Fund that focus on mainstreaming HIV into SRH programmes; or
- proposals approved by the Global Fund that focus on SRH in HIV and AIDS programmes from Rounds 4 and 5.

Furthermore, the IPPF research found that the lack of information about the Global Fund itself and of the roles and responsibilities of the CCM, Global Fund processes, etc., is the biggest impediment to inclusion and participation of MAs.

HIV prevention is difficult in many settings. Integrating SRH and HIV services and programmes will provide opportunities for primary and secondary prevention, increasing HIV awareness and reducing risk. In addition there will be opportunities to increase HIV testing rates, which is vital given that the vast majority of people remain unaware of their HIV status, and many people only learn of their HIV-positive status in the latter stages of infection.

Integrating SRH and HIV services and programmes is also cost effective, particularly in many rural settings, where often the only available health service is a family planning clinic. Integrating services and programmes will result in better use of existing health staff and infrastructure, responding to the training needs of health staff already working in SRH services and programmes.

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[1] http://content.ippf.org/output/ORG/files/13139.pdf
[2] Note that these proposals were for sub-recipient grants.
[3] These data are somewhat compromised by the fact that some responding Member Associations considered this a question of whether there had ever been a call for proposals on SRH by any source, rather than specifically by the CCM or Global Fund.

As Round 6 approaches, the Global AIDS Alliance (GAA) (see **Annex 2**) has developed these Guidelines in order to fill these information gaps with the aim of:

- encouraging and facilitating more proposals to the Global Fund for increased investment in linking sexual and reproductive health programmes with HIV programmes, and vice versa; and
- assisting countries not yet ready to submit such proposals to understand what is needed to get to that point, including gaining knowledge about the Global Fund and building capacity of MAs to join CCMs, where they have not already done so.

1.2. Target audiences

The primary target audiences are CCMs and national AIDS committees, task forces, and organizations working on sexual and reproductive health and/or HIV in countries where specific strategic planning in this nexus has already occurred.

The secondary target audiences include CCMs and national AIDS committees, task forces, and organizations working on sexual and reproductive health and/or HIV in countries where specific strategic planning in this nexus has not yet begun or is just getting underway, and which might consider proposals benefiting sexual and reproductive health programmes.

The main focus of the Guidelines is to provide the primary target audiences with information that will assist them to develop high-quality SRH proposals as part of the Country Coordinated Proposal for Round 6. The Guidelines aim to help countries submit proposals to the Global Fund to support elements of their existing strategic plans, not to provide guidance to countries on how to do their strategic planning processes.

Please note that Aidspan is developing a *Guide to Developing Global Fund Proposals to Benefit Children Affected by HIV and AIDS*.

1.3. Description of content

These Guidelines have been developed to bring the *Draft Proposal Form: Sixth Call for Proposals* and *Draft Guidelines for Proposals: Sixth Call for Proposals* into the context in which SRH organizations work.

Chapter 2 provides general HIV epidemiological data, and data related to women and HIV. Section 2.3 Integrating SRH into the HIV/AIDS Component of a Country Coordinated Proposal is an extremely important section that outlines the links between SRH and HIV. Furthermore, it discusses six priority areas, highlighting the types of services that SRH organizations may include in a SRH-HIV proposal. Several boxes are included that provide country examples of successful Country Coordinated Proposals that have included SRH-related interventions.

Chapter 3 begins with an outline of the Global Fund structures and a discussion of CCM composition, followed by an analysis of the current makeup of CCMs and SRH organizations' inclusion in or involvement with CCMs. A box is included, which discusses IPPF Member Associations' experiences in becoming CCM members. Steps that SRH organizations can take to join their CCMs are outlined, followed by a discussion of the proposal invitation and development processes, highlighting the absolute requirements for a broad consultative process.

The information provided in Chapter 4 supplements but does not replace that provided in the *Draft Guidelines for Proposals: Sixth Call for Proposals*. While the *Draft Guidelines for Proposals: Sixth Call for Proposals* are designed to assist in the formulation of a Country Coordinated Proposal by the CCM; this section highlights the areas on which a SRH organization should concentrate in ensuring that its proposal provides all the information necessary for inclusion in a Country Coordinated Proposal.

Chapter 4 also outlines the relationship between National Strategic Plans on Sexual and Reproductive Health and National AIDS Plans, and ways in which these linkages should be included in proposals. A generic discussion of Technical Review Panel (TRP) assessment and

eligibility criteria follows. Application types are discussed, including the possibility of submitting a proposal by a Regional Organization. The Component section provides suggestions as to where information specific to SRH should be introduced. This is followed by practical tips and advice on developing a proposal.

Chapter 5 provides a list of essential reading plus links to resources for CCM- and SRH-related documents, as well as health system strengthening reference documents. Documents focused on indicators are also listed. Finally, links to organizations that provide information on the Global Fund or SRH are provided.

Chapter 2 – Background

2.1. Epidemiological situation by region[4]

In 2005, there were close to five million new HIV infections worldwide, with three million people dying of AIDS-related causes, more than half a million of whom were children. Today the total number of people living with HIV stands at 40.3 million, double the number in 1995. Despite progress made in reducing HIV prevalence in a small but growing number of countries, the AIDS epidemic continues to outstrip global efforts to contain it.

Sub-Saharan Africa has just over 10% of the world's population, but is home to more than 60% of all people living with HIV—25.8 million. In 2005, an estimated 3.2 million people in the region became newly infected, while 2.4 million adults and children died of AIDS- related causes.

In 2005, some 8.3 million people were living with HIV in Asia, including 1.1 million people who became newly infected in the previous year. AIDS claimed some 520,000 lives in Asia during 2005. National HIV infection levels in Asia are low compared with other continents, notably Africa. But the populations of many Asian nations are so large that even low national HIV prevalence means large numbers of people are living with HIV. Injecting drug use is the strongest initial driver of HIV infection in Asia.

In a number of countries, predominantly in Western Europe, where HIV levels have been low for many years, HIV prevalence has begun to rise sharply among people whose behaviours carry a high risk of exposure to HIV—injecting drug users, male, transgendered and female sex workers and their clients, and men who have sex with men. Inevitably, HIV infection has filtered from individuals in these groups to their regular sex partners, who may have no other risk of exposure to the virus. This pattern accounts for a rise in HIV rates among women who report being monogamous, and it might lead to a rise in the number of HIV-positive infants.

The AIDS epidemic claimed an estimated 24,000 lives in the Caribbean in 2005, making it the leading cause of death among adults aged 15-44 years. A total of 300,000 people are currently living with HIV in the region, including 30,000 people who became infected in 2005. The region's epidemics are driven primarily by heterosexual intercourse, with sex work a prominent factor, against a backdrop of severe poverty, high unemployment and gender inequalities. The overall share of reported HIV infections attributed to sex between men is approximately 12%.

The Eastern Europe and Central Asia regions have the fastest growing HIV epidemics in the world, largely driven by injecting drug use. An estimated 1.6 million people are now living with HIV, with around 270,000 newly infected in 2004. AIDS claimed almost twice as many lives in 2005 as it did in 2003, and killed an estimated 62,000 adults and children. Overall in Central Europe, the epidemics have remained contained and small.

It is in Eastern Europe and Central Asia that are located so-called "Second Wave" countries. These are countries whose HIV epidemics are currently localized or whose HIV burden is currently low- to mid-level, but with the potential for a serious generalized epidemic—unless intensive prevention efforts are undertaken immediately. While HIV transmission in these countries has been driven largely by injecting drug use, a growing number of people, particularly youth, are now becoming infected through sexual transmission. Experts warn that a second wave of HIV infections spread by sexual contact could follow the current drug-driven epidemic and lead to a generalized epidemic in just a few short years. The countries most often considered to be Second Wave are China, Russia and India. Other Second Wave countries are Ethiopia and Nigeria.

The number of people living with HIV in Latin America has risen to an estimated 1.8 million. In 2005, approximately 66,000 people died of AIDS- related causes, and 200,000 were newly infected. Among young people 15–24 years of age, an estimated 0.4% of women and 0.6%

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[4] UNAIDS, *Report on the Global AIDS epidemic,* 2005.
http://www.unaids.org/epi/2005/doc/download.asp

men were living with HIV in 2005. HIV in Central America is being transmitted sexually among men who have sex with men and sex workers, their clients and regular sexual partners, and, in a number of countries, across the wider population.

The advance of AIDS in the Middle East and North Africa has continued, with latest estimates showing that 67,000 people became infected with HIV in 2005. Approximately 510,000 people are living with HIV in the region. An estimated 58,000 adults and children died of AIDS-related illnesses in 2005.

An estimated 74,000 people in Oceania are living with HIV. Although fewer than 4,000 people are believed to have died of AIDS- related causes in 2005, about 8,200 are thought to have become newly infected with HIV in that same year. Among young people 15–24 years of age, an estimated 1.2% of women and 0.4% of men were living with HIV in 2005. HIV infections have now been reported in every country or territory in Oceania, barring Niue and Tokelau. More than 90% of the 11,200 HIV infections reported across the 21 Pacific Island countries and territories by the end of 2004 were recorded in Papua New Guinea.

For more detailed regional epidemiological data see UNAIDS 2005 *AIDS Epidemic Update.*[5]

2.2. Epidemiology related to women and HIV

Globally, HIV infection rates among women continue to rise disproportionately to those of men. In 2005, 17.5 million women were living with HIV—one million more than in 2003. Today, nearly 50% of adults living with HIV globally are women; in sub-Saharan Africa women make up 60% of adults living with HIV.

Women have a dual vulnerability to HIV: biologically—as they are twice as likely as men to be infected through a single act of unprotected sex—and socially—due to gender inequities. Male-to-female HIV transmission during sex is about twice as likely to occur as female-to-male HIV transmission. For many women in developing countries, the ABC prevention approach (abstinence, being faithful or reducing the number of sexual partners, and condom use) may insufficient. Gender-based violence; economic dependence due to lack of property rights, education, vocational or income-generating opportunities; lack of access to women-specific prevention and care; and cultural beliefs around sex and condom use mean that the ABC approach is not realistic for many women.

In several southern African countries, more than three-quarters of all young people living with HIV are women: in sub-Saharan Africa overall, young women between 15 and 24 years old are at least three times more likely to be HIV-positive than young men. In South Africa, the rise in HIV prevalence among women older than 34 years is particularly striking. In Botswana, where HIV infections have remained steady among pregnant women aged 15-24 since 1999, prevalence among those over 25 has been rising constantly since 1992 and reached 43% when last measured in 2003. Most HIV-positive women who die are at the prime of their productive life, depriving families and communities of food producers, teachers, mothers, and caregivers.

While most HIV-positive women live in sub-Saharan Africa, the epidemic is affecting growing numbers of women in South and Southeast Asia, where almost two million women are now HIV-positive, and in Eastern Europe and Central Asia.

2.3 Integrating SRH into the HIV/AIDS component of a Country Coordinated Proposal

The five core aspects of sexual and reproductive health are:

1. improving antenatal, perinatal, postpartum and newborn care;
2. providing high-quality services for family planning, including infertility services;
3. eliminating unsafe abortion;
4. combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and

[5] http://www.unaids.org/Epi2005/doc/download.html.

5. promoting sexual health.

Reproductive and sexual ill-health accounts for 20% of the global burden of ill-health for women and 14% for men.[6] More than half a million women die annually in pregnancy and childbirth from largely preventable causes; almost all of these deaths occur in resource-constrained settings.[7] Globally, 13% of all maternal deaths is due to the complications of unsafe abortion, resulting from the estimated 19 million unsafe abortions occurring annually.[8] More than 340 million new cases of curable STIs occur annually, and sexually transmitted human papillomavirus (HPV) infection—closely associated with cervical cancer—is diagnosed in more than 490,000 women and causes 240 000 deaths every year.[9]

Most of the 17.6 million women living with HIV are of childbearing age and face difficult choices concerning their sexuality and childbearing.[10] Women's choices are made at a particular time and in a given context and are complex, multi-factorial and subject to change. Moreover, their choices may be limited by direct or indirect social, economic and cultural factors, medical factors, and gender-based violence and its consequences. Accurate information and counselling are critical components of all sexual and reproductive health services to support women in making these choices and carrying them out safely and voluntarily.

The majority of HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding, and are therefore preventable. The interactions between sexual and reproductive health and HIV are now widely recognized. In addition, sexual and reproductive ill-health and HIV share root causes, including poverty, gender inequity and social marginalization of the most vulnerable populations.[11]

HIV affects or potentially affects all the dimensions of women's sexual and reproductive health—pregnancy, childbirth, breastfeeding, abortion, use of contraception, exposure to, diagnosis and treatment of STIs and, exposure to gender-based violence. For instance, HIV infection accelerates the natural history of some reproductive illnesses and increases the severity of others. HIV also adversely affects a woman's ability to become pregnant.

At its heart, AIDS is a crisis of gender inequity, with women less able than men to exercise control over their bodies and lives. In many settings, cultural expectations have encouraged men to have multiple partners, while women are expected to abstain or be faithful. There is also a culture of silence around some components of SRH. Simply by fulfilling their expected gender roles, men and women are likely to increase their risk of HIV infection.

Gender plays an important role in determining a woman's vulnerability to STIs, HIV infection and violence, and her ability to access treatment, care and support, and to cope if HIV-positive or otherwise affected by HIV. The current scope of HIV interventions and policies needs to be expanded to make gender equity a central component in the fight against HIV.[12]

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[6] http://www.who.int/reproductive-health/strategy.htm

[7] World Health Organization, United Nations Children's Fund and United Nations Population Fund, (2004). *Maternal mortality in 2000: estimates developed by WHO, UNICEF and UNFPA*. http://www.who.int/reproductive-health/publications/maternal_mortality_2000/index.html

[8] World Health Organization (2004). *Unsafe abortion – global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000.* 4th ed.
http://www.who.int/reproductive-health/publications/unsafe_abortion_estimates_04/index.html

[9] World Health Organization (2004). *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*. http://www.who.int/reproductive-health/strategy.html

[10] UNAIDS and World Health Organization (2005). *AIDS epidemic update: December 2005.* http://www.who.int/hiv/epiupdate2005/en/index.html

[11] WHO, UNFPA, UNAIDS and IPPF (2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages.*
http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf.

[12] UNAIDS, UNFPA, UNIFEM (2004). Women and HIV/AIDS: Confronting the Crisis
http://genderandaids.org/downloads/conference/308_filename_women_aids1.pdf

However, gender disparities go far deeper than sexual relations. Women in many regions do not own property or have access to financial resources, increasing their dependence on men—husbands, fathers, brothers and sons—for support. Without resources, women are susceptible to abuses of power. Poverty pushes some women into risk-taking behaviours. With no other options, women may resort to sex work to feed their families. For example, in southern Africa, many older men seek out young women and adolescent girls for sexual favours, providing them with school fees, food and highly sought after consumer goods.

The Declaration of Commitment from the UN Special Session on HIV/AIDS in 2001[13] and the Millennium Development Goal (MDG) of halting and beginning to reverse HIV by 2015[14] are internationally agreed-upon targets for responding to HIV. Three of the eight MDGs are directly related to reproductive and sexual health, namely, improving maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases.

Responding to HIV by integrating HIV services with sexual and reproductive health services and programmes will also support:

- the G8 commitment to develop and implement a package of HIV prevention, treatment and care, with the aim of achieving as closely as possible universal access to treatment for all those who need it by 2010, as agreed at the Gleneagles Summit in July 2005;[15] and
- the United Nations General Assembly 2005 World Summit Outcome Document, which also adopted the concept of scaling up toward universal access.[16]

As many countries in the global South face huge burdens in their health and family planning systems due to population increases and HIV, the support from global North countries for SRH services and supplies is shrinking in relation to the scale of the problem. According to the United Nations Population Fund (UNFPA), the money needed to buy contraceptives and condoms is projected to rise from US $954 million in 2002 to US $1.8 billion in 2015. In spite of this upward trend in costs, donor government support for these supplies actually fell in 2002 to only $197.5 million. The gap between the need for essential condom and contraceptives supplies and the funds available to purchase them is projected to reach hundreds of millions of dollars annually by 2015.[17]

Scarce global resources and growing demand for HIV-related health care compel the integration of SRH and HIV services, programmes and research. Establishing links between maternal and neonatal services and other primary health care services addressing needs such as HIV, STIs, and family planning is an effective way to meet the health care needs of individuals and communities in resource-constrained settings. Coordinating investments in different programmes within the health sector promotes harmonization, facilitates the government's management, strengthens health systems and will increase the impact on related health outcomes.

Medical care in resource-limited settings may rely on just one provider or facility, or a single community health worker. Integrating HIV with family planning and other SRH services allows women and men to receive SRH care through a single provider to meet a range of health care needs: dual protection against pregnancy and STIs including HIV, pregnancy care for HIV-positive women, care, support and treatment services for those living with HIV, prevention of mother-to-child transmission, and referral to specialized services when

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[13] United Nations General Assembly Special Session on HIV/AIDS. *The Declaration of Commitment*. New York, United States, 25 - 27 June 2001
http://www.unaids.org/Unaids/EN/Events/UN+Special+Session+on+HIV_AIDS/Declaration+of+Commitment+on+HIV_AIDS.asp

[14] Millennium Development Goals. Goal 6
http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186386

[15] The Group of 8 (2005). The Gleneagles Comuniqué. Paragraph 18(d)
http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique,0.pdf

[16] The United Nations General Assembly. World Summit Outcome. General Assembly fifty-ninth session, 20 September 2005.
http://daccessdds.un.org/doc/UNDOC/LTD/N05/511/30/PDF/N0551130.pdf?OpenElement

[17] UNFPA (2004). Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2004.
http://www.unfpa.org/upload/lib_pub_file/539_filename_donor_2004_report.pdf

required. In addition, integration of VCT, family planning and SRH services can also contribute to reducing HIV-related stigma, creating the potential for increased access to VCT and treatment services for HIV and HIV-related ailments.

Linkages between SRH and HIV programmes work in both directions, by integrating HIV issues into ongoing SRH programmes, and conversely, SRH issues into HIV programmes, and are mutually reinforcing. They should enhance SRH, contribute to reversal of the AIDS epidemic and mitigate its impact.

Based on experience and programming realities, six priority areas for action have been identified:

1. Learn HIV status;
2. Promote safer sex;
3. Optimize connection between HIV and STI services;
4. Identify and intervene in situations of gender-based violence, where possible;
5. Integrate HIV with maternal and child health (MCH); and
6. Integrate HIV with family planning services.[18]

These linkages are likely to lead to important public health benefits.

Selection of those action(s) to support will depend on the national context and the local situation, including HIV prevalence, as well as the organization in question and use of health services. For example, in settings with high HIV prevalence and high utilization of family planning services, offering all family planning clients the opportunity to learn their HIV status would likely enhance the quality of family planning services and make an important contribution to HIV prevention efforts. This approach may not be as useful, however, in settings with low HIV prevalence and/or poor utilization of family planning services.

The HIV services that SRH clinics can offer will also depend upon resources. Such services may include all or some of the following:

- Education about integrated HIV prevention.
- Voluntary counselling and testing.
- HIV counselling, including advice on lifestyle management.
- Contraceptive counselling, including dual protection and contraceptives for HIV-positive women.
- PMTCT services and HIV management, including ARV therapy.
- Provision of ARV therapy and management of opportunistic infections when indicated.
- Education about and screening for gender-based violence, especially sexual violence, which can increase risk of HIV, and treatment of the health consequences, including mental health.
- Identification of referral services and referral networks.
- STI management.

