# ACTIONAID INTERNATIONAL

## HIV THEME REVIEW

2005-2010

**Final Report**

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## Abbreviations

| | |
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| AA | ActionAid |
| AAI | ActionAid International |
| AIDS | Acquired Immune-Deficiency Syndrome |
| ART | Anti-Retroviral Therapy |
| ARV | Anti-Retroviral |
| CBAP | Community Based AIDS Programme |
| CC | Community Conversation |
| CCM | Country Coordination Mechanism |
| CP | Country Programme |
| CSO | Civil society Organization |
| DA | Development Area |
| DFID | Department for International Development (UK) |
| FBO | Faith-Based Organisation |
| GAWA | Global Week of Action |
| GBV | Gender-Based Violence |
| GF | Gates Foundation |
| GFATM | Global Fund for fighting AIDS Tuberculosis and Malaria |
| GIPA | Greater Involvement of people living with HIV and AIDS |
| HBC | Home Based Care |
| HIV | Human Immune-Deficiency Virus |
| IDU | Injecting Drug User |
| ILO | International Labour Organization |
| INGO | International Non-Government Organization |
| MARP | Most At Risk Population |
| M&E | Monitoring and Evaluation |
| MDG | Millennium Development Goal |

| | |
|---|---|
| MSM | Men who have Sex with Men |
| NACP | National AIDS Control Programme |
| NGO | Non-Government Organization |
| OI | Opportunistic Infection |
| OVC | Orphans and Vulnerable Children |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PHC | Primary Health Care |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother to Child Transmission |
| PR | Principal Recipient |
| RBA | Rights based Approach |
| SIPAA | Support to International Partnership Against AIDS in Africa |
| SS | Stepping Stones |
| STAR | Societies Tackling AIDS Through Rights |
| STI | Sexually Transmitted Infection |
| TG | Transgender |
| VCT | Voluntary Counseling and Testing |
| SRH | Sexual and Reproductive Health |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNFPA | United Nations Population Fund |
| UNGASS | United Nations General Assembly Special Session |
| VAW | Violence Against Women |
| WAD | World AIDS Day |
| WHO | World Health Organization |

# Executive Summary

## 1 Background to the review

### 1.1 Purpose of the Review

The AAI HIV thematic team is undertaking a review of HIV work. The review is aimed at assessing the impacts of the activities of the country programmes for the period 2005-2010.

### 1.2. Methods:

The review was informed by a desk review of relevant literature which included within its scope a web-search (key words such as AAI and HIV, AAI Country Programme; AAI HIV projects/programmes). In addition a large amount of AAI HIV project literature including annual thematic reports was collected with the assistance of the HIV Thematic Team. A survey questionnaire was sent out to AAI country programmes with HIV thematic work to map HIV work and to identify key issues.

Field visits were made to AAI programmes in Ethiopia (assisted by Ruth Aura-Odhiambo), India and Nigeria. Telephone interviews were conducted with Uganda and Sierra Leone country teams. A separate report focusing on AAI's HIV work in Africa was completed by Catherine Muyeka Mumma (See Annex 1). The key findings of this have been integrated into this overall report. Detailed case studies were prepared for Ethiopia and India (See annexes 2 and 3).

### 1.3. Limitations:

The main challenge was the limited timeframe in which to process the large amount of information obtained. Not all AAI country offices responded to the questionnaire.

### 1.4. HIV, poverty and rights.

The HIV epidemic is almost 30 years old. Its impacts have been especially severe in sub-Saharan Africa, in particular in East And Southern Africa, where today with over 22 million people infected, the greatest challenges to development are still to be faced. The predicted devastating epidemics in Asia have not happened, partly because the forecast scenarios were based on faulty assumptions, but also due to effective interventions as exemplified by the successful national response in Cambodia. However, much work remains to be done in Asia in HIV prevention, treatment and impact mitigation. Developments in treatment now mean that HIV infection is not an automatic death sentence in low-income countries. However, the right to life for many people living with HIV (PLHIV) involves a struggle to obtain life-saving medication, including for opportunistic infections, and the nutrition that makes it effective. This involves health systems strengthening, particularly in rural primary health care and social welfare provision for PLHIV and their families.

The spread of HIV has been facilitated by poverty and gender inequality. Its impacts on the family exacerbate existing levels of poverty. HIV is judged to be sufficiently important for poverty reduction to be included among the Millennium Development Goals. Accordingly, MDG 6 is: Combat HIV/AIDS, Malaria and other diseases. The targets are:

**Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS; and**

**Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it.**

The UNGASS Declaration of Commitment on HIV and AIDS in 2001 provided unprecedented government commitments to respond and targets to be achieved. To monitor progress towards UNGASS targets, a comprehensive M&E framework which includes core indicators has been developed by UNAIDS and has been adopted by all countries. National UNGASS reporting, which is undertaken every two years is increasingly sophisticated and provides a means of holding governments to account. It is unlikely that Universal Access targets will be met by 2010 in many countries and many UNGASS targets have yet to be achieved.

Human rights are fundamental to any response to HIV. This has been recognized since the first global AIDS strategy was developed in 1987. Human rights have the goal of promoting and protecting the wellbeing of all individuals. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV on those affected. Stigma and discrimination against people living with or affected by HIV are major obstacles to delivering prevention, treatment and care services. Supportive frameworks of policy and law are essential to effective responses.

