

Involvement of Key Populations and People Living with the Diseases

Achieving Inclusiveness of Country Coordinating Mechanisms

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This report presents case studies of the Country Coordinating Mechanisms of Moldova, Morocco, the Philippines and Viet Nam and examines how these countries have been able to make significant improvements in the involvement of civil society and key populations in the design and delivery of programs.

Acronyms and Abbreviations

ECUO	East Europe and Central Asia Union of People Living with HIV
EPA	Eligibility and Performance Assessment (of the Country Coordinating Mechanism)
ITPC	International Treatment Preparedness Coalition
LGBT	Lesbian, gay, bisexual and transgender
MDR-TB	multidrug-resistant tuberculosis
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organization

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I. Introduction

A recent audit of Country Coordinating Mechanisms by the Global Fund's Office of the Inspector General acknowledged that "significant improvement has been made in the involvement of civil society and affected communities in designing and implementing programs" while at the same time concluding that "membership and meaningful engagement of civil society and key populations is not optimal."ⁱ The case studies contained in this collection help illustrate how that significant improvement has been made in specific country contexts.

They are presented here in the hope that they may be an inspiration to Country Coordinating Mechanisms in other country contexts. They also illustrate some of the complexities around achieving the participation of key populations and people living with disease in Country Coordinating Mechanisms. In particular, they demonstrate that "adequate representation" and "meaningful engagement" are not the same thing. While the former might lend itself to being measured by membership quotas, the latter most certainly does not.

Moreover, the considerable work required to achieve meaningful engagement invariably starts after adequate representation has been secured, and the responsibility for achieving it often falls on individuals and communities that are already inadequately resourced and suffering from under capacity. The case studies included here demonstrate how some Country Coordinating Mechanisms have risen to the challenge of making the engagement of key populations and people living with disease more meaningful in the face of these considerable constraints.

Each situation is different but, presented together, they suggest that a good starting point for achieving the desired results is to acknowledge that the meaningful engagement of marginalized groups is a process that needs political support, adequate resourcing, and a proper appreciation of the significant demands that are being placed on individuals when we ask them to represent their constituencies.

In what follows there is first a general overview of how the need for the meaningful engagement of key populations/people living with disease on Country Coordinating Mechanisms follows from the Global Fund's founding principles and supports a more efficient targeting of resources. This includes a summary of previously identified issues around realizing this ideal, and some recent measures that have been put in place to address them. This is followed by four country case studies that detail the experiences of the Country Coordinating Mechanisms in Moldova, Morocco, the Philippines, and Viet Nam in relation to strengthening engagement. A final section draws some conclusions based on these case studies.

II. Background

The need to secure meaningful representation of key populations and people living with disease on Country Coordinating Mechanisms follows directly from the Global Fund's founding principles of partnership and country ownership.ⁱⁱ The partnership principle recognizes that the only way to end the epidemics of AIDS, TB and malaria is by involving a broad range of stakeholders - including those affected by and living with the diseases - in the decision-making processes that determine national responses to those diseases. The country ownership principle stresses self-determination in the national response and acknowledges that those on the ground "know best how to respond to HIV, TB and malaria in their local contexts."ⁱⁱⁱ As a country-level multistakeholder platform, with core governance functions in relation to grant oversight, the Country Coordinating Mechanism sits in a pivotal position in relation to the achievement of the Global Fund's commitment to local ownership and participatory decision-making. It is the mechanism whereby these critical principles are put into practice at the national level.

The advent of the Global Fund's new funding model in 2014 afforded a significant opportunity to take the realization of these principles to the next level. The new funding model emphasized the need for a strengthened and iterative dialogue between the country and the Global Fund Secretariat to ensure a more strategically focused investment. To achieve this it also required a more inclusive dialogue process at the national level: "as part of ongoing strategic dialogue, countries are expected to bring together a range of stakeholders, including key populations and people living with the diseases, to discuss strategies to combat the main drivers of the diseases, decide on the most appropriate interventions and on the right timing for implementing them."^{iv} The task of convening this strategic dialogue at the country level falls to the Country Coordinating Mechanism; the new funding model thus demands a "stronger leadership role"^v from Country Coordinating Mechanisms, particularly with regard to convening a broad range of stakeholders to engage in national strategic plan and concept note development.

The Country Coordinating Mechanism encapsulates a vision of community participation in the governance of national disease responses that brings the viewpoint and experiences of communities of affected populations into the process of designing and coordinating a response. This is an ambitious ideal with a very strategic purpose. It acknowledges that, in order to ensure that resources are optimally allocated to where they will have the most impact, we need to involve the people whom the diseases most impacts. The Global Fund defines key populations as "those that experience a high epidemiological impact from one of the diseases combined with reduced access to services and/or being criminalized or otherwise marginalized."^{vi} The exact mix of affected populations will vary to some extent from country to country depending on the nature of the respective epidemics, but, typically, will include men who have sex with men, transgender people, people who inject drugs and sex workers for HIV, prisoners, people with HIV, migrants, refugees and indigenous populations for TB, and refugees, migrants, internally displaced people and indigenous populations in malaria-endemic areas for malaria. Together with people living with the three diseases, key populations represent, therefore, the people whom interventions ought to be reaching if we are to increase the efficiency and effectiveness of the response. Their inclusion is critical to ensuring the appropriate targeting of resources.

01 Putting principles into practice

Achieving meaningful representation of key populations and people living with the diseases on Country Coordinating Mechanisms is not without its challenges. Prior to the advent of the new funding model in 2014, these challenges had already been well documented and stem, to a large extent, from the fact that the Country Coordinating Mechanism model requires the participation and representation of populations that are more typically marginalized and excluded.^{vii} Since the inception of the model there has been a growing realization that making the mechanism work as envisioned is a more complex matter than simply ensuring an appropriate allocation of seats on the Country Coordinating Mechanism. These are disempowered voices being brought into the governance process; hearing them will inevitably involve addressing the power imbalances that make it so difficult to get them there in the first place.

A series of case studies commissioned by the Global Fund in 2008 found that while “Country Coordinating Mechanism governance functions and civil society participation have improved with time”, there were still significant issues around civil society representation and participation.^{viii} These included culturally dictated power differentials resulting in civil society representatives being deferential to government representatives, weak technical skills limiting civil society representatives’ ability to contribute to strategic deliberations, and the lack of systems to enable civil society representatives to consult widely with the constituencies they represent. These findings were echoed in the International Treatment Preparedness Coalition (ITPC)’s Country Coordinating Mechanism Advocacy Report of the same year, which argues that addressing these and other challenges requires an investment in capacity building for civil society.^{ix}

Since the 2008 case studies, and in conjunction with the roll out of the new funding model, a number of initiatives have been undertaken to further address barriers to full key population/people living with the diseases’ engagement in Country Coordinating Mechanism governance processes. Alongside the launch of the new funding model, the Global Fund issued a new requirement for Country Coordinating Mechanisms to undergo an annual Eligibility and Performance Assessment as a precondition for funding.

