



## **Advocacy Action Plan:**

### **Integration of Sexual and Reproductive Health**

### **Within the HIV and Malaria Components of**

### **Country Coordinated Proposals:**

### **Global Fund Round 7**

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## **Abbreviations**

ANC	Antenatal clinic
ART	Antiretroviral therapy
CBD	Community Based Distributor
CCM	Country Coordinating Mechanism
DOTS	Directly Observed Treatment Short Course
FBO	Faith-based Organization
Global Fund	Global Fund for AIDS, TB and Malaria
GIST	Global Joint Problem Solving Implementation Team
GTT	Global Task Team
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IFRC	International Federation of Red Cross and Red Crescent Societies
ITN	Insecticide-treated bed net
IMCI	Integrated Management of Childhood Illness
IPPF	International Planned Parenthood Federation
IPT	Intermittent preventive therapy
LLIN	Long-lasting insecticide treated bed net
LFA	Local Fund Agent
MDG	Millennium Development Goals
MoH	Ministry of Health
MNCH	Maternal Neonatal and Child Health
NGO	non governmental organization
PEPFAR	President Bush Emergency Plan For HIV/AIDS Relief
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Paper
PR	Principal Recipient
PSI	Population Services International
RBM	Roll Back Malaria
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SWAP	Sector Wide Approach
TB	Tuberculosis
TERG	Technical Evaluation Reference Group
TRP	Technical Review Panel
UNAIDS	Joint United Nations Programme on HIV and AIDS
VCT	Voluntary Counselling and Testing
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drug and Crime
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization

## **Executive Summary**

The Global AIDS Alliance (GAA), the International HIV/AIDS Alliance (the Alliance), the International Planned Parenthood Federation (IPPF), Interact Worldwide, and Population Action International (PAI) have formed a partnership aimed at increasing the level of funding for the integration of sexual and reproductive health (SRH) within the HIV and malaria components of Round 7 proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

As a first step in this process the partners held an *Advocacy Summit on Global Fund Round 7: Integrating of Sexual and Reproductive Health within the HIV and malaria Components of Country Coordinated Proposals*, in Geneva, Switzerland 4-6 December, 2006. The aim of the Advocacy Summit was to increase the number of (successful) sexual and reproductive health (SRH)-related proposals within the HIV and malaria components of the Global Fund. The objective was to develop an Advocacy Action Plan for the integration of SRH into the HIV and malaria components of Country Coordinated Proposals for the 7<sup>th</sup> Round of Global Fund funding and beyond.

This Advocacy Action Plan is a result of the Advocacy Summit and is intended to bring opportunities identified at the Summit to the attention of key decision-makers and stakeholders at the national and global levels. SRH organizations with capacity to engage in-country Global Fund structures and to conduct related advocacy are the key actors in this agenda. Advocacy efforts will build on what is already occurring in countries.

For information beyond that which is contained in this document, the Action Plan should be read in tandem with:

- HLSP (2006). Integration between Sexual and Reproductive Health and HIV and AIDS and Malaria: Opportunities and Strategic Options for the Global Fund for AIDS, TB and Malaria.
- HLSP (2006). Report of Advocacy Summit on Global Fund Round 7: Integration of Sexual and Reproductive Health into the HIV/AIDS and Malaria Component Proposals.

These documents are available at [www.interactworldwide.org](http://www.interactworldwide.org) and [www.globalaidsalliance.org](http://www.globalaidsalliance.org).

The Advocacy Action Plan promotes two strategies:

1. Stimulating political commitment and demand to integrate SRH into HIV and malaria Country Coordinated Proposals.
2. Catalyzing Global Fund policy, institutional and operational reforms to support and facilitate the integration of SRH into the HIV and malaria components of Country Coordinated Proposals.

Strategy 1 has three components:

1. Representatives from six countries (Cambodia, Ethiopia, Madagascar, Malawi, Mongolia and Pakistan) were present at the Advocacy Summit and will continue to be supported by the partners to produce Round 7 proposals for SRH integration into HIV and/or malaria components.
2. In-country advocacy to promote and watch the development of the Country Coordinated Proposal on SRH, HIV and malaria integration.
3. Reaching out and providing assistance to other countries that were not present at the Advocacy Summit.

Strategy 2 has two components:

1. Global Level Advocacy.
2. Global Fund Institutional Level Advocacy.

### **Action Plans and Commitments:**

During the course of the Advocacy Summit, draft action plans were developed and all participants committed to following up on these. These action plans cover Rounds 7 and 8 (as funding rounds will now be annual and predictable), but with a predominant focus on the period ending 4 July, 2007 (the deadline for submission of Global Fund Round 7 proposals). The draft action plans cover:

1. Action Plans for the six countries present at the Summit;
2. Advocacy and other efforts to be pursued in other countries;
3. Advocacy with key Global Fund stakeholders;
4. Advocacy with the United Nations system (and potentially other international donor agencies); and
5. Developing materials, tools and guidelines.

The specific actions can be found in HLSP (2006), *Report of Advocacy Summit on Global Fund Round 7: Integration of Sexual and Reproductive Health into the HIV/AIDS and Malaria Component Proposals*.

The advocacy actions suggested and committed to by the six countries present at the Summit, which are described in greater detail in this document, serve as examples of how countries not present at the Summit could undertake this integration agenda according to their own context and capacity. Similarly, commitments made by regional- and global-level advocates are intended to provide guidance to allies around the world. For example, PAI and other SRH organizations committed to raising awareness within the SRH community and at international meetings, as relevant. The Alliance committed to engaging with the Communications Focal Point for the Communities Living with the Three Diseases delegation, and to liaising with the Global Fund Board members from the developing and developed countries delegations. For a complete list of commitments made by all organizations present at the Summit, please see HLSP (2006), *Report of Advocacy Summit on Global Fund Round 7: of Sexual and Reproductive Health into the HIV/AIDS and Malaria Component Proposals*.

For its part, the Global Fund committed to remaining involved in the dialogue commenced at the Advocacy Summit. The Global Fund expressed its appreciation of the Summit, including having the opportunity to listen to participants and provide feedback to other staff of the Secretariat. The Global Fund stated that it will be pleased to continue making available any amplification and clarifications on structure and processes that may be requested.

**Developing materials, tools and guidelines:**

In order to highlight the integration of SRH with HIV and malaria, as well as ways this can be achieved in practice, various materials are to be developed.

A Discussion Paper, *Integration between sexual and reproductive health and HIV and AIDS and malaria: Opportunities and strategic options for the Global Fund for AIDS, TB and Malaria*, was prepared by HLSP (2006) for the Advocacy Summit. The document outlines the current evidence on the two-way integration of sexual and reproductive health with HIV and malaria programming, and discusses current opportunities for Global Fund funding. It is available at [www.interactworldwide.org](http://www.interactworldwide.org) and [www.globalaidsalliance.org](http://www.globalaidsalliance.org).

As per its mandate, the Global Fund needs to concentrate its financial support on evidence-based approaches. Therefore, the consolidation of evidence on integration as it relates Global Fund programmes to support national AIDS and malaria control programmes should be accorded a high priority as an essential support and counterpart to country-level efforts. Given the role of the Technical Review Panel (TRP) and WHO (in its role as ‘the standard setting agency’ on health, and in its specific role in briefing the TRP and being ‘on-call’ during TRP deliberations), it is highly desirable that an updated summary is prepared of evidence supporting integration. This summary would focus partly on the effectiveness of integration, especially in terms of contributions this will make to fulfil the Global Fund’s mandate. Such a summary would be for the TRP, and could also potentially be used for dialogue with CCMs (where up-to-date international evidence may not always be so readily available). Such a summary would also be useful in other country-level dialogue.

Contributions to the preparation of the updated evidence summary include:

- Findings from the multiple, diverse initiatives in which UNFPA is currently involved (with WHO, World Bank, IPPF and several others);
- Documentation from several scientific and policy meetings and documents over the past few years. This toolkit is forthcoming;
- The Guttmacher Institute<sup>i</sup>, Family Health International (FHI)<sup>ii</sup>; Johns Hopkins<sup>iii</sup> and Resources for HIV/AIDS and Sexual and Reproductive Health Integration<sup>iv</sup> websites.

In addition, a number of research studies, evaluations and case studies are also underway:

- The Alliance is engaged with a research programme supported by the UK Department for International Development (DFID); a proposal is currently being developed for research on SRH and HIV integration. Comments on this proposal would be welcome, through the listserv discussed below;
- A collection of case studies of successful proposals with integration components. These case studies would not only analyze the successful text of the proposal, but also explore in-country CCM dynamics that supported the process;
- The GAA, with support from PAI, is developing an advocacy brief on procurement bottlenecks.

A number of guidelines for ongoing advocacy will be available:

- SRH, HIV and Malaria Round 7 Guidelines;
- Guidelines for civil society on engaging with CCMs, either through direct involvement or in a watchdog role;
- SRH integration—technical tools, support and collection of case studies on integration, including advocacy messages and talking points.

A listserv has been established: [GFR7-SRH\\_HIV\\_AIDS@yahoogroups.com](mailto:GFR7-SRH_HIV_AIDS@yahoogroups.com).<sup>v</sup> All relevant documents will be available at [www.interactworldwide.org](http://www.interactworldwide.org) and [www.globalaidsalliance.org](http://www.globalaidsalliance.org) as they are finalized.

