Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

MATCHING RESOURCES TO NEED OPPORTUNITIES TO PROMOTE EQUITY
INFORMATION NOTE

I. INTRODUCTION AND PURPOSE

The Global Fund has promoted **equitable and rights-based approaches to health as core principles** of its funding since inception.[1] As a major global financing institution in health, the Global Fund is committed to ensuring that its investments promote the highest attainable standard of health for all, through services that are available, accessible, affordable, acceptable and of good quality for everyone in need, particularly those who are the most marginalized or vulnerable or at highest risk. Promoting equity and human rights are also key strategic directions of the new Five-Year Strategy of the Global Fund.

While access to HIV, TB and malaria services has increased substantially over the past years overall, major inequities and barriers remain, and funding allocations do not always follow need.[2] Further, analyses have shown that although effective interventions may be adequately included in proposal submissions, they may not always be adequately integrated into grant[3] work plans, budgets or monitoring frameworks.[4]

Equity considerations will be included systematically into performance-based funding decisions as an integral part of program-based reviews.[5] In this context, the Global Fund emphasizes the importance of **country-level assessments of inequities and barriers** in reaching populations in need – particularly the most marginalized or vulnerable – to enable country stakeholders to make optimal use of Global Fund financing to address gaps. Where information gaps exist, Global Fund financing may be used to strengthen data collection and analysis to monitor progress in achieving equity.

Progress in promoting equity will be assessed by the Secretariat at Renewal[6], based on information provided by Country Coordinating Mechanisms (CCMs) and Principal Recipients (PRs). Hence all new proposals, and the first Renewal for ongoing grants will establish the baseline against which progress will be monitored for the next Phase/Implementation Period. This baseline would be established through an analytical assessment of inequities, gaps and

[1] Framework Document of the Global Fund, January 2002. The Framework Document commits the Global Fund to "support proposals which (…) strengthen the participation of communities and people, particularly those infected and directly affected *by the three diseases, in the development of proposals; give due priority to the most affected countries and communities*, and to those countries most at risk; aim to eliminate stigmatization of and discrimination against those infected and affected by HIV/AIDS, especially for women, children; and vulnerable groups."

[2] Global Fund HIV Investments Targeting Most-at-Risk Populations: An Analysis of Round 8 (2008) Phase 1. The Global Fund, 2010.

[3] Please note that under the new Global Fund grant architecture, grants refer to Single Streams of Funding (SSF).

[4] UNDP, UNAIDS and the Global Fund. Analysis of key human rights programs in Global Fund-supported programs. UNDP, New York, 2010.

[5] Periodic Reviews and Commitments Policy (Annex 2a Version 2 to GF/B20/4 "Report of the Policy and Strategy Committee")

[6] Renewal refers to renewal of funding which was previously called and the previously used terms of Phase 2 review and periodic review

barriers in current national responses to HIV, TB and malaria, include the identification of appropriate actions to address them in the next Phase/Implementation Period and describe how progress will be monitored.

The purpose of this guidance document is to provide **practical direction to CCMs and country stakeholders** to effectively undertake an equity assessment (either by using existing data or program reviews, or through a new assessment) in order to identify opportunities to promote equity throughout the four stages of the Global Fund grant lifecycle and monitor their implementation: 1) proposal development, 2) grant negotiation, 3) grant implementation and CCM oversight and 4) Renewal.[7]

The document is structured as follows:

Section I	Introduction and purpose
Section II	Working definitions of equity for Global Fund financing
Section III	Equity assessments – the process
Section IV	Ensuring Equity at the four stages of the Global Fund grant lifecycle
Section V	Technical assistance, capacity building and resources

The guidance, developed in collaboration with partners, aims to help CCMs to ensure that Global Fund support effectively contributes to achieving the goals of the broader national program. Sections III and IV of this guidance provide practical examples of how equity considerations can be integrated into Global Fund proposals and grant documents. Programmatic recommendations to address inequities are available from technical partners and are outside the scope of this document.

Attention to equity is essential to ensure that Global Fund financing makes an effective contribution to the national program by helping to promote universal access to key services for all populations in need - regardless of age, sex, sexual orientation and gender identity, past or present drug use, socio-economic status, geographical location, or other factors. An increased focus on equity is also essential to achieve the goals of the Gender Equality Strategy and the Strategy on Sexual Orientation and Gender Identities of the Global Fund, to address the needs of the most marginalized or vulnerable or those at highest risk, and promote decisions that also look beyond the health sector towards creating a more enabling environment for these populations.[8] Further, focusing resources on the right interventions for the right people is essential to ensure value for money and maximum health impact of investments.

In reviewing proposals the **Technical Review Panel** will give due consideration to the inclusion and/or omission of interventions that target population groups most in need. If interventions targeting most-at-risk populations are not included, the absence of a clear rationale to explain their omission may affect the outcome of the Panel's review[9]. Global Fund resources can be used to address any gaps in information and analysis related to most-at-risk populations as part of the grant's first Phase/Implementation Period. Similarly at Renewal, risks to equitable allocation of resources will not affect the performance rating of the grant; however they may affect the recommendation category through the use of conditions or management actions to address inequities during the next Phase/Implementation Period.

Progress in achieving equity through Global Fund funding may not be specific to the Global Fund grant. It needs to be **interpreted within the context of the national program**, including the contribution of other donors and implementing partners. Although this guidance is Global Fund specific, CCMs should consider what other country stakeholders and partners are

[7] Under the new Global Fund grant architecture, grants refer to Single Streams of Funding (SSF).

[8] The Global Fund's Strategy for Ensuring Gender Equality in the Response to HIV/AIDS, TB and Malaria, November 2008 and The Global Fund's Strategy in relation to Sexual Orientation and Gender Identities (SOGI), May 2009.

[9] Please also refer to CCM Request guidelines on 'focus of proposal' requirements in relation to the minimum thresholds to allocate to most-at-risk populations

doing in response to the three diseases, and establish whether Global Fund support is effectively contributing to national goals.