Stronger linkages between SRH and HIV programmes should lead to a number of important public health benefits. Much remains unknown, however, about how to best achieve these linkages so as to have the greatest impact and how best to scale up and strengthen selected linkages to achieve universal access. This provides opportunities for innovative and creative programming. Most commonly, integration has been largely in one direction. For example, provision of information about dual protection during family planning or condoms during a STI consultation is commonly included in counselling guidelines for high HIV prevalence settings; yet equipping VCT centres with other contraceptive methods or testing for syphilis is quite rare.

[18] These are based on the World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Planned Parenthood Federation (IPPF) (October 2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages.*
http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf

The benefits of integrating HIV with SRH services may be extensive. A broader range of clients can access a full spectrum of services. With fewer healthcare providers involved, clients are also more likely to have their confidentiality preserved and have easier access to services through a "one stop" approach. This approach may also serve to minimize stigma associated with entering a dedicated HIV facility. Also, there are multiple entry points for individuals to access integrated care: family planning, post-partum or post-abortion care, VCT, youth services, STI diagnosis and treatment, and many others. Coordination of programmes will also facilitate health sector management processes, reducing transaction costs for planning, budgeting and reporting, as well as streamlining other operational procedures and strengthening health systems.

With careful priority setting and judicious programme implementation, the following benefits from mainstreaming SRH and HIV services can be expected:

- Improved access to and uptake of key HIV and SRH services;
- Better access of PLHIV to SRH services tailored to their needs;
- Improved public HIV awareness;
- Reduced HIV-related stigma and discrimination;
- Increased intervention in cases of gender-based violence;
- Improved coverage by SRH services of underserved and marginalized populations, such as injecting drug users, sex workers or men who have sex with men;
- Greater support for dual protection against unintended pregnancy and STIs, including HIV, for those in need, especially young people;
- Decreased HIV incidence, including the incidence of mother-to-child HIV transmission;
- Improved quality of care, including increased contraceptive use;
- Improved quality of HIV and SRH services; and
- Enhanced programme effectiveness and efficiency.

However, scaling up services takes time. It may require a reorganization of clinical services, initially burdening health care workers with limited financial resources and training, who may need to adapt to new procedures and practices (and perhaps build their skill base). Scarce resources mean that services must be efficient and effective, built on evidence for best practices and on knowledge of risks and benefits for different clients. This knowledge must be translated into evidence-based guidelines and tools for use at the point of care.

It is essential that those providing SRH services have the knowledge and skills to address the particular concerns and problems of women living with HIV. Due to the stigma and discrimination so often attached to HIV, it is particularly important that service providers be able to protect the reproductive rights of women living with HIV. These rights include having access to sexual and reproductive health services and accurate sexuality education, being able to choose a partner, deciding whether and when to be sexually active, and deciding freely and responsibly the number, spacing and timing of their children. Women have the right to make these decisions free of discrimination, coercion and violence.[19]

Principles

Key policies and programmes must build upon the following principles.

Address structural determinants. Root causes of HIV and sexual and reproductive ill-health need to be addressed. This includes action to reduce poverty, ensure equity of access to key health services and improve access to information, education and vocational opportunities.

Focus on human rights and gender. Sexual and reproductive rights of all people, including women and men living with HIV, need to be emphasized, as well as the rights of marginalized populations such as injecting drug users, men who have sex with men, and sex workers. Gender-sensitive policies to establish gender equity and eliminate gender-based violence are additional requirements.

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[19] WHO, UNFPA, UNAIDS and IPPF (2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages.* http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf.

Promote a coordinated and coherent response. Promote attention to sexual and reproductive health priorities within a coordinated and coherent response to HIV that builds upon the principles of one national AIDS framework, one broad-based multisectoral AIDS coordinating body, and one agreed-upon country-level monitoring and evaluation system (Three Ones Principle).

Meaningfully involve PLHIV. Women and men living with HIV need to be fully involved in designing, implementing, monitoring and evaluating policies, programmes and research that affect their lives.

Foster community participation. Young people, key vulnerable populations and the community at large are essential partners for an adequate response and for meeting the needs of affected people and communities.

Reduce stigma and discrimination. More vigorous legal and policy measures are urgently required to protect PLHIV and vulnerable populations from discrimination.

Pointing out the benefits of two-way integration is a strategy that needs to be used to expand the possibilities for supporting integrated SRH-HIV responses within the CCM and the Global Fund. In order to achieve internationally agreed-upon development goals, it is vital that the linkages between reproductive health and HIV prevention, care and treatment be addressed. The Global Fund is one mechanism to raise resources to fund the global AIDS response, including SRH-related programmes. It is essential when developing proposals that the links between national strategies (SRH and AIDS) are shown.

Prioritized services and/or programmes that could receive financial support from the Global Fund include:

1. Scaling-up of adolescent STI and HIV prevention programmes, including greater support for age-appropriate comprehensive sexual health education and services, and provision of information and services to achieve dual protection against unintended pregnancy and STIs, including HIV, for those in need;
2. Integration of family planning and STI treatment services at the point of service delivery, for example where VCT, prenatal and antenatal care, antiretroviral therapy or prevention of mother-to-child HIV transmission services are provided. VCT also offers the opportunity of reaching men, which needs to be consistently supported. Support could also be given to those who currently run or manage stand-alone VCT centres to increase interventions and services to include STI screening and treatment, and to discuss dual protection and PMTCT+;
3. Integration of family planning and STI treatment services for vulnerable populations, including sex workers and their clients and regular partners, men who have sex with men, and injecting drug users and their sexual partners;
4. Combating gender-based violence by strengthening the ability of health care providers to recognize signs and symptoms of sexual, physical or emotional assault and to provide treatment and referral services to people in need;
5. Prevention of parent-/mother-to-child HIV transmission (PMCTC+); and
6. Provision of antiretroviral therapy and comprehensive care for PLHIV.

The six areas are briefly described below, indicating what types of services are included under each heading. However, no attempt has been made to analyze services, describe them in detail or identify gaps. Furthermore, no advice is offered on which services should be included in individual proposals. However, references and web links to best practices for scaling up such interventions are provided in **Chapter 5 — Resources**.

2.3.1. Scaling-up of adolescent HIV prevention programmes

Current HIV prevention efforts reach only a few at-risk adolescents. A minimum coverage of 80% is needed in high-prevalence countries for adolescents at risk.[20] Adolescents cannot protect themselves if they do not know the facts about HIV transmission and how to prevent it. In many parts of the world, knowledge about HIV transmission is still low, particularly among women. In none of the 34 countries in sub-Saharan Africa recently surveyed for a Demographic and Health Survey were more than half of young women aged 15–24 aware of critical prevention and transmission methods.[21] Furthermore, young men were on average 20% more likely to have correct knowledge about HIV than were young women. One consequence is that millions of young people are becoming sexually active each day with no access to basic HIV information or prevention services.

Adolescents have the right to accurate information and skills, youth-friendly services for HIV prevention and AIDS treatment, care and support. They have the right to know about HIV and how to protect themselves. They have the right to information that is appropriate for their age—in and out of school—before they become sexually active and/or use drugs. Such information could include the ABC formula (Abstinence, Be Faithful, Condom use). At the same time, life saving commodities, including condoms for those who are sexually active; clean needles and syringes for those who inject drugs; and antiretroviral drugs and treatment of opportunistic infections for those who are HIV-positive; must be made available.

Adolescents have the right to youth-friendly services, including voluntary counselling and testing, diagnosis and treatment of STIs, and drug dependence treatment. The prevention of HIV infection works best when adolescents and young people can control their health and their futures, are empowered to make informed choices and possess the skills needed to change their behaviour. Peer-to-peer approaches are known to be particularly effective.

However, recent programming has emphasised the need to support other community-level interventions that recognize those elements of the community that influence and pressure young people, such as schools, or identify role models from within the immediate community, including parents, community leaders, etc. Interventions that support a "whole-community site" approach to adolescent HIV prevention should be supported.

Scale up what works:

- Health communication programmes that provide age-relevant, culturally-contextualized, gender-sensitive sexual and reproductive health information, skills and services to reduce adolescent risk and vulnerability to all STIs, including HIV.
- Increased access to youth-friendly health services that offer counselling, testing, outreach, referral, and diagnosis and treatment of STIs, and VCT for HIV.
- Supporting whole-community site interventions, which respond to the local and cultural determinates of young people's vulnerability to STIs, HIV and unwanted pregnancies.
- School- and community-based life skills interventions supporting balanced and comprehensive prevention strategies that promote abstinence, faithfulness, partner reduction and correct and consistent condom use, as well as other contraceptive choices (e.g., emergency contraception).
- Focus on building life skills for young people as they move through the different stages of puberty and adolescence, which supports a sense of choice, empowerment and respect.
- Gender-based violence outreach and gender sensitivity training with men and boys as well as women and girls through school- and community-based life skills interventions.
- Access for all adolescent girls to family planning information and services, within both PMTCT+ and VCT services.

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[20] UNAIDS (2005). Resource needs for an expanded response to AIDS in low- and middle-income countries.
http://www.unaids.org/html/pub/publications/irc-pub06/resourceneedsreport_en_pdf.pdf

[21] AIDS Indicator Surveys (AIS), Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) for 2000–2004.

- Programming to scale for adolescents at greatest risk.
- Prevention of HIV transmission through injecting drug use.
- Strengthened political, legal and social frameworks to ensure greater attention is given to survivors of rape and sexual assault to ensure that the maximum steps are taken to prevent infection with HIV and other STIs and pregnancy.
- Provision of post-rape care (including pregnancy testing and abortion in settings where legally permitted) and post-exposure prophylaxis for HIV in countries with generalized epidemics.
- Increased use of skilled birth attendants present at adolescent deliveries to reduce obstetric fistula associated with adolescent maternity, which increases the risk of future HIV infection.[22]
- Advocacy to prevent early or child marriages.
- National monitoring and evaluation systems for HIV prevention based, for example, on the Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People.[23]

Box 1 Togo: Successful funding[24]

The Association Togolaise pour le Bien-Etre Familial (ATBEF) is a member of the Fédération des ONG du TOGO (FONGTO), which is a member of the CCM. ATBEF was involved in the development of the Togo Government's Global Fund proposal in 2002, which was approved in 2003. The disbursement of US $14,185,638 under the two year proposal (July 2003–June 2005) actually began in 2004.

ATBEF is a sub-beneficiary of the Global Fund and has received **US $60,000 for 2004** to implement:

- training of about 200 peer educators for young people both in and out of school;
- treatment of 30 HIV-positive women with ARV therapy, the provision of information on nutrition and social support to PLHIV;
- a national telephone HIV counselling hotline open from 7:00-20:00 daily; and
- counselling at two VCT centres, one in Lomé and the other in Sokode, a town 350 km from Lomé in the interior of the country.

In 2005, ATBEF received approximately **$US 20,000** to implement the above activities.

[22] Obstetric fistula, the most severe of all pregnancy-related disabilities, is an injury caused by prolonged or obstructed labour. It usually arises when a young woman with a small birth canal has obstructed and prolonged labour and cannot obtain a needed Caesarean section due to geography, economics, or both. The baby usually dies and the mother suffers from extensive tissue damage to her birth canal, causing tears in the vaginal wall and rendering her incontinent. Untreated women not only face a life of shame and isolation, but may also face a slow, premature death from infection and kidney failure. The open wounds in the vaginal tract facilitate access of HIV, increasing the risk of transmission. Obstetric fistula affects at least 50,000 to 100,000 women every year. Most of these cases can be corrected surgically, even after several years.

[23] UNAIDS, WHO, UNICEF, UNFPA, UNESCO, USAID, MEASURE DHS, World Bank, FHI (2004). Guide to Monitoring and Evaluating National HIV/AIDS Prevention Programmes for Young People. http://www.who.int/hiv/pub/me/en/me_prev_intro.pdf

[24] IPPF (2005). *Models of Care Country Coordinating Mechanisms Research.* http://content.ippf.org/output/ORG/files/13139.pdf

Box 2 Dominican Republic[25]
In the Dominican Republic, the HIV proposal was developed in 2002-3. Originally, funding should have been released in May 2004, yet only some US $5 million has been received from a total of US $47 million for the period 2004-2008. Under the HIV proposal, Profamilia has submitted proposals for two programmatic areas: social marketing of condoms and youth-based HIV prevention. A percentage of the funds would be used to support administrative and staff costs.

The condom social marketing proposal for **US $2.5 million over five years** is to buy and distribute condoms to all the other organizations, such as nongovernmental organizations and government, as well as to non-traditional selling points such as motels and hotels that are part of the Dominican Republic Global Fund proposal.

The youth-based HIV prevention programme focuses on HIV and pregnancy in *barrios*, extending existing programmes. It involves peer education of youth who, where allowed, provide sex education to their peers in schools, as well as to youth in communities and street-based young people. The proposal is for **US $400,000 for the first two years**. Profamilia presented this proposal in alliance with two other NGOs working with youth and the amount reflects only Profamilia's application. The latest information is that funding for youth-based programming is probably going to be reduced.

2.3.2. Integration of family planning and STI treatment services at the point of service delivery

Substantial progress has been made in understanding the dynamics of condom use outside of marriage, both with sex workers and with short-term partners. What is less well documented are the dynamics within marriage or stable relationships that both prevent condom use and provide opportunities for introducing condoms as a form of family planning or as STI prevention, or both. Married women in many resource-poor states are among the most vulnerable to HIV infection, yet they are often unable to negotiate condom use with their husbands.

For many women in developing countries, the ABC prevention approach (abstinence, being faithful or reducing the number of sexual partners, and condom use) is challenging. For example, among young women surveyed in Harare (Zimbabwe), Durban and Soweto (South Africa), 66% reported having one lifetime partner, and 79% had abstained from sex at least until the age of 17 (roughly the average age of first sexual encounter in most countries). Yet, 40% of these young women were HIV positive. Many had been infected despite staying faithful to one partner. In Rakai, Uganda, an ongoing study has found that more than 85% of women (and 90% of men) with HIV are currently or were previously married. Meanwhile, 45% of married men said they had multiple sexual partners compared with just 5% of women.

HIV testing and counselling is the primary entry point to HIV-related care and support, including ARV therapy. Knowledge of HIV status is essential for tailoring reproductive health care and counselling according to the HIV status of women and for assisting women in making decisions on such issues as the number, spacing and timing of pregnancies, use of contraceptive methods, and infant-feeding practices. Further, information and counselling are critical components of all SRH services and support women in making these decisions and carrying them out safely and voluntarily.

Infection with other sexually transmitted infections—such as syphilis, chancroid, gonorrhoea, chlamydia, trichomoniasis and genital herpes—increases the chance that HIV will be transmitted during unprotected sex among a serodiscordant couple. Research from South Africa suggests that infection with bacterial vaginosis could double a woman's susceptibility to HIV infection.

[25] IPPF (2005). *Models of Care Country Coordinating Mechanisms Research.* http://content.ippf.org/output/ORG/files/13139.pdf

As a result, the control of STIs has received renewed attention as one of the interventions that are feasible and cost-effective to contribute to attainment of MDG Goal 6, halting and reversing the spread of HIV and other diseases.[26] Appropriate and prompt comprehensive case management (syndromic management in low-resource settings) of STIs reduces the risk of transmitting HIV to sexual partners, and of the reproductive-tract and obstetric complications associated with STIs. However, people in general, particularly young people, tend to be ill-informed about STIs. Systematic assessment for STIs, consisting of history-taking, clinical examination and laboratory screening where feasible should be part of the initial clinical evaluation of HIV-positive and pregnant women, with emphasis on syphilis screening.

Women need more than access to testing services. The vast majority of women of all ages in sub-Saharan Africa and elsewhere are HIV negative. Their biggest need is to remain so. Family planning services have great potential for leading the way in promoting sexual health and in efforts to prevent and treat HIV. Further, helping women living with HIV avoid unintended pregnancies is an important component of programmes to prevent HIV among infants.

Transmission of HIV and other STIs warrants special consideration during family planning counselling. The correct and consistent use of condoms continues to be the most effective contraceptive method to protect against acquiring and transmitting HIV and other STIs. Family planning services need to be comprehensive and address HIV prevention including, where appropriate, the benefits of abstinence, the risk associated with unprotected sex with multiple partners, and the promotion and provision of dual protection.

A negative HIV test result is a key opportunity to reinforce behaviours for avoiding infection. Adolescent risks and vulnerability to HIV can be reduced by increasing access to sexual and reproductive health information, skills and services, and diagnosis and treatment of STIs. Integrating family planning and STI treatment services at the point of service delivery is a crucial step in making a comprehensive range of services available.

A number of factors have contributed to the current and projected shortage of SRH supplies, including greater knowledge and demand due to decades of successful family planning and SRH programmes. Yet, the AIDS epidemic continues to leave billions of people in need of protection. Furthermore, weak logistics systems compounded by a lack of commitment in many countries of the global South have had an impact on supplies. For example, shipments of condoms might reach capital cities in developing countries but not necessarily the rural areas where they are most needed. Condoms also need careful storage and safeguarding from sunlight and heat to preserve their integrity and thus the protection they can provide.

In order to ensure the long-term stability of SRH supplies, funding should be directed not simply to increase purchases of SRH supplies, but also to build in-country capacity to more effectively manage the increasingly complex financing of SRH supplies, as well as forecasting, procurement and delivery systems. The adequate provision of SRH supplies can be prioritized by ensuring their inclusion in national essential drug lists.

Scale up what works:

- Educate SRH staff to overcome prejudice or ignorance regarding HIV-positive people, particularly in relation to their reproductive health choices.
- Increase access of young people and members of vulnerable groups to information, education, commodities and services.
- Strengthen the involvement of men and boys, building on innovative achievements in family planning, and increase the skills of health care workers to see couples together.
- Direct prevention information and counselling messages to HIV-positive and -negative individuals.
- Provide family planning services.
- Provide information and services for dual protection—methods that protect against both unintended pregnancy and STIs.

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[26] Millennium Development Goals. Goal 6
http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186386

- Provide VCT.
- Provide primary point-of-care comprehensive diagnosis and treatment of STIs (syndromic management where diagnostic resources are limited), including among pregnant women, with screening and treatment for syphilis.
- Ensure access to ARV therapy, including PMTCT+ and management of opportunistic infections when indicated, and comprehensive SRH care.
- Refer to related services, palliative care and support those whose circumstances so indicate.
- Develop a reliable supply and effective delivery system for SRH commodities.

Box 3 The Ethiopian Experience[27]

The Family Guidance Association of Ethiopia (FGAE) is a member of a technical working group on VCT linked to the CCM, although it is not a CCM member. The technical working group is chaired by the MoH. The CCM is composed of the government as well as bilateral, multilateral and community-based organizations, including the Relief and Development Association (CRDA), PLHIV and professional associations.

FGAE developed a funding proposal, which was included in the CCP, in part due to its close working relationships with other partners and its significant contribution to VCT (FGAE has 33 VCT sites) in Ethiopia. FGAE is the recipient of **US $350,000** through the Global Fund and provides **US $50,000 in matching funding**.

The programme provides:

- IEC/BCC on stigma and discrimination
- VCT
- Condom promotion and distribution
- Diagnosis and treatment of STI
- Increased access to care, support and treatment for people living with HIV/AIDS
- Training of community members and religious leaders to provide support
- Monitoring and evaluation

2.3.3. Integration of family planning and STI treatment services for vulnerable populations

Injecting drug users

The sharing of injecting drug equipment remains the most important factor fuelling the epidemic among drug users in many parts of the world. Once HIV enters a community of IDUs, extremely rapid spread is possible. Shared injecting equipment is also a main driver of the epidemic of HIV in prisons worldwide.