### **Conclusion:**

SRH linkages are consistent with best practices of the agencies that provide technical support to the Global Fund structures responsible for setting priorities, issuing calls for proposals, and reviewing proposals submitted and funded. In order to ensure that SRH-HIV/AIDS and SRH-malaria linkages are translated to programs on the ground, Global Fund stakeholders at all levels must actively advocate to Global Fund, UN agencies and involved governments and civil society to prioritize proposals with strong linkages. This Advocacy Action Plan describes the many opportunities discussed at the Advocacy Summit in December 2006, and presents a range of possible actions for stakeholders to take so as to collectively advance this lifesaving agenda at all levels.

## **Strategies**

### **Strategy 1: Stimulate political commitment and demand to integrate SRH within HIV and malaria Country Coordinated Proposal.**

Strategy 1 has three components:

1. Supporting six countries to produce Round 7 proposals for SRH integration into HIV and/or malaria components.
2. Conducting in-country advocacy to promote and monitor the development of the Country Coordinated Proposal on SRH-HIV/AIDS and SRH-malaria integration.
3. Reaching out and providing assistance to other countries that were not present at the Advocacy Summit.

#### **Component 1: Supporting six countries to produce Round 7 proposals for SRH integration into HIV and/or malaria components.**

Six countries (Cambodia, Ethiopia, Madagascar, Malawi, Mongolia and Pakistan) were identified by the Summit partners, through their programme links, to attend the Advocacy Summit. These countries will continue to be assisted in producing Round 7 proposals that champion two-way integration of SRH within the HIV/AIDS and/or malaria components, which will add to the knowledge base on SRH-HIV/AIDS and SRH-malaria integration and on the operation of the Global Fund model. The Action Plans for the six countries can be found in the Annexes of the HLSP (2006), *Report of Advocacy Summit on Global Fund Round 7: Integration of Sexual and Reproductive Health into the HIV/AIDS and Malaria Component Proposals*. The action plans agreed to by these six countries' representatives can be adapted for use by other countries; similarly, the range of activities suggested below could be incorporated, where they have not already been, into existing action plans for these six countries.

#### **Component 2: Conducting in-country advocacy to promote and monitor the development of the Country Coordinated Proposal on SRH-HIV/AIDS and SRH-malaria integration.**

It has to be emphasized that scaling up or developing integrated approaches through Global Fund mechanisms is dependent on developing *country-led demand* for integration. Targeted advocacy and support to achieve country-led demand, which should be focused on national and international actors, will include:

##### **1. Identifying lead person/organization in each target country:**

In each country, one of the Summit partners and/or their in-country partners will act as the lead organization(s) for fostering collaboration, cooperation and coherence between SRH, HIV and malaria organizations in order to enhance opportunities to work with the in-country Global Fund mechanisms and to raise the profile of the integration approach among other stakeholders.

## **2. National Partners:**

National partners to be targeted include government actors, bilateral and multilateral agencies working in a given country, and the UN system at the country-level and at the international level as it relates to country-level activities.

### ***Government Ministries and Agencies***

Because government ministries are often members of their countries' CCMs and may also be Global Fund Principle Recipients (PR), ensuring that these ministries support linking SRH with HIV/AIDS and malaria can be fundamental to increasing the Global Fund's support of such proposals. Explicitly agreeing on the division of labour, roles and responsibilities between National AIDS Commissions (NACs) and Ministries of Health (MoH) can be conducive to strengthening integrated approaches between SRH and HIV policies, programming and service delivery. Coordinated by the NAC, HIV is increasingly being understood as a development issue. This has implications for mainstreaming in key sectors and provides opportunities to address wider structural issues such as gender inequalities through both male and female education; and through cross-sectoral responses by ministries and civil society to the needs of young people, women, children and vulnerable groups. Such integration also has implications for the health system as a whole, which, when strong, can serve entire populations with an integrated and effective approach.

Specific advocacy actions include:

- Advocating for a clear division of labour between Government ministries, backed by an effective monitoring and evaluation system;
- Advocating for the prioritization of SRH-HIV/AIDS and SRH-malaria integration approaches in the development of national health plans and the approval of corresponding budgets.

### ***Bilateral and Multilateral Agencies***

At the national level, policy constraints to developing more integrated approaches to SRH-HIV/AIDS and SRH-malaria services and programme delivery are reinforced by some donor policies, and compounded by earmarked (also known as ring-fenced) funding streams. The policies of several of the major HIV and SRH donors do not provide a favourable environment in which to implement international commitments to developing integrated approaches and strengthening health systems, with the significant exceptions of a number of bilateral donors and foundations.

In general, while support for the Three Ones principles is promoting a unified approach to national HIV response, this does not extend to integrated national-level SRH and HIV programmes, which are, in the main, developed separately and funded by different agencies. Separate financing of supplies and logistics is common for anti-retroviral drugs and other HIV-related commodities (such as condoms). There is little evidence as yet of how HIV and SRH programmes and other key health services providers will coordinate, collaborate and cooperate,

and more closely integrate and align their services and programmes with national health plans.

Despite the Global Fund's intent that funds be additional to existing budgets and not replace or reduce other sources of funds, in some countries, increased government and off-budget donor funding for HIV and other communicable diseases has taken place in parallel with reduced allocations of financial (and human) resources to SRH. There has therefore arguably been less additionality than expected (or desired) to the health sector as a whole, and in some settings public health systems have been weakened by these parallel structures.

Specific advocacy actions include:

- Advocating for improved coordination mechanisms between and within bilateral and multilateral agencies and Global Fund stakeholders working on HIV and malaria at the country level. Such coordinated mechanisms would provide opportunities for the Global Fund to receive regular feedback on what is happening on the ground, including information on the functioning of a CCM or any difficulties SRH organizations may be experiencing in becoming CCM members;
- Advocating with the Global Fund to provide proof that the requirement of additionality is in fact being adhered to. This could be assessed at the time of evaluating whether to approve Phase 2 funding.

### ***United Nations System***

The United Nations system has a key role to play in advocating for and providing leadership and technical support for linking SRH with HIV and malaria, but there is broad consensus that more progress is needed in operationalizing these linkages. There needs to be further clarification of the roles and responsibilities of UNAIDS, UNFPA, UNICEF, UNODC, WHO and the World Bank, among others, both in their relationship with the Global Fund as well as in their advocacy efforts and in improving service and programme integration.

The Global Fund has stated that “[f]or technical expertise - both to the Secretariat, to Country Coordinating Mechanisms (CCMs) and potential Principal Recipients - the Global Fund relies on international organizations like the World Health Organization (WHO), UNAIDS, UNDP and the World Bank.”<sup>vi</sup> Advocacy directed at these technical partners by local, national and international organizations needs to highlight and underline the UN system's role in promoting and supporting the integration agenda within its functions as technical support providers within Global Fund processes and to other national stakeholders.

The UN agencies' technical support capacities are governed by a division of labour, which defines a lead organization for a given technical support area, with the aim of clarifying for country-level actors the agency that should be approached for specific types of support. The organizations involved in the division of labour are UNAIDS, UNDP, UNICEF, UNFPA, UNESCO, UNODC,

UNHCR, WHO, WFP, ILO, and the World Bank. The lead organization then coordinates provision of the country-level support that has been requested.

The UN division of labour system has no lead agency on SRH linkages, and elements of SRH are scattered among the UN agencies. Under this system, UNFPA has the lead role on the provision of information and education, condom programming, prevention for young people outside schools and prevention efforts targeting vulnerable groups (except injecting drug users, prisoners and refugee populations),<sup>vii</sup> and is the main partner on many SRH-related issues. In collaboration with key partners, UNFPA is contributing to advocacy, policy and programmatic guidance, and technical support on SRH and HIV linkages.<sup>viii</sup>

The UNAIDS Secretariat is responsible for strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy, and monitoring and evaluations. The UNAIDS Intensifying HIV Prevention strategy urges links between HIV and SRH services and programmes. However, several Programme Coordinating Board (PCB) members are keen to see greater efforts to promote practical strategies at the country level as part of the UNAIDS coordinated process for dividing labour, mandated by the Global Task Team (GTT).

The UNAIDS Secretariat is also the lead organization on overall policy, monitoring and coordination on prevention, as well as on strengthening HIV/AIDS response in the context of security, uniformed services and humanitarian crises.

In regard to preventing sexual HIV transmission by injecting drug users, the relationship between UNODC (lead agency on this issue), the UNAIDS Secretariat and UNFPA (which is not one of the main partners under the division of labour), among others, needs to be clarified and increased programmatic work needs to be undertaken in this area.<sup>ix</sup>

WHO plays a pivotal role on SRH-HIV/AIDS and SRH-malaria integration, as well as a shared lead role with UNICEF on PMTCT, and is implicated in all areas of scaling up interventions.<sup>x</sup> WHO has made progress with 3 by 5, but a recent evaluation found that prevention did not feature sufficiently in the initiative. At the global level, relevant WHO departments include Reproductive Health, Maternal, Newborn and Child Health, HIV, the Global Malaria Programme and the Roll Back Malaria Partnership. Linkages with SRH and other health areas such as malaria and HIV are being further developed.

UNICEF is the other cosponsor, with a joint lead role, on PMTCT, and is undertaking the Unite for Children. Unite against AIDS Campaign, which aims to:

1. Prevent mother-to-child HIV transmission. By 2010, offer appropriate services to 80 percent of women in need;

2. Provide paediatric treatment. By 2010, provide either antiretroviral treatment or cotrimoxazole, or both, to 80 percent of children in need;
3. Prevent infection among adolescents and young people. By 2010, reduce the percentage of young people living with HIV by 25 percent globally;
4. Protect and support children affected by HIV/AIDS. By 2010, reach 80 percent of children most in need.

It is unclear how effectively the campaign approach is being implemented in countries.