The spread of HIV is disproportionately high among groups who already suffer from a lack of human rights protection, and experience discrimination. Many PLHIV continue to experience severe stigmatisation as a result of their infection. This is partly a result of fear and also due to judgments about the morality of those infected who may be engaged with sex work, men who have sex with men or inject drugs. It is the moral factor which is most likely to be resistant to change. Stigma drives HIV underground and contributes to hidden epidemics. PLHIV often cannot disclose their status for fear of the reactions of partner, family, community and workplace. All PLHIV face some violation of their human rights. Women living with HIV often face worse discrimination. Widows whose husbands have died of HIV-related illness are an especially vulnerable group. Children living with HIV tend to be a neglected and rejected group. In summary, HIV exacerbates the poverty and marginalization of those infected and their families. In this context, the importance of a rights-based approach to HIV cannot be overemphasized.

The principle of the Greater Involvement of People Living with HIV/AIDS (GIPA) aims to realize the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives. GIPA aims to enhance the quality and effectiveness of the AIDS response and is critical to progress and sustainability. It seeks to ensure that people living with HIV are equal partners. A range of resources is available to help realize the GIPA principle.

## 2. The HIV Thematic Strategy for 2005-2010.

### 2.1 ActionAid and HIV/AIDS

ActionAid International was a pioneer in the NGO movement responding to HIV. Its work in Africa in particular was important particularly in developing community-based prevention through the Stepping Stones methodology. This has been widely adopted and adapted. It remains an important tool in the HIV response. New tools include STAR (Societies Tackling AIDS through Rights) and Mutapola, a rights-based framework for integrating women's rights in the HIV response.

AAI's implementation of the DFID-funded Support to International Partnership against AIDS in Africa (SIPAA) from 2001-2005 was an important breakthrough for the organisation. SIPAA interventions were designed to build capacity in 9 countries: Burundi, Ethiopia, Ghana, Rwanda, Lesotho, Swaziland, Tanzania, Cameroon, and Nigeria. They provided AAI with valuable experience with national HIV responses and PLHIV in particular.

AAI is a signatory to the NGO Code of Good Practice on HIV and AIDS. It had put in place a workplace policy on HIV and AIDS in 2003.[1] The broad objectives of this policy include creating a supportive environment; ensuring all employees and their immediate families have all the information necessary for HIV prevention and access to affordable and appropriate medical care; reduction of HIV-related stigma and discrimination; to promote shared confidentiality and to comply with the ILO Code of Practice on HIV and AIDS.

[1] ActionAid International (2003). HIV/AIDS in the workplace policy.

AAI has increasingly taken on a rights-based approach (RBA) to development and poverty eradication. There is a very close fit between RBA and HIV. Preventing HIV, providing treatment and addressing social impacts all require the realization of rights and at the same time rights are likely to be violated as a consequence of societal attitudes to PLHIV and those most at risk. PLHIV constitute one of the most vulnerable and marginalised groups in many societies.

### 2.2. AAI priorities in the period under review (2005-2010)

AAI priorities in the period under review (2005-2010) are set by the global strategy for poverty eradication. Four goals are set and six themes (each with its own strategy), one of which is HIV expressed as *the right to a life of dignity in the face of HIV and AIDS*. It perhaps should be noted that at stake is actually the right to life itself. HIV is also mainstreamed in three of the other themes (women's rights; right to education and right to a just and democratic governance) recognizing the importance of education in the multisectoral response, that HIV is a woman's and a governance issue. There are also regional strategies for Africa, Asia and Americas which in turn are translated into country strategies and even sub-national strategies in the case of India. This is a complex framework which requires the alignment of all strategies and coordination of effort across themes and programmes. As with any cascade process, there is likely to be some content loss as one goes down the system.

**The purpose of the HIV Thematic Strategy is to:**

***To implement the Rights to End Poverty strategy through actions that enhance the right to life and dignity for poor and excluded people living with, vulnerable and affected by HIV and AIDS, especially women and children in a focused, better coordinated, more effective international HIV and AIDS programme.*** [1]

The purpose would be achieved through 5 goals and 5 strategic objectives. There is some overlap in the content of these 5 areas. Essentially they encompass empowering PLHIV; supporting women and girl's rights; comprehensive HIV prevention; partnership development and advocacy to influence policies, laws and rights for PLHIV.

A number of issues are quite striking. First, the strategy makes very limited reference to the international and national architecture for the HIV response or the key players in HIV work. Moreover, its problem analysis is technically weak on key HIV issues such as prevention, impact mitigation, stigma and discrimination and access to treatment. The AAI Thematic Strategy for HIV provides no guidance on responding to HIV in different epidemiological scenarios. The conceptualization of the rights based approach is also limited in relation to national HIV policies and programming. Moreover, there is no clearly set out monitoring and evaluation framework with which to track progress towards objectives. There is a striking disconnect between the elaborate M&E arrangements which have been developed by UNAIDS and adopted at the country level as part of the UNGASS commitments. The lack of a robust M&E plan significantly undermines accountability of the performance of AAI in achieving the objectives.

There are strategic plans for the period 2005-2010 for: women's rights, education, the right to food; human security during conflicts, HIV and just and democratic governance. Of these HIV is included in women's rights, education and just and democratic governance. It is not included in the right to food[2] or human security strategy.[3] This is surprising because food security and nutrition are widely recognized issues for poor people living with HIV, while HIV is often a major concern in emergency settings. In addition to the global HIV strategy, HIV was included in regional strategies for Africa, Asia and the Americas. This results in a multiplicity of strategies which are imperfectly aligned. It would have been preferable for there to be one Global HIV Strategy and this to have included separate sections for the three regions and other themes where relevant.

[1]

ILO (2001). Code of Practice on HIV/AIDS. Geneva.
ActionAid International. (2005). HIV and AIDS. Strategic Plan 2005-2010. Page 7.
[2] ActionAidInternational (2005) Right to food.Strategic Plan 2005-2010.
[3] ActionAidInternational (2005) Human security in conflict and emergencies.Strategic Plan 2005-2010.