Experience has shown that HIV epidemics among IDUs can be halted if IDUs are supported through a comprehensive approach in the early stage of the epidemic. A holistic package of prevention and care interventions reaches out to IDUs and their partners with information and education, needle and syringe provision, condoms, substitution maintenance therapy and treatment of STIs, as well as demand-reduction activities[28].

There should be a greater focus on young injecting drug users, given the HIV prevalence among IDUs in many countries. Action is needed to reduce the number of adolescents initiating drug use, along with large-scale harm-reduction programmes. Harm reduction is proven to reduce risk without promoting drug use. Information on sexual HIV transmission also needs to be provided to drug users, as this is an area often neglected; service providers often focus on their more narrow area of expertise, such as drug use or sexual transmission, rather than responding to the total needs of the person.

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[27] IPPF (2005). *Models of Care Country Coordinating Mechanisms Research.* http://content.ippf.org/output/ORG/files/13139.pdf

[28] UNAIDS (June 2005). Intensifying HIV prevention: UNAIDS policy position paper. Geneva, Switzerland. Endorsed by the 16th meeting of the UNAIDS Programme Coordinating Board. http://www.unaids.org/NetTools/Misc/DocInfo.aspx?LANG=en&href=http://gva-doc-owl/WEBcontent/Documents/pub/Governance/PCB04/pcb_17_05_03_en.pdf

Scale up what works:

- Education of SRH staff to overcome ignorance and prejudices about injecting drug users, and organization of SRH facilities to make them accessible, appropriate and affordable for IDUs.
- Provision of information and education.
- Needle and syringe distribution/exchange.
- Opioid substitution therapy.
- Behaviour-change interventions, including condom promotion and distribution.
- Treatment of STIs.
- Demand-reduction activities.
- Advocacy for policy and legal reform, along with efforts to ensure that authorities such as police and public health staff respect and protect IDUs' human rights.

Sex workers

Sex work and transactional sex have become an increasingly important factor in many countries' epidemics. Sex work occurs when there is a demand for sexual services, coexisting with women and girls who may benefit from such transactions, frequently due to extreme poverty. The context of sex work usually includes a concentration of a sexually active population, sufficient anonymity, a high ratio of males to females, and, more importantly, the socio-economic disparities that make sex work affordable to the client and an economic opportunity for the worker. For example, in Latin America and the Caribbean, the most common determinant of sex work is economic necessity, due to difficulties in entering the labour market compounded by limited schooling, a lack of opportunity and/or absence of professional qualifications. Sex work and transactional sex are often a survival strategy.

There is a great diversity of people in sex work (male, female, child, transgender) and the pathways into sex work include poverty, exploitation, occupation and trafficking. The motivations for involvement in sex work are also diverse, including money, drugs, favours, shelter, comfort, and immediate survival needs. Furthermore, the exchange of sex for drugs, or the use of sex to support drug use links the two pathways of HIV transmission. When these two routes of transmission—sex and injecting drug use—intersect, and when effective HIV prevention services are absent, the effects are dramatic. For example, a study of sex workers in St. Petersburg, Russia, showed that 33% of sex workers younger than 19 years of age were HIV positive.

The risks to those selling or exchanging sex can be reduced through the promotion of condoms, and providing services to prevent, diagnose and treat STIs in sex workers, their partners and their clients. The overlap between injecting drug use and sex work requires coordination among services. It is essential to understand the dynamics that underpin sex work in a given setting and to recognize the relationships between sex work and survival—both economic and physiological—and sex work and economic gain.

In many countries, programming among sex workers is one of the most cost-effective HIV prevention interventions. Sex workers are most likely to respond effectively to HIV prevention and care programmes when they are conducted without stigmatization or infringement on their human rights. Strengthening family planning, SRH and STI services to better respond to the needs of sex workers is an essential step to responding to and preventing HIV.

Scale up what works:

- Education of SRH staff to overcome ignorance and prejudices about sex workers, and organization of SRH facilities to make them accessible, appropriate and affordable.
- Promotion of safer sexual behaviour among sex workers, their partners, and clients (e.g., condom promotion, negotiation skills) and of sex worker solidarity and local organization (in particular, so that clients cannot 'shop around' for sex without a condom).
- Provision of STI prevention and care services, and access to commodities such as male and female condoms and lubricants.
- Peer education and outreach work including health, social and legal services, and defence against and response to sexual assault and gender-based violence.
- Care for sex workers living with HIV.

- Programmes to prevent entry into sex work and assistance in getting out of it, including access to education and vocational training.
- Anti-trafficking measures, including protection of and assistance to trafficked women and girls.
- Advocate for policy and legal reform, along with efforts to ensure that authorities such as police and public health staff respect and protect sex workers' human rights.
- Support broader approaches to reduce sex workers' personal, social, economic, and legal vulnerability.

Men who have sex with men
HIV prevention programmes for men who have sex with men are vitally important to stopping HIV transmission. However, they are often seriously neglected due to factors such as the relative invisibility of MSM, government denial, lack of research, stigmatization and legal discrimination. Another barrier to HIV prevention with MSM is varying beliefs around what defines sex, such as the belief that only sex with a woman is "sex", which means that MSM may not listen to safe sex messaging. In many countries, there is real concern that a hidden epidemic might be occurring among males having male-to-male sex, many of whom are married and/or have female sexual partners.

Scale up what works:

- Education of SRH staff to overcome ignorance and prejudices about men who have sex with men, and efforts to organize SRH facilities to make them accessible, appropriate and affordable.
- General and targeted promotion of high-quality condoms and water-based lubricants, and ensuring their continuing availability.
- Safer-sex campaigns and skills training, including education about HIV transmission modes, reducing the number of partners, condom use and alternatives to penetrative sex.
- Peer education among men who have sex with men, along with outreach programmes by volunteers or professional social or health workers.
- Provision of education and outreach to female partners of men who have sex with men.
- Programming tailored to particular subgroups such as those in the uniformed services, prisoners and male sex workers.
- Empowering individuals and strengthening organizations of self-identified gay men, enabling them to promote HIV prevention and care programmes.
- Advocate for policy and legal reform, along with efforts to ensure that authorities such as police and public health staff respect and protect the human rights of men who have sex with men.

2.3.4. Combating gender-based violence

Gender-based violence applies to men and transgendered people as well as women, and describes a range of abuses based on one's gender, including rape, sexual assault and incest; physical abuse and domestic violence; community violence; and psychological or emotional abuse.

Gender-based violence, including sexual violence against women, correlates strongly with women's risk of HIV infection. When surveyed, between one-third and one-half of women in Bangladesh, Brazil, Ethiopia, Namibia and Thailand, said their partners had physically and/or sexually assaulted them. For substantial numbers of girls, their first experience of sex is coerced. For example, of women surveyed in Rakai, Uganda, 14% said their first sexual experience had been coerced. There is in addition a cyclical nature to gender-based violence, such that, for example, of women whose first sex is forced, 60% later experience intimate partner violence, compared with only 25% of women whose first sex is consensual.

Basic HIV-prevention strategies such as abstinence, fidelity and condom promotion are often insufficient or irrelevant in the face of gender-based violence. Violence or the threat of it may limit a women's ability to protect herself from HIV, Women in abusive relationships may:

- risk violence if they insist on protection;
- stay in violent relationships because of a lack of property rights, economic dependence, etc.; or
- give in to male demands for unprotected sexual relations, even when they knows the dangers.

Furthermore, fear of violence, as well as the violence itself, reduces the effectiveness of HIV testing and care initiatives, as women may hesitate to seek testing or return for their results. Another consequence of violence is that violent sex can result in physical trauma such as traumatic gynaecological fistula, a biological risk factor of HIV infection.

Many health-care systems are not equipped to respond adequately to gender-based violence, clinically, forensically, or in terms of psychological and social support. HIV prevention efforts, including those provided by SRH services, need to address gender-based violence. At the same time, organizations and networks working on gender-based violence need to incorporate HIV prevention into their activities in view of the relationship between the two.

Scale up what works:

- SRH and HIV service providers need to be trained to recognize the signs and symptoms of gender-based violence during consultations for STIs such as HIV, and supported to address them by providing treatment and counselling.
- VCT providers need training on the signs, symptoms and treatment, including psycho-social, of gender-based violence and information on referral systems.
- Men and boys require interventions related to social norms around gender roles, and gender-based violence through school- and community-based life skills programmes.
- Implementation of a comprehensive approach, including:
    - Community awareness and education;
    - Health sector interventions, including:
        - Screening and referral for HIV infection of victims of rape. If available, post-exposure prophylaxis for HIV should be given within 72 hours of sexual assault, together with counselling; and
        - Incorporated violence-prevention strategies with VCT services, including identifying and counselling women who may be at risk of violence if they disclose their HIV-positive status, as well as the men who may perpetrate violence;
    - Education sector interventions, such as training education professionals to recognize signs and symptoms of gender-based violence and to provide counselling and referrals, gender-sensitivity trainings to reduce the chance that trusted teachers will become perpetrators, and attention to the physical layout of schools so that, for example, girls have private toilet areas;
    - Policy and legal reform, including education of members of the legal system;
    - Development of income-generation projects and literacy classes for women; and
    - Establishment of women-only HIV and gender-based violence support groups and community centres.

2.3.5. Prevention of parent-/mother-to-child HIV transmission

Children born to HIV-positive mothers may be infected during pregnancy, delivery or breastfeeding. Most infections can be prevented by proper treatment during pregnancy and childbirth, and through counselling in infant feeding risks and options. Although PMTCT is often restricted to the provision of antiretroviral therapy to HIV-positive pregnant women, safe delivery practices and infant feeding counselling and support, a broader approach has been defined and includes the following four elements:

- Preventing primary HIV infection in women;
- Preventing unintended pregnancies in women with HIV infection;
- Preventing transmission of HIV from infected pregnant women to their infants; and

- Providing care, treatment and support for HIV-infected women identified through PMTCT or VCT programmes and their families.[29]

All four elements are essential if the UN goals for reducing the proportion of infants infected with HIV by 50% by 2010 are to be attained. Current estimates indicate that, because of limitations in coverage, use of services and drug efficacy, using the third element of preventing mother-to-child HIV transmission alone will only reduce HIV in infants by between 2% and 12% in many countries. The most effective way to reduce the proportion of infants infected by HIV is by preventing primary HIV infection in women (element 1), and by preventing unintended pregnancy among women infected by HIV (element 2). These two measures have intrinsic benefits to women and can decrease the proportion of infants infected by HIV by 35% to 45% in some countries, with a significant contribution coming from the provision of family planning information, services and counselling.

Preventing primary infection requires strengthening and supporting initiatives that engage men at the early stages of family planning. Programming interventions must recognize that in many cultures and communities the high level of pressure to demonstrate reproductive well-being by having a baby is often not diminished in communities with high HIV prevalence. Programme interventions that increase follow-up and provide VCT for couples who have lost a child in the first year of infancy should be supported.

STI and HIV prevention must occur early enough to make a difference. Services to prevent mother-to-child HIV transmission include VCT; antenatal care; diagnosis and treatment of STIs, the provision of antiretroviral therapy and treatment of opportunistic infections; safe delivery practices; and replacement feeding and advice on feeding options. It also includes prevention of unintended pregnancies among HIV-positive women. There is a heightened risk of violence against women during pregnancy and an increased risk of STIs and HIV infection, as well as a common lack of adequate care. With VCT, women can learn their HIV status in time to benefit from such services.

Pregnancy

Women living with HIV need to know the risks of pregnancy to their own health as well as the risks of HIV transmission to their infants. They must also be aware of the effectiveness, availability and cost of ARV drugs for treating HIV and preventing HIV transmission to their infants, as well as the potential toxicity of such drugs.[30] Although pregnancy does not have a major effect on the progression of HIV, women living with HIV have a greater risk of certain adverse pregnancy outcomes, such as intrauterine growth restriction and preterm delivery.

Women need to know where safe legal abortion is available in those countries where there are legal forms of abortion and what restrictions may apply to them, about the abortion procedures being provided, the expected side effects and the risks of undergoing unsafe abortions (those performed by unskilled providers and/or in unhygienic conditions).

PLEASE NOTE THAT, WHILE AN ELEMENT OF A COMPREHENSIVE SRH PACKAGE, THE GLOBAL FUND WILL NOT FUND TERMINATION OF PREGNANCY SERVICES.

Birth and postpartum services

Skilled care during pregnancy, childbirth and the postpartum period includes considering the possibility of STIs and HIV-related complications during these events, paying attention to HIV-related treatment and care needs, and intervening to reduce STIs (e.g., congenital syphilis) and HIV transmission to infants.[31]

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[29] The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children 3-5 May 2004. http://www.who.int/reproductive-health/stis/docs/glion_cal_to_action.pdf

[30] UNFPA and WHO (Forthcoming). Reproductive and sexual health of women with HIV -Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.

[31] This and the following two paragraphs are taken from UNFPA and WHO (Forthcoming). Reproductive and sexual health of women with HIV -Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.

The benefit of elective caesarean section in reducing HIV transmission needs to be balanced against the risk of the surgical procedure. For example, women living with HIV have increased risks of postoperative morbidity following caesarean section, especially infective complications.

Comprehensive postpartum follow-up and care for women living with HIV and their infants extends beyond the six-week postpartum period and includes assessment of maternal healing after delivery, evaluation for postpartum infections and ongoing infant-feeding counselling and support for the woman's choice of how to feed her baby, contraceptive choice and birth spacing. PMTCT+ programs must provide care and treatment for mothers living with HIV, including ensuring their access to ARV therapy.

Pregnant women living with HIV have an increased risk of developing malaria and its consequences, and therefore require additional care. Note that malaria chemoprophylaxis for pregnant women can be requested as part of the antenatal care package that could be funded through the Malaria Component of the Global Fund. See Section 4 of the *Draft Proposal Form: Sixth Call for Proposals*. Proposals would need to clearly state how malaria chemoprophylaxis for pregnant women is linked to HIV treatment and care.[32]

Scale up what works:

- Make available, viable and cost-effective effective interventions to reduce mother-to-child HIV transmission, including community-level interventions, such as community engagement that builds awareness around HIV transmission from parents- and mother-to-baby, and corrects myths and misperceptions around HIV transmission. These must be scaled up to cover all pregnant women and sexually active women of reproductive age.
- Ensure access for all women to family planning information and services, within both PMTCT+ and VCT services.
- Prevention of mother-to-child HIV transmission must be part of all maternal, child and reproductive health services.
- PMTCT+ must be part of training for SRH workers.
- PMTCT+ services must be linked to others, such as drug dependence treatment, harm reduction and peer counselling, and to other public health initiatives, such as the Baby-Friendly Hospital Initiative and youth-friendly services. [33]
- Increase the use of skilled birth attendants attending women delivering to reduce trauma during birth, which in turn can increase the risk of HIV infection due to conditions such as fistula that arise from obstructed labour, often in adolescents and malnourished or ill mothers.
- Inclusion of non-health professionals (such as trained and traditional birth assistants and village health workers, who still attend to more than half the total births in many countries) in training and resourcing for PMTCT programmes.
- Operationalize the linkage between SRH and PMTCT through training; ensuring the supply of antiretroviral drugs, contraceptives, HIV testing kits, pregnancy testing kits, syphilis screening, and male and female condoms, and establishing referral systems and tracking mechanisms, so as to ensure quality services and to prevent supply shortfalls.
- Strengthen human, institutional and technical resources to carry out prevention programmes.

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[32] Paula E Brentlinger, Christopher B Behrens and Mark A Micek (2006). *Challenges in the concurrent management of malaria and HIV in pregnancy in sub-Saharan Africa.* The Lancet Infectious Diseases 2006; 6:100-111 (February 2006).
http://download.thelancet.com/pdfs/journals/1473-3099/PIIS1473309906703838.pdf
Approximately one million pregnancies are complicated by both malaria and HIV infection in sub-Saharan Africa annually. No published studies have shown whether standard intermittent malaria preventive treatment and antiretroviral regimens are medically and operationally compatible in pregnancy. Further research is urgently needed to define safe and effective protocols for concurrent management of HIV and malaria in pregnancy, and to define appropriate interventions for different populations subject to differing levels of malaria transmission and anti-malarial drug resistance.

[33] The Baby-Friendly Hospital Initiative (BFHI), launched in 1991, is an effort by UNICEF and the World Health Organization to ensure that all maternal centers, whether free standing or in a hospital, become centers of breastfeeding support. http://www.unicef.org/programme/breastfeeding/baby.htm

- Promote the concept of dual protection against transmission of HIV and other STIs, as well as of unintended pregnancy, by the use of condoms alone or in combination with other methods of contraception.
- Ensure that male and female condoms are available and distributed at family planning, PMTCT+ and VCT settings, together with the information and counselling necessary for their correct and consistent use.
- Improve antenatal VCT testing programmes to ensure greater uptake of testing, returns for results and sustained engagement with the PMTCT+ service for follow-up, care, treatment, safe delivery and postpartum management.
- Build on existing data to develop and improve monitoring and evaluation mechanisms for programmes linking family planning to PMTCT+ services, including measurement of the reduction in numbers of women and infants infected with HIV.

2.3.6. Provision of antiretroviral therapy

All women have the same rights concerning their reproduction and sexuality, but women living with HIV require additional care and counselling during their reproductive lives. HIV infection accelerates the natural history of some reproductive illnesses, increases the severity of others and adversely affects the ability to become pregnant. High-quality programmes and services that address sexuality positively and promote the sexual health of women living with HIV are essential for them to have responsible, safe and satisfying sexual lives.

Providing ARV therapy and HIV-related care for women living with HIV is essential for reducing maternal mortality, effectively preventing HIV infection among infants and improving the survival of children born to women living with HIV. All efforts should be made to ensure that all women who require ARV therapy have access to it.

ARV therapy programmes need to be sensitive to women-specific needs, particularly in relation to their sexual and reproductive health. The selection of an ARV therapy regimen for women should consider the possibility of a planned or unintended pregnancy and that ARV drugs may be taken in the first trimester of pregnancy during the period of foetal organ development and before a pregnancy is recognized. For women receiving ARV therapy, special efforts to support adherence may be needed during pregnancy, childbirth and the early postpartum period.

As the health and well-being of women improve with ARV therapy, women may reconsider previous decisions regarding their sexuality and reproduction. Women living with HIV can safely and effectively use most contraceptive methods. However, several ARV drugs have the potential to either decrease or increase the bioavailability of steroid hormones in hormonal contraceptives.

Providers of HIV-related care and treatment need to be aware that for most HIV-positive men and women, diagnosis does not mean an end to their sexual lives or to their childbearing aspirations. HIV-positive individuals will have continuing sexual reproductive health wants and needs that must be responded to. For example, some people may want to have a baby, whereas other people may choose to avoid pregnancy.

SRH providers will generally not be prescribing ARV therapy. However, SRH services can facilitate ARV therapy through referral and provide guidance on treatment, side effects and adherence—contributing to the support mechanisms available to people taking ARV therapy.