The World Food Programme (WFP) is the lead agency for dietary and nutritional support and is already working with the Stop TB Partnership, WHO, the World Bank, concerned governments and other international and local NGOs to find the best ways to attract TB patients to treatment and to help them complete medical regimens.<sup>xi</sup> From all indications, WFP food aid will play an increasingly important role in addressing HIV/TB co-infection.<sup>xii</sup> How SRH (i.e., VCT, positive prevention and dual prevention and condom distribution) and malaria control can be integrated into these services still needs to be determined.

UNDP has the lead role on human rights and gender, which means that it is responsible for sexual and reproductive health and rights, though its relationship with UNFPA, among others.<sup>xiii</sup> UNHCR is the lead organization for addressing HIV among displaced populations (refugees and internally displaced people (IDPs)).<sup>xiv</sup> The World Bank is responsible for human resources, capacity and infrastructure development, impact alleviation and sectoral work.<sup>xv</sup>

There are a number of UNAIDS-led taskforces, reference and working groups, including on family planning and HIV integration, as well as initiatives to develop a PMTCT Global Strategy. Advocacy is required to ensure that sexual and reproductive health rights are placed on the agenda of, inter alia, the United Nations Task Force on Injecting Drug Use and HIV/AIDS for Asia and the Pacific, the UNAIDS Human Rights Reference Group, and those dealing with sex work.

Greater delineation of agency roles and responsibilities overall is beginning to occur as a result of the implementation of the GTT recommendations and through the Global Joint Problem Solving Implementation Team (GIST) processes. The GIST functions as a forum for UN technical agencies and major funding entities, such as the Global Fund and World Bank, to mobilize and harmonize a rapid response for the effective use of resources to "make the money work" in countries. In June 2006, the UNAIDS PCB recommended "the further involvement of other development partners, such as bilateral and NGOs, where necessary."

Following a directive from the United Nations Secretary General on 12 December 2005, countries are establishing UN Theme Groups on HIV/AIDS supported by the joint United Nations teams on AIDS. The joint United Nations teams on AIDS

works under the authority of the United Nations Resident Coordinator System and the overall guidance of the United Nations Country Team, and is facilitated by the UNAIDS Country Coordinator. Based on UN directive, the UN Theme Group on AIDS should continue to function, focusing on ensuring policy coherence and strengthened advocacy for national efforts.

These joint UN teams on AIDS, once established, are further supported by the regional offices of the UNAIDS Cosponsors and the UNAIDS Regional Support Teams. At the global level, the Cosponsors and the Secretariat play a supportive role in setting global standards and systems to facilitate action at the country level, as well in mobilizing the international community for building a global constituency to support scaling up of HIV prevention programmes.

However, at the country level, the UCC, Resident Coordinator, the UN Theme Group Chair and individual agencies are entry-points for advocacy aiming at increasing integration and linkages between SRH and HIV and/or Malaria, in the context of reaching universal access. Additionally, countries are currently in the process of setting national targets for achieving universal access to HIV prevention, care, treatment and support.

Further, many countries have already committed to scaling up HIV interventions to achieve universal access by 2010. Part of this process involves setting “ambitious” targets. Target-setting should be a process that is contributed to and owned by various stakeholders within countries, especially civil society. The involvement with, and ownership of, this process by civil society is crucial in terms of agreeing on the programmes to be scaled up, including populations to be prioritized and implementation, and monitoring and evaluating progress.

The Global Fund could strengthen SRH-HIV and SRH-malaria integration by being more actively involved and supportive of agencies’ efforts to scale up their operations, which provide additional or supporting inputs into the programmes financed by the Global Fund. An example is the Global Fund’s call for donors to provide more resources for scaling up WHO’s technical assistance operations.

Specific advocacy actions for country-level and international actors include:

- Advocating for greater delineation of UN agency roles and responsibilities, such that SRH activities are more clearly identified;
- Advocating with UN agencies to include Global Fund-related activities in their work plans;
- Advocating with UN agencies for concrete agreement on how to address the “unfunded mandate” that the Global Fund processes place on agencies in country;
- Advocating for a stronger working relationship between UN agencies on specific issues, such as the provision of specialized technical assistance by the regional Technical Support Facilities (TSF);

- Supporting the development of a pool of technical support providers as well as facilitating South-to-South collaboration and operational/implementation skills sharing;
- Advocating for training proposal writers, i.e., the TSF and other technical assistance providers, on SRH, SRH-HIV/AIDS and SRH-malaria integration;
- Advocating with UNAIDS to develop a cadre of SRH experts to assist countries in proposal development.

### ***Civil Society***

It is widely recognized that the SRH, HIV/AIDS and malaria communities need to increase their collaboration on the development of integrated policies and service delivery to ensure that opportunities are maximized and the potential benefits of SRH, HIV and malaria integration are not missed. Civil society organisations, including faith-based organizations, could play a leading role in scaling up SRH-HIV and SRH-malaria integration by encouraging the greater involvement of SRH organizations in the CCM, and at national and regional, provincial and/or district levels. Furthermore, SRH organizations can play a “watchdog” role over Global Fund processes and grants in country if they remain outside the CCM. However, civil society organizations should be aware of any conflict of interest and avoid concurrently being implementers of Global Fund grants and carrying out watchdog functions. Most important is for SRH organizations to consider their own capacity and to determine how they can each best work with the integration agenda.

Community-based programmes represent a significant and neglected resource for service delivery. However, it appears that there are very few links made between health programmes such as home-based care, community-based DOTS, malaria and SRH services.<sup>xvi</sup> Community-based health care workers, midwives and birthing attendants, people living with HIV, and others such as members of vulnerable groups, women and young people should and must be involved in developing and providing SRH, HIV and malaria integrated services, particularly because of the absolute shortage of health care workers in many global South countries, and because these people have already proven themselves capable of providing services if adequate training and technical support is provided.

SRH NGOs often play a major role at the national level in providing and advocating for SRH policy and services. Many already have a good track record of working with government. However, while many have been slow to take HIV or malaria into account, they have also rarely had any influence on the policies and decision-making processes of their CCMs, and, generally, are not in receipt of Global Fund AIDS or malaria funding. Furthermore, while NGOs and CBOs play an increasingly important role in HIV responses, including in reaching vulnerable groups such as MSM, injecting drug users and sex workers; these organizations often have sexual health expertise but not reproductive health expertise.

Specific advocacy actions include (although there are many other actions indicated in this plan which SRH organizations can and should undertake):

- SRH organizations should advocate for increased funds for the three diseases targeted by the Global Fund, rather than perceiving the Global Fund as a source of funding for stand-alone SRH programming. This includes advocating for funding for the Fund itself and for monetary support for other relevant agencies and organizations;
- Civil society along with all partners, United Nations agencies and bilateral and multilateral agencies should consistently advocate for and promote community-led responses to SRH-HIV and SRH-malaria integration, including payment of health care workers;
- Advocacy for the inclusion of SRH organizations in Global Fund processes at the country level, particularly the CCMs;
- Advocacy for increased cooperation and partnership between SRH, HIV and malaria organizations in country so as to improve the technical capacity and efficiency of all concerned.

### ***Private Sector***

The private sector is an important provider of AIDS treatment and care and SRH services, especially to vulnerable groups. However, the quality of care and treatment for health problems such as STIs is usually poor and clients rarely receive counselling or advice about safer sex, pregnancy, positive prevention, dual protection and/or harm reduction measures for injecting drug users. Major opportunities for enabling and scaling up integration at national and local levels lie with the not-for-profit and private sector, and the demand side, through voucher and social marketing/franchising programmes.

Specific advocacy actions include:

- Advocating to private sector service providers to improve services and develop partnerships with SRH, HIV and malaria organizations;
- Advocating for social franchising and voucher schemes to improve service quality and affordability;
- Advocating with the private sector service providers to become involved in Global Fund structures, particularly CCMs, at the national and regional, provincial and/or district levels.

### **3. Global Fund Country Processes:**

The Global Fund is a financial agent, not an implementing agency, providing additional resources to support programmes that reflect national plans and which will have a measurable impact on the three diseases. There is a number of Global Fund structures that operate on or relate to the country level, which are appropriate targets for advocacy on SRH linkages with HIV/AIDS and malaria. These include Country Coordinating Mechanisms, the proposal development and technical assistance processes, principal recipients and sub-recipients, and reprogramming efforts.

### ***Country Coordinating Mechanism (CCM)***

CCMs were intended to comprise representatives from a wide range of sectors, which come together to assess country needs in relation to HIV, TB and malaria. Since their inception, CCMs have experienced a variety of problems. They are still largely perceived as public sector bodies with limited representation from the private sector and civil society, and even less representation from organizations whose mandate is broader than HIV, TB or malaria. Not even the three diseases are adequately reflected in all CCMs.

CCMs 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.<sup>xvii</sup> The membership of the CCM comprises a minimum of 40 percent representation of the non-governmental sectors, such as NGOs/community based organizations, people living with the diseases, religious-/faith-based organizations, private sector, and academic institutions.

For a detailed discussion of issues relating to CCMs, please see:

- HLSP (2006). *Integration between Sexual and Reproductive Health and HIV and AIDS and Malaria: opportunities and strategic options for the Global Fund for AIDS, TB and Malaria*. Available at [www.interactworldwide.org](http://www.interactworldwide.org) and [www.globalaidsalliance.org](http://www.globalaidsalliance.org).
- POLICY, GNP+ and GTZ (2004). *Challenging, Changing and Mobilizing: A Guide to people living with HIV (PLHIV) Involvement in Country Coordinating Mechanisms*. Available at [www.policyproject.com/pubs/policyplan/CCM\\_Handbook.pdf](http://www.policyproject.com/pubs/policyplan/CCM_Handbook.pdf).
- The Global Fund to Fight AIDS, Tuberculosis and Malaria (2004). *Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility*. At [www.theglobalfund.org/pdf/5\\_pp\\_guidelines\\_ccm\\_4\\_en.pdf](http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf).