In order to be eligible for funding, a Country Coordinating Mechanism must now ensure (a) adequate representation of key populations (based on the socio-epidemiology of the three diseases in the particular country), and (b) adequate representation of people living with the diseases. Moreover, all nongovernmental constituencies represented on the Country Coordinating Mechanism are required to be selected solely by the constituencies they represent through a transparent and documented process. These eligibility requirements are further supported by a set of minimum standards that include a minimum of 40 percent representation on the Country Coordinating Mechanism from civil society,^x and the need for clearly defined processes for soliciting constituency input and giving feedback to constituencies. Since 1 January 2015, funding from the Global Fund has been conditional on continued Country Coordinating Mechanism compliance with all eligibility requirements and minimum standards.^{xi} Key population and people living with the diseases representation on Country Coordinating Mechanisms, and systematized constituency consultation, are now a pre-condition for funding.

While making key population and people living with the diseases representation a pre-condition for funding helps ensure that every effort is made to bring it about, it does not of itself address the capacity and resourcing issues that have been identified as limiting the engagement of these representatives once they have a seat at the table. In June 2013 the Global Fund launched a pilot initiative providing top-up funding to ten selected Country Coordinating Mechanisms to help strengthen and systematize civil society engagement in the new funding model. The pilot funded two-year workplans to strengthen key population and people living with the diseases’ engagement with Country Coordinating Mechanisms, with accompanying technical support provided by regional civil society mentor organizations.

This initiative spoke to a number of issues raised by previous assessments and case studies with regard to key population/people living with the diseases’ engagement on Country Coordinating Mechanisms: it took on board the point that enabling full engagement would require capacity building and additional resourcing, and it specifically aimed to address the issues around the lack of systems for robust constituency consultation and feedback. Two of the four countries covered in this present collection of case studies, the Philippines and Moldova, were part of the key population pilot initiative. Evidence of its impact will be apparent in the narrative that follows.

Both the Country Coordinating Mechanism Eligibility and Performance Assessment requirement and the key population pilot initiative have been further bolstered by the publication of the Global Fund’s Key Populations Action Plan 2014-2017. This plan details a number of strategic objectives and related actions designed “to strengthen these efforts by articulating clearly the obligations of the Global Fund Secretariat, technical partners and other stakeholders in fulfilling the commitment to key populations.”^{xii} Strategic Objective 2 of the action plan, for example, addresses the inclusion of key populations in country and regional processes and commits the Global Fund to “robust assessments” of Country Coordinating Mechanisms with regard to “the meaningful inclusion and participation of key populations.” An intended outcome of this is an “increased number of key population advocates on Country Coordinating Mechanisms.”^{xiii}

02 The case studies

Previous assessments of civil society engagement in Country Coordinating Mechanisms have recommended the Global Fund to “publicize best practices: provide case studies and guidance to the civil society sector on how civil society Country Coordinating Mechanism representatives can have a maximum positive impact on Country Coordinating Mechanisms.”^{xiv} This document compiles case studies from four different countries that illustrate how their Country Coordinating Mechanisms have attempted to address the challenges around key population and people living with the diseases’ inclusion in their country contexts.

The studies were conducted in 2015 in Moldova, Morocco, the Philippines, and Viet Nam; all four countries have undergone Country Coordinating Mechanism Eligibility and Performance Assessment and two of them, as mentioned above, were involved in the key population pilot initiative. The case studies are based on key informant interviews conducted with Country Coordinating Mechanism Secretariats, key population/people living with the diseases and other civil society Country Coordinating Mechanism and non-Country Coordinating Mechanism members, bilateral, multilateral and technical partners, Global Fund country teams and the Country Coordinating Mechanism Hub of the Global Fund Secretariat. They illustrate the challenges around securing key population/people living with the diseases’ representation and meaningful engagement, and the fact that making it work requires a considerable investment of effort (and resources) from a broad range of in-country stakeholders. They also show how different countries with different contexts can innovate their own solutions to critical issues such as convincing government partners of the value of the inclusion of key populations and people living with the diseases, and giving these groups a voice once they have secured their seat on the Country Coordinating Mechanism.

III. Mainstreaming Key Population Participation in Global Fund Country Coordinating Mechanisms: The Case of the Philippines

01 Country context

Classified by the World Bank as a lower-middle-income country, the Philippines has a relatively young population of about 100 million people, predominantly Catholic and with a significant Muslim minority in the South.^{xv} According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the HIV epidemic in the Philippines remains concentrated with less than 0.1 percent of its adult population being infected.^{xvi} Among key populations, increasing rates of new infection among people who inject drugs and men who have sex with men are of particular concern. The country currently has 36,000 persons living with HIV. While classified by the World Health Organization (WHO) as having a heavy disease burden for both general and multidrug-resistant TB, the country is on the verge of eliminating malaria.^{xvii} By February 2016, the Global Fund had invested a total of US\$269 million in the Philippines with 12 percent, 56 percent and 32 percent allocated to HIV, TB and malaria, respectively. According to the United Nations Development Programme (UNDP), both sex work and drug use are illegal in the Philippines but sex between men is not criminalized.^{xviii}

The Philippines has a vibrant civil society^{xix} that is well known throughout the Southeast Asia region for its political activism, extensive networks, coalition building and service delivery. However, fragmentation among and between coalitions and networks, including those related to HIV (very few exist for TB and malaria), runs the risk of limiting their impact with regard to policy advocacy and service delivery. Since the People Power Revolution of 1986, the government has put in place policies enabling increased civil society engagement in the policy arena. These have created political space for civil society to, for example, hold local government accountable and give input and advice on the design of national policies and programs. There are relatively few legal barriers preventing grass-roots organizations from organizing and participating, but receiving funds and delivering health services require both legal and professional registration, respectively. Many registered nongovernmental organizations have received financial support from overseas donors, although the volume of this support has declined in recent years as a consequence of the country's economic growth. Faith-based organizations are actively involved in the delivery of many social services and the Catholic Church has a strong political influence on government policy, including health.