## 3 Main findings

3.1 **Programme Mapping**. A mapping of AAI country programmes and HIV showed the following results:

- Not all country programmes consider HIV to be a thematic priority;
- Appropriation of the HIV theme as a priority for country action is variable. Country epidemiological status is not a good predictor of activity;
- The response to HIV is strongest in sub-Saharan Africa, although there are some surprising omissions at country level (e.g. Mozambique);
- The Asia response shows most country programmes involved in HIV work. Some countries include it as thematic priority, some include it under other priority theme (e.g. Women's rights) and some omit it altogether.
- The HIV response is very weak in the Americas region;
- There is move in a few countries to include HIV under the Right to Health (NB. Not a thematic priority in the global strategy) or to merge it with other health issues (e.g. malaria);
- There is little evidence of an institutional focus on HIV in 'new wave countries' or countries emerging from conflict.

3.2 **AAI Niche for HIV work**

The picture obtained of AAI's strategic niche in HIV programming was complex, comprising multiple inter-locking elements. They involve the organisation's rights based approach to development; its target groups or partners; its methods; its capacity and its advocacy**.**

3.3 **Programme Outcomes**

**3.3.1 Goals and Objectives**. An attempt was made to assess progress made by the HIV and AIDS theme in relation to its goals and objectives as outlined in its strategic plan 2005-2010. The HIV Strategic Plan period saw a substantial scaling up of the HIV response, including a rapid expansion of access to treatment. There is no baseline from which to track progress. However, it is clear that there has been a significant expansion of HIV programming in Asia, while in Africa, the loss of SIPAA funding has been a challenge but programming is now taking place in 12 countries. This represents a very substantial portfolio of HIV interventions.

Progress towards achieving the 5 goals and satrgeic objectives of the strategy:

**Goal 1.** ***People living with HIV (PLHIV) will increasingly claim and exercise their rights, including access to comprehensive treatment, care and social security.***

**Strategic Objective 1.** ***Advocate for and support meaningful involvement of people living with HIV (PLHIV) and affected communities in shaping and taking action on the HIV response.***

This goal has been achieved. PLHIV are in a stronger position in many countries, in particular through AAI support to PLHIV organisations, to claim their rights and entitlements in health care and welfare provisions. This is most clearly the case in India, where PLHIV organisations have become pressure groups in several states and are in the process of emerging as a policy community, one which is able to influence government policy-making. A major contributory factor is the use of 'platform politics' to advance the agenda of PLHIV.

**Workplace policy**. This has not been systematically implemented. Some countries e.g. Cambodia have included activities to enforce the policy. However, commitment to the policy is not strong in all offices. This is attributed to the perceived costs of implementation. Resources do need to be allocated where HIV is an issue. Greater activism around the policy is required. A review is needed of implementation and revision of content and practices may be required as a result. Not all staff are aware of the policy. Not all those entitled to benefits are claiming or obtaining them. This suggests that a process of awareness raising, internally, is urgently needed. Staff-training sessions are also recommended. The workplace needs to be included in regular staff induction programmes. There also needs to be stronger commitment to GIPA in the workplace. Some country offices have hired PLHIV and are to be commended for this.

**Legal reform**. There is a need to strengthen AAI's work in policy development and legal reform. Tools need to be made available for country team members to undertake legal and policy analysis. At present no country team appears to have carried out any comprehensive policy or legal situation analysis from a rights-based perspective.

There are a number of success stories:

- **Nigeria**. In 2009, AA mobilised civil society organisations to work with the House Committee on Health to draft the national anti-stigma bill. AA Nigeria also facilitated the development and dissemination of national Islamic HIV/AIDS policy in the year. This policy is to guide HIV interventions within the Muslim community.[1]

- **Sierra Leone**. A HIV and AIDS bill was passed to promote the rights of PLHIV. Through this, the government committed to promote public awareness on causes, consequences, and means of prevention and control of HIV. With the passage of the bill discrimination against PLHIV is an offence. A network of women living with HIV was also launched to engage national and sub regional responses to HIV.

- In **Uganda, Nigeria, Zimbabwe,** and **Malawi** PLHIV circles lobbied and accessed ART and opportunistic infection treatments.

**Community-based programmes.** AAI has a toolkit of widely recognised community-based methods such as Stepping Stones, Reflect and STAR for addressing HIV-related stigma and other HIV issues. These, however, need to be more robustly evaluated as most evidence that is available is anecdotal and in individual narrative (story) form.

**GIPA**. AAI is working through is support for PLHIV organisations to put the GIPA principle into wider practice. It is ultimately the PLHIV activists themselves who will best placed to achieve GIPA through their own skills and commitment. Fellowship Training for PLHIV in India is an innovative way of supporting GIPA implementation and is recommended as a 'Best Practice'.

**Goal 2.** ***By exercising their rights, women and girls will measurably reduce their vulnerability to HIV and the impact of HIV on their lives including the burden of care.***

**Strategic Objective 2.** ***Support women and girls to claim their rights, reduce vulnerability and mitigate the impact of HIV on themselves***.

ActionAid Nigeria (2010). Annual Report 2009.Abuja.