Specific advocacy actions include:

- Advocating with the Global Fund to broaden CCM representation to include individuals with SRH-related expertise;
- Advocating with CCMs to allocate a part of a Global Fund Grant for capacity building of the CCM to include issues such as (i) decision-making processes, including the allocation of roles and responsibilities among CCM members; (ii) SRH competency training and SRH-HIV/AIDS and SRH-malaria integration, and (iii) advocacy and the role of civil society;
- Advocating with CCMs for the inclusion of SRH organizations on CCMs;
- Advocating with CCMs to include SRH regional networks and SRH-related issues on the agenda of regional CCM meetings so as to bring these issues to a wider audience for discussion and sharing of experiences;
- Advocating for the integration or coordination of CCMs with other national structures, such as National AIDS, TB and malaria control programmes;

- Advocating with the Global Fund to develop guidance on the role and function of civil society organizations in monitoring Global Fund projects at the country level, particularly where these are SRH-related, as well as more general guidance on monitoring conflicts of interest and resource distribution decisions;
- Advocating with the Global Fund to develop a rating system for CCMs based on a range of key characteristics. Ratings could be compiled based on a combination of objective data (e.g., greater stipulation of the composition of the CCM) and subjective opinions on the quality of the process;<sup>xviii</sup>
- Advocating for CCMs to develop a system for information dissemination, particularly for feedback and correspondence from the Global Fund. Many CCM members never see the TRP feedback, for example, on an unsuccessful proposal.

The NGOs Representative of the Communities Living with the Diseases, Developed Country NGO, Developing Country NGO, Point Seven (Denmark-Ireland, Luxemburg, Netherlands, Norway, Sweden) and the United Kingdom (Australia) delegations are well placed to advocate for these approaches.

Finally, in order to improve information flows, the Global Fund is establishing a web-based information exchange “myglobalfund.org,” which is expected to launch in mid-2007. This website could be used by in-country advocates to share best practices, ask questions, and seek regional and international support in securing increased attention to SRH linkages by in-country Global Fund structures.

### ***Proposal Development Process***

There is currently no explicit emphasis on SRH-HIV/AIDS or SRH-malaria integration in any of the proposal development documents. Round 6 proposal guidelines, however, appeared to allow the Global Fund to receive proposals that could include integrated components:

Proposals should clearly state how suggested activities are linked to other activities at national level that are already funded by a previous Global Fund grant or by other sources. In particular, it should make clear whether the new activities are complementary, are meant to scale up existing activities (i.e., by increasing coverage or by including additional services into existing interventions); or are necessary to improve the impact of existing services.<sup>xix</sup>

SRH integration could be positioned as a health system strengthening activity under the HIV and malaria components. This is timely, given that outcomes of the Global Fund’s Second Partnership Forum recommended to the Board that it seek a strong, clearly-articulated mandate to invest in a broad range of health system strengthening interventions. Integrated approaches could be constructed around specific areas of the health system, particularly human resources (i.e.,

management and service provision), quality of care, supplies and procurement, engagement with community and non-state providers, and operations research.

As proposals should be evidenced-based it is important to consider what UNFPA, IPPF and DFID,<sup>xx</sup> among others, have been publishing on the evidence base for two-way integration of various aspects of SRH, HIV and malaria policy, programming and service provision. Proposals should refer to the most up-to-date research available and identify what makes sense given the country context and epidemiology. Countries also need to deconstruct integration in various service areas to see the possible linkages. For example, family planning programmes can be expanded to cover not only family planning services but also the sexual health of clients. Finally, the current proposal format allows for proof of concept research relating to integration.

Specific advocacy actions include:

- Advocating with CCMs to incorporate evidence-based integration approaches into specific areas of the health system to meet the Fund's requirement that proposals attend to health systems strengthening while focusing on one or more of the three disease components. This could include human resources for health, commodities procurement and supply chain concerns, and others, as indicated above;
- Advocating with the CCM to begin negotiating and preparing its proposals well ahead of the call for proposals. This has become even more relevant as the Global Fund proposal process will, as of 2007, be held annually with pre-defined dates, beginning with a call for Round 7 proposals on or near 1 March 2007;
- Advocating with the CCM to make requests to the United Nations system, bilateral donors and/or international non-governmental organizations for early submission of technical assistance for proposal writing, as there is a limited pool of people available to provide this support;
- Advocating with the CCMs to include proof of concept research relating to integration in Country Coordinated Proposals (CCPs).

### ***Technical Assistance***

Evidence from previous rounds has shown that one of the primary reasons for failure is that the proposal does not fulfil the stated requirements. Targeted technical assistance and support should include:

- providing materials (i.e., country technical guidance on integration); and
- training of partners on technical aspects of integration and proposal development.

The development of practical guidance on SRH integration should cover the following.

- **Step 1:** Country analysis. Where and what services are currently being funded, coverage and groups.
- **Step 2:** Mapping of existing services. What are options for integration? Multiple services provided by a one-stop service provider or services offered through a referral system or by adapting existing health services, such as family planning programmes, programmes for the prevention of mother-to-child transmission of HIV or drug rehabilitation programmes. All or some of these can be used, depending upon the country context.
  - If this is not an option (which depends on the country), look at programmes (i.e., facility-based and home-based services). Look at what services are provided by the State, and the private and not-for-profit sectors. What is the coverage of each and what are the opportunities for integration?
- **Step 3:** Capacity mapping: Human resources and commodities. What are the gaps and opportunities for agreement for cooperation between State, private and not-for-profit service providers?
- **Step 4:** Generic cost analysis charts for each service and costs and benefits of integration by lower- and middle-income countries.

Specific advocacy actions include:

- Advocating with UN agencies, particularly UNAIDS and UNFPA, to develop practical guidance on SRH-HIV/AIDS and SRH-malaria integration;
- Advocating with the UNAIDS Technical Support Facility to provide consultants for writing the SRH integration parts of the HIV and malaria components of Country Coordinated Proposals;<sup>xxi</sup>
- Advocating for the training of TFS consultants on SRH-HIV/AIDS and SRH-malaria integration.

### ***Principal Recipients (PRs) and Sub-recipients***

Governments constitute about 60 percent of the PRs, with civil society and multilateral organizations, principally UNDP, each constituting 20 percent of the PRs worldwide. Early evidence suggests that non-governmental PRs implement programmes more quickly and achieve higher programme ratings than do governments and international agencies. With a NGO-based PR, there would be greater scope to build the capacity of civil society groups and NGOs, to create pilot programmes and, more importantly, to scale up successful programmes to integrate SRH, HIV and malaria services and programmes for the general population, and in particular for women, young people and children, people living with HIV and other vulnerable groups.

In the report of the Technical Review Panel and the Secretariat on Round 6 Proposals, it was stated that:

As many proposals are vague on the details of the proposed selection of sub-recipients, and the distribution of funds to these sub-recipients, the Guidelines and Proposal Form should make it clear that as much detailed information on these aspects as possible should be provided.<sup>xxii</sup>

Specific advocacy actions include:

- Advocating with the Global Fund to introduce a requirement that there be at least one non-governmental PR in each country. Establishing this principle could create an entry point to strengthen SRH, HIV and malaria integration by ensuring some funding would go directly to non-governmental groups;
- Advocating with government and multilateral PRs as well as with sub-recipients to ensure that funding flows to civil society actors;
- Advocating with the Global Fund to ensure that the Proposal Guidelines and Form require detailed information on the selection of sub-recipients, and the distribution of funds to these sub-recipients.

### ***Reprogramming Funds from Previous Funding Rounds***

The Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility provide that:

Before the end of the two years of initially approved funding, the CCM will assess implementation progress and submit a request for continued funding to the Global Fund. The request for continued funding should include consolidated information for the first 18 months of the program and the objectives, targets, and requested funding for up to three additional years of financing from the Global Fund. The CCM should also provide complementary information to support the request, including a country profile on key health indicators related to the three diseases, as relevant; a description of the functioning of the CCM, including partnerships brought about among different constituencies; linkages established between the program and other national initiatives/programs; and the level of and distribution of other financial resources at the country level to the three diseases and broader related purposes.<sup>xxiii</sup>

Specific advocacy actions include:

- Advocating to the CCM to assess whether existing funding should be reprogrammed to include SRH integration in existing grants.

### **4. Policy constraints on integration:**

It is important to recognize that significant management, policy and political constraints exist at the national level, which challenge integration efforts.

### ***Sector-wide Approaches***

International agency support to health sector-wide processes represents a major opportunity, particularly in sub-Saharan Africa, for developing comprehensive health sector responses to HIV as part of universal access commitments. Sector

strategies provide opportunities for stronger strategic and operational integration between various Ministry of Health programmes and coordinated efforts to strengthen policies, human resources, procurement, infrastructure and services. Further, international agencies can support cross-programming working groups, joint task forces, funding technical co-operation and Ministry of Health posts for mainstreaming HIV into relevant health services.

The Global Fund should support horizontal approaches through Sector-wide Approaches (SWAs) to demonstrate that it is funding national-led disease control programmes rather than “Global Fund programmes,” and that its funds are improving the effectiveness of country systems and the national response to the three diseases. In countries where sector-wide processes are working well, the Global Fund should accelerate the integration of its funds into existing processes and use country procedure as much as possible. However, integrating services requires integrating funding, something which some donors do not like.

Specific advocacy actions include:

- Advocating with the Global Fund Board and Secretariat to support SWAs in those countries where they are working well, as well as advocating to CCMs and regional networks of CCMs to express their support of SWAs to all levels of the Fund’s structures.