Scale up what works:

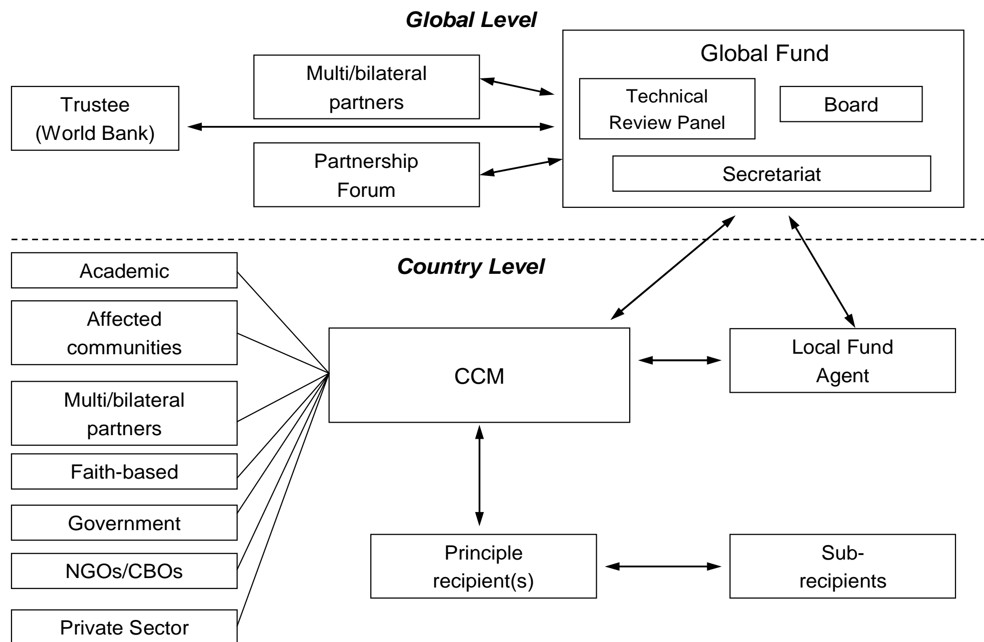
- SRH workers need training to provide high-quality information on HIV prevention, and AIDS treatment, care and support.
- Community capacity for treatment preparedness must be strengthened by providing accessible, easy-to-read guidance on treatment, side effects and adherence.

Chapter 3 — What is the Global Fund to Fight AIDS, Tuberculosis and Malaria?

3.1 Structures and Basic Facts

The Global Fund is a unique multilateral financing mechanism that seeks to combat AIDS, TB, and malaria by channelling large amounts of additional resources to the countries and communities most in need. The Global Fund collects donations from public and private sources; governments, multilateral institutions such as the World Bank, foundations such as the Bill and Melinda Gates and Ford Foundations and the Open Society Institute, and from the business sector. These funds are distributed to countries on the basis of their disease prevalence. Organizations within these countries submit proposals through their CCM in a Country Coordinated Proposal to the Global Fund, and successful proposals subsequently receive funding.

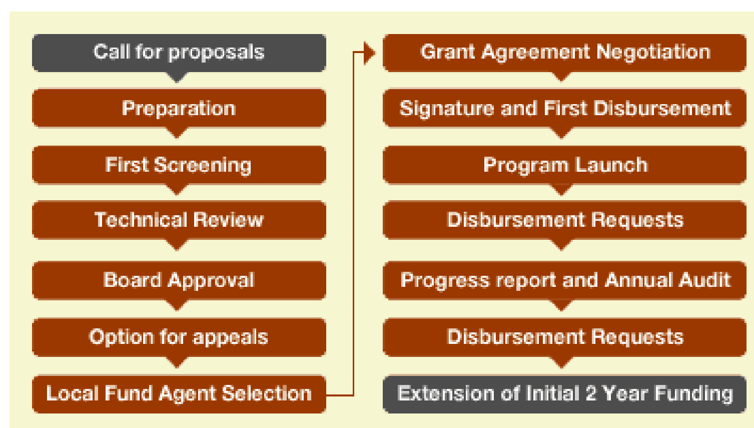
Figure 1 Global Fund Network



Box 4 Grant-making Process

The following is a brief description of the Global Fund's grant-making process.

- Global Fund Secretariat announces call for proposals.
- Country Coordinating Mechanism (CCM) prepares proposal based on local needs and financing gaps. As part of the proposal, the CCM nominates one or a few Principal Recipients (PR). In many cases, development partners assist in the preparation of proposal.
- Secretariat reviews proposals to ensure they meet eligibility criteria; forwards all eligible proposals to the Technical Review Panel (TRP) for consideration.
- TRP reviews all eligible proposals for technical merit and makes one of four recommendations to the Global Fund Board: (1) fund; (2) fund if certain conditions are met; (3) encourage resubmission; or (4) do not fund.
- Board approves grants based on technical merit and availability of funds.
- An Internal Appeal Mechanism allows applicants whose proposals were rejected in two consecutive rounds to appeal the second decision.
- Secretariat contracts with one Local Fund Agent (LFA) per country. LFA certifies the financial management and administrative capacity of the nominated PR(s). Based on the LFA's assessment, the PR may require technical assistance to strengthen capacities. Development partners may provide or participate in such capacity-building activities. The strengthening of identified capacity gaps may be included as conditions precedent to disbursement of funds in the grant agreement between the Global Fund and the PR.
- Secretariat and PR negotiate grant agreement, which identifies specific, measurable results, to be tracked using a set of key indicators.
- Grant agreement signed. Based on request from Secretariat, the World Bank makes initial disbursement to PR. PR makes disbursements to sub-recipients for implementation, as called for in approved proposal.
- Programme and services begin. As the coordinating body at the country level, the CCM oversees and monitors progress during implementation.
- PR submits periodic disbursement requests with updates on programmatic and financial progress. LFA verifies information submitted and recommends disbursements based on demonstrated progress. Lack of progress triggers request by Secretariat for corrective action.
- PR submits fiscal year progress report and annual audit of programme financial statements to Secretariat through the LFA.
- Regular disbursement requests and program updates continue, with future disbursements tied to ongoing progress.
- The CCM requests funding beyond the initially approved two-year period. The Global Fund approves continued funding based on progress and availability of funds.



3.2. Country Coordinating Mechanism

The Country Coordinating Mechanism (CCM) lies at the heart of the Global Fund's vision. The CCM is a group of individuals representing a wide range of sectors within a country, who come together to assess the country's needs in relation to AIDS, TB, malaria or any combination of these three diseases. A properly functioning CCM is a true manifestation of multi-stakeholder country ownership, of public-private partnership and of the greater involvement of people living with HIV (GIPA) Principle. CCMs are intended to be multisectoral, involving broad representation from government agencies, nongovernmental organizations, community- and faith-based groups, private sector institutions, individuals living with HIV, tuberculosis or malaria, and bilateral and multilateral agencies.

Although not specifically mentioned by the Global Fund, there are other groups, such as women's and young people's organizations, including those working on sexual and reproductive health, or those representing vulnerable populations such as injecting drug users (IDUs), men who have sex with men (MSM), sex workers, migrants, and or/refugees and displaced persons, whose contribution can be valuable to a CCM.

The role of the CCM is to:

1. Coordinate the submission of one Country Coordinated Proposal for funding, drawing on the strengths of various stakeholders to agree on strategy; identify financing gaps in achieving the strategy based on existing support; prioritize needs; and identify the comparative advantages of each proposed partner;
2. Select one or more appropriate organization(s) to act as the PR for the Global Fund grant;
3. Monitor the implementation of activities under Global Fund approved programs, including approving major changes in implementation plans as necessary;
4. Evaluate the performance of these programs, including of Principal Recipient(s) in implementing a program, and submit a request for continued funding prior to the end of the two years of initially approved financing from the Global Fund; and
5. Ensure linkages and consistency between Global Fund assistance and other development and health assistance programs in support of national priorities, such as Poverty Reduction Strategy Paper (PRS) or Sector Wide Approaches (SWAps).[34]

Membership of a CCM is an opportunity for active civil society participation, for SRH organizations to voice their opinions and to influence future action and responses to the epidemic. However, it should be noted that being a member of the CCM is not a prerequisite for having proposals accepted as part of the Country Coordinated Proposal. Section **3.5. The proposal invitation and development process** highlights the fact that CCMs are expected to publicly share information before the proposal is developed and the proposal development process should also allow all sectors and constituencies (both CCM members and non-members) enough time to provide input into the drafting of the proposal to be submitted to the Global Fund.

3.3. Analysis of current makeup of CCMs and their relationship to SRH actors in the field

The Global Fund is a unique funding mechanism because of the strength of its commitment to civil society participation. Civil society organizations are organizations, including for-profit and not-for-profit, outside of government. As such, SRH organizations are part of civil society and have an important role to play in the CCM.

There has been a significant shift in the recognition by some governments and international institutions of the considerable expertise, knowledge and skills that NGOs have. Civil society and NGOs are the foundation upon which effective responses to AIDS, tuberculosis and malaria are built. NGOs are the advocates, which in many countries stimulated the first AIDS

[34] Global Fund (2005). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility,* paragraph 7. http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

responses. It is members of civil society that are often the implementers of support, prevention and care programmes, particularly with the most vulnerable and hard to reach communities.

However, many governments continue to ignore the rich diversity and resources of civil society. Without this recognition and full support of all governments and international institutions of the need for the integration of NGOs in realizing the vision of the Global Fund, it will always remain a vision rather than a reality. The following section provides some background as well as arguments for SRH organizations to use in advocating with their CCM, Ministry of Health and other ministries, multilateral and bilateral institutions, and other civil society organizations for their inclusion in the CCM.

At the country level there are now requirements for the effective involvement of civil society representatives and people living with the diseases.[35] The Global Fund *Revised Guidelines* state that:

> The Global Fund recognizes the importance of national contexts, customs and traditions, and therefore does not intend to prescribe specific CCM compositions. However, in accordance with its guiding principles, the Global Fund expects CCMs to be broadly representative of all national stakeholders in the fight against the three diseases. In particular, the Global Fund encourages CCMs to aim at a gender balanced composition. The CCM should therefore be as inclusive as possible and seek representation at the highest possible level of various sectors.
>
> The membership of the CCM comprise a minimum of 40% representation of the non-government sectors such as NGOs/community based organizations, people living with the diseases, religious/faith-based organizations, private sector, academic institutions.
>
> CCMs include representation from state/provinces/districts either through direct geographical representation in national CCMs or through mechanisms such as sub national CCM, or state/province-level committees. [36]

A series of studies have been undertaken assessing the operation and composition of CCMs.[37] The analysis of Rounds 3 and 4 found the following.

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[35] Global Fund (2005). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility,* paragraphs 10-12.
http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

[36] Global Fund (2005). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility.* Paragraph 10.
http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

[37] The CCMs in the following countries were documented as case studies:

Africa:
In partnership with GTZ: Ghana, Kenya, Rwanda
In partnership with Italian bilateral Cooperation: Burkina Faso, Regional CCM (Southern Africa), Swaziland
In partnership with French Ministry of Foreign Affairs: Benin, Cameroon, Senegal
In partnership with French Ministry of Health: Morocco

Asia:
In partnership with GTZ: Cambodia, Indonesia, India, Pakistan
In partnership with French Ministry of Foreign Affairs: Vietnam

Eastern Europe:
In partnership with GTZ: Armenia, Ukraine

Latin America:
In partnership with GTZ: Peru, Honduras

- GNP+ (2003). *Report of a Multi-Country Study of involvement of People Living With AIDS in CCMs.*
- GNP+ and other (2004). *A synthesis and analysis of findings from the CCM Case Studies, Tracking Study, Survey's.* This paper reviews briefly the main Fund Guidelines on CCMs as the framework for the analysis, followed by a summary of the main findings and analysis from the case studies, surveys and meeting reports.
- *The CCM-Forum of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM): towards transparency through information sharing'.*

> Of the 78 CCMs analysed, on an average, the government sector, represented by the Ministry of Health (20%) and other ministries (19%) makes up approximately 39% of CCM membership. Multilateral and bilateral institutions comprise approximately 21% of the membership. Combined, these "public" entities make up 60% of the average CCM membership, the balance being composed of civil society including the private sector. This analysis indicates a marginal increase in Round 4 of the public sector membership as compared to Round 3.

None of the studies disaggregated civil society by area of work. This is perhaps one area in which the Global Fund could reform its procedures. Currently under 3b.1.2 of the *Draft Proposal Form: Sixth Call for Proposals,* it is requested that:

> Under "Type", please specify which sector the CCM member represents: academic/educational; government; non-governmental and community-based organizations; people living with HIV/AIDS, tuberculosis and/or malaria; the private sector; religious/faith-based organizations; or multi-/bilateral development partners in country.

This could easily be modified to collect more sector-specific data, which would assist analysis of CCM composition.

The only study to date that looks at SRH in the context of CCMs is IPPF (2005), *Models of Care Country Coordinating Mechanisms Research,* which assessed the role of Member Associations in Global Fund processes. [38]

Box 5 IPPF Country Coordinating Mechanisms Findings

Only 31 Member Associations responded that they are "members" of their country's CCM, including:

- *CCM member*—Bulgaria, China, Columbia, Ethiopia, Fiji, Georgia, Panama, Rwanda, Sri Lanka, Sudan (former member as another NGO has rotated onto the CCM), Togo, Trinidad and Tobago, Tunisia, Turkey and Yemen.
- *CCM Vice-Chair*—Mongolia and Tuvalu.
- *CCM Chair*—Vanuatu.
- *Principal Recipient*—Comoros and Dominican Republic (TB).
- *Sub-recipient*—Iran, Morocco, Namibia and the Gambia.
- *Loose Relationship*—Lebanon, Tanzania and Thailand. [39]

In total, 18 Member Associations are in fact CCM members.

59% (16 Member Associations) found little difficulty in joining the CCM; 19% (5 Member Associations) reported a neutral experience; and 22% (6 Member Associations) experienced difficulties. Member Associations identified a number of issues that increased their difficulty in becoming a CCM member, including competition between NGOs; ignorance of NGOs' role; restriction of selected NGOs to those experienced in AIDS, TB and malaria; and lack of information.

In general, Member Associations that are CCM members have either been involved in the CCM process since its inception (14 Member Associations) and were generally active in HIV responses and working with the government, or were well known to it beforehand and were subsequently invited to become a CCM member; or they have had a more difficult experience

- Analysis of CCM composition for Round 3 and Round 4. The purpose of the two sets of analysis was to gather information on representation in CCMs by the different sectors in the different regions, on the chairmanship and vice chairmanship of the CCMs, as well as to have preliminary information on the proposed Principal Recipients. http://www.theglobalfund.org/pdf/ccms/CCM%20R3%20Analysis.pdf http://www.theglobalfund.org/pdf/ccms/CCM%20R4%20Analysis.pdf

[38] http://content.ippf.org/output/ORG/files/13139.pdf

[39] For example, invited irregularly to CCM meetings or were invited to CCM inauguration but not invited thereafter.

in becoming a CCM member and have only recently (i.e., in the past 12 months) taken up their position (7 Member Associations).

As can be seen, those Member Associations that were already known to the government through their work and which had a good reputation were asked to be CCM members. If this group and other Member Associations asked by the CCM, National AIDS Committee or Ministry of Health are added together, they account for 52% of cases. While there is much discussion about transparency and accountability in CCM processes; it is also true that in many countries the number of entities that work on AIDS, TB and malaria is quiet small. As such, those that are known and respected will naturally gain a seat at the table.

In the IPPF *Models of Care* survey, 29 Member Associations outlined their reasons for becoming involved in their CCM. These included:

- the CCM is a way to securing funding;
- the CCM is a way to access information on funding opportunities;
- sharing of experiences;
- working on VCT;
- a general feeling that they thought they could help;
- collaboration to strengthen efforts;
- strengthening existing and future programmes; and
- the monitoring function of involvement, particularly ensuring that Global Fund funds go to credible organizations.

The CCM is also seen as a forum for strengthening a Member Association's capacity. Sudan's MA suggested that the CCM provides experience in implementation, monitoring and evaluation, and policy strategies, which are some of the central roles and responsibilities of the CCM. Trinidad and Tobago highlighted the CCM as an opportunity for creating links between HIV and AIDS and SRH work.

While involvement in the CCM can bring advantages, it can also have costs, particularly when expectations are not met. Disadvantages suggested by Member Associations included increased demands on time and resources; the way the CCM operates; conflicts of interest; issues of representation; and financial implications.

Participation in the CCM has many different possible benefits for Member Associations in addition to accessing funding. A number of Member Associations interviewed, including the Dominican Republic and Fiji, noted that while they have not received funding and the CCM has involved considerable work, in terms of their country's response the CCM has created more transparency and increased collaboration. If the overall aim is to have a significant impact on the three diseases, then success should not be measured by whether a particular SRH organization has received funding but by whether the process improves the quality of a country's response.

Furthermore, some Member Associations as well as some CCMs view the CCM as strictly dealing with NGOs responding to AIDS, TB and malaria. The Global Fund *Revised Guidelines* clearly present the case for an inclusive CCM, reflecting the needs of a country's response to the three diseases.[40] As such SRH organizations can, and should be, included within a country's CCM.

Finally, SRH organizations need to determine the level of involvement that they want to have with the Global Fund. While being a member of the CCM brings access to decision-making processes, any SRH organization must also make the commitment to undertake the roles and responsibilities outlined in Section **3.2. Country Coordinating Mechanism.** Alternatively, a SRH organization can decide that its primary focus will be to access Global Fund funding and to that end will coordinate and work with the CCM for the integration of SRH-related HIV programmes into the Country Coordinated Proposal. Neither approach is

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[40] Global Fund (2005). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility.* Paragraph 10. http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

better than the other, but SRH organizations must be clear on their level of involvement and expected outcomes given their capacity, financial and time constraints.

3.4. Steps for SRH providers to take in joining CCMs

The call for proposals for the fifth Global Fund round significantly strengthened the position of civil society, particularly by making grants conditional on a CCM having the non-governmental sectors selecting their own representatives based on a clear, sector-specific process.[41] This is also reflected in the *Draft Proposal Form: Sixth Call for Proposals*, which indicates in 2.2.1 broad and inclusive membership:

> Selection of non-governmental sector representatives
> Provide evidence of how those Coordinating Mechanism (CM) members representing each of the non-governmental sectors (*i.e. academic/educational sector, NGOs and community-based organizations, private sector, religious and faith-based organizations, and multi-/bilateral development partners in country)* have been selected by their own sector(s) based on a documented, transparent process developed within their own sector.
> *(Please summarize the process and, <u>for each sector</u>, attach as an annex the documents showing the sector's transparent process for CM representative selection, and the sector's minutes or other documentation recording the selection of their current representative. Please indicate the applicable annex number.)*

These requirements are onerous and open the possibility for SRH organizations to make a compelling case for their inclusion in the CCM. Firstly, SRH organizations as part of civil society are entitled to play a part in the Global Fund. SRH organizations should advocate for inclusion around the *Draft Guidelines for Proposals: Sixth Call for Proposals*, emphasizing the need to demonstrate that CCM members representing the non-governmental sectors have been selected by their own sector(s) based on a process meeting the Global Fund's requirements, as defined above.

Secondly, the arguments presented in Section **2.3 Integrating SRH into the HIV/AIDS component of a Country Coordinated Proposal** should be utilized to strengthen the case for SRH involvement in the CCM. SRH organizations need to be able to make their case to the CCM as to why SRH issues should be integrated into AIDS responses and what are the added or comparative advantages of integrating HIV into SRH services.

Thirdly, the experience and capacity that SRH organizations regarding SRH mean that such organizations have unique knowledge and experience to bring to the AIDS response. SRH organizations should advocate for a representative and inclusive CCM, which includes the voice and participation of SRH organizations.