Due to shortcomings in M&E, it is far from clear that vulnerability reduction among women and girls is taking place and if this is attributable to exercising their rights. Some success stories have been reported:

- **India**. The key achievement of the Mutapola project is that is has helped in reaching out to more than 5000 women in 24 districts of Gujarat resulting in more women seeking available health services and taking collective action to address issues related to Violence Against Women and HIV. The project has helped nearly 100 women avail benefits under the widow pension scheme and Antyodaya cards. In Orissa, the project is implemented by SHRADHA Network and has resulted in immense capacity development of women leaders, increased access to counselling, testing, treatment and also access to various state sponsored schemes. The women leaders met District Collector, District Social Welfare Officers and Municipality councillors at Puri and demanded for the timely delivery of Madhubabu Pension Scheme.

- **Lesotho**. Reported reduction of violence against women and girls;

- **Malawi**. Strategic partnerships built at national level with Coalition of Women Living with HIV (COWLHA)/ Women Forum have influenced decisions to improve access to treatment through mobile centers and have spoken out on malpractices in ART administration and nutrition supplementation.

- **Malawi.** GBV is being addressed through improved access to justice by survivors of violence through training in Prevention of Domestic Violence act; linkages created with victim support unit of the police; training of paralegals who support survivors to access justice through chiefs and the formal courts. Women have been trained in Treatment Literacy and are making a difference in educating others about ART drugs and how to promote drug efficacy.

- **Gambia**. Establishment of a strong and vibrant positive women's network that is taking a central role in the national HIV response;

- **Tanzania.** AA is managing a transforming education for girls' in northern Tanzania (TEGINT) project to address the underlying gender inequality which is keeping girls out of school and making them highly vulnerable to HIV infection and gender discrimination. The project targets girls, teachers, parents, school management committee, boys and policy makers in the project area. This project aims to help 30,000 girls to be enrolled, retained and complete their studies;

- **Uganda.** Through the Women Won't Wait Campaign development organizations have adopted the intersectional issues as their operational mechanism with TASO taking leadership. The experiences have also been used in documenting the Mutapola multi-country experiences for the development of a model program for strengthening women's rights in HIV.

The main approach has been the Mutapola Framework. There have clearly been implementation difficulties, although there are some success stories too. It is recommended that the Mutapola Framework be comprehensive reviewed and if necessary revised or incorporated into a broader human rights framework for HIV.

**Goal 3.** ***By exercising their rights, all those who are vulnerable to HIV infection will have the necessary information and skills to protect themselves from HIV infection.***

**Strategic Objective 3.** ***Support sustained comprehensive HIV prevention work to reduce vulnerability, especially women and children and high-risk groups.***

It is far from clear the extent to which the exercise of rights is reducing vulnerability to HIV. An assessment is needed to see how in practice this is contributing to empowerment and protection in the context of HIV prevention and impact reduction.

Most of the work taken place towards achieving this objective has been through the implementation of STAR and Stepping Stones. In all STAR countries, circle members have benefited from a number of income generating activities which include poultry, piggery, vegetable growing, cash crop sale, and various micro/informal businesses such as grinding and selling maize flour. Both of STAR and Stepping Stones are identified as best practices. The intended outcomes for this objective are all broadly positive, however they are beyond the capacity of AAI to monitor and measure.

Some success stories:

- **Bangladesh**. 126 STAR circles were established with, 126 community leaders (facilitators) and finally 10 CBOs were formed out of this 126 circles;
- **Gambia.** Created strong partnerships with relevant government agencies, CSOs and private sector for the national response. Facilitated in ensuring access to regular treatment, home based care and support for about 2000 PLHIV in the country.
- **Pakistan**. Enhancing the role of media through mobilizing to address the issue of victimization of vulnerable and disadvantaged sections of society e.g. female sex workers, transgenders etc.

**Goal 4.** ***PLHIV and other citizens will have the necessary organisations and movements to create sustainable and effective responses and spaces for advocacy in the fight against HIV.***

**Strategic Objective 4.** ***Facilitate strong, flexible and dynamic partnerships that aim to deliver an effective response against HIV based on the rights of PLHIV and affected communities, especially women and girls.***

The establishment and capacity building of PLHIV organisations is one of AAI's most important contributions to the international HIV response. This appears to be taking place in almost all countries where AA is implementing HIV activities.

Some success stories:

- **Afghanistan**. Strengthening the Capacity of Basic Package of Health Care Services staff in order to support PLHIV by ensuring their rights;
- **DRC.** Restoration of dignity, self confidence and reinsertion of PLHIV in society through psychosocial support and income generation activities;
- **Nigeria.** AA Nigeria contributed to establishing and strengthening 54 of the ward health committees in Delta, Kogi, Bayelsa, Nasarawa and Plateau states. The strengthened committees will facilitate access to primary health care within their wards and reduce the burden on secondary and tertiary health care providers;[1]
- **Nigeria.** HIV mainstreaming capacity building. AA Nigeria trained the State Agencies for the Control of AIDS (SACA) in Cross River, Akwa Ibom, Nasarawa, Kaduna and Benue states to enhance their capacities to mainstream gender within state HIV/AIDS policies and strategic frameworks.[2]
- **Malawi.** The capacity of local NGO / CBO partners, networks and alliances in programming and service delivery and advocating for increased resources to support grassroots responses have been strengthened.

**Goal 5.** ***States and other institutions will be accountable and responsive to their citizens, particularly by respecting and promoting the human rights of people living with and affected by HIV.***

**Strategic Objective 5.** ***Facilitate people-centred advocacy and campaigns that focus on supporting PLHIV and affected communities to claim their rights to life and dignity in the face of HIV and AIDS.***

It is not clear what the overall trend is in respect of states accountability and responsiveness in relation to HIV and rights. This needs to be reviewed at a country level. There is no evidence of AA undertaking any reviews or analytical work in this regard.