### ***Poverty Reduction Strategies***

Policy frameworks inadequately address SRH-HIV and SRH-malaria integration. Few national development instruments, such as poverty reduction strategies, provide analysis of links between poverty, development, population, HIV/AIDS, or malaria, or address linkages between SRH and HIV and/or malaria in the health section (with the exceptions of Cambodia, Madagascar and Ethiopia).<sup>xxiv</sup> Despite strong evidence illustrating the impact on poverty of adverse health outcomes linked to communicable diseases, there is less evidence to demonstrate the impact on poverty and the burden of disease of poor reproductive health outcomes, including unintended pregnancy and early childbearing, which disproportionately affect poorer women and adolescent girls.

Furthermore, challenges that affect poverty reduction strategies more generally, such as strategy development, implementation, and monitoring and evaluation, also affect a country’s capacity to take SRH-HIV and SRH-malaria integration forward. Greater and more effective mainstreaming of SRH, HIV and malaria into poverty reduction strategies is necessary if the Global Fund stakeholders want to demonstrate how integrated proposals support national planning frameworks.

Specific advocacy actions include:

- Advocating with Governments and the Global Fund in-country mechanisms for the mainstreaming of SRH, HIV and malaria into Poverty Reduction Strategy Papers (PRSPs);

- Advocating for investment in research that demonstrates the benefits, including cost, of integrated approaches to the three diseases;
- Advocating with in-country PRS Coalitions, such as in Zambia, to encourage participation, as broadly as possible, of civil society in the PRS process, including SRH organizations and young people.

### ***Programme Management***

Policy implementation is challenged by separate SRH and HIV programming and management. National-level SRH and HIV programmes tend to be independently designed, administered, funded, and supported by different technical agencies, and are often managed through decentralised integrated administrative systems at the regional provincial and/or district levels. Several departments or administrative entities need to be involved in planning and organising integrated services, and collaboration between these different actors is often inadequate.

Specific advocacy actions include:

- Advocacy with Ministries of Health and other relevant Ministries for the coordinated and harmonized management of SRH, HIV and malaria programmes.

### ***Procurement and Commodities Supply***

Separate programmes may be procuring commodities; developing policies, drug lists, training manuals and technical guidelines that cover family planning, maternal, newborn and child health (MNCH) and STI/HIV with little interdepartmental consultation. Coordination of supplies is of particular concern. Parallel supply systems often exist for antiretroviral therapy and other commodities funded by the Global Fund and PEPFAR; while SRH commodities, and drugs for opportunistic infections, STIs, including preventing congenital syphilis, and antiretroviral therapy, including for PMTCT, are subject to frequent stock-outs. There are moves to improve reproductive health commodity security in many countries but condoms continue to be supplied separately by national HIV control programmes, and integrated approaches between SRH and HIV condom policy and programming tend to be weak, with limited participation of HIV programmers in national SRH commodity security working groups (and vice versa).

Although requests for commodities must make sense within the context of the proposal, there are no restrictions on what commodities can be included as long as they fall within the mandate of the Global Fund (i.e., have a direct impact on HIV, TB and/or malaria outcomes). For example, if comprehensive family planning has a positive HIV outcome, and the proposal is technically sound, then the TRP would assess it on that basis. However, the provision of condoms in a TB component proposal with no clear linkages to the prevention of pregnancy or sexually transmitted infections, including HIV, and without evidence-based positive TB outcomes is unlikely to be funded.

Specific advocacy actions include:

- Advocating with Governments for an integrated and coordinated approach to the procurement and supply of SRH-, HIV- and malaria-related commodities;
- Advocating with the CCMs to include contraceptives, condoms, and other appropriate SRH and HIV commodities in their integrated proposals;
- Encouraging the participation of PRs in SRH commodity security working groups at the country level;
- Advocating with governments so that procurement processes for condoms are linked to SRH programmes in-country, so that SRH programmes do not face stock-outs;
- Advocate for the Local Funding Agent (LFA) to have in-house expertise on procurement, or the ability to contract for such expertise.

### ***Health Care Workers***

The insufficient numbers of health workers is a major constraint on the rapid scaling up of prevention, treatment, care and support services for the three diseases, as well as to providing adequate and integrated SRH services. Funding of HIV, TB and malaria programming represents an opportunity for recruiting staff into the public sector.

Health care workers also need to be trained in universal health precautions and provided with the means to prevent occupational exposure so as to create a safe working environment, and in social issues that effect individual health, such as gender-based violence, an important risk factor of HIV and a potential barrier to accessing SRH and HIV services. Such awareness on the part of health workers will in turn reduce stigma against clients, particularly people living with HIV and vulnerable groups. International and domestic advocacy to secure sufficient salaries and training for health care workers is another important element in retaining those who have already been trained.

Specific advocacy actions include:

- Advocating at the national and international levels for an increase in the number of doctors and nurses, as well as community health care workers, and on securing a safe work environment (i.e., commodities for universal health precautions) with adequate financial compensation;
- Advocating at the national and international levels for additional finances for the health care sector;
- Advocating for national health strategies to mandate training for health care workers on issues such as universal precautions, gender-based violence awareness and response, and stigma reduction;
- Advocating at a national level for increased sectoral spending on health; in Africa, civil society can use as a basis for its advocacy the Abuja Pledge of 15 percent of national annual budgets promised in 2001 by African governments to their health systems.

### **Component 3: Reaching out and providing assistance to other countries that were not present at the Advocacy Summit.**

There is a need to build the knowledge base, political and community support and technical capacity at the country level to reach out and provide technical assistance to countries on SRH-HIV/AIDS and SRH-malaria integration.

National partnership forums or working groups should be initiated to plan, strategize (including costing) and set up a division of labour for developing Round 7 and subsequent proposals. These must bring together HIV, SRH, malaria organizations and networks; Government, including the ministry responsible for SRH and the national AIDS and malaria control programmes; Global Fund in-country mechanisms; bilateral and multilateral agencies; FBOs; the National Red Cross or Red Crescent Society; people living with HIV, women, young people and vulnerable group organizations. The forum must emphasize individual roles and responsibilities for implementing service integration. This requires SRH, HIV or malaria organizations to take a lead as well as financial support and/or technical assistance. These groups should not only reach out to countries that were not present at the Advocacy Summit, but should also provide support in their own countries and regions, as the creation of parallel structures or separate groups with overlapping mandates may prove inefficient and ineffective.

Country-level advocacy must be focused on a long-term commitment to meeting the needs for integration of services and not overly concerned with the benefits from proposed funding.

SRH, HIV and malaria organizations can:

- Use their own country links and inter-country connections to share information on SRH-HIV and SRH-malaria integration, as well as on Global Fund processes and mechanisms;
- Advocate for national partnership forums or working groups on SRH-HIV and SRH-malaria integration as these relate to developing Global Fund proposals;
- Identify regional focal points to link with regional networks, attend regional meetings, and generally build awareness and education at the regional level.

Several opportunities developed by different regional and sub-regional networks at the Advocacy Summit are presented in HLSP (2006), *Report of Advocacy Summit on Global Fund Round 7: Integration of Sexual and Reproductive Health into the HIV/AIDS and Malaria Component Proposals* (available at [www.interactworldwide.org](http://www.interactworldwide.org) and [www.globalaidsalliance.org](http://www.globalaidsalliance.org)).

## **Strategy 2: Catalyze Global Fund policy, institutional and operational reform to support and improve the integration of SRH within the HIV and malaria components of Country Coordinated Proposals.**

Strategy 2 has two components:

1. Global Level Advocacy
2. Institutional Level Advocacy

It is suggested that those interested in advancing this agenda utilize their existing networks and forge new relationships in order to support the range of actors listed below in intensifying their Global Fund involvement in a way that increases SRH-HIV/AIDS and SRH-malaria linkages in Global Fund priorities and in country-level work.

### **Component 1: Global Level Advocacy.**

The key to influencing policy change at the global level lies in creating country-level demand for integrated approaches. While the Global Fund is primarily a country-driven financing mechanism, there are some key entry points at the global level to influencing policy and operational reform.

#### **1. Harmonization and Coordination:**

Recognition by the international community of the need to use resources and coordinate partnerships more effectively has led to the development of the Three Ones principles for nationally-led coordination compatible with the Paris Declaration for Aid Effectiveness.<sup>xxv</sup> Commitment to the Three Ones and processes such as the Global Task Team's division of labour recommendations,<sup>xxvi</sup> the establishment of joint UN country AIDS teams, the recent review of the comparative advantages of the World Bank and the Global Fund<sup>xxvii</sup> and the Report of the Secretary-General's High Level Panel<sup>xxviii</sup> have all identified factors that affect the ability of countries to implement effective programmes. These processes have the potential to increase coordination among multilaterals, donors and government departments working in HIV, SRH and malaria through better dialogue, programme coordination and clearer delineation of the responsibilities of each agency.

In the case of malaria, the Roll Back Malaria (RBM) Partnership<sup>xxix</sup> takes the lead role in advocating integration. Two of the milestones for "action at country level," specified in the RBM Global Strategic Plan 2005-15, refer explicitly to strengthening SRH systems:

Existing delivery systems [including those relating to ANC] are strengthened and used to increase the coverage of malaria interventions' and 'malaria interventions are integrated in to health packages of ANC, IMCI and the essential health package.<sup>xxx</sup>

The constituencies responsible for achieving each of these milestones are the endemic country governments, the private sector, Organization for Economic Co-

operation and Development (OECD) donor countries, multilateral development partners, foundations and NGOs all working together under the umbrella of the sub-regional RBM networks.