02 Best practice

The Philippines case speaks to a number of important outstanding challenges with regard to key population and people living with the diseases' participation in Country Coordinating Mechanisms. These include (1) the "disempowered voice" issue, whereby existing power differentials make it hard for community members to speak up in forums typically inhabited by government players; (2) the "capacity to perform governance functions" issue, whereby community members need technical capacity building in order to enable them to fully perform their Country Coordinating Mechanism role; and (3) the "constituency consultation" issue whereby the roles and mechanisms that enable a community representative to provide a two-way consultative communication link between the Country Coordinating Mechanism and the community constituencies they represent are inadequately defined.^{xx} To address these various issues the Philippines Country Coordinating Mechanism has:

- 1) Formalized a key populations committee within the Country Coordinating Mechanism governance structure;
- 2) Resourced this committee with dedicated staff and budget;
- 3) Operationalized it with a concrete workplan of activities to promote and support broader key population engagement in Global Fund processes; and
- 4) Made the key populations committee accountable to the objective of making Global Fund processes more accessible to key populations.

03 Outcomes

As one of the ten countries participating in the 2013-2015 Key Populations Pilot Initiative sponsored by the Global Fund, the Philippine Country Coordinating Mechanism's Key Populations Committee has achieved:

- An increase in the number of key population Country Coordinating Mechanism members from just two in 2013 (representing people living with HIV and people living with TB) to five in 2015 (adding representatives for people living with malaria, transgender people and youth.)
- The creation of a key population-friendly learning space within the Country Coordinating Mechanism for new key population members to discuss with, learn from and get support from other veteran key population Country Coordinating Mechanism members.
- An increased level of understanding and engagement by the broader key population community with Global Fund processes, particularly with regard to the development of a national strategic plan and a concept note.

04 Process

1. **Formalizing a Key Populations Committee within the Country Coordinating Mechanism governance structure** – In 2013, during the Global Fund Key Populations Pilot, the Philippines Country Coordinating Mechanism decided to establish a Key Populations Committee to promote key population member participation in Country Coordinating Mechanism governance processes. This committee was subsequently made into a permanent standing committee in 2014, whose role and functions are detailed in the Country Coordinating Mechanism Governance Manual. All civil society Country Coordinating Mechanism members, including those from key population communities, automatically became part of this Key Populations Committee. Committee members select from among themselves the committee chair. Upon initial establishment, there being few key population members on the Philippines Country Coordinating Mechanism at the time, the Key Populations Committee was allowed to invite non-Country Coordinating Mechanism key population community members to participate in its activities as observers. By 2015, the Key Populations Committee had representatives from all three diseases, plus representatives for transgender and youth. The committee members selected the faith-based organization Country Coordinating Mechanism member (the Catholic Church) to be the committee chair.
2. **Resourcing the Key Populations Committee with dedicated staff and budget** – After establishing the Key Populations Committee and making it permanent, the Philippines Country Coordinating Mechanism committed to providing both human and financial resources to support its operation. The Country Coordinating Mechanism Secretariat staff team now includes a Key Populations Engagement Focal Point person and the Key Populations Committee has biannual workplans and budgets approved by the Country Coordinating Mechanism. While the first biannual budget (2013-2015) was supported by the Global Fund Key Populations Pilot, the committee's second biannual budget (2015-2017) is now officially part of the regular Country Coordinating Mechanism funding request to the Global Fund.
3. **Operationalizing the Key Populations Committee with concrete activities and deliverables** – The work of the committee has evolved with the grant cycle. The first biannual plan focused more on engaging the broader key population communities in the development of the national strategic plans and the concept notes for the three diseases. The current biannual workplan (2015-2017) focuses on:
 - a) Supporting the direct involvement of key populations in oversight of Global Fund grants (by building key population communities' capacity to monitor grants and identify service access barriers, and by opening up Country Coordinating Mechanism oversight visits to key population communities.)

- b) Building key population Country Coordinating Mechanism members' capacity to strengthen local key population community groups' oversight of the implementation of Global Fund grants by training key population community leaders on Country Coordinating Mechanism oversight site visits, public health knowledge of the three diseases, behavioral change communication, coalition building and networking skills.

The Key Populations Committee holds regular preparatory meetings before Country Coordinating Mechanism meetings to review progress against planned work, and, more importantly, to support key population Country Coordinating Mechanism members in selecting and presenting the issues their constituencies would like them to convey to the Country Coordinating Mechanism. The committee often tables issues at Country Coordinating Mechanism meetings on behalf of key population constituencies to maximize the chances of key population viewpoints being taken into account by the Country Coordinating Mechanism. The committee regularly consults broader key population constituencies, both regionally and nationally, on Global Fund processes such as national strategic plan and concept note development.

4. ***Holding the Key Populations Committee accountable*** – As a standing committee of the Country Coordinating Mechanism, the Key Populations Committee submits work reports to the Country Coordinating Mechanism on an annual basis. More importantly, it uses various forums (TB Key Population National Convention, HIV Key Population Convention, National Malaria Key Population Convention, and Regional Forums in Luzon, Visayas and Mindanao), on an ongoing basis, to keep the wider key population communities it represents informed about its work.

05 Outstanding issues and recommendations

- Two critical key populations – people who inject drugs and men who have sex with men - are still not represented on the Country Coordinating Mechanism. Given the dynamics of the HIV epidemic in the Philippines this needs the Country Coordinating Mechanism's urgent attention:
 - The Key Populations Committee should continue to advocate for these epidemically critical key populations to be represented on the Country Coordinating Mechanism. This should be aligned with the Country Coordinating Mechanism's Eligibility and Performance Assessment improvement plan put in place in 2014 to increase the number of key population Country Coordinating Mechanism members and strengthen their constituency representation. As an interim measure, the Key Populations Committee should be authorized by the Country Coordinating Mechanism to co-opt non- Country Coordinating Mechanism members from the relevant key population coalitions/networks to join the committee.
- The Country Coordinating Mechanism also needs to strengthen the constituency representation of new key population Country Coordinating Mechanism members by supporting the Key Populations Committee to:
 - Coordinate with the larger key populations community, ensuring both technical and financial support are available to support key population Country Coordinating Mechanism members to carry out their bi-directional communication with constituencies, both online and in-person.
 - Ensure that the Country Coordinating Mechanism calls for nominations for key population Country Coordinating Mechanism members provide clear definitions of which constituencies are being represented (who are the constituencies, individuals/organizations or the larger community), specify that networks/coalitions are preferred to organizations/individuals as key population Country Coordinating Mechanism members, and state clearly the communication skills and community consulting obligations expected of a key population member to ensure effective two-way feedback between his/her constituency and the Country Coordinating Mechanism.

- The Country Coordinating Mechanism also needs to strengthen the skills for oversight site visits of new key population Country Coordinating Mechanism members by supporting the Key Populations Committee in:
 - Ensuring that Country Coordinating Mechanism funding provides financial and technical resources to enable key population Country Coordinating Mechanism members in maximizing their potential contributions during Country Coordinating Mechanism oversight site visits. This would mean, for example, boosting capacity around basic disease knowledge, listening skills needed for interviews with program beneficiaries, identifying issues relevant to program performance and contributing to the site visit report.