The objective of equity assessments is *not* to add new reporting requirements for the CCMs and country stakeholders. Rather, the equity assessments aim to **encourage *better use* of existing data (quantitative and qualitative)** to inform and improve Global Fund supported programming as part of sound national strategic planning processes.[10] The equity assessment need not be a standalone exercise; rather it may be part of an overall program review of effectiveness and progress towards impact. Existing country-led, multi-stakeholder national review or assessment processes (e.g. national program reviews, joint health sector reviews, external program impact evaluations etc.) that provide an assessment of equity should be encouraged and serve as an input to assessing equity within the context of Global Fund support. The Monitoring & Evaluation (M&E) budget of grant agreements should have sufficient allocation to strengthen existing assessments (or to plan for such assessments, in case they are not currently happening in the country) and strengthen M&E systems overall. The lack of data should not be seen as a barrier to addressing the needs of different sub-populations, particularly those who are the most marginalized.

II. WORKING DEFINITIONS OF EQUITY FOR GLOBAL FUND FINANCING

The Global Fund supports the WHO definition of "health" as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[11] Vulnerability to ill-health and its consequences are influenced by social determinants, or "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness, that give rise to forms of social position and hierarchy, whereby populations are organized according to income, education, occupation, gender, race/ethnicity and other factors."[12] Equity in health is thus "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage or disadvantage.[13]

The Global Fund understands equity as a principle to guide decision-making around the allocation of its financing to HIV, TB, malaria and health systems strengthening, as well as a way to enhance focus towards addressing the structural and social determinants of health. Promoting equity through Global Fund financing involves addressing inequities in social determinants of HIV, TB and malaria and ensuring that those in need of HIV, TB and malaria services are able to access the interventions they require.

The burden and underlying determinants of disease caused by HIV, TB and malaria are distributed unequally across regions and population groups, with implications for program planning and implementation. The Global Fund Board has defined **underserved and most-at-risk populations** as 'subpopulations, within a defined and recognized epidemiological context, that have significantly higher levels of risk, mortality and/or morbidity; whose access or uptake of relevant services is significantly lower than the rest of the population'.[14] Depending on the disease and the country context, the Global Fund recognizes that some population groups may therefore require explicit attention. These include women and girls; men who have sex with

[10] UNAIDS. Practical guidelines for intensifying HIV prevention: towards universal access. http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

[11] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946.

[12] Social determinants to health: Key concepts. WHO, http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html accessed on 6 March 2011.

[13] P Braveman, S Gruskin. Defining equity in health. J Epidemiol Community Health 2003; 57:254-258

[14] Policy on eligibility criteria, counterpart financing requirements and prioritization of proposals for funding from the Global Fund, GF/B23/14 Attachment 1, May 2011.

men; transgender persons; people who use drugs; sex workers and their clients; prisoners; refugees, migrants or internally displaced populations; people living with HIV; adolescents, and young people; vulnerable children and orphans; people with disabilities, ethnic minorities; people in low-income groups; people living in rural or geographically isolated settings or other group(s) specific to the country context.[15]

Further, achieving equity requires a focus on all dimensions of **access**: availability of services (including reachability, affordability, acceptability and quality); their coverage; and their outcomes and impact in terms of reduced new infections or improvements in health status and survival.[16] It also requires efforts to address the underlying determinants of disease.

The Global Fund supports multiple **approaches** to achieve equity, including:

- Targeted services to address the needs of different population groups;
- Health systems strengthening, including human resources, health financing interventions and investments in health information systems;
- Community systems strengthening to support and mobilize community demand in order to build capacity among the most marginalized or vulnerable or those at highest risk and/or provide outreach;
- Interventions to address structural risk factors and barriers to access, such as advocacy, socio-political or legal services and reform,
- Interventions to address socio-cultural and behavioural risk factors and barriers to access, and
- Interventions to promote human rights, such as HIV-related legal services, legal audit/reform, training and sensitization of health or law enforcement workers on human rights, stigma reduction and protection against violence.

Programmatic guidance is available from technical partners (such as WHO, UNAIDS, UNICEF, UNFPA, UNDP and other international organizations, bilateral donors as well as from civil society organizations) to help Global Fund stakeholders to select interventions and design programs that address social determinants and inequities in relation to their epidemiological and country context. These partners also provide technical assistance for proposal development and grant implementation (see Section V for details).

Efforts to promote equity must acknowledge the fact that equity is a multidimensional concept with multiple relevant criteria. A focus on equity aims to promote decisions and choices that match limited resources to need and help to shift investments to look beyond the health sector and to the supportive and enabling environment.

III. EQUITY ASSESSMENTS – THE PROCESS

An equity assessment is an **on-going analytical process that allows CCMs and country stakeholders to operationalize the principle of "know your epidemic; know your response".** It aims to help CCMs and country stakeholders to better understand the epidemic and the current response to the epidemic, and allows them to inform and improve future implementation through Global Fund support. The convening and oversight role of the CCM is central to ensuring that programs are achieving their goals and reaching those most in need. CCMs should also ensure that activities to strengthen equity assessments and M&E systems are adequately budgeted in new proposals and CCM requests for Renewal.

[15] The Global Equity Gauge Alliance identifies eight "PROGRESS" markers of inequities – Place of residence, Religion, Occupation, Gender, Race/ethnicity, Education, Socioeconomic status and Social capital/networks. Global Equity Gauge Alliance: Concepts and Definitions. (http://www.gega.org.za/concepts.php)

[16] WHO Framework for monitoring progress towards universal access, defined in Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector, WHO 2007.

The process of conducting equity assessments should 1) be participatory and include multiple stakeholders, including key affected and marginalized populations, 2) draw on multiple data sources, 3) include analysis of the evidence, and 4) use the results of the analysis to implement effective programming that addresses the identified gaps and barriers.