## **2. United Nations System:**

Several of the United Nations agencies have a crucial role in advocacy for, development of and support for programmes that aim to scale up integration. Furthermore, at the country level, the United Nations is normally involved in the CCM processes and in discussions with the Government and other stakeholders. At the international level, the United Nations can promote and advocate for integrated programming and services, including with the Global Fund structures and mechanisms.

The UNAIDS Secretariat can ensure that information on this initiative and SRH integration more generally is sent to UNAIDS Country Coordinators (UCC) and on to the United Nations Theme Group. However, a key challenge is to get this information out to other partners in-country.

## **3. Bilateral and Multilateral Agencies:**

Some donor countries have already been working on the integration of SRH and HIV for a number of years. These include:

- AIDSNET, Denmark;<sup>xxx1</sup>
- DFID;<sup>xxx2</sup>
- SIDA;<sup>xxx3</sup>
- NORAD; and
- Foreign Ministry of the Netherlands.<sup>xxx4</sup>

Strategies need to be developed to increase the level of awareness of and political support for SRH-HIV and SRH-malaria integration with donors, including AusAID, CIDA, GTZ, IDA Irish Aid<sup>xxx5</sup> and USAID. Donors can also raise the issue of integration at the UNAIDS PCB and through the Board and Committees of the Global Fund.

## **4. Foundations:<sup>xxx6</sup>**

Foundations such as:

- Bill and Melinda Gates Foundation;<sup>xxx7</sup>
- William and Flora Hewlett Foundation;<sup>xxx8</sup>
- David and Lucile Packard Foundation;<sup>xxx9</sup>
- Elton John AIDS Foundation;<sup>x1</sup> and
- Ford Foundation<sup>x2</sup>

have been supporting the work of SRH, HIV and malaria organizations, including the integration of services. However, while providing resources is critical, their voices in advocacy efforts within the Global Fund's Board and Committees to scale up integration are also critical.

## **5. Civil Society:**

Civil society has been at the forefront of treatment advocacy efforts and has extensive experience advocating with national and donor governments and bilateral and multilateral bodies. Civil society organizations also have voting rights on the Global Fund Board through the developing and developed countries NGO delegations, and the people from the Communities of People Living with the 3 Diseases Delegation, as well as a presence on some Board committees. However, not all civil society organizations are supportive of SRH and HIV prevention efforts and many SRH, HIV and malaria organizations, among others, still have limited knowledge of the Global Fund, its structures and mechanisms and its operations. In general, partnerships should be formed with caution.

Advocacy efforts need to be directed at External Relations in the Secretariat and the CCMs to ensure flows of information on the proposal development process and provision of feedback to communities on proposals they have submitted. Further, CSO partners need to be mobilised to promote this agenda through the NGO Delegations of the Global Fund's Board and to the broader development community. Likely partners include:

- Global Network of People Living with HIV (GNP+);<sup>xlii</sup>
- International Community of Women Living with HIV/AIDS (ICW);<sup>xliii</sup>
- Young Positives;<sup>xliv</sup>
- International Council of AIDS Service Organizations (ICASO);<sup>xlv</sup>
- International Treatment Preparedness Coalition (ITPC);
- Young Women's Christian Association (YWCA);<sup>xlvi</sup>
- Global Coalition on Women and AIDS;<sup>xlvii</sup>
- Sexual and Reproductive Health organizations, including those involved in the Integration Advocacy Summit (IPPF, Interact Worldwide, Population Action International, Center for Health and Gender Equity, and the International Women's Health Coalition), and others such as John Snow International<sup>xlviii</sup>, Pathfinder, Family Health International<sup>xlix</sup>, EngenderHealth<sup>l</sup>, Population Services International<sup>li</sup>, Futures Group<sup>lii</sup>, Ipas<sup>liii</sup> and Population Council;<sup>liv</sup>
- Roll Back Malaria (RBM) Partnership;<sup>lv</sup>
- Stop TB Partnership;<sup>lvi</sup>
- Aidspace;<sup>lvii</sup>
- International Federation of Red Cross and Red Crescent Societies (IFRC);<sup>lviii</sup>
- Open Society Institute;<sup>lix</sup> and
- The Reproductive Health Supplies Coalition, and its working groups on Resource Mobilization and Awareness, Systems Strengthening, and Market Development.

Other possible partners include:

- Rotary International;<sup>lx</sup>
- International Olympic Committee;<sup>lxi</sup>
- International Cricket Council;<sup>lxii</sup> and

- Fédération Internationale de Football Association (FIFA)<sup>lxiii</sup> (particularly in Africa).

## **6. Faith-based Organizations:**

There are some concerns about the role of certain faith-based organizations in policy and programming of SRH services and HIV prevention. However, faith-based organizations provide a large percentage of health services and care in developing countries<sup>lxiv</sup> and need to be engaged in advocacy efforts supporting integration, as well as integrating their own services where possible. Faith-based organizations with experience in Global Fund advocacy and which have large outreach include:

- World Council of Churches;<sup>lxv</sup>
- Ecumenical Advocacy Alliance;<sup>lxvi</sup>
- CARITAS;
- TearFund;<sup>lxvii</sup>
- World Vision;<sup>lxviii</sup>
- VIVA Network;<sup>lxix</sup>
- Muslim Aid, United Kingdom;<sup>lxx</sup> and
- African Network of Religious Leaders living with or personally affected by HIV and AIDS (ANERELA+).<sup>lxxi</sup>

## **7. Private Sector:**

The Private Sector Delegation on the Board provides businesses and business associations with an opportunity to contribute to the governance and work of the Global Fund. The focal point for the Private Sector Delegation is the Global Business Coalition on HIV/AIDS, which leads and coordinates the work of the delegation and facilitates the broader engagement of the private sector.<sup>lxxii</sup> As the global response to combat the three diseases gathers momentum, the continued and expanded engagement of the private sector will play a critical role in ensuring the long-term success of the Global Fund and the fight against AIDS, tuberculosis and malaria, including in supporting the scale-up and integration of SRH, HIV and malaria services and programmes, as well as of those pertaining to TB.

In 2005, the Private Sector Delegation developed a workplan to define the next steps for priority engagement. The focal point, Global Business Council (GBC), will take the lead on workplan development, in close consultations with interested parties such as World Economic Forum (WEF)/Global Health Initiative (GHI), other Private Sector Delegation (PSD) members, Friends of the Fund organizations and the Global Fund Secretariat. Consequently, the in-country and policy-level activities of the various parties, and in particular those of the GBC and WEF/GHI, will be closely aligned while still operating independently.<sup>lxxiii</sup>

There are several major areas of partnership through which the private sector can support the work of the Global Fund:

- Marketing campaigns and cash contributions;<sup>lxxiv</sup>

- Pro bono services and product contributions;
- Governance of the Global Fund; and
- In-country co-investments and operational contributions.<sup>lxxv</sup>

In 2005, the Private Sector Delegation raised concerns that the level of participation by the private sector in CCM's is not ideal. According to general data available on CCM membership, 82 percent of CCMs had some form of private sector representation in Round 4. Of the 78 CCMs analyzed, the private sector makes up on average 7 percent of CCM membership. Quite often the "private sector" represented on CCMs is heavily biased towards private medical services delivery professionals and firms, while large local corporations and Fortune 1000 companies with large employee workforces and extensive supply-chain networks are underrepresented.<sup>lxxvi</sup>

In terms of SRH, HIV and malaria integration advocacy, the private sector is a clear partner in endeavours to have CCM membership expanded to include organizations or sectors defined in terms of area of work, i.e., business and sexual and reproductive health.

From the perspective of the private sector, priority plans would include:

- Mainstreaming of co-investments in Global Fund operations;
- Development of a coordinated approach to co-investment;
- Participation of the private sector in Country Coordinating Mechanisms, notably the participation of local major corporations and branches of Fortune 1000 companies—a critical step to enrolling the power of corporations with great infrastructure and resources;
- Expanded capacity to identify and respond to emerging in-county needs related to proposal development, grant negotiation and implementation; and
- Improved ability to retrofit co-investments into approved grants.<sup>lxxvii</sup>

## **Component 2: Global Fund Institutional Level Advocacy.**

While the Global Fund is a country-driven financing mechanism, there are entry points at the Global Fund Secretariat itself to influence policy and operational reform. But the key to influencing policy change lies in creating country-level demand for integrated approaches.

### **1. Global Fund Board:**

SRH integration could be well served by ensuring that donor and recipient government delegations and the three civil society delegations include representatives with SRH backgrounds. A review of the current membership of the civil society delegations would identify current capacity and any gaps in SRH capacity. These individuals need to be brought into advocacy processes and encouraged to advocate on integration issues alongside their many other institutional concerns and agendas. Similarly, donor and recipient government delegations should also include representatives with SRH backgrounds.

The Global Fund Board could play a leading role in scaling up SRH-HIV/AIDS and SRH-malaria integration by:

- Strengthening SRH-HIV/AIDS and SRH-malaria integration through the inclusion of SRH experts on Board and in the Committees, particularly on civil society and donor-recipient government delegations;
- Including UNFPA as a non-voting member of the Board and ensuring UNFPA representation alongside WHO, UNAIDS and the World Bank in the Policy and Strategy and Portfolio Committees; <sup>lxxviii</sup>
- Encouraging the greater involvement of SRH organizations in the Global Fund planning processes;
- Responding to country demand to strengthen SRH-HIV/AIDS and SRH-malaria integration by developing a call for proposals that explicitly endorses such programming;
- Including an explicit statement on the possibility of SRH integration by approving Round 7 guidelines that include SRH-HIV/AIDS and SRH-malaria integration or, more forcefully, requiring evidence that the CCM has considered SRH integration in its Country Coordinated Proposal; and
- Considering funding operational research, particularly to address knowledge gaps about SRH-HIV/AIDS and SRH-malaria integration. In the case of malaria, additional research is needed on interactions between antiretroviral and antimalarial drugs, as well as on whether HIV infection in children results in a decreased response to standard antimalarial treatment, an increased risk of infection with malaria and increased malaria parasite density; whether malaria infection in adults results in an increased risk of HIV infection; and whether malaria increases the viral load of HIV-positive children.