IV. Building a Common Platform - Integrating TB and HIV Community Constituencies in Global Fund Country Coordinating Mechanisms: The Case of Moldova

01 Country context

The Republic of Moldova is a lower-middle-income country that became independent in 1991. It is currently the poorest in the WHO European Region. TB and HIV are the main communicable diseases in the country and it is among the world's 27 multidrug-resistant tuberculosis (MDR-TB) high-burden countries. Although gradually declining, TB incidence in 2013 remained high, with 226 [113-375] per 100,000 and an estimated prevalence of 7,900 (source: WHO). Estimated HIV prevalence is 15,000 [13,000-17,000] and the HIV prevalence rate is 0.6 [0.5-0.7] (source: UNAIDS). Transnistria, a territory remaining outside of government control for political reasons, is one of the most affected areas in the country. The legal framework in the country supports the development of civil society organizations and fundamental human rights and freedoms are guaranteed and protected. Public authorities do engage with civil society in policy dialogue, although advocacy and lobbying are subject to some legal constraints.^{xxi} By February 2016, the Global Fund had invested a total of US\$97.6 million in Moldova, 44 percent of which was dedicated to HIV/AIDS, 44 percent to TB, and an additional 12 percent to an integrated response that addresses both diseases.

Currently the Moldovan Country Coordinating Mechanism fulfils the requirement of having at least 40 percent of its members from civil society. Directly represented key populations include people living with HIV, men who have sex with men and lesbian, gay, bisexual and transgender (LGBT). There is one representative of a platform of civil society organizations active in TB control, and organizations working on harm reduction programs indirectly represent people who inject drugs and sex workers. Although the platform of civil society organizations active in TB control has among its members an organization of people with TB, there is no representative of people with TB sitting on the Country Coordinating Mechanism. The Country Coordinating Mechanism by-laws and its operational manual detail the required selection processes for representatives from the civil society sector and their constituency consultation/communication obligations.

Like the Philippines, Moldova was one of ten countries participating in the Global Fund's key population pilot initiative. Although the level of key population representation was not boosted (the key population constituency representatives detailed above were already in post prior to the project), the quality of representation significantly improved. Prior to the pilot, different key population networks had little information about each other's activities and their advocacy work was often uncoordinated. Furthermore, language was a barrier to their full participation in the functioning of the Country Coordinating Mechanism as not all key populations are well versed in the Romanian language. The deadlines for the country dialogue process were too tight to allow for the extensive time and effort required for a meaningful constituency engagement process on the part of civil society.

02 Best practice

The Moldova case demonstrates how an investment in strengthening and systematizing key population representation on Country Coordinating Mechanisms can result in improved consensus building among community constituencies, thereby enabling targeted advocacy. Moreover, the key population pilot initiative was an opportunity for the Moldovan Country Coordinating Mechanism to increase the level of civil society engagement in new funding model processes. To achieve this, a Key Populations Committee was formed in the Country Coordinating Mechanism, consisting of representatives of several well-established civil society networks. The objectives of this Key Populations Committee were to:

- 1) Strengthen communication with key population constituencies,
- 2) Develop a faster and more effective mechanism for collecting standardized information,
- 3) Improve advocacy at the Country Coordinating Mechanism level and beyond, and
- 4) Pool resources.

To achieve these objectives a regional mentoring organization was appointed to provide technical support. A rotation mechanism was developed for Key Population Committee coordination. Capacity building was provided to Key Population Committee members in the areas of strategic planning and community mobilization. Unified positions were developed on particular advocacy issues, and communication between different key population sectors was significantly improved.

03 Outcomes

Regular Key Population Committee meetings necessitated more frequent communication and collaboration between the different key population constituency representatives, resulting in increased transparency, mutual understanding and engagement.

The Key Population Committee developed standardized tools for systematically collecting input and feedback from the various key population constituencies. These tools were then used for a large-scale consultative HIV assessment, providing data of better quality and compatibility for the HIV Concept Note. Additionally, the platform of civil society organizations active in TB control conducted a survey of service quality, which was subsequently used in dialogue with the Ministry of Health to influence the National TB program. The design and use of these various tools enabled beneficiaries and service providers to communicate in a more organized and structured way.

A capacity building workshop on strategic planning resulted in a strategic plan for the Key Population Committee (Feb 2015-Dec 2017) with the main goal of sustainability and continuation of quality service provision. The plan has four objectives:

- 1) Advocacy to lower the price of medicines;
- 2) Capacity building for community organizations to support active and meaningful engagement in the national HIV and TB responses,
- 3) Conducting a pilot whereby a civil society organization receives funding from the national budget, and
- 4) Diversifying the funding sources of the Key Population Committee.

04 Process

1. **Appointing a mentoring organization.** Based on broad stakeholder consultations, in November 2013 the Secretariat of the Country Coordinating Mechanism selected the East Europe & Central Asia Union of PLWH (ECUO) to oversee the key population pilot initiative. ECUO would act as a mentoring organization and provide technical support. ECUO's identity as a regional network of national-level networks meant that it had the required experience of managing multiple stakeholders with a view to building consensus.

2. **Systematizing Key Population Committee coordination.** Initially the Secretariat coordinated the key population pilot project. A preliminary workshop developed a workplan, with attendant budget and indicators, to guide the work of the Key Population Committee members. Subsequently, it was decided to establish a separate Key Population Committee Secretariat and rotate both the coordination and the Secretariat roles among the committee members. A Key Population Committee member was deemed eligible to take up the coordinator role after having served at least one term as an alternate. The idea behind the rotation was to open up the opportunities and experience that came with the roles to multiple key population representatives. It also helped share the expense of hosting the Secretariat. Rotation was originally conceived to be on a quarterly basis but this was adjusted to six-monthly for reasons of practicality. It is anticipated that the Key Population Committee may eventually establish a permanent Secretariat, while continuing to rotate the coordination function.

3. **Building capacity.** Capacity building for the Key Population Committee focused on strategic planning and community mobilization. This was designed to address the technical capacity of key population representatives to fulfil (a) their grant governance and oversight roles on the Country Coordinating Mechanism and (b) their constituency consultation and representation obligations. Standardized constituency communication methods and tools were developed at a community mobilization workshop. Membership of the Key Population Committee also afforded opportunities for the TB and HIV communities to learn from each other's respective capacities, experiences and community know-how.