[1] ActionAid Nigeria (2010). AnnualReport 2009.Abuja.
[2] ActionAid Nigeria (2010). AnnualReport 2009.Abuja.

Some success stories:

- **China**: Over 10,000 persons took part in the photo exhibition, covering 5 provinces. It improved basic knowledge on HIV;

- **DRC**: Awareness raised on World AIDS Day and during GAWA;

- **Kenya. Advocacy on stigma and discrimination**. AA Kenya in partnership with Women Fighting AIDS in Kenya published a study on stigma (The Extent and Impact of HIV and AIDS Related Stigma and Discrimination on Women and Children). The study documents cases where fear, stigmatization and discrimination of PLHIV has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected by the disease.

- **Malawi**. Conducted campaigns to address cultural practices like early and forced marriages with bye laws enacted at community level to protect girls and keep them in schools

- **Pakistan**. Lobbying at districts level for the functioning and straitening of Basic Health Units and allocation of trained staff at few is the achievement. Advocacy, networking and liaison to combat rights based HIV related issues with policy makers, INGOs and NGOs to act as a pressure groups and concerned authorities.

- **Tanzania**. Conducted 2 policy research studies on community access to health services in remote areas and Primary Health Care facilities which influenced operational policies and frameworks.

**3.3.2 Key intervention areas**. An attempt was made to identify and document interventions which had critical impact and made changes in the lives of people living with HIV and other vulnerable communities. The main intervention areas were as follows:

- **Support for people living with HIV (PLHIV)**. There is considerable richness in the work involving supporting PLHIV empowerment and protection. This is a distinctive feature of AAI's work and arguably its main comparative advantage. The work involves establishing, strengthening and supporting various types of PLHIV organisation. The forms of organisation are varied and evolving. There is considerable anecdotal evidence to support the proposition that working to empower PLHIV to claim their entitlements and rights is an effective strategy. This work needs to be objectively evaluated. It is very promising. Other strands of PLHIV support include leadership training through the PLHIV Fellowship Programme in India, which is considered to be another 'Best Practice.' Again, it is in need of formal evaluation. It is time to focus the strategy on working with PLHIV and scale up where it is most effective.

- **Support for children including orphans and vulnerable children (OVC)**. Support for children affected by or living with HIV appears to be more limited. There are examples of good practice in India and Cambodia in Asia and Gambia, Kenya and Uganda in Africa. There is need to consolidate and deepen work across Africa where the impacts of HIV on the family and the child are most severe. More focus is needed on children living with HIV including adolescents. In summary, the work needs to be more strategic and a higher priority.

- **Gender-based interventions focused on women and girls**. There is a considerable range of gender-responsive programming with a strong focus on girls and women. It involves women and girl PLHIV, gender based violence; engaging women's groups; HIV prevention and impact mitigation. It is a theme within a theme. The impact of the Mutapola Framework seems very variable. Some country teams have embraced it, others have not. It is need of a comprehensive review. It was remarked by women living with HIV that the focus on women neglected the importance of men in the family and the community. It is recommended that a more holistic approach to gender analysis be used in HIV programming than the primary focus on women. Specific attention needs to be paid to HIV widows; positive prevention among HIV discordant couples; and strengthening networks of women living with HIV. The work needs to be more strategic.

- **Community based interventions**. There is a range of HIV-related community-based programme. Among these STAR and Stepping Stones stand out as being important models for community based HIV prevention, social mobilsiation and other areas of intervention. They have very wide application and represent golden assets of the organsation.

- **Capacity building of local government. NGOs and CBOs/coalition building**. It was difficult to obtain a clear picture of capacity building of local government CBOs, NGOs and networks as this work is typically embedded in broader programmatic work. Clearly a great deal of capacity building is taking place and is well attested by the organisations which have either been established with support from AAI or have been strengthened in partnership. It would be useful to tease out the most effective interventions especially with regard to PLHIV organisation capacity building. Capacity of local government has been built in India (Orissa) and Nigeria (multiple states).

- **Advocacy**. The advocacy work has been a constant strand within HIV programming. It appears as though much of this is not especially strategic, opportunistic or event oriented, though focused work is increasingly taking place. Some work has been innovative. It is unclear how effective the research has been and whether there has been adequate follow up. There is a need for an advocacy strategy with M&E indicators.

**3.3.3 Best practices**. A number of innovations were developed by the theme to achieve its goals. Some of these may be replicable. The best practices identified included:

- Stepping Stones;
- STAR;
- PLHIV fellowships (India);
- CBAP (Ethiopia);
- TSF (South Asia);
- PLHIV organization capacity building.

## 4 Key lessons learnt from the implementation of strategic plan

- There is a very good fit between HIV work and a rights-based approach to development. HIV provides an excellent entry point for addressing a wide range of human rights issues with one of the most oppressed and marginalized groups, PLHIV;

- While AAI has made progress in developing its RBA in HIV work, it cannot yet be described as comprehensive. It needs further articulation particularly in line with the increased emphasis on treatment and the commitment to Universal Access;

- Policy action has taken place in some countries. New HIV-related policies have been put in place in some countries. However, the UNAIDS 2010 Outlook report[1] indicates that in many countries there is a lack of clarity and agreement between government and civil society as to which policy areas have been addressed concerning stigma and discrimination, sex work, MSM and IDUs. It appears that many countries have yet to put in place adequate policies, to disseminate and to implement them. It is noted that AAI currently has no methodology at the country level for assessing the laws/policies and linkage to rights within its rights-based approach;

- It is far from clear that national HIV funding is being used most efficiently and effectively, benefiting those most in need, people living with HIV and populations most at risk. There is much informal mention of corruption and wastage of resources. Much more work with Social Audits and Budget Tracking is needed to enable rights-holders to hold duty-bearers to account, though this is an area of extreme sensitivity for many governments (e.g. Ethiopia) and a politically cautious approach is required;