1) The participatory process of an equity assessment

A key part of successful equity assessments is the participation of multiple stakeholders, including the most marginalized or vulnerable or those at highest risk, and/or their advocates, convened through a **transparent and inclusive process**. The Global Fund already emphasizes the importance of multi-stakeholder participation, transparency, and documented decision-making at proposal development, Renewal and grant oversight.[17] Extending this to include equity assessments will significantly improve the likelihood of program success.

Deciding which stakeholders should be included is an extremely important step in the overall process. Applying the concept of equity to development policies and programs can involve difficult choices and conversations. In many cases it will require challenging dominant ideologies or re-focusing priorities. CCM decisions about who to include in a health equity assessment may require the inclusion of population subgroups at increased risk, but that may not have the resources or may not be sufficiently empowered to ensure their participation in program design and priority-setting. The CCMs should put in place and maintain a transparent, documented process to select stakeholders who will participate in equity assessments.[18]

2) Gathering evidence to assess equity

CCM oversight should ensure that all relevant sources of data for equity assessments are identified and collected. Examples of main types and sources of data are listed in Table 1 below. The equity assessment should use one or more of these sources depending on the disease and country context.

Many of these data are already collected and compiled at national and international levels.[19] Other data need to be collected in-country. CCMs should verify whether an equity assessment has already been conducted in the recent past, either stand-alone or as part of a more comprehensive disease program review by country stakeholders. Where such assessments have been conducted, the CCM should use these data to inform requests for future Global Fund financing. Where such an assessment does not exist, the CCM should convene country stakeholders to gather data and conduct the analysis.

The Global Fund recognizes that M&E systems may have weaknesses. The Global Fund recommends that applicants invest 5-10% of program budgets in M&E to address gaps identified in the system. This budget may be used, for example, to introduce or strengthen collection of disaggregated data, enhance analytical capacity to interpret data; to fill the information gaps with qualitative and/or quantitative studies, etc.

[17] Guidelines and Requirements for Country Coordinating Mechanisms
http://www.theglobalfund.org/en/ccm/guidelines/?lang=en

[18] Stakeholders who may be considered for inclusion in equity assessments include representatives from the national health sector and non-health sector ministries including ministries of justice, labour and education; donors, technical partners, representatives of key population subgroups living with or affected by the disease, community based and non-governmental organisations; women's organisations, local authority organisations and civic groups; academic institutions; churches, traditional leaders, and private sector representatives.

[19] For example, databases from WHO, UNAIDS, World Bank and other international partners.

Table 1: Examples of data sources to assess equity

Type	Source	Examples of data use
Demographic data	Census, vital registration	e.g. population size; general health status (by sex, age, geographical region, risk group or other variables)
Disease morbidity and mortality	Sentinel surveillance, integrated behavioural surveillance surveys, population-based surveys (e.g. DHS, MICS), special studies, vital registration, etc.	e.g. HIV prevalence, malaria incidence, TB deaths, etc. (by sex, age, geographical region, risk group or other variables)
Social determinants of health and risk factors	Behavioural surveillance surveys, population-based surveys,	e.g. condom use, prevalence of sexual or gender-based violence, etc.
Health service use	Health facility records, patient registries, population-based surveys (e.g. DHS, MICS), etc.	e.g. ART coverage, ITN use, TB case detection, etc. (by sex, age, geographical region, risk group or other variables); service quality
Qualitative data	Qualitative research, operational research	e.g. research on risk factors and barriers to accessing health care in a population group; service quality
Grey sources	Information from civil society, key informants, media (mainstream e.g. newspapers or social e.g. twitter), etc.	e.g. reports of deteriorating service quality, human rights violations in program implementation, etc.

Quantitative data need to be collected in relation to different population subgroups as relevant to the country and disease context. This includes disaggregation of data by sex, age or other subgroup; as well as data on targeted interventions for particular population groups in need. *Qualitative* information is equally important to help understand the underlying socio-economic or cultural context that have an impact on health and health-seeking behaviour.

Data may be lacking on certain population groups, specially marginalized population groups. This may be especially true when risk factors for disease are illegal in the country, (e.g., homosexuality, drug use or residence status), highly stigmatized (e.g., sex work, sexual orientation or positive HIV status) or legal or civil rights do not exist (e.g., refugees, women). The CCM should also **consider using M&E budgets in Global Fund grants** to address these gaps in data. Where data collection is not feasible, grey sources may be used to inform programming and be made available to the Technical Review Panel on request. Lack of comprehensive or quality data should never be used as a rationale to neglect the needs of a marginalized group.

3) Analysing the evidence to identify gaps and opportunities

The next stage in an equity assessment is to use the most recently available evidence to **understand which population groups face barriers and why, and agree on how Global Fund financing can be most effectively used to address them.** These barriers may be related to *health system constraints* (such as economic barriers for low-income groups due to high out-of-pocket payments for health service use; physical barriers for rural populations due to lack of trained human resources, etc.). They may also be related to *structural constraints* related to the legal, social, political or cultural environment (such as barriers faced by men who have sex with men due to criminalization of same sex relations; or barriers faced by young women due to traditional gender norms such as the obligation to get permission from a

male family member to seek health care, or barriers faced by people who use drugs due to criminalization of drug use or drug possession and other factors affecting access to services).

Further, the equity assessment may identify *weaknesses in planning and programming in the previous implementation period* (such as in situations where adequate data on a geographical region may not have been previously available, but have been revealed through a new survey). There may also be situations where a service delivery approach has *unintended harmful consequences* which become visible after the first phase of implementation, such as targeted HIV testing which may increase stigma for the population group.