4. ***Developing consensus for effective advocacy.*** Bringing together diverse key population communities into a single committee has facilitated the development of a consensual community voice on particular advocacy issues. For example, in 2014 the Key Population Committee petitioned the Prime Minister to state their support for dual-track financing and for the proposed division of activities between the government and civil society Principal Recipients. In 2015, key populations jointly presented their recommendations, and participated in the Technical Working Groups, for the respective national strategic planning processes for TB and HIV. Overall, by developing a common platform for both the HIV and TB communities, the Key Population Committee is contributing significantly to the improved integration of HIV and TB within the national program.

5. ***Improving communication links between the Country Coordinating Mechanism and key population communities.*** Shared tools for collecting community feedback have resulted in more streamlined consultation processes and standardized data. The use of internet platforms such as a Google Group has established new communication links between mature networks and younger organizations from across the country, giving all an equal opportunity to express their views. In addition to Romanian and English, Country Coordinating Mechanism documents are now also translated into Russian to enable wider key population engagement; this relatively small investment has had a significant impact on inclusiveness.

05 Outstanding issues and recommendations

- People with TB are still not represented on the Country Coordinating Mechanism.
- The Key Population Committee should advocate for a representative of people living with TB.
- The Key Population Committee still needs capacity building in a number of areas to strengthen their position on the Country Coordinating Mechanism and further increase their contribution to grant oversight.
- Assistance is needed to help Key Population Committee members, and the communities they represent, to formulate more concretely their requests regarding domestic funding and drug procurement.
- The Key Population Committee needs to strengthen its technical knowledge in relation to national strategic planning, and to improve its understanding of the strategy development process. This could be achieved by, for example, continuing the mentoring relationship with ECUO.
- Further “professionalization” of the committee is desirable to strengthen its members’ knowledge and skills with respect to understanding epidemiological information, engaging in procurement and adopting new approaches to service provision.
- The sensitization of HIV organizations on TB issues needs to continue.
- Constituency consultation and representation remains a critical function of the Key Population Committee and requires continued attention:
- It would be beneficial to have an external evaluation of the effectiveness of the Key Population Committee’s current constituency communication mechanisms and processes. This could serve as a validation of the current self-evaluations.
- Differences between key population constituencies (for example, with regard to internet access and literacy) require the deployment of a diverse range of communication mechanisms for constituency consultation by the different key population networks (Google groups, newsletters, monthly bulletins, focus groups). It is important that consultation processes be tailored to particular constituencies in this regard.
- There may also be a need to revisit the Key Population Committee’s composition to make sure the balance of interests of all the constituencies is maintained.

V. Advocating for Key Population Inclusion in Global Fund Country Coordinating Mechanisms: The Case of Viet Nam

01 Country context

Reforms initiated by the Vietnamese government in the 1980s have led to rapid economic development over the last two decades. As a result, the World Bank^{xxii} now ranks the country in the lower-middle-income category, alongside such countries as the Philippines and Indonesia. Viet Nam's HIV epidemic is concentrated among people who inject drugs, sex workers, men who have sex with men and transgender people. UNAIDS estimates that about 0.5 percent (or 250,000) of its adult population is living with HIV. A decline in new infections in recent years is thought to be due to the impact of harm reduction programs for people who inject drugs. However, sexual transmission, particularly among men who have sex with men, is on the rise. According to UNDP, while both sex work and drug use are illegal, sex between men is not criminalized.^{xxiii} With regard to TB, the country is currently classified by WHO as a heavy-disease-burden country for both general and multidrug resistant strains.^{xxiv} The prospects for malaria are better, with elimination considered to be within reach. By February 2016, the Global Fund had invested US\$301 million in Viet Nam, of which 41 percent was for HIV, 23 percent for TB, and 17 percent for malaria. A further 19 percent was in support of non-disease-specific interventions such as health and community systems strengthening.

The country's civil society organizations^{xxv} can be broadly classified into two distinct categories: those that are government sponsored (professional and academic organizations – sometimes referred to as “mass organizations”) and those that are not. While the former enjoy relatively stable funding from the government, the latter rely largely on funding from overseas donors, particularly to support work in the areas of health and poverty reduction. Some of these nongovernmental organizations have also succeeded in obtaining legal registration, enabling them to open bank accounts and receive funding from overseas donors. Despite its infancy, the nongovernmental civil society sector is relatively well organized, with the more established registered groups taking the lead in building coalitions and networks of smaller, often-unregistered, community-based organizations.^{xxvi} The last decade has seen the emergence of coalitions and networks covering all key populations affected by HIV and TB. However, this growth in the civil society response is threatened by its dependence on declining international funding.

02 Best practice

The Viet Nam case illustrates the complexities of implementing principles of civil society inclusion in health program governance in country contexts where such inclusion is not the political norm. In this challenging context of limited domestic political support for nongovernmental civil society organizations, securing a role for key population members on the Country Coordinating Mechanism to meet the Global Fund's new Country Coordinating Mechanism eligibility requirements required a coordinated advocacy strategy on the part of development partners, nongovernmental civil society and the Global Fund country team. Achieving the required level of key population representation on the Country Coordinating Mechanism took a three-pronged approach:

1. Development partners coordinated among themselves to conduct targeted advocacy with individual government Country Coordinating Mechanism members (particularly those from outside the health sector such as finance, public security and narcotics control) with whom they already had good working relationships, to help them overcome their initial hesitation around key population representatives on the Country Coordinating Mechanism;
2. Nongovernmental civil society organizations, with support from development partners, familiarized themselves with the Country Coordinating Mechanism's functions, and the new eligibility requirements, and provided evidence of their contribution to the country's response to the three diseases to gain the trust of existing government Country Coordinating Mechanism members; and

3. The Global Fund country team issued repeated reminders that the new key population representation requirements (for all three diseases supported by Global Fund grants) are a non-negotiable pre-condition for the receipt of funds.

03 Outcomes

The collective advocacy efforts by development partners, nongovernmental civil society and the Global Fund country team has contributed to:

- An increase in the number of key population members on the Country Coordinating Mechanism from two in 2013 (people living with HIV and people living with TB) to four by 2014 (adding men who have sex with men and people who inject drugs).
- An increase in nongovernmental civil society organizations' understanding of Global Fund processes, particularly the development of the national strategic plan and the concept note.

04 Process

To bring about these outcomes the various stakeholders had to undertake a number of tasks in support of the overall advocacy strategy:

1. ***Development partners***

- a) Informing nongovernmental civil society organizations about the new Country Coordinating Mechanism eligibility requirements, including the requirement of having key populations represented on the Country Coordinating Mechanism.
- b) Supporting the Ministry of Health in addressing barriers within the government system (e.g. a lack of understanding by the Ministries of Public Security and Narcotics of the public health case for key population involvement in the disease response, and a lack of awareness on the part of the Ministry of Finance about the implications of non-compliance on funding.)
- c) Lobbying, negotiating and suggesting compromises acceptable to the government (e.g. opting for an ex-injecting drug user as Country Coordinating Mechanism member instead of a current user, and selecting a nongovernmental civil society organization with a proven track record of successful delivery of services that is well aligned with the national strategic plan.) This helped reduce the government's perception of risk related to nongovernmental civil society inclusion; and
- d) Technically and financially supporting the Country Coordinating Mechanism Secretariat to facilitate the elections of key population Country Coordinating Mechanism members.