The NGOs Representative of the Communities Living with the Diseases, the Developed Country NGO, the Developing Country NGO, Point Seven (Denmark-Ireland, Luxemburg, Netherlands, Norway, Sweden) and the United Kingdom (Australia) delegations are ideal partners to promote this, as well as integration more generally. In general, the way to talk to the Board is through the constituencies; they need to be reached if integration is to be adopted and this is best achieved through interactions at the local and regional levels.

Furthermore, the new Executive Director, Michel Kazatchkine, could be requested to make a supportive statement concerning policy, service and programme integration, a follow-up action to a letter sent to Executive Director candidates in January 2007, which requested their focus on the issue of SRH linkages and the Fund.

**Immediate advocacy on the above issues is required as the Board is meeting in March 2007, and Round 7 calls for proposals are expected to be issued then.**

## **2. Committees:**

The Global Fund Committees are important in setting the direction and defining the operations of the Global Fund. They are a way of “talking” to the Board.

### ***Policy and Strategy Committee***

Advocacy should be undertaken with the Policy and Strategy Committee to:

- Develop a call for proposals that explicitly addresses/stipulates SRH-HIV/AIDS and SRH-malaria integration.

### ***Portfolio Committee***

Advocacy should be undertaken with the Portfolio Committee to:

- Include SRH integration language in the Global Fund proposal guidelines;
- Adapt proposal application forms to accommodate SRH-HIV/AIDS and SRH-malaria integration;
- Develop specific guidance on what it would like to see in proposals benefiting integrated SRH-HIV/AIDS and SRH-malaria programmes;
- Strengthen integrated approaches to SRH, HIV and malaria by revising policies and procurement guidelines to include reproductive health supplies, including condoms, needles, gloves and alcohol swabs for universal precautions, as HIV-related commodities; <sup>lxxix</sup>
- Revise the procurement guidelines to encourage the Principal Recipient(s)' participation in SRH commodity security working groups at the country level; and
- Ensure that procurement processes for condoms are linked to SRH programmes in-country, so that SRH programmes do not face stock-outs.

With the Portfolio Committee meeting 22-23 February 2007, a sign-on letter was sent to the Chair of the Global Fund Board and Portfolio Committee with endorsements from nearly 100 organizations focused on SRH, HIV/AIDS, and global health in general.

## **3. Secretariat:**

The Global Fund Secretariat is establishing a roster of pre-qualified suppliers of management consulting services to make readily available a team of skilled consultants to:

- Improve governance and oversight processes for Country Coordinating Mechanisms (CCMs);
- Provide grant management support by enhancing the Secretariat's capacity to assist when grant implementation issues have been detected. Diagnostic analyses of grant implementation challenges and resulting remedial action plans will help the Secretariat to leverage support from partners and enable partners to identify technical and management assistance as and when needed; and
- Analyze and document case studies of innovative country partnerships, including, but not limited to, co-investment schemes, harmonization and

alignment experiences, or CCM functions that provide examples of emerging best practices or offer models to share among partners.

Specific advocacy should be undertaken with the Secretariat to:

- Recruit SRH experts based in the Secretariat (particularly the Operations Unit and the Global Partnerships Team, including the civil society team) who can support and promote SRH-HIV/AIDS and SRH-malaria integration at country and global levels;
- Develop guidance to inform stakeholders about and raise awareness of how SRH-HIV/AIDS and SRH-malaria integration can be considered and supported under existing disease-targeted health system strengthening components;
- Secure a commitment from the new Executive Director to pursue this agenda and to ensure integrated approaches are incorporated into future proposal rounds.

In addition, Interact Worldwide contacted the Global Fund to recommend the inclusion of indicators on SRH in the Global Fund five-year evaluation. This was not met with support from the Secretariat, which stated that SRH had not been identified as a Global Fund priority and therefore did not meet requirements for inclusion in this evaluation.

### ***Leadership and Staffing***

The senior staff of the Secretariat needs to show leadership on SRH-HIV/AIDS and SRH-malaria integration, and to ensure that there is sufficient staff expertise, particularly in Operations, Performance Evaluation and Policy, and External Relations, including the civil society unit, so that integration is promoted and supported. The External Relations unit of the Global Fund, including the community liaison officer, has a pivotal role in promoting awareness around SRH-HIV/AIDS and SRH-malaria integration, distributing information and addressing concerns about equity of program uptake and access (i.e., how many children are reached through funded programmes). The latter is something that the civil society unit has not viewed previously as falling under its jurisdiction.

Specific advocacy should be undertaken with the Secretariat to:

- Ensure that there is sufficient staff with technical expertise on SRH-HIV/AIDS and SRH-malaria integration; and
- Ensure that the civil society unit, and the Secretariat as a whole, takes a more active role in ensuring equity of access to programmes funded through the Global Fund.

### ***Monitoring and Evaluation (M&E)***

The Global Fund targets tend to reinforce the use of highly specific indicators that emphasize coverage rather than impact (although impact analysis is beginning to take place through the Technical Evaluation Reference Group processes).

Advocacy should be undertaken with the Global Fund to revise current indicators to include more specific indicators and reporting requirements that assess the development, progress and impact of integrated SRH, HIV and malaria.

Suggested indicators can be found in HLSP (2006), *Integration between Sexual and Reproductive Health and HIV and AIDS and Malaria: opportunities and strategic options for the Global Fund for AIDS, TB and Malaria*. Additional indicators for SRH and HIV integration could include:

1. Numbers of commodities, i.e., condoms, contraceptives, safe motherhood supplies, and HIV testing kits;
2. Number of basic supplies such as needles, gloves and alcohol swabs for health care workers to take universal precautions;
3. Number of men and women receiving comprehensive VCT, including family planning;
4. Number of HIV-positive couples counselled on family planning and SRH services; and
5. Number of HIV-positive men who have sex with men, sex workers and injecting drug users receiving HIV prevention, care, support and treatment services or referral.

Indicative examples for SRH and malaria integration could include:

- Numbers of commodities, i.e., those needed to provide chemoprophylaxis for malaria for HIV-positive women.

Advocacy should also be undertaken with the Secretariat to develop tools and indicators to assist countries in assessing their strengths and weaknesses in systems capacity and service delivery in order to appropriately focus proposal development towards filling these gaps. An example would be the development of generic needs assessments and development tools with clear linkages to HIV, TB or malaria for human resources needs, covering both the public and private sectors. The development of such indicators could be in partnership with UNAIDS, UNFPA, UNODC, UNICEF and WHO (departments with jurisdiction over SRH, HIV and malaria).

Finally, the number of condoms purchased can be assessed through information on the Global Fund website, by looking at each grant by country, and should be monitored by civil society conducting advocacy for increased SRH-HIV/AIDS and SRH-malaria integration.

#### **4. The Technical Review Panel (TRP):**

Appointment of the current TRP (for four rounds of proposals, i.e., through 2010) took place in April 2006. The next TRP renewal recruitment procedure will commence in 2008 and will address lessons learnt from the 5-Year Evaluation and a 50 percent renewal of the TRP after Round 8. In order to strengthen linkages between SRH, HIV and malaria, advocacy should be undertaken with the Global Fund to consider the following options:

- Negotiating with current TRP members with greater expertise on gender and/or women's rights in the hope that they can be tasked with raising the profile of the integration agenda;
- Working to ensure that at least one TRP member is appointed who has a background in SRH integration through advocacy to the Board and Secretariat, and amendment of the selection criteria;
- Educating and training the new TRP members on SRH-HIV/AIDS and SRH-malaria integration;
- Developing guidance for the TRP on SRH-HIV/AIDS and SRH-malaria integration so the TRP is able to differentiate between various approaches for each disease, contexts and countries (i.e., should a country submit an SRH-HIV integration proposal, the reviewers can assess it on the basis of whether it makes sense given the disease prevalence in that country);
- Mandating that there be a specific number of SRH experts for the next TRP recruitment process to ensure integrated proposals are assessed by those who understand the processes and value added of linked programming. This requires amending the TRP selection criteria;
- Refining the definition of cross-cutting experts to include individuals who have extensive experience with national SRH, HIV and malaria priorities, and programming and implementation experience of linking SRH, HIV and malaria. This requires amending the TRP selection criteria;
- Encouraging coordination with and integration of SRH, HIV and malaria into comprehensive multisectoral national plans. It is recommended that the TRP considers to what extent proposals are coherent with or inform the development of these plans.

In the report of the Technical Review Panel and the Secretariat on Round 6 Proposals, it was stated that:

- Several problems were noted in the gender analysis elements in the proposals. The TRP would like to recommend the following in this regard:
- a. The term 'gender analysis' should be used in place of 'gender issues';
  - b. The vast majority of applicants respond to the gender issues section by addressing women's issues, while neglecting often critical issues impacting on men;
  - c. The gender analysis requested in the Proposal Form should be linked more explicitly to the proposed activities, targets, implementation aspects of the proposal, rather than being isolated in one section only;
  - d. The social stratification tables are not well completed and should be modified, or better guidance provided in how to complete them; and
  - e. Overall, the TRP finds that the information provided on gender related issues is not particularly helpful to the TRP review process in its current form. The TRP recommends that this section be carefully reviewed with a view to deciding on how much of this information is really necessary in the Proposal Form, and to the extent that it is required, how to structure it so as to obtain useful information.<sup>lxxx</sup>

A complete gender analysis by CCMs in their Country Coordinated Proposals would allow for discussion of human sexuality of women, men, young people and vulnerable populations, including people living with HIV and pregnant women. This in turn could be linked to the need for sexual and reproductive health services and programmes to respond to the analysis (gap analysis and justification) and further linked to the HIV and malaria component activities, targets and implementation aspects of the proposal.