The goal of the CCM should be to convene country stakeholders to agree on opportunities to use Global Fund financing to address these barriers. The analysis should answer the following **questions**:

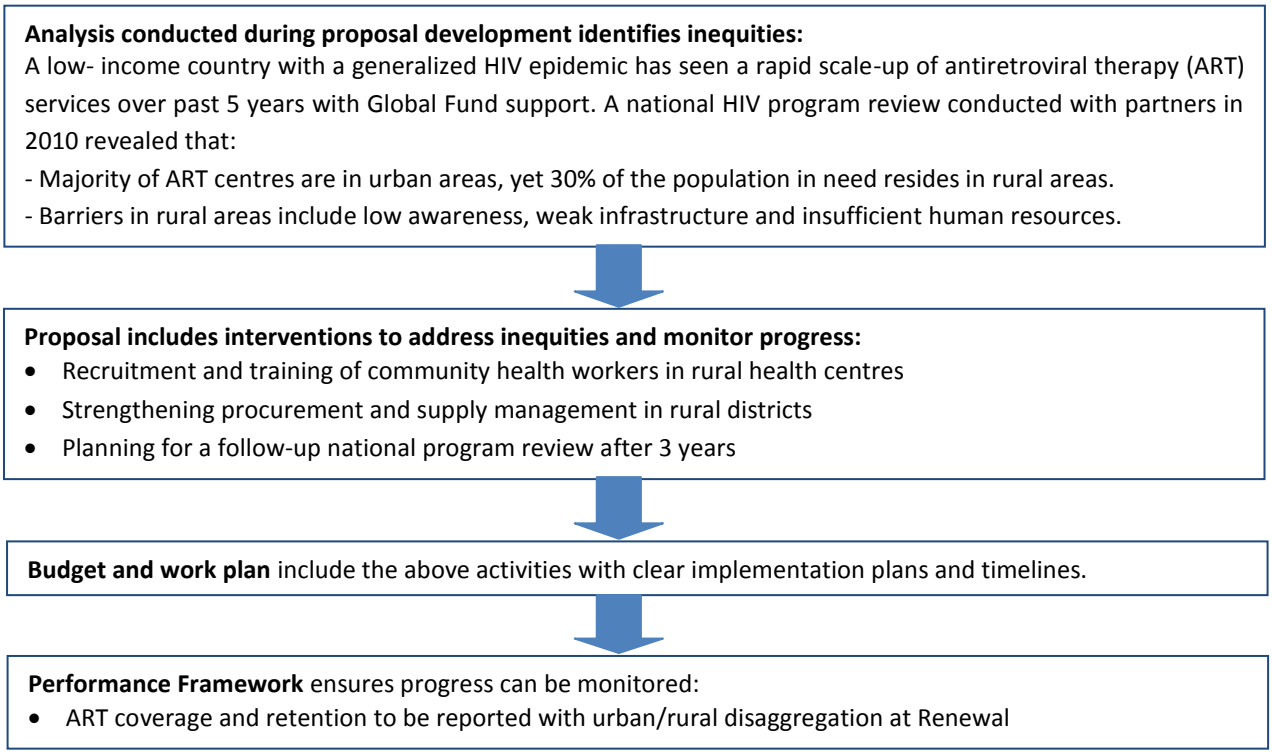
(a) What is the prevalence/incidence of disease among different population subgroups? Which population subgroups are most affected by the disease and why are they particularly affected (i.e. what are the underlying determinants of these inequities)?
(b) What are the current levels of access to key services for these population groups? What are the gaps in relation to need?
(c) What are the main constraints or barriers to addressing inequities? These may include gaps in data availability and data use; health system barriers in accessing services; structural barriers in accessing services; stigma and discrimination; or gaps or weaknesses in planning, programming or implementation of activities.
(d) What are the opportunities for the CCM to use Global Fund financing to address these gaps in the next Phase 2/Implementation Period? Or, how can the CCM ensure that Global Fund financing does not, at a minimum, exacerbate existing inequities? How do other partners, including government, contribute to reducing inequities?
(e) How can progress be monitored in the next Phase/Implementation Period?

4) Translating results of analysis into actions

The goal of the equity assessment is to be able to translate the results of the analysis into effective, evidence- and rights-based programming and re-programming that addresses the needs of the population subgroups most affected.

A common challenge is that a good analysis is not translated into work plans, budgets and performance frameworks. The analysis conducted in the previous step should be discussed by country stakeholders and appropriate actions should be included in the proposal or the request for continued funding to the Global Fund. Figure 1 provides an example. The choice of interventions should be informed by normative guidance developed by technical agencies. It should be kept in mind that Global Fund financing can be requested not only to scale up health interventions for the three diseases, but also to strengthen health and community systems and address structural barriers to health care access.

Figure 1: Translating results of equity assessment into actions - Example



The next section provides more details on opportunities to promote equity through Global Fund financing, including a checklist of the key questions to be asked at each stage of the Global Fund grant lifecycle.