2. ***Non-governmental civil society organizations***

- a) Liaising with development partners to keep up to date on Country Coordinating Mechanism eligibility requirements;
- b) Identifying resources available from the Global Fund to increase key population representation on Country Coordinating Mechanisms (e.g. technical assistance from the Community, Rights and Gender department of the Global Fund);
- c) Familiarizing themselves with Country Coordinating Mechanism basics such as oversight and constituency definitions;
- d) Documenting service delivery successes by nongovernmental civil society organizations;
- e) Making a case to the government about how these successes contribute to the country's response to the diseases; and
- f) Mapping out an agenda of constituency concerns for elected key population representatives to bring to the Country Coordinating Mechanism.

3. ***Global Fund Country Team***

- a) Ensuring that the Country Coordinating Mechanism understood that the eligibility requirements are non-negotiable; and
- b) Highlighting the consequences of non-compliance, or a lack of commitment toward full compliance. These ranged from the Country Coordinating Mechanism being potentially ineligible to submit concept notes to funding disbursement requests potentially being denied (regardless of the quality of the concept note or the subsequent performance of the grant implementers.)

05 Outstanding issues and recommendations

1. New key population Country Coordinating Mechanism members still lack confidence to speak up in Country Coordinating Mechanism meetings:

- The Country Coordinating Mechanism could consider establishing a Key Population Caucus within the Country Coordinating Mechanism (similar to the Key Population Committees of the Filipino and Moldovan Country Coordinating Mechanisms) to provide a less intimidating environment for new key population members to test their ideas, build confidence and get support from other veteran key population and nongovernmental civil society Country Coordinating Mechanism members.
- The Country Coordinating Mechanism could consider, as part of new member induction, an introductory meeting between new key population members and the Country Coordinating Mechanism Chair and Vice Chair(s.) This would help demonstrate the Country Coordinating Mechanism's commitment to inclusion and would welcome new key population Country Coordinating Mechanism members and support them in speaking up at meetings.

2. New key population Country Coordinating Mechanism members still lack a clear understanding of the mechanics of constituency representation and lack capacity in grant implementation oversight:

- The Country Coordinating Mechanism should ensure that calls for nominations clearly define what community representation is and who the represented constituencies are (e.g. the larger community vs. organizations or individuals.) Individuals chosen by networks and coalitions may have access to broader constituency communication networks than those chosen by just one organization. Specific communication skills and a proactive communication strategy are needed to ensure an effective link between the constituency represented and the Country Coordinating Mechanism.
- The Country Coordinating Mechanism should ensure that its funding request to the Global Fund includes funds to build key population members' grant implementation oversight capacity and to support them in conducting regular constituency consultations.

3. Other TB and HIV key populations (e.g. prisoners, sex workers) are still not represented on the Country Coordinating Mechanism:

- The Country Coordinating Mechanism could consider inviting key populations not on the Country Coordinating Mechanism to participate as observers in meetings or to join the suggested Key Population Caucus.

VI. Ensuring the Anonymity of Key Population Candidates During Country Coordinating Mechanism Elections: The Case of Morocco

01 Country context

Morocco is a lower-middle-income country with a relatively young and predominantly Muslim population of about 33 million^{xxvii}. The HIV burden is considered relatively low (0.1 percent, or 29,000, of its adult population being infected with HIV)^{xxviii} and new HIV infections have declined by 15 percent since 2001. However, a relatively high proportion of those infected are not on treatment. The epidemic is increasingly concentrated in urban areas among people who inject drugs, female sex workers and men who have sex with men. All of these three key populations are criminalized and highly stigmatized in Morocco, making the delivery of HIV services very challenging^{xxix}. While an expanded screening program in the past decade has kept the TB burden largely stable^{xxx}, the low level of treatment adherence is contributing to an emerging problem of multidrug-resistant TB in the country. Between 2003 and 2015, the Global Fund invested US\$64 million in Morocco, of which 86 percent was for HIV and the remaining 14 percent for TB.

Political reforms that have taken place since 2000 have largely eliminated the barriers that prevented civil society organizations from registering legally as charitable organizations. This is significant because registration is a prerequisite for accessing public funds. However, administrative barriers continue to exist for civil society organizations engaged in sensitive issues, including those that are perceived to challenge the established religious consensus^{xxxi}. That said, health issues such as HIV and TB are generally considered to be aligned with national priorities and health authorities support and work with numerous civil society organizations to provide services to key populations. This is evidenced by the fact that a number of HIV civil society organizations have secured legal registration as charitable organizations (e.g. ALCU). With government support, these HIV organizations are now responsible for raising awareness of HIV, providing prevention services to key population communities and referring them to government health services. Despite these successes, key populations continue to be stigmatized and criminalized, and lack the political space to organize networks or coalitions among themselves to directly voice their concerns. They often rely on the civil society organizations serving them to channel their views.

02 Best practice

The Moroccan case demonstrates the need to balance the requirements of adequate representation and participation with concern for the protection and safety of community constituents in country contexts where key populations are both criminalized and highly stigmatized. Ensuring this protection meant that the election of key populations to the Country Coordinating Mechanism required a fair and transparent election process that protected the anonymity of key population candidates.

Key elements of this process included:

- After deciding to expand Country Coordinating Mechanism membership to key populations and human rights nongovernmental organizations, the Country Coordinating Mechanism appointed a membership renewal committee to lead the process. The committee began with consulting civil society on the design of the election process (nominations by civil society organizations,) and related selection criteria, in order to ensure fairness, transparency and anonymity for key population candidates;
- A process of name-blind candidacy facilitated by a notary appointed by the Country Coordinating Mechanism ; and
- A conflict-of-interest-free election oversight mechanism (an independent external committee appointed by the Country Coordinating Mechanism) to assure the fairness and transparency of the election process.

03 Outcomes

The name-blind candidacy approach to the election process has contributed to the Country Coordinating Mechanism's achieving its objective to expand membership to key populations while protecting their anonymity:

- The number of key population members on the Country Coordinating Mechanism increased from just one in 2013 (people living with HIV) to five by 2014 (adding people living with TB, people who inject drugs, sex workers and men who have sex with men).
- The oversight committee now includes three of these key population Country Coordinating Mechanism members and has included the issue of stigma and discrimination in meeting agendas and oversight site visits.