- The mention of along term liberation war on HIV is in conflict with UNAIDS guidelines on language to be used to describe HIV. Conflict and war metaphors are to be avoided (even 'fighting HIV')

- AAI has worked hard to promote the rights of women in the HIV response. Significant work has been carried out with women living with HIV in a number of country programmes. Further work is needed. There is a need to evaluate the Mutapola Framework. It appears that women are still far from central in the HIV response;

- AAI has taken the GIPA principle seriously in many country programmes as reflected by the work in strengthening PLHIV organisations and leadership;

- The issue of space for CSO advocacy is critically important in the HIV response and the empowerment of PLHIV. This is an area of considerable political sensitivity which varies from country to country in terms of democratic traditions and culture. PLHIV empowerment needs to be carefully strategised;

- Mass movements on HIV have not arisen. This is partly a result of stigmatization and 'silent epidemics.' It would be more appropriate to consider the potential for developing effective PLHIV organisations and coalitions that support them.

## 5 Challenges and risks

**Funding.** Inadequate funding to achieve plan objectives and to implement programmes is a frequently cited challenge. The issue appears to be complex. There are multiple competing priorities as well as competing organisations for funds. It is clear that AAI has experienced a declining resource envelope for HIV over the period 2006-2009 as revealed in annual reports and accounts.

**Staffing constraints.** Staffing constraints are frequently mentioned. These include staff shortages, high staff turnover rates and lack of continuity, lack of HIV focal point or theme head and lack of training and expertise both internally and in partner organisations. Lack of internal understanding of HIV issues is also cited.

The impact of staff changes and losses in the international team are easy to discern. There appears to have been a loss of direction and commitment at a central level. The technical needs of AAI country teams are not being met adequately. There is an urgent need for high quality technical leadership at the international level within AAI and the space and support for this to function effectively.

**Management issues.** There is a hint of country programme management difficulties in the responses and documentation. These imply some difficulties in priority setting, human resource management, follow up and monitoring and evaluation. There is report of weak internal coordination across themes as well as a fragmentation of effort when HIV is mainstreamed. It would be helpful if thematic coordination mechanisms which are in place could be compared and the best practices promulgated.

**Development environment constraints.** The difficulty of operating in HIV where political will is lacking and health infrastructure is weak is mentioned. High levels of stigma and discrimination continue to make this a difficult area for development workers, especially where there are competing and more comfortable policy areas for attention. Competing priorities such as climate change may erode international commitment to HIV.

## 6. The internal operating environment of the theme and the wider organization

The internal operating environment varies form country to country. Some offices are clearly working very well. Others face constraints as a result of inadequate levels of staffing, lack of technical skills and insufficient funding. Support to country programme teams needs to be more strategic and improved.

The area of greatest concern is that of technical leadership at global and regional levels. The original concept of an International HIV Secretariat appears not to have functioned as envisaged. There have been staffing gaps and discontinuities. As a result it is very difficult to identify significant value added from the international level to country level work during the latter part of the strategic plan period in particular.

## 7. Key Recommendations

AAI has a unique niche in HIV programming. In particular, it plays an important role in empowering and protecting PLHIV. It is also active in addressing gender issues and community-based HIV prevention. Many of its staff are highly committed in this field. They are a valuable asset and need to be further empowered through training and exposure visits.

AAI is a relatively small player on the international scene compared with the World bank, bilateral donors, the Global Fund and the Gates Foundation if measured in terms of financing capacity. This means that scarce funds must be used in a highly strategic way, catalytically in concert where possible with other partners. It means that AAI's work must be explicitly within the national HIV response framework and recognized by all stakeholders to be contributing to the achievement of its objectives. This in turn entails new forms of partnership with Government and civil society actors. A corollary of this approach is that AAI's work must in great measure be accountable in terms of the national HIV M&E framework which is part of the Three Ones Principles. These rules make it unacceptable for the organisation to operate on the basis of its own unique set of indicators and processes for M&E. These planning factors should be clearly reflected in country programme strategies and the international strategy on HIV and AIDS.

The following key recommendations are made:

i.AAI to develop a new 5-year strategic framework for HIV which includes equity and primary health care and closely aligned with international and national frameworks for addressing HIV;

ii. The primary focus of HIV work should be the empowerment and realising the rights of PLHIV and their families;

iii. Gender should continue to be mainstreamed within the HIV strategy and should be broader in concept to include men and transgenders/sexual minorities. A strong focus on Women's Rights should be maintained;

iv. A focus should be on the empowerment of individual PLHIV leaders; community based groups and national networks to bring about measurable change for PLHIV;

v. Community-based work should continue in particular through STAR and Stepping Stones with the focus on Universal Access. This is an area of comparative advantage for AAI;

vi. AAI to develop comprehensive and user-friendly RBA guidance for HIV programming;

vii. AAI technical leadership on HIV to be strengthened and empowered at central and regional levels;

viii. A high priority to be given to strengthening M&E within the AAI strategic plan framework for HIV;

ix.AAI staff working on HIV to be given appropriate technical training on a regular basis;

x. AAI to renew its voice on HIV and AIDS.