SRH, HIV and malaria organizations should collectively develop a summary document to inform the TRP on how to consider HIV, malaria and SRH integration. Alternatively, advocacy should be undertaken with the Secretariat to provide such information.

### **5. Partnership Forum:**

The next Partnership Forum will take place in 2008. Advocacy is required with the Global Fund to ensure that future Partnership Forums address integration either as a key agenda item in the plenary presentations, and/or in the breakout groups for developing strategic solutions.

### **Conclusion**

As an integral element of successful HIV/AIDS and malaria programs, it is essential that all related actors incorporate advocacy to the Global Fund for its support of such linkages into their operations. This document contains a broad range of opportunities and entry-points for such advocacy at the country, regional and international levels. SRH, HIV/AIDS and malaria organizations are encouraged to work together to promote this integration agenda according to their own capacity and mandates, and to utilize the ideas provided here as appropriate.

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<sup>ii</sup> <http://www.fhi.org/en/index.htm>

<sup>iii</sup> <http://www.jhu.edu/>

<sup>iv</sup> <http://www.hivandsrh.org>

<sup>v</sup> To subscribe, send an email to [GFR7-SRH\\_HIV\\_AIDS-subscribe@yahoogroups.com](mailto:GFR7-SRH_HIV_AIDS-subscribe@yahoogroups.com)

<sup>vi</sup> “Development Partners” on <http://www.theglobalfund.org/en/partners/international/>.

<sup>vii</sup> The main partners are ILO, UNAIDS Secretariat, UNESCO, UNICEF, UNODC and WHO. UNESCO is the lead organization on prevention for young people in education institutions.

<sup>viii</sup> UNAIDS (2005). UNAIDS Technical Support Division of Labour. Summary and Rationale. At [http://data.unaids.org/una-docs/JC1146-Division\\_of\\_labour.pdf](http://data.unaids.org/una-docs/JC1146-Division_of_labour.pdf).

<sup>ix</sup> Prevention of transmission of HIV among injecting drug users and in prisons. Main partners UNDP, UNICEF; WHO and ILO.

<sup>x</sup> Prevention of HIV transmission in healthcare settings, blood safety, counselling and testing, sexually transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services. Main partners are UNICEF, UNFPA and ILO.

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<sup>xiv</sup> Main partners are UNHCR UNESCO, UNFPA, UNICEF

<sup>xv</sup> Main partners are ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF and WHO.

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<sup>xvii</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria (2004). Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility. A [http://www.theglobalfund.org/pdf/5\\_pp\\_guidelines\\_ccm\\_4\\_en.pdf](http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf)

<sup>xviii</sup> Radelet S (2004) "The Global Fund to fight AIDS, TB and Malaria: Progress, Potential and Challenges for the Future. Centre for Global Development"

<sup>xix</sup> Global Fund Guidelines for Proposals: Sixth Call for Proposals.

<sup>xx</sup> Human Development Group, early 2007, which will review reproductive health and HIV and how well DFID is integrating these.

<sup>xxi</sup> UNAIDS has supported 80% of successful proposals.

<sup>xxii</sup> Global Fund (2006). Report of the Technical Review Panel and the Secretariat on Round 6 Proposals. Fourteenth Board Meeting, Guatemala City, 31 October - 3 November 2006. 5.15 Proposal Form and Guidelines. [http://80.80.227.97/en/files/boardmeeting14/GF-BM-14\\_10\\_TRPReportRound6.pdf](http://80.80.227.97/en/files/boardmeeting14/GF-BM-14_10_TRPReportRound6.pdf)

<sup>xxiii</sup> The Global Fund to Fight AIDS, Tuberculosis and Malaria (2004). Revised Guidelines on the Purpose, Structure and Composition of Country Coordinating Mechanisms and Requirements for Grant Eligibility. Paragraph 18. [http://www.theglobalfund.org/pdf/5\\_pp\\_guidelines\\_ccm\\_4\\_en.pdf](http://www.theglobalfund.org/pdf/5_pp_guidelines_ccm_4_en.pdf)

<sup>xxiv</sup> Clare Dickinson (2006). Integration Between Sexual Reproductive Health and HIV and AIDS and Malaria: Opportunities and Strategic Options for the Global Fund for AIDS, TB and Malaria. HLSP, November 2006.

<sup>xxv</sup> Paris Declaration on Aid Effectiveness, signed in March 2005 by 60 countries, including all major donor governments.

<http://www.aidharmonization.org/download/253038/DraftParisDeclaration-English.pdf>

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Sexual Health and Rights Project <http://www.soros.org/initiatives/health/focus/sharp>

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International Harm Reduction Development program  
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Dr Peter Piot, Executive Director of UNAIDS said, “One third of the 40 million people living with HIV are young people under the age of 25, many of whom are involved in sports, either as spectators or as participants. It is vitally important for young people to have access to information about HIV so that they can stay HIV-free and lead healthy and productive lives. The sports community is a key partner in reaching out to young men and women, whether in their village or town, or globally.”

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<sup>lxviii</sup> <http://www.worldvision.org/>

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<sup>lxxii</sup> The Private Sector Delegation focal point - the Global Business Coalition on HIV/AIDS: [psd@businessfightsaids.org](mailto:psd@businessfightsaids.org). The Global Fund Secretariat - Private Sector Partnerships Team: [privatesector@theglobalfund.org](mailto:privatesector@theglobalfund.org)

<sup>lxxiii</sup> Ibid at page 21.

<sup>lxxiv</sup> For example, (Product)RED is a brand created to raise awareness and money for the Global Fund by teaming up with the world's most iconic brands to produce RED-branded products. A portion of profits

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from each RED product sold will go directly to the Global Fund to invest in African AIDS programmes, with a focus on women and children.

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[http://www.theglobalfund.org/en/files/about/replenishment/private\\_sector\\_report\\_3dreplenishment.pdf](http://www.theglobalfund.org/en/files/about/replenishment/private_sector_report_3dreplenishment.pdf)

The Chair and Alternate of the Private Sector Delegation are leading a short-term outreach effort to secure by October 2005 some US\$500,000 in seed funding over two years for an expanded fundraising initiative that is expected to be self-sustaining by the third year. Once the seed funding is secured, the current focal point of the Private Sector Delegation (the GBC) will start putting in place the additional expertise and capacity to expand cash fundraising for the Global Fund, in addition to the extensive staff time and expertise it already dedicates to Global Fund business. The most promising channels for these efforts are cause-related marketing, employee giving and grant solicitations. GBC and Private Sector Delegation members are already leading or actively supporting the negotiation of new CRM, employee giving and major corporate grants, some of which should be announced very soon.

The Private Sector Delegation also wishes to stress the importance of other resource mobilization vehicles, namely pro bono services and product contributions, and in-country co-investments and operational contributions.

- Options for pro bono services and product contributions will be revisited in 2006 by the PSD, with WEF/GHI as a lead. The potential of pro bono services and product contributions, once estimated at up to one-fifth of the Global Fund's cash commitments, make them a significant resource that cannot be ignored.
- In-country co-investments and operational contributions represent significant and vastly untapped opportunities. The potential for leveraging Fortune 1000 companies' infrastructures and resources is great, but their involvement to date has been limited, in part due to the current design and operations of CCMs. The PSD is developing a work plan to support these efforts.

A total contributions target for private sector resource mobilization cannot be as easily set as in the context of public, governmental contributions. Therefore what is laid out here are commitments of means (rather than commitments of results). They are nonetheless significant and timely. These commitments are the by-products of a thoughtful and concerted engagement to reshape the involvement of the Private Sector Delegation to the Global Fund, to reach out to a wider constituency in an advocate and broker role, and to catalyze new forms of corporate engagement in the policy, programming and funding of the Global Fund.

We know from successful examples in the past that increasing corporate engagement in the work of the Global Fund at every level - especially at the country level through inclusive CCMs - is the key to mobilizing significant resources from the private sector. This approach has worked before and we are confident that the plan outlined in this report will work for the Global Fund (page 22).

<sup>lxxvii</sup> Ibid at page 20.

<sup>lxxviii</sup> Note that as UNAIDS consists of 10 Cosponsors, one of which is UNFPA; UNFPA is in effect already represented on the Board. The issue to ensure that SRH integration-related issues are brought to the Board's attention.

<sup>lxxix</sup> The term "reproductive health supplies" refers to those mentioned in WHO (2006). Interagency List of Essential Medicines for Reproductive Health. At [http://www.who.int/reproductive-health/publications/essential\\_medicines/index.html](http://www.who.int/reproductive-health/publications/essential_medicines/index.html).

The list includes: contraceptives, condoms, safe motherhood supplies, supplies needed for safe abortion, HIV testing kits and others.

<sup>lxxx</sup> Global Fund (2006). Report of the Technical Review Panel and the Secretariat on Round 6 Proposals. Fourteenth Board Meeting, Guatemala City, 31 October - 3 November 2006. 5.15 Proposal Form and Guidelines. At

[http://80.80.227.97/en/files/boardmeeting14/GF-BM-14\\_10\\_TRPReportRound6.pdf](http://80.80.227.97/en/files/boardmeeting14/GF-BM-14_10_TRPReportRound6.pdf).