04 Process

A total of 24 nominations were received and 21 were deemed complete and submitted on time. Below are the details of the process:

1. ***Civil society consultation***

- a) The Country Coordinating Mechanism appointed a membership renewal committee to consult civil society organizations - both those who were members of the Country Coordinating Mechanism and some that were non-members - to design the election framework.
- b) The committee and civil society representatives decided that only civil society organizations that had been providing services to key populations would be eligible to nominate key population candidates. It was further decided that each civil society organization could nominate up to a maximum of two candidates for each of the key population seats. It was also stipulated that to minimize potential conflict of interests, none of the nominated candidates could be paid staff of the nominating organizations.
- c) The committee then specified selection criteria that the independent external committee (see "Election oversight" section below) should adhere to in evaluating each candidate.
- d) Selection criteria included community leadership, communication skills and the capacity to coordinate two-way communication between the Country Coordinating Mechanism and their constituencies.
- e) The committee also designed a nomination form. This was designed so that the name of the key population candidate and the nominating organization were on the first page of the form while the candidate's other qualifications were presented on subsequent pages.

2. ***Name-blind candidacy***

- a) The Country Coordinating Mechanism appointed a notary lawyer (independent and without conflict of interest) to receive the nomination forms submitted by civil society organizations in sealed envelopes to ensure confidentiality.
- b) The notary then checked the completeness of all nomination forms submitted on or before the submission deadline.
- c) The notary then removed the first page of each complete nomination form (containing the name and address of the nominee, the name of the nominating organization, and details of which key population seat the nominee was being nominated for,) and assigned a unique identification code to the nomination form to protect the nominee's anonymity.
- d) The notary then passed all the name-blind nomination forms to the independent external committee.

3. ***Election oversight***

- a) The Country Coordinating Mechanism appointed an independent external committee made up of two consultants with no conflict of interest with any of the nominees and nominating civil society organizations.
- b) The committee, in the presence of the notary, interviewed, evaluated and scored each nominee according to a set of selection criteria specified by the civil society organizations (see “Civil society consultation” above).
- c) The committee then ranked the nominees for each of the key population seats. On the basis of this ranking, the nominees with the highest and second-highest scores were recommended to the Country Coordinating Mechanism to serve as the Country Coordinating Mechanism member and alternate, respectively, for a particular key population seat.

05 Outstanding issues and recommendations

1. Oversight capacity building for new key population/people living with the diseases Country Coordinating Mechanism members:

- There is a need for the Country Coordinating Mechanism to strengthen key population/people living with the diseases’ members’ ability to interpret dashboards, and ability to conduct interviews with program beneficiaries during oversight site visits - particularly about the quality of services funded by the grant and barriers to service access such as stigma and discrimination. The Country Coordinating Mechanism should come up with the appropriate recommendations after their oversight site visits and proactively follow up on them.

2. Key population/people living with the diseases members’ bidirectional communications between the Country Coordinating Mechanism and their constituencies:

- The Country Coordinating Mechanism should ensure that all key population/people living with the diseases members receive technical and financial support to overcome stigma and discrimination and to develop and maintain regular communication with their constituencies.
- As part of the improvement plan resulting from the Eligibility and Performance Assessment, the Country Coordinating Mechanism should support and ensure that key population/people living with the diseases members develop and implement workplans that are endorsed by their constituencies.

VII. Conclusion

The case studies presented here illustrate some of the very real challenges faced by country partners as they attempt to put into practice the Global Fund's principles of inclusion and participation with regard to key population/people living with the diseases representation on Country Coordinating Mechanisms.

They also demonstrate a number of measures that can be put in place to help address those challenges: measures that may contain useful lessons for other countries facing similar or related issues. The challenges range from obstacles preventing the representation of key populations and people living with the diseases on Country Coordinating Mechanisms (limited understanding, for example, on the part of stakeholders with power, of the rationale behind the required inclusion), to the need for enabling mechanisms and appropriate resourcing to ensure that once key population/people living with the diseases' representatives are appointed to Country Coordinating Mechanisms they can carry out their constituency consultation and grant oversight functions as required by the model.

Many of these challenges are directly related to the fact that key populations typically come from marginalized, stigmatized, criminalized and disempowered communities. They are also related to the fact that health program governance systems are not often established with this type and level of participation in mind. There are thus two core dimensions to the challenge of meaningful inclusion of key populations and people living with the diseases on Country Coordinating Mechanism; one is about the capacity and readiness of community constituents, the other is about the receptivity and readiness of health program governance systems. Both need to be addressed if the ideals behind the Country Coordinating Mechanism model are to be fully realized.

The Viet Nam and Morocco case studies illustrate some of the groundwork that needs to be done on the health program governance side of the challenge to create the political space needed for key population/people living with the diseases inclusion. It cannot be assumed that everyone on a multistakeholder health program governance platform fully understands the public health case for inclusion. In some country contexts, this case still needs to be made and it can be made most effectively by coordinated advocacy involving a range of stakeholders. This can help create the political support needed to open up governance mechanisms to key population/people living with the diseases' participation. It is also important that efforts to secure inclusion are highly mindful of any risks that inclusion and participation might present to those the organization is trying to include. In some countries, simply being identified as belonging to some key populations can present a threat to an individual. In such contexts, efforts need to be made to protect the identity of representatives to ensure that they do not face adverse consequences as a result of coming forward to represent their constituencies. The case studies presented here have demonstrated some of the ways in which the case for inclusion can be effectively made (Viet Nam) and how the anonymity of the representatives can be preserved where necessary (Morocco.) The key issue here is the extent to which health program governance systems are ready for the type of inclusion and participation that is required. An investment needs to be made in improving systems readiness in order to bring about the inclusion and ensure that it is meaningful and productive.

Accommodating representation is only half the struggle. To reap the full public health benefits of key population/people living with the diseases' inclusion, Country Coordinating Mechanisms need to create their own "enabling environments" to nurture and support the active engagement of these representatives. The Global Fund's Key Population Pilot Initiative enabled the Philippines and Moldova Country Coordinating Mechanisms to establish key population committees that served as a supportive incubating space for developing the key population/people living with the diseases' agenda before full presentation to the Country Coordinating Mechanism. Part of the advantage of this type of approach is that it creates a safe key population-friendly space where representatives, especially those new to the role, can find their voice (the Philippines). It also facilitates better mutual understanding between different key population constituencies for different diseases and the establishment of a common advocacy agenda (Moldova.) In the case of the Philippines this mechanism has been fully institutionalized and brought into the regular Country Coordinating Mechanism funding request, thereby ensuring continuity. It would be worthwhile looking at the possibility of rolling out this type of set-up more widely to help address well-documented issues with supporting key population/people living with the diseases community representatives to have a voice in Country Coordinating Mechanism deliberations.