In general, SRH organizations, whether CCM members or not, should be advocating with their CCMs for them to follow the procedures in the *Revised Guidelines*[42] and the *Draft Guidelines for Proposals: Sixth Call for Proposals* concerning the selection of CCM members. SRH organizations at the national level experiencing difficulties in becoming CCM members should inform their parent organizations of their situation, as the parent organization can only advocate on its behalf if it is informed about what is happening in country. Furthermore, United Nations agencies and donor governments in-country should also be made aware of any difficulties.

At a minimum, SRH organizations that are not engaged with their CCMs should take steps to become a member, or should at least become informed about the CCM and Global Fund practices and procedures in country.

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[41] Global Fund (2005). *Guidelines for Proposals: Fifth Call for Proposals*. http://www.theglobalfund.org/pdf/3_pp_guidelines_5_en.pdf

[42] *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility,* paragraphs 10-12. http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

Finally, as representation is by sector, there is the possibility for a number of SRH organizations to select one SRH organization to be their CCM representative. The advantages of such an approach are that it keeps the number of CCM members manageable and should create coordination and harmonization between SRH organizations rather than competition and duplication of efforts. While a similar strategy could be used to form partnerships with other sectors, such a maternal and child health or VCT services, logically it makes sense to have a representative from the SRH sector, which can reflect the views of this sector

The IPPF *Models of Care* Action Research found that:

> In terms of whether IPPF Member Associations work in partnership or collaborate with organizations, which are members of the CCM; 32 Member Associations (from a total of 47 Member Associations which responded to this question) stated that they did, while 15 Member Associations stated that they did not.
>
> While there is some level of collaboration and partnership between SRH and other organizations on the CCM, this could clearly be increased, and is something that should be advocated at different levels within SRH organizations. As with many aspects of Member Association involvement with the Global Fund, lack of information is one of the greatest impediments to forming partnerships. [43]

SRH organizations can play an important role in monitoring the implementation of Global Fund projects in country. Some IPPF Member Associations have been active in building and strengthening partnerships. For example, FPAK (Family Planning Association of Kenya) was a founding member of KECOFATUMA (The Kenya Consortium of Organizations Fighting AIDS, Tuberculosis and Malaria), which comprises 500 NGOs and acts as an independent monitor of the CCM.

3.5. The proposal invitation and development process

The guidance provided for proposal invitation and development is also onerous. The General information to applicants of the *Draft Guidelines for Proposals: Sixth Call for Proposals* states:

> In accordance with its guiding principles, the Global Fund expects proposal development and submission to the Global Fund to be coordinated through **Coordinating Mechanisms** (constituted nationally, sub-nationally, or regionally, together a 'CCM'). These Coordinating Mechanisms are expected to have members who are broadly representative of all national constituencies involved in responding to the impact and spread of the three diseases.
>
> Only in exceptional circumstances can applications be made other than through a CCM. This is explained in section 3A.6 of the *Draft Guidelines for Proposals: Sixth Call for Proposals*.
>
> To seek as broad input as possible into any CCM proposal submitted to the Global Fund, CCMs are expected to disseminate widely all information related to the proposal process to **all** stakeholders actively involved in the diseases, including the broad range of non-government stakeholders and constituencies in the community.
>
> **Information that is expected to be publicly shared by the CCM before the proposal is developed includes**: the timing relevant to the Global Fund's Call for Proposals; how interested stakeholders may apply to the CCM for a proposal to be included in the CCM's consolidated proposal to the Global Fund; the criteria upon which individual proposals will be evaluated by the CCM for possible inclusion in the consolidated proposal; and other guidance believed relevant (e.g., information on items such as national priorities for each of the three diseases, updated disease burden

[43] IPPF (2005). *Models of Care Country Coordinating Mechanisms Research.* http://content.ippf.org/output/ORG/files/13139.pdf

statistics, and perceived gaps in existing services being provided to most at risk groups).

The proposal development process should also allow all sectors and constituencies (both CCM members and non-members) enough time to provide input into the drafting of the proposal to be submitted to the Global Fund. CCMs must have in place a fair, transparent, documented process for reviewing all qualitatively sound submissions they receive for integration into the proposal prior to final submission. [44]

2.2.3 Documented and transparent processes of the Coordinating Mechanism of the *Draft Guidelines for Proposals: Sixth Call for Proposals*, requires that:

In this section of *Draft Proposal Form: Sixth Call for Proposals*, all Coordinating Mechanisms (CCMs, sub-CCMs and RCMs) are requested to explain the fair, transparent, documented process that the Coordinating Mechanism has transparently adopted to:

- Broadly solicit submissions for possible integration into one consolidated proposal;
- Review all qualitatively sound submissions received for integration into the proposal prior to final submission;
- Nominate technically capable Principal Recipient(s);
- Oversee program implementation; and
- Ensure the input of a broad range of stakeholders, including Coordinating Mechanism members and non-members, in the proposal development and grant-oversight process.

Summary information as to how the Coordinating Mechanism's processes satisfy each of these **eligibility requirements** should be given in the Proposal Form, and detailed documentation should be provided as an annex. Such annexes could typically include:

- The Coordinating Mechanism's standing rules of procedure, terms of reference, operational manual, or other governance documentation;
- Examples of the process which the Coordinating Mechanism used to broadly announce the proposal development process and seek input in to the proposal content and drafting; and
- The adopted minutes from those Coordination Mechanism meeting(s) at which the proposal development process was discussed, the Principal Recipient(s) evaluated and nominated, and the involvement of a broad range of stakeholders into the drafting process was discussed. [45]

While these requirements are for the country proposal submission, SRH organizations can use them and those in the general information to applicants to advocate either for their inclusion in the CCM or their involvement in the Country Coordinated Proposal development. Ultimately for many SRH organizations the issue will be the inclusion of SRH-related proposals in the Country Coordinated Proposal rather than full membership of the CCM.

Note that the CCM leadership and members must endorse the country proposal individually (3B1.1. and 3B.1.2 respectively of the *Draft Proposal Form: Sixth Call for Proposals*).

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[44] Also see

- Sections 2.2 and 3B.1 of *Draft Guidelines for Proposals: Sixth Call for Proposals*; and
- In the Global Fund's "Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility" (**CCM Guidelines**).

[45] Also see

- Sections 2.2 and 3B.1 of *Draft Guidelines for Proposals: Sixth Call for Proposals*; and
- In the Global Fund's "Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility" (**CCM Guidelines**).

Chapter 4 – Developing a Proposal Benefiting SRH Programmes

The principle difference between Round 5 and Round 6 proposals is that Health Systems Strengthening is no longer a separate component. However, applicants can still apply for funding for health systems strengthening activities by including such activities in the specific disease component sections in section 4 of the Proposal Form.

The *Draft Guidelines for Proposals: Sixth Call for Proposals* and the *Draft Proposal Form: Sixth Call for Proposals* should be read in tandem. The *Draft Guidelines for Proposals: Sixth Call for Proposals* offer a wealth of practical information as to what information, including annexed documents, country proposals need to include.

The information provided in this chapter supplements, but does not replace, that provided in the *Draft Guidelines for Proposals: Sixth Call for Proposals.* The *Draft Guidelines for Proposals: Sixth Call for Proposals* are designed to assist in the formulation of a Country Coordinated Proposal by the CCM. This section highlights the areas on which a SRH organization should concentrate to ensure that its proposal provides all the information necessary for inclusion in a Country Coordinated Proposal.

4.1 National Strategic Plans on Sexual and Reproductive Health

At the Fifty-fifth World Health Assembly in 2002, Resolution WHA55.19 was adopted, requesting WHO to develop a strategy for accelerating progress towards attainment of international development goals and targets related to reproductive health. This first WHO Global Reproductive Health Strategy was presented and adopted at the Fifty-seventh World Health Assembly in May 2004.[46]

The strategy was developed as a result of extensive consultations in all regions with representatives from ministries of health, professional associations, non-governmental organizations, United Nations partners and other key stakeholders. Three of the eight MDGs are directly related to reproductive and sexual health, namely, improving maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases.

The strategy lays out actions needed for accelerating progress towards the attainment of the MDGs and other international goals and targets relating to reproductive health, especially those from the International Conference on Population and Development (ICPD) in 1994, and its five-year follow-up (ICPD+5). The strategy has five priority areas:

1. Improving antenatal delivery, postpartum and newborn care.
2. Providing high-quality services for family planning, including infertility services.
3. Eliminating unsafe abortion.
4. Combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities.
5. Promoting sexual health.[47]

As part of the monitoring of the implementation of the Global Reproductive Health Strategy, the Department of Reproductive Health and Research (RHR) of WHO undertook a survey in 2005 seeking information, inter alia, whether countries have, since May 2004,

> taken measures to strengthen existing reproductive and sexual health policies/strategies or to develop a new strategy, as a result of the adoption of the WHO Global Reproductive Health Strategy?

Forty-three countries have replied to date. The responses were:

- **Yes:** Afghanistan, Armenia, Bahrain, Brazil, Chad, Chile, China, Cote d'Ivoire, Djibouti, Dominican Republic, Indonesia, Iran, Iraq, Jamaica, Lao PDR, Latvia, Maldives, Mongolia, Myanmar, Nicaragua, Oman, Paraguay, Peru, Qatar, Sudan, Syria, Tanzania, East Timor, Turkey and Uzbekistan.
- **No:** Burundi, Gambia, Nepal, Slovakia, and Thailand.

[46] Resolution WHA 57.12 http://www.who.int/reproductive-health/strategy.htm
[47] Resolution WHA 57.12 http://www.who.int/reproductive-health/strategy.htm

- **No Reply/Didn't Know:** Bolivia, Honduras, and Jordan.

In drafting a Country Coordinated Proposal, the above data are useful; however, it is important to contact your Ministry of Health to check if a country does in fact have a reproductive health strategy, as is known that additional countries have developed strategies who did not so indicate in the aforementioned survey. Furthermore, you need a copy of your national strategy on sexual and reproductive health to compare with the national AIDS strategic plan so as to be able to point out the linkages between the two for inclusion in a SRH proposal as part of the Country Coordinated Proposal.

Many National Reproductive Health Strategies are likely to be modelled on the Global Reproductive Health Strategy and to include the five priority areas outlined above. Of particular importance are improving antenatal delivery, postpartum and newborn care; providing high-quality services for family planning; combating sexually transmitted infections, including HIV; and promoting sexual health.

References in the National Reproductive Health Strategies should be cross-referenced with what is contained in the National AIDS Plan to illustrate linkages or conflicting priorities between the two.

Other issues that should be compared between the National Reproductive Health Strategies and the National AIDS Plan are:

- strengthening health systems capacity;
- creating supportive legislative and regulatory frameworks; and
- strengthening monitoring, evaluation and accountability.

In terms of the proposal form, information concerning national strategic plans on SRH should be integrated into:

- 4.4.1 Other national documentation;
- 4.4.3 Disease-control initiatives and broader development frameworks; and
- 4.6.2 Link with overall national context.

4.2 TRP assessment

The discussion of what the Technical Review Panel (TRP) is looking for in relation to SRH is generic, since the Global Fund has not issued any guidance on what it would like to see included in proposals benefiting SRH programmes. However, for SRH-related proposals the key is to highlight and integrate SRH interventions into HIV prevention, and AIDS treatment, care and support, placing particular emphasis on the added value and additional opportunities that such strategies provide.

To reiterate, this section provides limited insight into what the TRP is looking for in proposals. Under the General information to applicants in the *Draft Guidelines for Proposals: Sixth Call for Proposals* three criteria for proposal review are discussed:

1. Soundness of approach
2. Feasibility
3. Potential for sustainability

Relevant aspects of “soundness of approach” include:

- Use interventions consistent with international best practices (WHO and UNAIDS strategies and guidance) to increase service coverage for the region in which the interventions are proposed, and demonstrate a potential to achieve impact;
- Give due priority to groups and communities most affected and/or at risk, including by strengthening the participation of communities and people infected and affected by the three diseases in the development and implementation of proposals;
- Involve a broad range of stakeholders in implementation;
- Address issues of human rights and gender equality, including contributing to the elimination of stigmatization of and discrimination against those infected and affected by HIV/AIDS; and
- Are consistent with national law and applicable international obligations.

Programmatic approaches included in the proposal should be consistent with international norms, standards, and best practices. If the proposal does not adhere to international best practices, there should be a clear justification for why this is the case. Materials such as those found on the websites of WHO and UNAIDS and noted in **Chapter 5 Resources** should be consulted prior to preparing a proposal.

SRH interventions often give priority to women and other vulnerable populations as well as contribute to human rights and gender equality. A strong case should be developed as to how a given proposed intervention will either focus on a particular population or improve human rights and gender equality.

Ways in which the proposal relates to national reproductive strategies is discussed in Section **4.1 National Strategic Plans on Sexual and Reproductive Health.**

Given that there have not been many country proposals involving SRH, the most relevant aspects of "feasibility" for SRH interventions include:

- Provide strong evidence of the technical and programmatic feasibility of implementation arrangements relevant in the specific country context, including a detailed Work Plan and Budget;
- Demonstrate that interventions chosen are evidence-based and represent good value for the money;
- Build on, complement, and coordinate with existing programs in support of national policies, plans, priorities and partnerships, including Poverty Reduction Strategies and sector-wide approaches (where appropriate);
- Build on, complement and coordinate with existing Global Fund grants;
- Utilize innovative approaches to scaling up programs;
- Focus on performance by linking resources to the achievement of clear, measurable and sustainable results based on the identification of measurable indicators for proposed interventions;
- Demonstrate how the proposed interventions are appropriate to the stage of the epidemic and to the specific epidemiological situation in the country (including issues such as drug resistance); and
- Demonstrate needs for technical assistance.

Section **4.1 National Strategic Plans on Sexual and Reproductive Health** contains a discussion of coordination with existing programs to support national policies and priorities**.**

Relevant aspects of potential for "sustainability" include:

- Demonstrate that Global Fund financing will be additional to existing efforts to combat HIV/AIDS, tuberculosis, and malaria, rather than replacing them;
- Demonstrate the potential for the sustainability of the approach outlined, including addressing the capacity to absorb increased resources (such as through innovative approaches to overcoming human resource capacity constraints), and the ability to service recurrent expenditures; and
- Coordinate with (including in the identification of indicators and targets) multilateral and bilateral initiatives and partnerships, such as the WHO/UNAIDS "Universal Access" initiative, the "Three Ones" principles[48] and UNICEF's "Unite for Children. Unite against AIDS" campaign.

The financial additionality requirement is crucial to the success of proposals. SRH organizations must not be tempted to see the Global Fund as an exclusive funding source for their work on SRH and HIV. 4.5 Financial and programmatic gap analysis of the *Draft Proposal Form: Sixth Call for Proposals* clearly requires that proposals indicate how the funding sort is additional to existing efforts rather than replacing them. In essence, SRH organizations would have to illustrate their financial commitment or other sources of funding to complement any funds received through the Global Fund.

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[48] One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS coordinating authority with a broad-based multisectoral mandate, and one agreed country-level monitoring and evaluation system. See www.unaids.org for more information. Proposals addressing HIV/AIDS should indicate how these principles are put into practice.

4.3 Eligibility Criteria

Only those proposals that meet the Global Fund's eligibility criteria of a technical competent and functioning CCM will be reviewed by the Technical Review Panel.

4.3.1 Technical Eligibility

The first step for a country is to assess whether it is eligible to apply to the Global Fund for funding. The country classifications for
- Low income countries,
- Lower-middle income countries, and
- Upper-middle income countries

are contained in Attachment 1 to the *Draft Guidelines for Proposals: Sixth Call for Proposals.* High income countries cannot apply for Global Fund support.

Lower-middle income and upper-middle income countries
Proposals from lower-middle income and upper-middle income countries must demonstrate an increasing reliance on domestic resources by meeting defined counterpart financing requirements (see Section 2.1.2).

Applicants from lower-middle income and upper-middle income countries must demonstrate focus on poor or vulnerable populations, in particular describing (see Section 2.1.3):
- which poor and vulnerable populations are targeted by the proposal;
- why and how these population groups have been identified; and
- how they will be involved in planning and implementing the proposal.

High disease burden countries
Upper-middle income countries must demonstrate a high current national disease burden, defined by a ratio of adult HIV seroprevalence (as reported by UNAIDS, multiplied by 1000) to Gross National Income per capita (Atlas method, as reported by the World Bank) that exceeds 5. [49]

Applicants from upper-middle income countries applying for funding under the HIV/AIDS component, but who do not face a high general disease burden, are nevertheless eligible if there is an HIV seroprevalence rate of more than 5% in a vulnerable population group in the country. This may include but is not limited to injecting drug users, men who have sex with men and commercial sex workers. The following requirements must be met by such applicants:
1. The proposal must be targeted at the identified vulnerable population;
2. The applicant must provide a definition of the nature of the vulnerable population, the size of the population and evidence of the seroprevalence rate within such population; and
3. The evidence provided by the applicant must be validated by WHO or UNAIDS. Such evidence could be a letter signed by one of these organizations verifying the data provided by the applicant.

Such applications must also fulfil the counterpart financing requirement for upper-middle income countries.

[49] Applicants that qualify under the "small island economy" lending eligibility exception to the International Development Association's requirements (see section C of Attachment 1 to *Draft Guidelines for Proposals: Sixth Call for Proposals*)

4.3.2 Functioning CCM

There are certain minimum requirements that CCMs must meet for the Country Coordinated Proposal to be eligible for funding, as explained in the *Draft Guidelines for Proposals: Sixth Call for Proposals:*

- 2.2.1 Broad and inclusive membership;
- 2.2.2 Documented procedures for the management of conflicts of interest; and
- 2.2.3 Documented and transparent processes of the CCM.

The corresponding sections in the *Draft Proposal Form: Sixth Call for Proposals* are required to be completed.

The selection processes that were used for non-governmental sector members to select their own sector representative in a transparent way should be summarized in the Proposal Form. Additional documentation for each sector should be attached in an annex, as evidence that the sectors themselves selected their own representatives. This could include minutes of sector meetings and other documentation recording the selection of the current representatives. In relation to SRH organizations and/or CCM members, they need to provide such information in order to complete the country proposal.

These requirements are discussed above in Section **2.3 Integrating SRH into the HIV/AIDS Component of a Country Coordinated Proposal.**

4.4 Applicant Type

There are several options for applying to the Global Fund for funding:

- national Country Coordinating Mechanism (CCM),
- sub-national Coordinating Mechanism (sub-CCM),
- Regional Coordinating Mechanism (RCM),
- Regional Organization (RO), or
- Non-CCM applicant.

Most SRH organizations' proposals will be part of CCM, sub-CCM or RCM Country Coordinated Proposal.

However, a potential alternative for SRH organizations is to submit a Regional Organization (RO) application, described in 3A.5 of the *Draft Proposal Form: Sixth Call for Proposals* for a coordinated proposal to address cross-border or regional issues. The principle caveats are:

- The ROs must clearly explain why such an approach has been chosen for the implementation of the proposal, and fully demonstrate added value beyond what can be achieved in individual countries under the guidance of a national CCM.
- Proposals from ROs should also demonstrate how the implementation strategy will include measures to maximize operational efficiencies in administrative processes and functions of the RO (e.g., strategies may include focusing on efficient communication methods and rationales for use of administrative resources) in order to maximize the funds available to the implementing entities in the countries included in the proposal.