### 5.4.4 Specific Recommendations

It is recommended that

xi) AAI work with PLHIV organisations be comprehensively reviewed and in selected countries in order to showcase the rights- based approach and identify the characteristics of effective interventions. AAI should invest in developing a best practice report based on its wide-ranging experience on capacity building of PLHIV organisations including documenting its work with women PLHIV in Africa and Asia to bring out rights issues and promising solutions in different country contexts;

xii) Efforts be made by AAI to encourage the scientific evaluation of the effectiveness of STAR in a selected country context(s);

xiii)The HIV Workplace Policy to be reviewed and revised. It should be implemented consistently across the organization;

xiv) HIV leadership in AAI develop and maintain policy dialogue with UNAIDS in Geneva and other key international players in the HIV field;

xv) A specific rights-based M&E framework be developed by AAI to monitor HIV work in country programmes in line with national HIV frameworks for M&E;

xvi) In future only one strategic plan be prepared for HIV work which includes the inputs from all contributing thematic and regional teams;

xvii) Consideration to be given to enhancing the coordination mechanisms for effective interdisciplinary, cross-thematic work at international and country levels in particular;

xviii) The technical content of the international and country strategies on HIV should be strengthened. This indicates a need for stronger technical oversight by HIV team leaders and more investment in capacity building within the organization;

xix) The Three Ones Principles in that AAI should be internalized by AAI have at international and country levels one HIV action framework, one coordinating mechanism and one M&E plan.

xx) The Fellowship Programme in India should be documented as a best practice;

xxi) The internationally accepted ‘GIPA’ be used rather than AAI’s ‘MIPA’;

xxii) A complete list of AAI research publications relating to HIV be drawn up and put on the main website with hyperlinks to PDF versions;

# Chapter -1

## 1. Background

### 1.1 The purpose of the review

The AAI HIV thematic team is undertaking a review of HIV work. The review is aimed at assessing the impacts of the activities of the country programmes in relation to the reduction of poverty (Rights to End Poverty) for the period 2005-2010.

The specific objectives of this review are:

- To assess progress made by the HIV and AIDS theme in relation to its goals and objectives as outlined in its strategic plan 2005 -2010;
- To identify and document interventions which had critical impact and made changes in the lives of people living with HIV and other vulnerable communities;
- To report on innovations and replicable models which were developed by the theme to achieve its goals;
- To document key lessons learnt from the implementation of the HIV strategic plan;
- To review the external environment globally and nationally in countries to assess the opportunities seized and missed out in the HIV response;
- To highlight challenges and risks faced by theme, countries and partners during implementation;
- To assess the internal operating environment of the theme and the wider organization (staffing, team capacity, organizational coherence, inter-thematic working and how this has contributed to or impede the achievement of the thematic objectives; and
- To outline opportunities and directions for future work with focus on policy influencing, programme interventions and sustainable resources.

### 1.2. Methods

The review was informed by a desk review of relevant literature which included within its scope a web-search (key words such as AAI and HIV, AAI Country Programme; AAI HIV projects/programmes). In addition a large amount of AAI HIV project literature including annual thematic reports was collected with the assistance of the HIV Thematic Team. A survey questionnaire was sent out to AAI country programmes with HIV thematic work to map HIV work and to identify key issues.

Field visits were made to AAI programmes in Ethiopia (assisted by Ruth Aura-Odhiambo), India and Nigeria. Telephone interviews were conducted with Uganda and Sierra Leone country teams. A separate report focusing on AAI's HIV work in Africa was completed by Catherine Muyeka Mumma (**See Annex 1**). The key findings of this have been integrated into this overall report.

### 1.3. Limitations

The main challenge was the limited timeframe in which to process the large amount of information obtained. Not all AAI country offices responded to the questionnaire.

# Chapter 2

## 2. The context: HIV, human rights and development

### 2.1 HIV, then and now

While the early response to HIV was slow, it eventually became a global issue of major importance. As a result of the rapid spread of the epidemic across the world, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was launched in 1996 to strengthen the United Nations response to the pandemic. It now coordinates the HIV/AIDS activities of 10 U.N. organizations (cosponsors), provides strategic information, and advocates for a greater political and financial commitment to control HIV. In recent years, there have been unprecedented financial and political commitments which have resulted in funding for HIV/AIDS in low and middle income countries to increase from $300 million in 1996 to $13.6 billion in 2008. This has strengthened HIV prevention programming and permitted millions of people to benefit from access to treatment and live longer lives as a result.

In the year 2005, at the point of departure for the AAI HIV Strategy, close to 5 million people were infected and an estimated 40 million people were living with the virus.[1] Sub-Saharan Africa was the hardest hit with 25.8 million living with HIV and there was evidence that epidemics were intensifying especially in Southern Africa. An increasing number of women were being infected and affected. Responses to HIV had grown and improved considerably but they still did not match the scale or pace of the epidemic. Access to antiretroviral treatment had improved markedly, but huge challenges were being faced in sub-Saharan Africa and Asia in ensuring that those in need of treatment were receiving it. The main challenges identified by UNAIDS in 2005 were the need for intensification of HIV prevention; HIV treatment and prevention efforts needed to be accelerated simultaneously; HIV prevention needed to be focused among marginalised groups, such as sex workers, injecting drug users, men who have sex with men as well as people living in poverty and in conflict situations.HIV stigma and discrimination had proved to be one of the most difficult obstacles to effective HIV prevention; Special focus was needed for children to ensure that they started life free from HIV through prevention of mother to child transmission (PMTCT);Universal access to prevention, treatment and care based on ‘best practice’ approaches.

By 2010, an estimated 33.4 million people were living with HIV.[2] Annually 2 million deaths were being reported each and 2.7 million new infections, almost half a million of these among children and almost a million among young people. Only about 40% of those infected know their status. Sub-Saharan Africa remained the worst affected continent with 22.4 million people living with HIV (PLHIV). Some 4.7 million were living with HIV in Asia and 2 million in Latin America. South Africa, Nigeria, Mozambique and India reported the largest numbers of people living with HIV.