It is clear from several of the case studies presented here that there are outstanding issues regarding the formalization of constituency consultation processes. It does seem fair to say that the various initiatives that have been taken to boost key population/people living with the diseases' inclusion have resulted in much better and broader engagement with national strategic plan and concept note development processes (see, for example, the Philippines and Moldova.) There have also been achievements in standardizing and improving the quality of data collected from key population/people living with the diseases' constituencies for national strategic plan and concept note development purposes (Moldova). However, there are still a number of remaining ambiguities about the representative role and the practicalities, logistics and operational costs of being the communication bridge between the Country Coordinating Mechanism and a represented constituency. Efforts to systematize the representation function need to be clear that it is constituencies as a whole, rather than particular organizations or groups, which are being represented. Systematizing the constituency consultation mechanism needs to take account of this intended scope of the representation role. It also needs to take account of the access that different key population/people living with the diseases constituencies have to different types of media and communication forum, and the extent to which the different constituencies are organized into formal or informal networks. These factors are unlikely to be the same for each constituency in any given country context, so systematized consultation (and feedback) mechanisms will undoubtedly need to be tailored to each community.

There is also a need for induction processes that build awareness of the responsibilities that go with constituency representation. This is not just for the key population/people living with the diseases representatives, but for all Country Coordinating Mechanism members, so that they fully appreciate the resources required to be an effective representative. Resourcing key population/people living with the diseases' inclusion on Country Coordinating Mechanisms involves a number of different types of support: support for capacity and awareness building about the nature of the role, support for systematization of consultation and feedback mechanisms, and support for the direct communication and time-and-effort costs involved with formal consultation are among them. Given the disadvantaged backgrounds that many representatives come from it is important that participation on the Country Coordinating Mechanism does not put them in a position of having to perform a complex consultative function without the resources that are needed to properly execute the role. As we move along the scale from token to meaningful representation the resources required by that representation function (in time, effort and direct communication costs) will inevitably increase. Building awareness about the need for constituency representation to be properly resourced will help ensure that full and meaningful representation actually happens.

Finally, it is worth stressing that previous examinations of the issues that prevent the meaningful engagement of key populations/people living with the diseases on Country Coordinating Mechanisms have tended to focus on the community representatives' capacity deficit. While there are undoubtedly capacity issues that need to be addressed, and appropriately resourced, it is clearly not just key population representatives' capacity that gets in the way of realizing the principles of full inclusion. There are systems-side issues about the extent to which governance culture and function are able to accept, accommodate and enable the key population contribution. In addition to the question of allocating a place, there is also the question of creating and resourcing an enabling space that gives the disempowered voice the courage to contribute. The Country Coordinating Mechanism, and the principles on which the model was designed, represent an important opportunity to bring equity into health program governance and ensure that resources are more effectively targeted towards communities where they will have the greatest impact. It is to be hoped that the experiences of the Country Coordinating Mechanisms outlined in these case studies can contribute toward achieving that goal by making the inclusion of key populations and people living with the diseases a reality.

ⁱ *The Global Fund Country Coordinating Mechanism*, Audit Report, Office of the Inspector General, 25th February 2016, P8

ⁱⁱ The full list of the Global Fund's Principles can be found here: <http://www.theglobalfund.org/en/overview/>

ⁱⁱⁱ *ibid.*

^{iv} *The Global Fund's New Funding Model*, The Global Fund, April 2013, p3.

^v See <http://www.theglobalfund.org/en/ccm/> for an outline of the CCM's role under the NFM.

^{vi} *Key Populations Action Plan 2014-2017*, The Global Fund, p6. This document also gives a more comprehensive overview of how the Global Fund defines "key populations" with respect to the three diseases.

^{vii} It is presumably in this regard that ITPC's CCM Advocacy Report, *Making Global Fund Country Coordinating Mechanisms work through full engagement of civil society*, October 2008, describes the CCM model as "revolutionary in health financing", P1.

^{viii} The Global Fund Implementer Series, *Country Coordinating Mechanism Model – Governance and Civil Society Participation*, The Global Fund

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- ix *Making Global Fund Country Coordinating Mechanisms work through full engagement of civil society*, ITPC CCM Advocacy Report, October 2008
- x The civil society sector is broader than the KAP/PLWD constituencies as it also includes NGOs, academic institutions and other national nongovernmental entities.
- xi For the full set of requirements and minimum standards for Country Coordinating Mechanisms see *Guidelines and Requirements for Country Coordinating Mechanisms*, The Global Fund, Latest version November 6th 2013.
- xii *Key Populations Action Plan 2014-2017*, The Global Fund, P9,
- xiii *ibid.* P12
- xiv *Making Global Fund Country Coordinating Mechanisms work through full engagement of civil society*, ITPC Country Coordinating Mechanism Advocacy Report, October 2008, P6.
- xv <http://www.worldbank.org/en/country/philippines>
- xvi <http://www.unaids.org/en/regionscountries/countries/philippines>
- xvii <http://www.who.int/countries/phl/en/>
- xviii http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2015-hiv-and-the-law-in-south-east-asia.pdf
- xix <http://www.adb.org/publications/civil-society-briefs-philippines>
- xx https://www.theglobalfund.org/documents/fdocuments/fccm/fccm_2008ThematicCivilSocietyParticipation_Report_en%2F&usg=AFQjCNEMgKoWMUgHI_J-twEf626pt_GWTw
- xxi Mapping study of Civil Society Organizations in Moldova: Civil Society. Dialogue for Progress conducts comprehensive research, L. Chiriac, E. Tugui, 2014
- xxii <http://www.worldbank.org/en/country/vietnam>
- xxiii http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/hiv_aids/rbap-hhd-2015-hiv-and-the-law-in-south-east-asia.pdf
- xxiv <http://www.who.int/countries/vnm/en/>
- xxv <http://www.adb.org/publications/civil-society-briefs-viet-nam>
- xxvi Cumbersome registration requirements present more of a challenge for smaller, informally organized groups.
- xxvii <http://www.worldbank.org/en/country/morocco>
- xxviii <http://www.unaids.org/en/regionscountries/countries/morocco>
- xxix http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2015.pdf,
http://www.unaids.org/sites/default/files/media_asset/JC2257_UNAIDS-MENA-report-2011_en_1.pdf
- xxx <http://www.who.int/countries/mar/en/>, http://www.aidsplan.org/sites/default/files/publications/MENA-report-en_o.pdf
- xxxi <http://www.icnl.org/research/monitor/morocco.html>