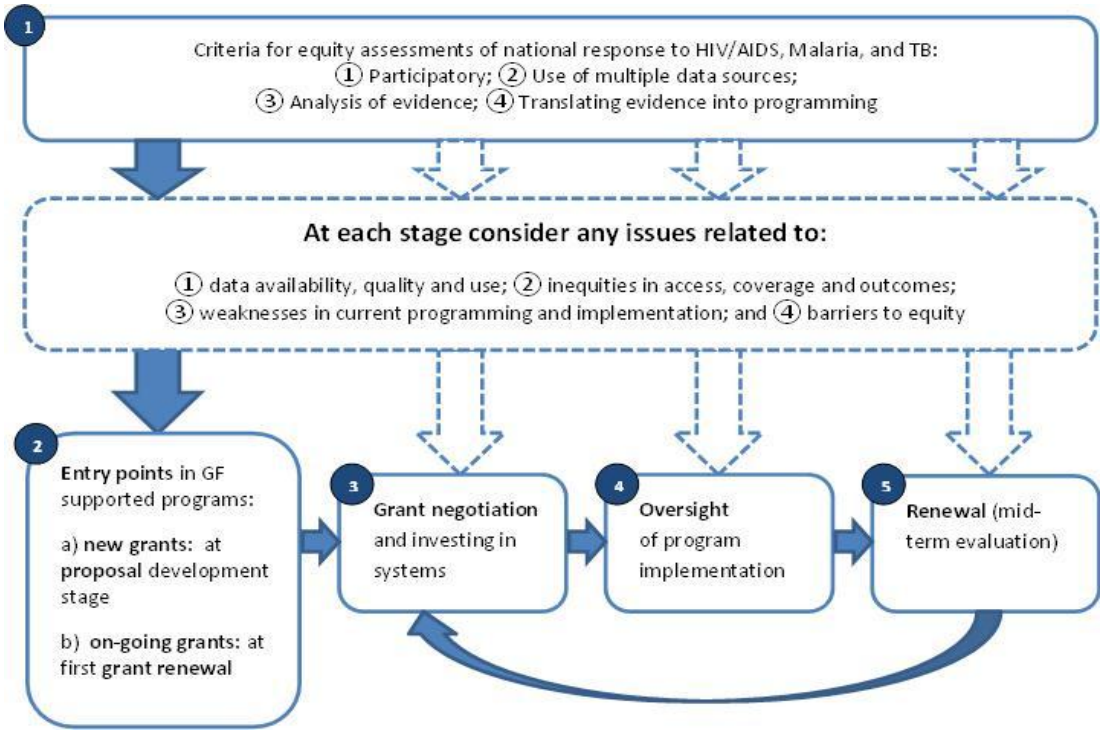
IV. ENSURING EQUITY ACCESS IN HEALTH AND PREVENTION SERVICES FOR HIV, TB AND MALARIA AT THE FOUR STAGES OF THE GLOBAL FUND GRANT LIFECYCLE

Equity can be promoted through all four stages of the Global Fund grant lifecycle. The two main entry points to promote equity are proposal development and Renewal. Equity can also be enhanced and monitored at other stages of the grant lifecycle, i.e. during grant negotiation and grant implementation and CCM oversight. Grant consolidation may also be considered as a good opportunity to address equity through the newly signed grant.

This section of the guidance lists i) key questions and ii) expected outcomes for each of the four stages of the grant lifecycle and how they should be monitored. In general, the key questions to be answered concern **who** is affected, **how** they are affected, and if the current response is **effective, right- and evidence-based.**

In terms of oversight, at any stage of the grant life cycle, CCMs should consider whether there are any major issues in the following areas and try to address them: a) data availability, quality and use, b) inequities in access, coverage, and outcomes, c) weaknesses in current programming and implementation, d) structural barriers. Figure 2 illustrates the integration of the equity assessment into the grant lifecycle and the key issues to be considered at each stage.

Figure 2: Integration of equity assessment into the grant life-cycle



1) The two entry points:

There are two main entry points to promote equity: proposal development and Renewal.

1. For new proposals: Equity assessments should inform new proposal development establishing the baseline. Responses to inequity/ies should be built into the grants and the progress monitored throughout their lifecycle. Progress will be evaluated at Renewal.

2. For on-going grants: Equity assessments at the first Renewal will set the baseline. Responses to inequity/ies will have to be built into the next Phase/Implementation Period and the progress monitored throughout the remaining lifecycle. The PR will evaluate progress at the next application for new funding or Renewal (whichever comes first).

a. <u>Proposal development</u>

Key questions:

- Was the equity assessment participatory (including all key stakeholders, networks of affected and marginalized populations, etc.)?
- Have you established:
  i) Which population groups are most affected?
  ii) How are they affected?
  iii) Why are they affected? What are the factors that contribute to their vulnerability (e.g. poverty, gender, and marginalization)?
  iv) Is the current response appropriate? If not, how can it be improved?
  v) What are the barriers to equity (e.g., social, cultural, legal, geographical or in term of infrastructure, etc.)?
  vi) Do other donors contribute to reducing inequities for affected population groups?

vii) Can the barriers be overcome with Global Fund supported funding? If so how?

- Does the national disease strategy address identified equity issues? If so, is the proposal building on it?
- Does the proposal include programming to address the identified inequity/ies and barriers?
- Does the proposal include related M&E system strengthening measures (e.g. data disaggregation, analytical capacity, data use etc.) and corresponding budget?

Example:

In preparation for the proposal development of a new Round an applicant performed a participatory equity assessment of the national TB response. Findings suggested that more men are infected with TB than women; however, more women enrol in treatment and have also better treatment outcomes. Reflecting on barriers, one reason given for this was that many TB clinics are open only during the day, when most men go to work. In order to address this barrier the applicant sought Global Fund funding to extend the opening hours of key TB clinics to make them accessible to working men. In addition, in the first implementation period it was proposed to do an operational research study to look into effectiveness of this approach.

Expected outcomes:

- Equity assessment conducted in a transparent and participatory way (including all key stakeholders, networks of affected and marginalized populations etc.).
- Provided evidence for target population(s) and programming selected.
- Proposed programming addresses the findings of the equity assessment.
- Equity programming integrated in i) proposal strategy and interventions, ii) relevant indicators in the Performance Framework, if applicable, and iii) the budget, etc.
- Established plans to strengthen data collection (incl. disaggregation of data for important variables as identified in the equity assessment), analysis and use with a corresponding budget.

The Technical Review Panel will give due consideration to the inclusion and/or omission of interventions that target population groups most in need. Appropriate budget allocation is essential (e.g., in a concentrated HIV epidemic, 80% of resources should not target the general population without clear rationale). The Performance Framework should include relevant disaggregated impact/outcome, and if relevant output indicators to monitor progress in reaching groups which are targeted and most in need. Applicants may also propose output indicators measuring specific activities in a given context to address inequities. Finally, specific plans to strengthen equity related data collection, e.g., disaggregated data and/or analytic capacity should be proposed.

b. Renewal

For grants that integrate equity at the first Renewal, please review "Key questions" and "Expected outcomes" outlined above in Section I (proposal development). For grants which have integrated equity at proposal stage already, consider these **additional** questions and expected outcomes:

Key questions:

Has the grant contributed to improved equity?