ROs must explain how in their existing operations, they give effect to the principles of inclusiveness, multisectoral consultation and partnership in the development and implementation of regional cross-border proposals. Such explanations may include how stakeholders (including representatives of national CCM members) from countries included in the proposal were engaged in proposal development and will be informed of performance during implementation.

Prior experience of the RO should also be described in regard to the component(s) included in the proposal, identifying key recent performance achievements in efficiently and effectively responding to reduce the impact and spread of the disease(s). In support of this section, ROs should provide additional documentation, such as statutes, by-laws of the organization, official registration papers, and a summary of the main sources and current amounts of funding.

Proposals from RO applicants are expected to be supported by the governing body of the Regional Organization in the usual manner relevant to an application for external funds for programme implementation. Importantly, to be eligible for funding these proposals must be accompanied by the same level of endorsement from the national CCM of *each country* included in the proposal as applies to RCMs.

Whether submission of a RO proposal is a realistic alternative for regional SRH organizations will largely depend on the interventions to be implemented. Cross-border cooperation is logical in the context of migration, during which people move between countries and interventions can take place at departure and reception points. Similarly, transnational movement of sex workers could be an area in which regional SRH organizations may seek to be involved.

However, such an approach is time consuming and likely to create more issues than it resolves, as it largely removes the organization from national responses even though there is the requirement for each country's endorsement. The time involved in developing a complete proposal is far greater than that involved in developing a proposal as one component of a CCM, sub-CCM or RCM proposal. Furthermore, the funding would have to justify such an investment in time and resources.

In relation to funding levels, the *Draft Guidelines for Proposals: Sixth Call for Proposals* state:

> There are no fixed upper limits on the size of a proposal, and the size of proposals may vary considerably based on country context and type of proposal. However, evidence of sufficient absorptive capacity is an important criterion for support. The TRP may view negatively proposals that request large amounts where the ability to absorb such funding has not been demonstrated (for example, annual requests that are disproportionate relative to existing yearly health sector expenditure).
>
> There are also no fixed lower limits on the size of a proposal. However, as the Global Fund promotes comprehensive programs and particularly those aimed at scaling-up proven interventions, the TRP may view negatively requests for small projects (of the order of several hundred thousand US Dollars or below). Smaller requests by individual partners and/or smaller non-governmental organizations should be aggregated into the overall comprehensive proposal. In this way, smaller and more innovative approaches can receive funding.

4.5 Component Section

In general, the CCM would complete this section as it is at the heart of a Country Coordinated Proposal. In this respect, a close reading of the *Draft Guidelines for Proposals: Sixth Call for Proposals* is required. This section provides suggestions as to where in the Component Section of the *Draft Proposal Form: Sixth Call for Proposals* information specific to SRH should be introduced.

Proposals can address one or more of the following components:

1. HIV/AIDS
2. Tuberculosis
3. Malaria

Proposals cannot target any other disease. SRH organizations are most likely to be interested in submitting proposals related to the HIV component as the linkages between SRH and HIV are well established. (See Section **2.3 Integrating SRH into the HIV/AIDS component of a Country Coordinated Proposal**)

The Executive Summary 4.3.1 of the *Draft Proposal Form: Sixth Call for Proposals* is for the entire proposal and should describe the overall strategy of the proposal component, by referring to the goals, objectives and main activities, including expected results, associated timeframes, beneficiaries and expected benefits (including target populations and their

estimated number). Where SRH proposals are included in the HIV component of the Country Coordinated Proposal these should be mentioned in the Executive Summary.

Section 4.4.1 of the *Draft Proposal Form: Sixth Call for Proposals* requests identification and annex of existing key documents, specifically a National Disease Specific Strategic Plan and Budget, a National Monitoring and Evaluation Plan, the most recent disease surveillance report, or any other document relevant to the national disease programme context. It is here that reference should be made to National Reproductive Strategy. See Section **4.1 National Strategic Plans on Sexual and Reproductive Health.**

Section 4.4.3 of the *Draft Proposal Form: Sixth Call for Proposals* requests information on disease-control initiatives and broader development frameworks. The role of HIV in key developmental frameworks, such as Poverty Reduction Strategy Papers, the Highly-Indebted Poor Country (HIPC) Initiative, plans to meet the Millennium Development Goals, and sector-wide approaches should be described.

Again reference should be made to National Sexual and Reproductive Health Plans where they are in place. The *Draft Guidelines for Proposals: Sixth Call for Proposals* state that:

> This should specifically describe how the Global Fund is documented and incorporated in these development frameworks and any relevant constraints e.g. budget or public sectors spending ceilings.

In relation to 4.5 Financial and programmatic gap analysis of the *Draft Proposal Form: Sixth Call for Proposals*, the Country Coordinated Proposal requires:

- an analysis of the national goals and careful analysis of disease surveillance data and target group population estimates for fighting the disease component, describing the overall programmatic needs in terms of people requiring these key services; and
- an analysis of the national goals and objectives for fighting the disease component, describing the overall financial needs.

In relation to the financial needs assessment, SRH organizations should provide cost estimates based on a package of services provided to an estimated number of recipients. This information would then be fed into the overall financial needs. Similarly as part of efforts to assess the financial gap, SRH organizations would feed information on current and planned sources of funding for SRH-related programmes to the CCM. Hence, the financial gap in terms of SRH-related programmes can be assessed.

Section 4.6 Component Strategy of the Proposal Form is critical, as it describes the specific interventions for which funding is sought. As such, this section is where SRH-related programmes should be described. It is advisable to develop this section using the Multi-Agency (January 2006) *Monitoring and Evaluation Toolkit.*[50]

In support of the information provided in this section, proposals must include a summary of the component strategy in a tabular form. The Targets and Indicators Table in Attachment A of the *Draft Proposal Form: Sixth Call for Proposals* is to help applicants clearly summarize the strategy and rationale behind this proposal. Within this table, the interventions that are planned ('the indicator'); the current situation with regard to an intervention ('the baseline'); what performance measures will apply during implementation ('the performance targets'); and what will be the overall impact of the interventions with strong performance ('the outcome or impact') are to be described.

The proposal must also include a component work plan covering the first two years of the proposal period. This work plan should be structured along the same lines as the component strategy. That is, it should reflect the same goals, objectives, service delivery areas and main activities.

Section 4.6.1 Goals, objectives and service delivery areas requires that proposals describe interventions in the form of a coherent overall strategy based on goals and impact indicators.

[50] http://www.theglobalfund.org/pdf/guidelines/pp_me_toolkit_en.pdf

These are implemented through specific objectives, service delivery areas, coverage indicators and main activities.

Overall Goals are broad and overarching, for example reduced HIV-related mortality or halting HIV transmission. A number of high-level goals have been defined as part of the Millennium Development Goals (MDGs), UNGASS targets, and G8 leaders' commitment:

Millennium Development Goals (MDGs):

1. Goal 6: Combat HIV/AIDS, Malaria and other diseases. Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS. [51]

UNGASS targets—Universal access to ARV programs by year 2010:

2. By 2010, 95% of young women and men aged 15-24 both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission.
3. By 2010, 25% reduction globally of young women and men aged 15-24 who are HIV positive.
4. By 2010, 50% reduction of HIV-positive infants born to HIV-positive mothers. [52]

G8 leaders' commitment:

5. To provide as close as possible universal access to treatment for AIDS by 2010. [53]

Note that it is the CCM which will decide the overall goal for the HIV component of the Country Coordinated Proposal.

For each goal, impact indicators must be chosen. These describe the changes over program term in sickness, death, disease prevalence (burden), and behavioural change in the target populations, which indicate that the fundamental goals of the interventions are being achieved. Impact indicators should be linked to goals. For each goal at least one impact indicator should be provided.

Objectives need to be clearly described for each goal. An objective describes the intention of the programs for which funding is sought and provides a framework under which services are delivered. Examples of objectives include to:

- improve survival rates in people with advanced HIV infection in four provinces;
- reduce HIV transmission among MSM in three cities; or
- reduce MTCT in seven rural districts.

Service Delivery Areas and the key services to be delivered must be identified as the next step, and the core of regular performance-based funding. It is essential to provide, for each key service to be delivered, indicators with targets that can be measured and can show regular programmatic progress. Under each objective, indicators are therefore grouped under their respective Service Delivery Areas (a service delivery area corresponds to a specific service that is to be provided). Examples for the sample objectives listed above include:

- antiretroviral treatment and monitoring for HIV;
- BCC and provision of lifesaving commodities; or
- PMTCT.

Indicators and reporting thereof are particularly valued by the Global Fund. There must be a set of indicators measuring people reached with services that the Global Fund can report on internationally and regularly across its entire portfolio. These are standard services that can be reported at the international level. They are for frequent routine reporting and for regular

[51] Millennium Development Goals. Goal 6
http://www.millenniumcampaign.org/site/pp.asp?c=grKVL2NLE&b=186386

[52] United Nations General Assembly Special Session on HIV/AIDS. *The Declaration of Commitment.* New York, United States, 25 - 27 June 2001
http://www.unaids.org/Unaids/EN/Events/UN+Special+Session+on+HIV_AIDS/Declaration+of+Commitment+on+HIV_AIDS.asp

[53] The Group of 8 (2005). The Gleneagles Comuniqué. Paragraph 18(d)
http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique,0.pdf

disbursements of money. These indicators should be incorporated into grant reporting wherever the services are provided. Shorter-term indicators for HIV include:

- Number of people with advanced HIV infection currently receiving antiretroviral combination therapy (ARV);
- Number of people counselled and tested for HIV, including provision of test results;
- Number of HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce mother to child transmission (PMTCT);
- Number of condoms distributed to people;
- Number of people benefiting from community-based programs (specify, a. Prevention, b. Orphan support, or c. Care and support);
- Number of cases treated for infections associated with HIV (specify, a. Preventive therapy for TB/HIV, or b. STIs with counselling); and
- Number of service deliverers trained according to documented guidelines (specify a. Health services, or b. Peer and community programs).

In the medium- to long-term (1-5 years), outcome and impact indicators that show decreases in disease incidence or prevalence and behaviour change should be selected. Please note that planning for these indicators should begin at the start of the grant, and that they require clear baseline values. These indicators are usually more difficult and costly to collect and correspond to the contribution of all stakeholder efforts and programs in country. Medium- to long-term indicators for HIV include:

- Percentage of young women and men aged 15-24 who are HIV infected (HIV prevalence) (applicable to most-at-risk populations in areas with concentrated/lower epidemics) [UNGASS];
- Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy (extend to 2, 3, 5 years as program matures) (Reduced mortality) [UNGASS];
- Percentage of infants born to HIV-infected mothers who are HIV infected (Reduced mother-to-child HIV transmission) [UNGASS];
- Percentage of young people aged 15-24 who had sex with more than one partner in the past year (Multiple Partners) [WHO/ UNAIDS];
- Percentage of 15-19 year olds who have never had sex (Primary abstinence) and percentage of 15-24 year olds who have ever had sex who have not had sex in the past year (Secondary abstinence) [WHO/ UNAIDS]; and
- Percentage of young people aged 15-24 reporting the consistent use of condoms with non-regular partners [WHO/ UNAIDS].

Indicators should be:

- Harmonized with national plans and systems wherever possible, including with reporting cycles, rather than being developed in parallel. Where existing monitoring and evaluation plans and systems do not already include appropriate indicators, the Global Fund suggests applicants make use of indicators recommended by international monitoring and evaluation partners.
- Selected for their usefulness, whether for providing data for decision-making or evaluating outcomes and impact. Baseline figures should be included for all indicators (or supporting data to estimate these). If those baselines are not available, the first year of the proposal development should include activities to determine them.

Pages 27-32 of the Multi-Agency (January 2006) *Monitoring and Evaluation Toolkit* provides a series of selected programmatic, impact and output indicators. [54] This is a useful starting point for developing and choosing indicators; however, it should be noted that the indicators presented are not comprehensive. Individual indicator guidelines (**Chapter 5 — Resources**) should be consulted for a more complete listing of all core and additional indicators in this area.

In summary, the HIV component in a Country Coordinated Proposal has one or two goals. Each goal has an objective, each objective includes several Service Delivery Areas, and each Service Delivery Area is evaluated on one or more indicators.

[54] http://www.theglobalfund.org/pdf/guidelines/pp_me_toolkit_en.pdf

4.6.3 Activities: These should describe the main activities linked to each Service Delivery Area. Examples of the Service Delivery Areas listed above include:

- developing an adherence support program for people on antiretroviral therapy;
- people reached by BCC prevention outreach and peer education (number) [UNGASS] (can be applied for MARP or population sub-groups) and condoms distributed for free (number); or
- HIV-positive pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child HIV transmission (number and percentage).

Key indicators and key implementing partners involved in the activities should be summarized.

4.5.1 Activities to strengthen health systems

The principle difference between Round 5 and Round 6 proposals is that Health Systems Strengthening is no longer a separate component. However, applicants can still apply for funding for health systems strengthening activities by including such activities in the specific disease component sections in section 4 of the *Draft Proposal Form: Sixth Call for Proposals*.

SRH organizations need to focus on current capacity for implementing SRH interventions and needs for scaled-up responses. CCMs that have identified in section 4.4.4 National Health System constraints to achieving and sustaining scale up of HIV, but do not presently have adequate means to fully address these constraints, are encouraged to complete section 4.6.6. Capacity constraints should be addressed in proposals for SRH-related programming.

Section 4.6.6 Activities to strengthen health systems seeks the following information in relation to health systems activities:

- Description of activities included, how they are linked to the disease and why they are necessary—sub-points a) and b); and
- Description of how these activities fit within the wider national context and policies—sub-point c) (see Section **4.1 National Strategic Plans on Sexual and Reproductive Health**).

Note that in **Chapter 5 — Resources**, documents that provide health systems strengthening indicators are referenced along with documents and links that discuss issues related to health systems strengthening. Health systems strengthening activities included in the proposal are to be described, including how they are linked to the HIV component and the impact indicators in Section 4.6.1 Goals, objectives and service delivery areas.

Specific activities that can be funded will depend on individual circumstances and on linkages that can be demonstrated. However, activities to strengthen health systems may include, but are not limited to:

- Health workforce mobilization, training and management capacity development;
- Local management and planning capacity in general, especially financial management;
- Health infrastructure renovation and enhancement, equipment, and strengthening maintenance capacity;[55]
- Laboratory capacity;
- Health information systems, inclusive of monitoring and evaluation;
- Supply chain management, especially drug procurement, distribution, and quality assurance. Note that weaknesses in supply chain management and procurement are an important cause of contraceptive and condom stock-outs;
- Innovative health financing strategies to respond to financial access barriers;
- High-level management and planning capacity;
- Engagement of community and non-state providers;
- Quality of care management; and
- Operations research.

[55] This does not include large-scale investments, such as building hospitals and clinics.

Health system strengthening activities are not limited to health sector-related activities and may also target other sectors, including education, the workplace and social services, provided that these activities are directly related to reducing the spread and impact of HIV. Proposals should also, when appropriate, seek to establish mechanisms for civil society and other stakeholders in the health system to have a voice in developing policies to strengthen health systems, and to take part in activities to this effect.

Given that many SRH organizations have only recently begun or are in the process of developing HIV-related programmes, strengthening their systems in areas such as workforce mobilization; training and management capacity development; health information systems; or operations research is likely to be a high priority for inclusion in proposals.

Sections 4.6.8 to 4.6.12 Target groups, social stratification and principles of equity requires that the planning for what comprises appropriate interventions be included within the proposal and that this should take into account human rights considerations, including gender inequalities, as well as behavioural practices that fuel HIV transmission. Proposals should identify gender inequities regarding access to health and identify ways to address these. Proposals should include interventions targeted at reducing stigma and discrimination and should also address the social services needs of women, adolescents, youths and orphans. When responding to these sections, proposals should explain why it is that interventions are proposed to target certain population and/or most-at-risk groups, with a particular focus on explaining any linkages between socially stratified groups, as appropriate.

The input provided by SRH organizations in these areas should be strong due to the fact that these groups are often targeted by SRH-related programmes. One area that generally needs to be improved is the inclusion of target populations in the planning, implementation, monitoring and evaluation of programmes. Specific mention should be made of how this is being done.

Section 4.9.1 Monitoring and evaluation requires that the proposal describe how the targets and activities indicated in the Targets and Indicator Table (Attachment A of the *Draft Proposal Form: Sixth Call for Proposals*, see section 4.6) will be monitored and evaluated.

The monitoring and evaluation plan should build on existing national programs and policies wherever possible. The monitoring and evaluation plan is a central part of grant applications, the grant agreement signed by both sides, and the basis for ongoing Performance-based Funding.

Whenever a monitoring and evaluation plan exists for a national program, the monitoring and evaluation reporting framework for the Global Fund should be drawn from it. Existing surveys should be leveraged, and data analyzed as part of a national collective effort. Programmes should draw as much as possible from existing surveillance information, including impact and evaluation studies implemented in-country. If these surveys do not exist, the Global Fund encourages the country to develop and implement such studies in partnership with other technical partners in-country. Global Fund programme funds should be used to fill in gaps, and investments in both monitoring and evaluation are strongly encouraged.

This is one opportunity for SRH-related programmes to develop monitoring and evaluation tools for HIV-related programmes, if these do not already exist. This is likely to be the case in a number of countries, given the relatively recent moves to integrate the two areas. Furthermore, SRH organizations should identify in their proposals any surveys to which the monitoring and evaluation of the Global Fund proposal is contributing as part of the country's overall monitoring and evaluation framework.

Section 4.11 Technical and management assistance and capacity building requires that proposals describe capacity constraints that will be faced in implementing the proposal, and the measures that are planned to address these constraints. SRH organizations should link this to health system gaps identified as needing strengthening (Section 4.6.6).

4.6 Common sense tips regarding the development of a proposal

Most importantly, read the *Draft Proposal Form: Sixth Call for Proposal* and *Draft Guidelines for Proposals: Sixth Call for Proposals* before filling out the Proposal Form.

Follow the proposal form format.

The documents required are quite extensive and can be time consuming to prepare. Collect necessary documentation from the beginning. A proposal without the requisite documentation CANNOT be included in the Country Coordinated Proposal.

Discuss your proposal with others to assess feasibility, sustainability and linkages with other programmes. The Proposal Form places a great emphasis on showing linkages at the national and programmatic levels.

Seek assistance of development partners, including WHO and UNAIDS country offices. Assistance could be advice, technical information, help with drafting a proposal, etc. These offices are also well positioned to facilitate partnerships and bring together organizations with similar interests. This is particularly important when drafting a proposal, as the final Country Coordinated Proposal must be of sufficient scope to result in scaled-up interventions.

Additional assistance may possibly be obtained by contacting CCM members themselves or Fund Portfolio managers; the names and contact details for nearly all CCM members and managers are available on the Global Fund website.[56] Alternatively, it may be useful to be in touch with a member of the Global Fund Board delegation for communities living with the diseases or the Developing Country NGO or Developed Country NGO delegations to the Global Fund Board. Contact details are available at
http://www.theglobalfund.org/en/about/board/contact/#devngo1.

TRP comments can be a useful source of information concerning a country or a component:

- For successful proposals, the TRP data by round, within each round by country, and within each country by component (HIV, TB or malaria) can be found at www.aidspan.org/globalfund/grants. Look up each country in which you are interested. Then click on the grant (to that country) you would like to review. Then, on the page this takes you to, one of the options you'll see is "TRP comments". At present, Round 5 grants are not shown. Round 1 TRP comments were never made available. This method will work for getting TRP comments for Rounds 2, 3 and 4.
- For unsuccessful proposals the Global Fund's standing rule is not to share proposal information for unsuccessful proposals. One option is to ask your CCM whether it has had a rejected proposal. If yes, it may be informative; obtain a copy of the proposal(s) and the TRP comments so that the same mistakes are not repeated.