- Have targets for the selected indicators been met?
- Have grant work plan activities been implemented?
- Have equity-enhancing actions been fulfilled?
- If there was an identified need, have M&E systems been strengthened?
- Have structural barriers been addressed?
- Are there any challenges that need to be addressed (e.g., data collection and/or analysis, program implementation) if the grant will receive continued funding?
- Have there been any unintended negative consequences of the programming?
- Have corrective actions been proposed to address unintended consequences in the next implementation period?

Example:

During the first implementation period of a grant in a country with a generalized HIV epidemic, HIV prevention targeted young people with peer education and other awareness raising activities. Studies from the country showed that girls were twice as likely to be HIV infected and much less knowledgeable about HIV as compared with boys of same age. Interventions were conducted in 10 centres for young people located in the capital city. The program was considered successful because it achieved 120% of the targeted number of participants. However, data disaggregated by sex showed that 80% of the participants were boys from the capital city. During the first implementation period, boys were reached disproportionately although girls had been identified as those more affected by HIV. Therefore the equity issue as identified in the proposal was not effectively addressed. Young people living outside of the capital city were not considered either. At the time of Renewal, corrective interventions were proposed to attract girls to use the centres (e.g., incentives to girls, parental involvement), as well as a reallocation of resources to decentralize the program to rural areas.

Expected outcomes:

- Comprehensive assessment and presentation of progress towards equity based on the equity assessment at proposal development stage
- Progress against selected indicators as negotiated in the grant agreement reported
- Reprogramming and/or reallocation of resources proposed in response to findings from the equity assessment of the current Phase/Implementation Period, if applicable.
- M&E system has been strengthened to collect, analyse and use disaggregated data throughout the current Phase/Implementation Period.

Starting in 2012, progress towards achieving equity will be formally assessed at Renewal, for those grants for which equity considerations were inbuilt during the proposal development stage and translated into the grant agreement. It is expected that corrective actions will be developed and implemented to address inequity during the next Phase/Implementation Period.

2) Enhancement of equity during the grant life-cycle

Equity can be enhanced and monitored at other stages of the grant lifecycle, i.e. grant negotiation and grant implementation and CCM oversight.

c. Grant negotiation and investment in systems

Key questions:

Are grant documents consistent with the equity programming described in the proposal, and TRP clarifications, if applicable:

- Does the grant work plan include specific activities to respond to identified inequities?
- Has corresponding budget been allocated?
- Have selected disaggregated impact/outcome and if relevant output indicators with corresponding targets been included in the performance framework?
- Does the M&E plan (or an annex to it) include clear plans to address data issues (e.g., disaggregation of data, data missing for target population, planned surveys, including qualitative studies, surveillance strengthening, strengthening of analytic capacity)?

Example:

In a country with a concentrated HIV epidemic, one of the five key objectives in a TRP-approved proposal was to create a supportive environment for an effective response. However, at the time of negotiation, the applicant proposed a shift from prison to community settings for harm reduction approaches for drug users. The rationale was that it is too hard to work in prisons because drug use is illegal and it may be easier to 'by-pass' the challenges posed by the legal environment in community settings. While work in the community could be supported, targeting the legal environment to make changes in the law or policy would help the applicant provide harm reduction both inside and outside of prisons.

Expected outcomes:

- Equity related programming integrated into grant work plans and grant budget, performance frameworks include relevant indicators and targets;
- Management actions proposed by GF Secretariat, if applicable, to be monitored during the first implementation period.
- Identified data issues and corresponding budgeted strengthening plan included in work plan and/or M&E plan.

For new grants, the grant negotiation stage is critical to make sure that activities to promote equity approved by the TRP are carried forward into the Grant Agreement. Programming for equity as described in the proposal should be included in grant work plans, budgets and performance frameworks. Programming that attempts to create a 'supportive environment' should not be overlooked during grant negotiation. For grants integrating equity at the time of the first Renewal, programming shall be informed by the findings of the equity assessment.

Equity related programming can be monitored in different ways:

i. Through selected disaggregated impact/outcome, and if relevant output **indicators** according to findings in the equity assessment, or output indicators measuring specific activities.
ii. If data cannot be measured through indicators, such as legal or policy reforms, grants may also include **milestones in the grant work plan.**
iii. **Actions** may be proposed by the Secretariat to monitor progress of required activities, such as strengthening of the M&E system to collect, analyse and use disaggregated data.

d. Grant implementation and CCM oversight

Key questions:

- Is the grant being implemented as negotiated?
- Are there any specific bottlenecks in program implementation in relation to equity? If so, can they be addressed and how?
- Are there unfavourable shifts in the national program environment? Can the Global Fund supported program address them?
- Has the CCM discussed how it will respond to allegations of human rights violations or political, social or legal threats to equity-enhancing activities as contained in the grant workplan?

Example:

In a malaria endemic country, the main focus of a malaria grant was to improve malaria prevention, diagnosis and treatment in the most affected regions of the country. The Global Fund is the main funding source for LLINs in the country. The grant is performing well, and the number of LLINs distributed has increased substantially during the first 12 months of implementation. However data from a new DHS survey have become available. They suggest that while LLIN ownership and use are increasing overall, the distribution of LLINs has been inequitable. The percentage of pregnant women and children who report having slept under an ITN is lower in rural areas as compared to urban areas. This issue has also been flagged by media reports. Further discussion revealed that the needs assessment had not been completed in certain rural catchment areas by the SR. Regular oversight by the CCM allowed this issue to be raised with the PRs to ensure that LLIN distribution plans are reviewed and revised accordingly in a timely manner during the current Phase/Implementation Period.

Expected outcomes:

- Improved CCM oversight and knowledge of interventions, including uptake and impact
- Mechanisms in place to make sure that programming is implemented as negotiated and problems are quickly addressed
- Stakeholders take ownership of the program
- CCMs work collaboratively with a wide variety of stakeholders (e.g., through meetings, information sharing, problem solving)
- CCMs identify and flag any issues (e.g., data collection, program implementation, unanticipated negative impacts).