Ensure that your proposal is comprehensive but also feasible. Proposed SRH interventions should respond to the epidemiological situation in a given country. The strengthening health systems section should be used to assist in filling identified gaps in a proposal aimed at scaling up interventions. Capacity building needs should be critically assessed and the proposal should request what is truly needed.

Note that malaria chemoprophylaxis for pregnant women can be requested as part of the antenatal care package that could be funded through the malaria component of the Global Fund. Proposals would need to clearly state how malaria chemoprophylaxis for pregnant women is linked to HIV treatment and care.

PLEASE NOTE THAT THE GLOBAL FUND WILL **NOT** FUND TERMINATION OF PREGNANCY SERVICES, SO DO NOT INCLUDE THEM IN A PROPOSAL.

[56] *See* http://www.theglobalfund.org/en/apply/mechanisms/#people_behind for a complete list of CCMs and contact details.
See http://www.theglobalfund.org/en/contact/default.asp for Global Fund Secretariat contact details.

Chapter 5 – Resources

There are many documents that give detailed explanations of the various stages of a Global Fund grant cycle, of the roles of the various actors involved, and of their relationships with each other. Below are listed the most relevant.

Essential reading

Global Fund (2005). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility.*
http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf

Multi-Agency (January 2006). *Monitoring and Evaluation Toolkit.*
http://www.theglobalfund.org/pdf/guidelines/pp_me_toolkit_en.pdf

Global Fund. Guide to Writing a Procurement and Supply Management Plan"
http://www.theglobalfund.org/en/about/procurement/guides/

Other Global Fund policies and guidelines:
http://www.theglobalfund.org/en/about/policies_guidelines/

CCM-related documents

Global Fund. *Analysis of CCM composition for Round 3 and Round 4.*
The purpose of the two sets of analysis was to gather information on representation in CCMs by the different sectors in the different regions, on the chairmanship and vice-chairmanship of the CCMs, as well as to have preliminary information on the proposed Principal Recipients.
http://www.theglobalfund.org/pdf/ccms/CCM%20R3%20Analysis.pdf and
http://www.theglobalfund.org/pdf/ccms/CCM%20R4%20Analysis.pdf

USAID and GTZ (2004). The Global Network of People Living with HIV/AIDS (2005). *Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms.*
This handbook is the product of numerous consultations with and input of over 400 people living with HIV/AIDS from more than 30 countries in every region of the world, with the vast majority of those involved living in developing countries and countries in transition. The handbook was created primarily for people living with HIV/AIDS who are already working on HIV/AIDS issues in their country and who have some prior knowledge of the Global Fund.
http://www.policyproject.com/pubs/policyplan/CCM_Handbook.pdf
http://www.gnpplus.net/files/CCM-Handbooks/handbook-EN.pdf
GNP+ has released translations in French, Russian and Spanish.
http://www.gnpplus.net/files/downloadpage.html

Global Fund (2004). *The CCM-Forum of the Pacific Islands Regional Multi-Country Coordinating Mechanism (PIRMCCM): towards transparency through information sharing.*
http://www.theglobalfund.org/pdf/ccms/CCM%20Forum%20of%20the%20Pacific%20Islands.pdf

GNP+ (2004). *A Multi-Country Study of the Involvement of People Living with HIV/AIDS (PLWHA) in the Country Coordinating Mechanisms (CCM).*
http://www.theglobalfund.org/pdf/ccms/plwha_ccm_en.pdf

Global Fund Governance and Partnership Committee, (8 April 2004). *Country Coordinating Mechanisms: A Synthesis and Analysis of Findings from CCM Case Studies, Tracking Study, GNP+ and other Surveys.* Working Document
http://www.theglobalfund.org/pdf/ccms/Synthesis%20&%20Analysis%20of%20findings%20from%20CCM%20Case%20Studies.pdf

Global Fund (June 2004). *Country Coordinating Mechanisms Building Good Governance. Global Fund to Fight Against Aids, Tuberculosis And Malaria.* Discussion Paper.
http://www.theglobalfund.org/pdf/ccms/CCM%20Building%20Good%20Governance.pdf

IPPF (2005). *Sexual and Reproductive Health Organizations and the Global Fund, Research into the experiences of IPPF Member Associations in relation to the Global Fund to fight AIDS, Tuberculosis and Malaria.*
http://content.ippf.org/output/ORG/files/13565.pdf

Other Global Fund-related documents

USAID (2006). *Strengthening Health Systems to Improve HIV/AIDS Programs in the Europe and Eurasia Region Using Global Fund Resources.*
http://pdf.usaid.gov/pdf_docs/PNADF481.pdf

Information Services

Global Fund Observer (GFO) Newsletter
GFO is a bimonthly, independent source of news, analysis and commentary about the Global Fund. To receive GFO, send an email (subject line and text can be left blank) to: receive-gfo-newsletter@aidspan.org

For GFO background information and previous issues, see www.aidspan.org/gfo

For a collection of papers on the Global Fund, see www.aidspan.org/globalfund and www.theglobalfund.org/en/about/publications

Health, Population, and Nutrition: News & Notes
A weekly newsletter supported by Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) providing information on a variety of health-related topics, including HIV and AIDS, and sexual reproductive rights. Email Dieter Neuvians at dieter.neuvians@gtz.de.

SRH reference documents

World Health Organization (2004). *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets.*
The strategy is the World Health Organization's first global strategy on reproductive health. It was adopted by the 57th World Health Assembly (WHA) in May 2004.
http://www.who.int/reproductive-health/strategy.htm

World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Planned Parenthood Federation (IPPF) (October 2005). *Sexual and Reproductive Health & HIV/AIDS: A framework for priority linkages.*
This framework proposes a set of key policy and programme actions to strengthen linkages between sexual and reproductive health (SRH) and HIV/AIDS programmes. These linkages work in both directions, by integrating HIV/AIDS issues into ongoing SRH programmes, and conversely, SRH issues into HIV/AIDS programmes. This should enhance SRH, contribute to reversal of the AIDS epidemic and mitigate its impact.
http://www.who.int/reproductive-health/rtis/docs/framework_priority_linkages.pdf

World Health Organization (WHO), United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/AIDS (UNAIDS) and International Planned Parenthood Federation (IPPF), (2005). *Linking sexual and reproductive health and HIV/AIDS - An inventory.*
Linking HIV/AIDS and sexual and reproductive health (SRH) programmes has the potential to significantly curtail the AIDS epidemic. Furthermore, it also addresses the unmet need and rights of women and men living with HIV/AIDS to SRH services. This annotated inventory contributes to strengthening linkages between HIV/AIDS and SRH programmes by providing access to relevant programming tools for fostering such linkages and pointing out gap areas for which tools need to be developed.
http://www.who.int/reproductive-health/stis/docs/inventory_linkages_shr_hiv.pdf

Jerker Liljestrand, Jacqueline Bryld, Jeffrey Victor Lazarus and Lise Rosendal Østergaard, Aidsnet and the Sexually Transmitted Infections/HIV/AIDS Programme of the World Health Organization Regional Office for Europe (2005). *Synergising HIV/AIDS and Sexual and Reproductive Health and Rights – A Manual for NGOs*
http://www.aidsnet.dk/files/filer/aidsnet/sm/extranet/srhr%20manual/aidsnetwhosynergisingmanual_ver2.pdf

IPPF (2004). *Mainstreaming Checklist & Tools.*
Mainstreaming HIV/AIDS into sexual and reproductive health and rights policies, plans, practices and programmes.
http://www.ippf.com/ContentController.aspx?ID=8401

The Well Project - Women and HIV Think Tank, Dave Gilden (August 2003). *Not* Jay Satia and Chye Pei Ooi, The International Council on Management of Population Programmes (ICOMP) (2005). *HIV/AIDS and Reproductive Health: Linked Response for Sustained Impact* A Discussion Brief.
"Linked response" implies how Reproductive Health (RH) and HIV/AIDS programmes could work more effectively together to encompass notions of integration, collaboration, coordination and independent but informed action. ICOMP implemented a project in Ethiopia, Tanzania, Uganda and Zambia, with the goal to create a sustained impact on Sexual and Reproductive Health and HIV/AIDS by increasing institutional capacity on linking SRH and HIV/AIDS programmes.
http://www.icomp.org.my/Programdev/Discussion%20Brief.doc

UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS (2006). *Resource Pack on Gender and HIV/AIDS.*
http://www.unfpa.org/publications/detail.cfm?ID=279&filterListType.
This Resource Pack aims to strengthen the impact of national HIV programmes by tackling a key underlying factor that fuels the epidemic: gender inequality. It analyzes the impact of gender relations on the AIDS epidemic and provides guidance, including tools for effective advocacy and programming and contains the following documents:
Operational Guide on Gender and HIV/AIDS: A Rights-Based Approach
http://www.unfpa.org/hiv/docs/rp/op-guide.pdf
Review paper, 'Integrating Gender into HIV/AIDS Programmes'
http://www.unfpa.org/hiv/docs/rp/integrating-gender.pdf
17 Fact Sheets with concise information on gender-related aspects of HIV/AIDS
http://www.unfpa.org/hiv/docs/rp/factsheets.pdf

UNAIDS, UNFPA, UNIFEM (2004). *Women and HIV/AIDS: Confronting the Crisis.*
http://genderandaids.org/downloads/conference/308_filename_women_aids1.pdf

Population Reference Bureau for the Interagency Gender Working Group (IGWG) & World Health Organization (WHO) C. Feldman-Jacobs, P. Olukoya and M. Avni (July 2005). *A summary of the 'so what?' report: a look at whether integrating a gender focus into programmes makes a difference to outcomes.*
In a lengthy 2004 publication reviewing interventions, the IGWG has concluded that the evidence does suggest that integrating gender into reproductive health programs has a positive impact on achieving reproductive health outcomes. This summary of that lengthy review is intended to present policymakers and program managers with a clear and accessible picture of what happens when gender concerns are integrated into reproductive health programs.
http://www.prb.org/pdf05/So_What_Report_A_Look_at_Whether_Integrating_a_Gender_Focus.pdf

Department of Reproductive Health and Research (RHR), World Health Organization (2001). *Transforming health systems: gender and rights in reproductive health manual.*
The result of a four-year testing and adaptation process involving strong collaboration with institutions in different parts of the world, this book contains six core modules covering gender and ethical issues in research policy and how to influence change, and health systems.
http://www.who.int/reproductive-health/publications/transforming_healthsystems_gender/text.pdf

The links between violence against women and HIV and AIDS - Quick guide through the key issues.
This Eldis guide examines the links between violence against women (VAW) and HIV and AIDS, highlighting key issues, research and resources. It outlines how HIV and AIDS is a consequence of VAW, how VAW is precipitated by HIV, the economic factors that increase women's vulnerability and the interaction between VAW and conflict. It also offers strategies and actions for ending VAW and reducing HIV and AIDS infection.
http://www.eldis.org/hivaids/vaw_consequences.htm

Mary Ellsberg, Senior Advisor for Gender Violence and Human Rights, PATH, 2005
Violence against Pregnant Women: A Global Health Crisis.
There has been a profound policy shift in recent years within the international health community with regard to violence against women. Only 10 years ago, the health needs of abused women were virtually ignored, outside of a few industrialized countries. Now, violence against women is recognized globally as a grave public health concern as well as a human rights issue.
http://www.globalhealth.org/reports/report.php3?id=216

N.N. Nizova, S.P. Posokhova and V. Zaporozhan (2005). *Preventing Mother-To-Child Transmission of HIV A Practical Guide to Counselling and Testing Procedures.*
This guide is intended for healthcare workers—obstetricians, gynaecologists, family doctors, and infectious disease specialists—who provide voluntary HIV counselling and testing to pregnant women as part if an integrated PMTCT programme.
http://www.eurasiahealth.org/resources/mdlDoc/1512-e.pdf

The Swedish Association for Sexuality Education (RFSU) (February 2004). *Breaking Through - A Guide to Sexual and Reproductive Health and Rights.*
This guide provides a comprehensive introduction to the political debate surrounding sexual and reproductive health and rights (SRHR). It discusses the changes in the approach to population issues that emerged from the 1994 International Conference on Population and Development, emphasising the conference's explicit recognition of reproductive rights as human rights. The guide discusses the controversy over the goals that were adopted and the reservations expressed by many countries.
http://www.crlp.org/pdf/pdf_BreakingThrough_04.pdf

IPPF. *Integrating Voluntary Counselling and Testing***.**
Guidelines for programme planner, managers and service providers.
http://www.ippf.com/ContentController.aspx?ID=8401

Bonnie L. Shepard and Jocelyn L. DeJong, International Health and Human Rights Program, François-Xavier Bagnoud Center for Health and Human Rights, Harvard School of Public Health (2005). B*reaking the Silence and Saving Lives: Young People's Sexual and Reproductive Health in the Arab States and Iran.*
This research reviews young people's sexual and reproductive health and gender issues affecting young people ages 10-24 in 19 Arab States and the Islamic Republic of Iran. The situation analysis reveals an urgent need for investment in young people's programmes and for increased attention to this age group.
http://www.hsph.harvard.edu/fxbcenter/Bonnie_publication.pdf

The Centre for Reproductive Rights (December 2005). *Women of the World: Laws and Policies Affecting their Reproductive Lives - East and Southeast Asia.*
The publication provides an extensive compilation of laws and policies influencing women's reproductive health in five countries of the region—China, Malaysia, the Philippines, Thailand and Vietnam—and draws attention to specific issues that require legal and policy reform. It serves as a resource for those interested in advancing and protecting women's reproductive health and rights through legal advocacy, and ensuring that states comply with their obligations to respect, protect and fulfil women's reproductive rights under international law.
http://www.reproductiverights.org/pub_bo_seasia.html

Just a Complication, but a Basic Variation: A literature review on sex differences and women's issues in HIV.
It is part of the essential biologic pattern that there is a divergence in the male and female response to invasion by HIV. The female mode of response, long dismissed as a trivial biological complication, is better viewed as a central variation on a theme. Studying the way women's bodies differ from men's when confronting HIV is vital to learning how HIV causes disease and how to more appropriately treat it.
http://www.phishare.org/files/3605_Women_and_HIV_Think_Tank___Backgrounder.pdf

World Health Organization (2003). *Safe Abortion: Technical and Policy Guidance for Health Systems.*
Despite dramatically increased use of contraception over the past three decades, an estimated 40-50 million abortions occur annually, nearly half of them in circumstances that are unsafe. At the Special Session of the United Nations General Assembly in June 1999, governments agreed that "in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health." This document provides guidance to turn this agreement into reality.
http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.pdf

Sudha Talluri-Rao and Traci L. Baird. *Medical-Abortion Counselling and Information.* Information and Training Guide for Medical-Abortion Counselling
Each year more than 75 million women worldwide experience an unintended pregnancy, and approximately two-thirds of those pregnancies end in abortion. Clearly, women need access to safe, effective abortion services.
http://www.ipas.org/publications/en/Medical_Abortion/INFMEDAB_E03_en.pdf

Health system strengthening reference documents

Department for International Development (DFID) Health Resource Centre (HRC), (March 2006). *Reproductive health commodity security (RHCS) country case studies synthesis: Cambodia, Nigeria, Uganda and Zambia*. By Nel Druce.
This report analyses the key factors that influence the financing, procurement, forecasting, and supply of reproductive commodities and how national and international agents interface and coordinate their activities. Findings show that while there have been some successes to strengthen commodity supply, there are continued limitations in national capacity. They also highlight how the role of external agencies in financing and procurement tends to undermine ownership and discourage national government accountability.
http://www.dfidhealthrc.org/Shared/publications/Synthesis/RHCS%20synthesis_Mar06.pdf

IPPF (2005) *Models of Care project, Linking HIV/AIDS treatment, care and support in Sexual and Reproductive Healthcare settings: examples in action.*
http://content.ippf.org/output/ORG/files/13125.pdf

Financing

National health accounts
http://www.who.int/nha/en/

WHO (Jean-Pierre Poullier, Patricia Hernandez, Kei Kawabata). *National health accounts: Concepts, data sources and methodology.*
http://www.who.int/nha/docs/en/NHA_concepts_datasources_methodology.pdf

WHO Health financing policy
http://www.who.int/health_financing/en/

WHO (2005). *Designing health financing systems to reduce catastrophic health expenditure.* Technical brief for policy makers. Number 2.
http://www.who.int/hinari/en/

Human resources for health

WHO Human Resources website http://www.who.int/hrh/en/

Global Health Trust http://www.globalhealthtrust.org/

World Health Organization (2004). *A guide to rapid assessment of human resources for health.* http://www.who.int/hrh/tools/en/Rapid_Assessment_guide.pdf

WHO (1998). *Workload indicators of staffing need (WISN) A manual for implementation.* http://www.who.int/hrh/documents/en/workload_indicators.pdf

WHO (2004). *Scaling up HIV/AIDS care: service delivery and human resources perspectives.* http://www.who.int/hrh/documents/en/HRH_ART_paper.pdf

WHO (2000) Discussion paper 1. *Strategies for assisting health workers to modify and improve skills.* http://www.who.int/mipfi les/2359/Disc1-AProcessofChange.pdf

WHO (2000) Discussion paper 2. *Achieving the right balance: The role of policy-making processes in managing human resources for health problems.* http://www.who.int/hrh/documents/en/right_balance.pdf

WHO (2000) Discussion paper 3. *Determining skill mix in the health workforce: Guidelines for managers and health professionals.* http://www.who.int/hrh/documents/skill_mix.pdf

WHO (2002*). Human resources and national health systems. Final report.* http://www.who.int/hrh/documents/en/nhs_shaping_agenda.pdf

Management Services for Health (MSH). Managing Human Resources. http://www.msh.org/what_MSH_does/chs/index.html

Global Health Trust: Joint Learning Initiative in Human Resources for Health http://www.globalhealthtrust.org/

Information systems and operational research

Health metrics network
http://www.who.int/healthmetrics/en/

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http://erc.msh.org/

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http://www.jsi.com/JSIInternet/Projects/ListProjects.cfm?Select=Expertise&ID=4&ShowProjects=No

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http://www.measureprogram.org/

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- The Importance of the Supply Chain
  http://www.rhsupplies.org/pdfs/facsheet_chain.pdf
- Why Reproductive Health Supplies are Crucial to Achieving the Millennium Development Goals (MDGs)
  http://www.rhsupplies.org/resources/doc/MDGs_factsheet.pdf
- Access to Condoms and Contraceptives – Vital For the Prevention of HIV
  http://www.rhsupplies.org/pdfs/factsheet_hiv.pdf
- Sexual and Reproductive Health Services Undermined by Supply Shortfall
  http://www.rhsupplies.org/pdfs/factsheet_service.pdf

UNFPA Tools to Help Countries Manage their Own Supplies
http://www.unfpa.org/supplies/tools.htm

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http://www.who.int/3by5/publications/briefs/monitoring/en

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WHO/UNAIDS/Global Fund/USAID/MEASURE Evaluation/FHI (2005). National AIDS Programs- A guide to indicators for monitoring and evaluation national antiretroviral programs. WHO, Geneva.
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Core health indicators, survey and tools

WHO Statistical Information System (WHOSIS) Evidence and Information for Health Policy.
http://www3.who.int/whosis/menu.cfm?path=evidence,whosis&language=english