The core function of the CCM is to provide on-going strategic oversight to grant implementation.

The Global Fund recognizes that only through a country-driven, coordinated and multi-sector approach, *involving all relevant partners,* will additional resources have a significant impact on the three diseases. To this end, the CCM is required to engage program stakeholders in oversight, including both CCM members and non-members, and in particular non-government constituencies and people living with and/or affected by the diseases.

The oversight role of CCMs is central to ensuring the implementation of equitable programs. In this respect, throughout the program life, CCMs should:

- Ensure that program activities promote equity and contribute to the elimination of stigma and discrimination against those living with and affected by the three diseases, especially populations that are marginalized or criminalized.
- Ensure that programs are implemented as negotiated throughout the grant lifecycle.
- Be aware of, and respond to developments in the national program environment which may affect program implementation (e.g. enactments of legislation criminalizing homosexuality, drug use or sex work).
- Strategically select information and/or indicators for follow up with PRs to ensure delivery of equitable program outcomes.
- Consider requesting reprogramming of funds when necessary to improve more equitable outcomes.
- Coordinate the provision of technical assistance for PR(s) and SR(s), and facilitate government or other partner involvement to resolve challenges as necessary.

While CCMs are responsible for oversight, others share responsibility to make sure the programming is implemented as negotiated. PRs and SRs are directly responsible for implementing interventions in an effective and appropriate way. Technical agencies and civil society partners (e.g., GNP+) can contribute to problem solving, on-going equity promotion, and ad-hoc analyses of performance. Global Fund staff may also help make sure that equity issues are being addressed, particularly in challenging country contexts. The expectation is that all stakeholders will take ownership of the program, and that strategies and programming will be adapted or included in national HIV, TB and malaria programs. The CCMs job is to help make this happen.

V. TECHNICAL ASSISTANCE, CAPACITY BUILDING AND RESOURCES

Efforts to promote equity through Global Fund financing may require technical assistance (TA) at any time of the process (e.g. at the time of the equity assessment, translating the findings into respective programming or during implementation). Technical partners can assist when such need is identified.

Usually, TA provision can occur at three stages of the grant lifecycle: the proposal development, pre-implementation (between grant approval and signature), and during the implementation phase.

Financing for technical assistance may currently be obtained through the grant TA budget line (this should be incorporated at proposal stage) and from partner financing, if available. In case no such provision was made at the proposal stage, the PR should consult with their CCM and the GF secretariat for guidance.[20] Some of the possible TA providers are listed below:

- **Grant Management Solutions**: www.gmsproject.org
- **Deutsche Gesellschaft fuer Internationale Zusammenarbeit**: www.giz.de; and http://www.gtz.de/en/themen/soziale-entwicklung/hiv-aids/4397.htm
- **UNAIDS**: for UNAIDS Regional Support Teams (RSTs) please see www.unaids.org and for Technical Support Facilities please see:
  www.unaids.org/en/CountryResponses/TechnicalSupport/TSF/
  Technical Support Facilities by Region:
  Southern Africa
  http://www.tsfsouthernafrica.com/
  Eastern Africa

[20] For more information consult the Global Fund Operations manual under:
http://www.theglobalfund.org/es/library/documents/

http://www.tsfeasternafrica.org/
West and Central Africa
http://www.tsfwca.org/
Southeast Asia and the Pacific
http://www.tsfseap.org/
South Asia
http://tsfsouthasia.org/

- **The World Health Organization (WHO) Regional offices and disease specific programs please see** www.who.int
- **Roll Back Malaria (RBM) Partnership ; f**or more information and the listing of countries in each network, please see: www.rollbackmalaria.org/countryaction/
- **The WHO Stop TB Department** http://www.who.int/tb/about/en/.
- **Technical assistance for civil society partners:** CSAT http://www.csactionteam.org/;
- **International HIV/AIDS Alliance regional Technical Support Hubs:** http://www.aidsalliance.org/Pagedetails.aspx?id=265 and contact the relevant regional hub directly.

In addition to technical capacity building by technical partners, the Global Fund will take advantage of CCM regional meetings, workshops, proposal road-shows, and TRP briefings to support and promote the integration of equity into the grant lifecycle.

Resources can also be made available to CCMs to convene meetings of members and country stakeholders to review equity assessments under the expanded CCM Funding Policy[21]. Funding can be used to strengthen CCM outreach, communication, and the quality of stakeholder participation and constituency engagement. Funds can be used to support constituency consultations, CCM meetings, training and workshops to share lessons learned, improve measurability and transparency of CCM performance and capacity building and addresses gender & sexual orientation strategies and concerns. Ultimately, the goal is to help CCMs make sure that Global Fund support of HIV, TB and malaria programming contributes to achieving equity in the broader national program context.

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[21] The CCM Funding Policy can be found under: http://www.theglobalfund.org/en/ccm/guidelines/#ccmfunding

Additional supporting Material

Global Fund Resources

Quick summary of Performance based funding process:
http://www.theglobalfund.org/en/library/documents/

Monitoring and evaluation toolkit resources:
http://www.theglobalfund.org/en/me/documents/

WHO/UNAIDS Resources

UNAIDS. (2007), Prevention guidelines towards universal access.
http://data.unaids.org/pub/Manual/2007/20070306_Prevention_Guidelines_Towards_Universal_Access_en.pdf

UNAIDS. (2010), Annual report on the global AIDS epidemic.
http://www.unaids.org/documents/20101123_GlobalReport_em.pdf

WHO. (2007),WHO *Towards Universal Access: Scaling up priority HIV/AIDS interventions in the health sector*.
http://data.unaids.org/pub/Report/2007/20070925_oms_progress_report_en.pdf

WHO. (2010), World Malaria Report.
http://www.who.int/malaria/world_malaria_report_2010/worldmalariareport2010.pdf

WHO (2010), *Monitoring Equity in Access to AIDS Treatment Programmes. A review of concepts, models, methods and indicators*.
http://whqlibdoc.who.int/publications/2010/9789241564120_eng.pdf

Additional Health Equity Impact Assessment resources

WHO Health Impact Assessment homepage: http://www.who.int/hia/en/

NICE (National Institute for Health and Clinical Excellence) (2006). *The Public Health Guidance Development Process. An Overview for Stakeholders Including Public Health Practitioner, Policy Makers and the Public*. London: NICE.