WHO Evidence and Information for Policy
http://www3.who.int/whosis/menu.cfm?path=evidence&language=english

World Bank: Survey Tools for Using Household Survey Data.
http://www.worldbank.org/html/prdph/lsms/tools/index.htm

LINKS

Advocates for Youth
Advocates for Youth is dedicated to creating programs and advocating for policies that help young people make informed and responsible decisions about their reproductive and sexual health. Advocates provides information, training, and strategic assistance to youth-serving organizations, policy makers, youth activists, and the media in the United States and the developing world.
http://www.advocatesforyouth.org/index.ht

Family Planning and HIV/AIDS Integration
This site is hosted for the HIV/AIDS Integration Partners Working Group by Information & Knowledge for Optimal Health (INFO) Project, Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. It allows users to:

- Find materials and resources to influence policymakers;
- Identify tools for integrated service delivery;
- Search relevant integration materials; and
- Research evidence-based approaches to integration.

http://www.fpandhiv.org/

Global Fund to Fight AIDS, Tuberculosis and Malaria
www.theglobalfund.org

Health Communication Partnership (HCP)
The HCP links five leading institutions together to accomplish its goal of strengthening public health in the developing world through strategic communication programs. Through its strategic approach to communication, HCP and its partners work to create an environment that supports individuals, families, and communities to act positively for their own health and to advocate for and have access to quality services. This integrated communication approach to improving health is based on growing evidence that strategic health communication can influence behaviour.
http://www.hcpartnership.org

Implementing Best Practices in Reproductive Health Knowledge Gateway
Initiated by the World Health Organization and USAID, and supported by an increasing number of international and local reproductive health agencies, the IBP Initiative responds to several challenges in the reproductive health community in low resource settings. Among them are:

- The lack of targeted and coherent information on what does and does not work;
- Costly duplication of efforts;
- Costly implementation of ineffective programs;
- Limited access to evidence-based tools, materials and strategies; and
- Limited opportunities to share new knowledge with local and international colleagues.

http://www.ibpinitiative.org

INFO Project
The INFO Project offers a range of information resources and services, all complementing one another, to ensure that information, knowledge, and best practices for family planning/reproductive health (FP/RH) are accessed by multiple audiences with different needs.
http://www.infoforhealth.org

International Planned Parenthood Federation
IPPF has been providing sexual and reproductive health services since 1952. IPPF has Member Associations and millions of volunteers working to support people's rights in around 180 countries worldwide—particularly those populations that are poor, underserved or marginalized. IPPF work in five priority areas: adolescents, HIV/AIDS, abortion, access and advocacy, and enabling people to make informed choices about their sexual lives and to receive care, counselling, diagnosis and treatment.
http://www.ippf.org/

Maximizing Access and Quality Web Site
The purpose of the Maximizing Access and Quality (MAQ) Initiative is to bring together USAID Washington, USAID Missions, the cooperating agency (CA) community and other partners to identify and implement practical, cost-effective, and evidence-based interventions aimed at improving both the access to and quality of family planning and reproductive health services. The MAQ Initiative was established in 1994 in response to the large unmet demand for voluntary contraceptive services. It is based on the understanding that removing barriers, promoting access and improving quality by focusing on specific practical interventions can serve the needs of clients and thereby markedly improve programs.
http://www.maqweb.org

Reproductive Health Outlook
Reproductive Health Outlook (RHO) is the reproductive health website produced by Program for Appropriate Technology in Health (PATH). RHO is especially designed for reproductive health program managers and decision-makers working in developing countries and low-resource settings.
http://www.rho.org/

The Sexual Violence Research Initiative (SVRI)
Sexual violence is a public health problem and a violation of human rights. It occurs worldwide and has a profound impact on physical, mental and social well-being both immediately and in the long-term. Despite this, sexual violence has received little attention so far from researchers, policy makers and programme designers. Interventions to prevent or respond to sexual violence are limited and many have not been evaluated. The Sexual Violence Research Initiative (SVRI) hosted at the Medical Research Council in South Africa is committed to action to address these gaps.
http://www.svri.org/

The Supply Initiative: Meeting the Need for Reproductive Health Supplies
The Supply Initiative/ Population Action International is involved in the Reproductive Health Supplies Coalition (RHSC)—a high-level forum in which donors, countries, NGOs, technical groups and other major stakeholders are coming together to jointly address the causes of shortfalls of the supplies needed for reproductive health services, particularly contraceptives and condoms throughout the developing world.
www.rhsupplies.org

UNAIDS
Provides information on prevention, treatment and care.
http://www.unaids.org/en/Issues/Prevention_treatment/default.asp

UNFPA
Condom supply
http://www.unfpa.org/

WHO Reproductive Health and Research
Includes the *Reproductive Health Strategy* and a project to develop policy and programmatic guidance for health systems to ensure that men and women living with HIV have access to sexual and reproductive health services.
http://www.who.int/reproductive-health/index.htm

Sexually Transmitted and Other Reproductive Tract Infections: A guide to essential practice
http://www.who.int/reproductive-health/stis/index.htm

Guidelines for the management of sexually transmitted infections
http://www.who.int/reproductive-health/publications/rhr_01_10_mngt_stis/index.html

Annex 1 — List of successful SRH-related proposals from Rounds 4 and 5

Round	Country	Title	Approved Maximum (USD)	5-year Maximum (USD)	Total Approved for this round (USD)	Nr of countries with SRH component	Total approved (USD) with SRH component	STI mgt (prev/detection/ tx)	Condoms	Other
FIVE										no proposal posted
	ALBANIA	Strengthening Albania's National Response to HIV/AIDS Among Vulnerable Groups	2,502,858.00	4,990,645.00						
	BENIN	Intensification and Improvement of the Fight Against HIV/AIDS in Benin	19,753,166.00	51,958,004.00				P	P	
	BOSNIA AND HERZEGOVI NA	Coordinated National Response To HIV/AIDS & Tuberculosis in a War-Torn and Highly Stigmatised Setting	4,832,387.00	11,042,257.00						VCT centres
	BURUNDI	Support the Program of Decentralizing and Intensifying the Fight Against HIV/AIDS in Burundi	13,053,866.00	32,353,173.00				P	P	VCT centres, bcc
	CAMBODIA	Addressing gaps in services in the fight against AIDS, Malaria and TB	16,292,779.00	34,963,654.00				P		
	CAMEROON	Cameroon's CCM Proposal for the 5th Round	4,954,660.00	12,087,022.00				P		pmtct
	CHINA	Preventing a New Wave of HIV Infections in China	12,544,128.00	28,902,074.00				P	P	lubricants, HIV surveillance
	CONGO	Décentralisation et passage à l' échelle des actions de prévention et de prise en charge globale des personnes vivant avec le VIH/SIDA en République du Congo	12,043,407.00	45,553,763.00				P	P	bcc
	CÔTE D'IVOIRE	Prevention et Prise en charge du VIH/SIDA en situation post conflit	3,530,586.00	3,530,586.00				P	P	awreness, education
	EAST TIMOR	Expanded comprehensive response to HIV and AIDS in Timor Leste	4,304,454.00	9,110,302.00				P		strategic information acces, strengthen health systems
	ERITREA	Going to Scale with Targeted Prevention, Treatment, Care, and Support Interventions for Priority Diseases, and Health Systems Strengthening in Eritrea	13,139,010.00	33,892,005.00						strengthen HIV/AIDS delivery structure

GHANA	Accelerating access to prevention, treatment, care and support for HIV/AIDS towards achieving Millennium Development Goals	31,630,098.00	97,098,678.00	P		
HAITI	Rapid Expansion of HIV Treatment Services in Haiti	19,205,567.00	49,927,069.00	P	P	behavioral change, VCT, PMTCT, ART, care & support for orphans
LESOTHO	Scaling up HIV/AIDS prevention, care and treatment interventions and a viable health system for their implementation	10,013,383.00	40,346,059.00			
MALAWI	Orphan Care and Support	7,770,655.00	19,104,775.00			
MAURITANIA	Programme de renforcement de la reponse nationale de lutte contre le VIH/SIda en Mauriatnie	6,584,973.00	15,755,931.00			strengthening epid surveillance, improve tx & continuity of care, reduce transmission risks
MONGOLIA	Scaling up targeted national HIV/AIDS prevention programs in Mongolia	1,898,775.00	4,235,640.00	P		
Serbia and Montenegro	Support to Montenegrin HIV/AIDS strategy implementation	$1,608,203.00	$2,931,253.00			no proposal accessible
NIGERIA	Scale-up of Comprehensive HIV & AIDS Treatment, Care & Support in Nigeria	$46,424,283.00	$180,642,512.00			scale up ARV, VCT, PMTCT, care for OVCs
PERU	Closing Gaps: To achieve the Millennium Development Goals for TB and HIV/AIDS in Peru, Proposal with a participatory multisectorial decentralized approach	9,874,896.00	12,967,865.00	P		PMTCT, prevent congenital syphillis, ART, HAART
PHILIPPINES	Upcaling the National Response to HIV-AIDS Through the Delivery of Services and Information to Populations-at-Risk and PLWHA's	3,011,919.00	6,478,058.00			tx of OI, ARV support, home-based care
Russian Federation	Scaling up access to HIV prevention and treatment by strengthening HIV services for injecting drug users in the Russian Federation	3,783,278.00	12,218,007.00			enhance coverage for IDUs

	SAO TOME AND PRINCIPE	Strengthening the HIV/AIDS epidemic response in Sao Tome & Principe	506,480.00	1,407,452.00		P	P	decrease transmission in vuln pops & bld borne infx icnl HIV, hepatitis & syphillis, PMTCT, inst. capacity
	SUDAN		29,421,145.00	112,553,237.00				no proposal accessible
	SURINAME	Reducing the spread and impact of HIV/AIDS in Suriname through expansion of prevention and support programs	2,395,000.00	4,195,000.00			P	bcc
	ZIMBABWE	Proposal to provide ART in 22 districts, strengthen the National TB control programme and make ACT available for treatment of malaria in Zimbabwe	35,931,159.00	62,478,891.00				improved QOL & reduced mortality from HIV/AIDS among PLWHA, increase ART
					14	**13**	**8**	
FOUR	ANGOLA	Reducing the Burden of HIV/AIDS in Angola	27,670,810.00	91,966,080.00				institution capacity, prevent transmission, reduce socioeco impact of HIV
	AZERBAIJAN	Scaling-up the Reponse to HIV/AIDS in Azerbaijan	6,098,600.00	10,341,550.00		P	P	VCT, institutional capacity, care & support of PLHIV
	CAMBODIA	Continuum of Care	8,794,982.00	36,546,134.00				increase survival of PLHA, decrease HIV infx in infants born to HIV+ mothers
	CAMEROON	Civil Society Mobilization for the Fight Against AIDS	6,347,296.00	16,335,409.00		P		increase capacity of vulnerable pops to avoid behaviors contributing to HIV transmission, bcc, psych support

CENTRAL AFRICAN REPUBLIC	Strengthening Overall Care for Orphans and Other Children Affected by HIV/AIDS	4,695,012.00	16,265,930.00				med mgt of OVCs, strengthen inst mgt framework, ensure regular M/E activities of OVCs
CHINA	Reducing HIV Transmission Among and From Vulnerable Groups and Alleviating its Impact in Seven Provinces in China	23,936,918.00	63,742,277.00				VCT, mostly for IDUs and SWs
DJIBOUTI	Consolidation of the National program for the global care of People Living With HIV/AIDs and their families and for the prevention for the most vulnerable population in the Republic of Djibouti	7,271,400.00	11,998,400.00		P		cov/tx of PLWHIV7families, improve awareness of HIV/AIDS epi, psychosocial assistance, family approach
EQUATORIAL GUINEA	Project Component on Strengthening National Capacities and Competence to Manage Integrated Activities and Services in the Fight Against HIV/AIDS	4,398,764.00	9,824,836.00				improve QOL, decrease mortality of PLHIV 6 families, institutional capacity, adoption of safe practices to prevent HIV emp on vulnerable pops
ETHIOPIA	HIV/AIDS Prevention and Control	41,895,884.00	401,905,883.00		P		mass media, community dialogue, ART, expand access to HIV care & tx
GUINEA-BISSAU	Scaling up the Response to the HIV/AIDS Epidemic	$1,166,801.00	$5,078,607.00		P	P	youth education, IECs, reducing blood transmission of STI/HIV, PMTCT

INDIA	Access to care and treatment (ACT)	25,831,024.00	140,878,119.00			improve survival & QOL of PLHIV/AIDS & at reducing HIV transmission, increase awareness, encourage behavioural change, promote healthy sexual behaviours
INDONESIA	Indonesia HIV/AIDS Comprehensive Care	31,129,618.00	65,035,569.00	P		VCT, ART, Tx & prophylaxis for OI
LAOS	Scaling up the fight against HIV/AIDS/STI, TB an Malaria in the Lao P.D.R. (HIV/AIDS Component)	3,014,946.00	7,747,873.00			ensure human producitivty & QOL for high risk groups & low risk beh partners, bcc focused on women
MALI	Expansion of the integrated prevention and care networks for STI/HIV/AIDS in Bamako and the 8 regional capitals of Mali	23,483,234.00	56,340,436.00	P		reduce MTCT of STI/hiv/aids, reducs blood-borne transmission incl STIs, ensure therapeutic, psych, socioeco care for PLHIV
Multi-country Americas (Meso)	Mesoamerican project in Integral Care for Mobile Populations: Reducing Vulnerability of Mobile Populations in Central America to HIV/AIDS	2,181,050.00	4,776,250.00			improving quality of care services to mobile pops, decrease vulnerability
Multi-country Americas (CRN+)	Strengthening the Community of PLWHA and those affected by HIV/AIDS in the Caribbean – A Community Based Initiative	1,947,094.00	3,839,794.00			empower community of persons PLHIV, capacity-bldg, reduce barriers posed by

							stigma & discrimination
PAPUA NEW GUINEA	Scaling up HIV/AIDS prevention, care and treatment through an intensified multi-sectorial community based programme in Papua New Guinea	8,492,240.00	29,957,415.00				VCT, ART, develop networks of natl-intl NGOs, CBOc, FBOs & private sector working on STI/HIV/AIDS issues
Russian Federation	Promoting a Strategic Response to HIV/AIDS Treatment an Care for Vulnerable Populations in the Russian Federation	34,176,931.00	120,543,828.00				reduce HIV-related morbidity & mortality by expanding access to HIV prevention, tx, care & support for PLHIV
SIERRA LEONE	Development of a comprehensive national response to HIV/AIDS that includes adequate prevention, treatment, care and support for those affected.	8,574,255.00	17,905,201.00		P	P	developed comprehensi v national response to HIV/AIDS incl VCT, ART, STI services, condoms dist
SOMALIA	Implementing the Strategic Framework for Prevention and Control of HIV/AIDS and Sexually Transmitted Infections within Somali Populations	10,004,644.00	24,922,007.00		P		bcc, OI tx & prophylaxis, ART, PMTCT, home-based & palliative care, VCT, mass media
SUDAN	HIV Prevention and Care Program for South Sudan	8,817,170.00	28,435,366.00		P	P	bcc, HIV/STI prev measures fro gen adult popn, youth & vulnerable pops, expand tx & care

SWAZILAND	Swaziland's programme to scale-up key components of the national HIV/AIDS response	16,396,810.00	48,283,310.00				promote safe sex, delay sexual debut, reduce HIV/AIDS impact, strengthen home-based care & clinical mgt of HIV/AIDS px, ensure M/E of HIV/AIDS progs.
TAJIKISTAN	Reducing the Burden of HIV/AIDS in Tajikistan	2,508,720.00	8,128,972.00				expand activities on migrants, prisoners & street children, suitable care for PLHIV incl those on HAART, raise awareness among gen popn to break down traditional taboos on sex
TANZANIA	Filling Critical Gaps for Mainland Tanzania in the National Response to HIV/AIDS in Impact Mitigation for Orphans & Vulnerable Children	103,191,298.00	293,263,191.00			P	impact mitigation for OVCs, ART, VCT expansion, access to package of care & support services
TOGO	Closing the Gaps: An Integrated Approach to HIV/AIDS Prevention in Togo	11,517,643.00	32,421,013.00			P	increase access to and informed demand for condoms among sexually active adults, VCT, increase safe sex beh among youth, tuck drivers, CSWs, rural popn,

						workplace popn, PMTCT
TURKEY	Increase Access of Vulnerable Populations to HIV/AIDS Prevention Services	3,891,762.00	3,891,762.00			improve VCT, active preventive intervention for CSWs, improve M/E of national programmes
ZAMBIA	Scaling up of Antiretroviral Treatment for HIV/AIDS in Zambia	26,770,776.00	253,608,070.00	P		avail ARVS, mental health awareness & training,

Annex 2 —About the Global AIDS Alliance

What is the Global AIDS Alliance, and what does it do?

The Global AIDS Alliance (GAA) is a non-profit organization based in Washington, D.C., United States. Our mission is to galvanize the political will and financial resources needed to slow, and ultimately stop, the global AIDS crisis, and reduce its impacts on poor countries hardest hit by the pandemic. We combine media outreach and public education with targeted coalition-building and grassroots mobilization in order to raise awareness and inspire activism in support of advocacy to persuade United States policymakers and other decision-makers to implement a comprehensive response to AIDS globally.

What are GAA's priorities?

GAA's primary goal is to persuade United States policy makers and other stakeholders to mount a long-term, comprehensive response to the global AIDS epidemic. We are currently working to:

1. ensure a fair-share United States contribution to efforts to combat AIDS globally, including to the Global Fund to Fight AIDS, Tuberculosis and Malaria;
2. accelerate progress toward ensuring universal treatment access, including expanded availability of paediatric AIDS treatment;
3. address the mounting crisis of orphaned and other vulnerable children, including children living with HIV;
4. eliminate school fees and accelerate progress toward universal basic education to reduce HIV infection rates among young people, particularly girls, who are at disproportionate risk;
5. hold stakeholders such as the President's Emergency Plan for AIDS Relief (PEPFAR) accountable for advancing a comprehensive, science-based HIV prevention strategy, including condom distribution;
6. accelerate the reduction and cancellation of foreign debt so that poor countries can devote more of their own resources to fighting HIV; and
7. promote the integration of HIV and AIDS and reproductive health policies and programs to help address the epidemic's disproportionate impact on women, including the relationship of gender-based violence and HIV.

Who does GAA serve?

GAA serves the millions of people living with HIV and at risk of HIV infection in poor countries hardest hit by the pandemic. We are also actively involved in efforts to ensure comprehensive protection for the millions of orphans and other vulnerable children affected by HIV, and to expand educational opportunities for girls, who are at disproportionate risk of contracting HIV. With over 25 million people now living with HIV/AIDS, sub-Saharan Africa remains the epicentre of the epidemic. But GAA also seeks to focus attention on the growing impact of AIDS in India, China, and the former Soviet Union—the so-called "second wave" of the pandemic.

GAA empowers concerned Americans to get personally involved in the fight against global AIDS. Specifically, we organize and support grassroots activists who can help shape global AIDS policy through public education, media outreach, and citizen lobbying of elected officials and other decision-makers. Our Washington D.C.-based staff help to:

1. teach local activists the fundamentals of advocacy, including contacting elected officials and other decision-makers, writing and publishing letters to the editor and op-eds, and influencing the budget and appropriations processes;
2. develop trained rapid response teams that can monitor and respond to AIDS-related news and build relationships with key media; and
3. organize community education forums and local advocacy events. We also inform policymakers and the media about global HIV issues.