Tanahashi T. (1978), Health service coverage and its evaluation. *Bulletin of the World Health Organization*. 56(2):295–303.

Gwatkin, D. R. (2007), '10 best resources on... health equity', *Health Policy Plan,* 22 (5), 348-51.

European Centre for Health Policy. (1999), Health Impact Assessment: main concepts and suggested approach *Gothenburg consensus paper*.
http://www.hiaconnect.edu.au/files/Gothenburg_Consensus_Paper.pdf

The Wellesley Institute Home Equity Impact Assessment homepage:
http://www.wellesleyinstitute.com/policy-fields/healthcare-reform/roadmap-for-health-equity/heath-equity-impact-assessment/

Data and indicator resources

Monitoring and evaluation toolkit (3rd edition September 2011):
http://www.theglobalfund.org/en/me/documents/

The HIV/AIDS Survey Indicators Database: http://www.measuredhs.com/hivdata/start.cfm

World Health Organization – The WHO TB Epidemiology and Surveillance Virtual Workshop: http://apps.who.int/tb/surveillanceworkshop/default.htm

World Health Organization – The World Malaria Report: http://www.who.int/malaria/world_malaria_report_2010/worldmalariareport2010.pdf

USAID Measure DHS: http://www.measuredhs.com/aboutsurveys/mis/start.cfm

UNDP 2010 Human Development Indices homepage: http://hdr.undp.org/en/statistics/indices/

UNDP Gender inequality index: http://hdr.undp.org/en/statistics/gii/

UNDP Multidimensional poverty index: http://hdr.undp.org/en/statistics/mpi/

ADePT Software platform homepage: http://econ.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTRESEARCH/EXTPROGRAMS/EXTADEPT/0,,contentMDK:22595675~menuPK:7108374~pagePK:64168176~piPK:64168140~theSitePK:7108360,00.html

UNDP Human Development Report homepage: http://hdr.undp.org/en/reports/global/hdr2010/

Statistical tables: http://hdr.undp.org/en/media/HDR_2010_EN_Tables_reprint.pdf

ADePT Software homepage: http://go.worldbank.org/TVT8Y5HG81

GEGA Equity Indicators: http://www.gega.org.za

World Health Organization Global Health Observatory – Selected Indicators, HIV/AIDS, tuberculosis & malaria: http://apps.who.int/ghodata/

World Health Organization World Health Survey - Selected indicators for HIV/AIDS & Tuberculosis http://www.who.int/healthinfo/survey/en/index.html

Demographic and Health Surveys (DHS) - Selected indicators: http://www.measuredhs.com/aboutdhs/

AIDS Indicator Surveys (AIS) – Overview http://www.measuredhs.com/aboutsurveys/ais/start.cfm

Malaria Indicator Surveys (MIS) – Overview http://www.measuredhs.com/aboutsurveys/mis/start.cfm

Socio-Economic Differences in Health, Nutrition, and Population within Developing Countries (reanalysis of DHS) - Selected indicators http://go.worldbank.org/YL3L1CNR90

Broadening the equity framework

WHO Social Determinants of Health homepage: http://www.who.int/social_determinants/en/

The social determinants of health: developing an evidence base for political action. http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf

National Collaborating Centre for Broadening Healthy Public Policy: Health Impact Assessment review of tools: http://ccnpps.ca/docs/HIAGuidesTools2008en.pdf

The Adelaide Statement on Health in All Policies http://www.who.int/entity/social_determinants/hiap_statement_who_sa_final.pdf

Benchmarks of Fairness for Health Care Reform: A Policy Tool for Developing Countries. http://www.gega.org.za/download/benchmark.pdf

Community Interventions and Epidemiological Technologies (CIET International) http://www.ciet.org

Rasanathan K, Norenhag J, Valentine N.Realizing human rights-based approaches for action on the social determinants of health. HHR, Vol 12, No 2 (2010). http://www.hhrjournal.org/index.php/hhr/article/view/368/565

Hargreaves JR, Boccia D, Evans CA, Adato M, Petticrew M, Porter JDH, MD. The Social Determinants of Tuberculosis: From Evidence to Action . AJPH. 2011 Apr; 101 (4): 654-662. DOI:10.2105/AJPH.2010.199505.
http://ajph.aphapublications.org/cgi/content/abstract/101/4/654

Lavis JN, Lomas J, Hamid M, Sewankambo NK. Assessing country-level efforts to link research to action. Bull World Health Organ 2006 Aug;84(8): 620-8. ;

Lavis JN, Robertson D, Woodside JM, McLeod CB, Abelson J. How Can Research Organizations More Effectively Transfer Research Knowledge to Decision Makers? Milbank Quarterly 2003;81:221–48.

Lavis JN, Guindon GE, Cameron D, Boupha B, Dejman M, Osei EJ, Sadana R; Research to Policy and Practice Study Team. Bridging the gaps between research, policy and practice in low- and middle-income countries: a survey of researchers. CMAJ. 2010 Jun 15;182(9):E350-61. Epub 2010 May 3.

Guindon GE, Lavis JN, Becerra-Posada F, Malek-Afzali H, Shi G, Yesudian CA, Hoffman SJ; Research to Policy and Practice Study Team. Bridging the gaps between research, policy and practice in low- and middle-income countries: a survey of health care providers. CMAJ. 2010 Jun 15;182(9):E362-72. Epub 2010 May 3.