Medical advances mean that with the provision of antiretroviral prophylaxis and replacement feeding, mother to child transmission can be reduced from around 30-35% to 1-2 % in ideal conditions according to UNAIDS.[3] The introduction of antiretroviral drugs (ARVs) in 1996 transformed the treatment of HIV and AIDS, improving the quality and greatly prolonging the lives of many infected people in places where the drugs are available. An estimated 5.2 million people in low and middle-income countries were receiving life-saving HIV treatment at the end of 2009, according to WHO (2010). WHO estimates that 1.2 million people started treatment in 2009, bringing the total number of people receiving treatment to 5.2 million, compared to 4 million at the end of 2008.

Estimates developed through epidemiological modeling suggest that HIV-related mortality can be reduced by 20% between 2010 and 2015 if new guidelines for early treatment are broadly implemented. Earlier treatment can prevent opportunistic infections (OIs) including tuberculosis (TB), the number one killer of people with HIV. Deaths from TB can be reduced by as much as 90%, if people with both HIV and TB start treatment earlier. he strength of a person’s immune system is measured by CD4 cells. A healthy person has a CD4 count of 1000 - 1500 cells/mm3. WHO previously recommended starting HIV treatment when a person’s CD4 count drops below 200 cells/mm3, but now advises starting HIV treatment at 350 cells/mm3 or below.

[1] UNAIDS. (2005). AIDS epidemic update. December 2005. Geneva
[2] UNAIDS. (2010). Outlook Report. 2010. Geneva.
[3] Op cit.

The revised treatment guidelines expand the number of people recommended for HIV treatment from an estimated 10 million to an estimated 15 million. The cost needed for HIV treatment in 2010 will be about US$ 9 billion, according to UNAIDS estimates.

Nevertheless, ARVs are not a cure. If treatment is discontinued the virus becomes active again, so a person on ARVs must take them for life. Although the price of ARVs has fallen significantly in recent years, their cost remains an obstacle to access in the developing world. Moreover, the health infrastructure required to deliver antiretroviral therapy is lacking in many places.

Access to drugs depends not only on financial and human resources. It depends also on people who need them being aware of their HIV status, knowledgeable about treatment, and empowered to seek it. Thus public information and education are important elements in widening access, alongside efforts to build or strengthen the health services. The campaign for universal access to life saving drugs for HIV and AIDS, started originally by grassroots AIDS activists, is today a major focus of attention of UN agencies and other influential organisations at national and global levels.

**2.2 ) HIV and the MDGs**

In September 2000, building upon a decade of major United Nations conferences and summits, the largest gathering of world leaders at United Nations Headquarters in New York adopted the **United Nations Millennium Declaration**. The Declaration, endorsed by 189 countries, committed their nations to a new global partnership to reduce extreme poverty and set out a series of targets to be reached by 2015 that have become known as the Millennium Development Goals (MDGs). The eight MDGs, which range from halving extreme poverty to providing universal primary education have galvanised unprecedented efforts to meet the needs of the world's poorest. The sixth MDG involves halting the spread of HIV. Targets have been set for this goal (See Box 1 below) and involve both prevention and treatment.

**Box 1. MDG 6 targets: Combat HIV/AIDS, Malaria and other diseases**

**MDG 6: Combat HIV/AIDS, Malaria and other diseases**

The targets of Millennium Development Goal 6 "Combat HIV/AIDS, Malaria and other diseases" include: ***Target***

***6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS***

6.1 HIV prevalence among population aged 15-24 years;

6.2 Condom use at last high-risk sex;

6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS;

6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years. ***Target 6.B:***

***Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it***

6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs.

**2.3 ) UNGASS and an unprecedented response**

In June 2001, Heads of State and Representatives of Governments met at the United Nations General Assembly Special Session (UNGASS) dedicated to HIV and AIDS. The meeting was a major milestone in the response. It was recognized that the AIDS epidemic had caused untold suffering and death worldwide. The UN Special Session also served to remind the world that there was hope. With sufficient will and resources, communities and countries could change the epidemic's deadly course. The theme of 'global crisis requiring global action' served to underline the need for urgent attention. At the meeting, Heads of State and Representatives of Governments issued the **Declaration of Commitment on HIV/AIDS**.[1] The Declaration remains a powerful tool that is helping to guide and secure action, commitment, support and resources for the AIDS response.

The UNGASS declaration of Commitment sets out national, regional and global targets for leadership (by 2003); and national targets for HIV prevention; care, support and treatment; human rights; reducing vulnerability to HIV; children orphaned or made vulnerable by HIV; alleviating the social and economic impact; research and development; HIV in conflict and disaster affected regions; and resource mobilization (targets to be achieved by 2003, 2005 and 2010).

### 2.4 HIV and Human Rights

Human rights are fundamental to any response to HIV.[1] This has been recognized since the first global AIDS strategy was developed in 1987. Human rights have the goal of promoting and protecting the wellbeing of all individuals. The promotion and protection of human rights are necessary to empower individuals and communities to respond to HIV, to reduce vulnerability to HIV infection and to lessen the adverse impact of HIV on those affected. Stigma and discrimination against people living with or affected by HIV are major obstacles to delivering prevention, treatment and care services. Supportive frameworks of policy and law are essential to effective responses.

The spread of HIV is disproportionately high among groups who already suffer from a lack of human rights protection, and experience discrimination. This includes groups that have been marginalized socially, culturally and economically; for example, injecting drug users (IDUs), sex workers and men who have sex with men (MSM). People living with HIV (PLHIV) or those affected by it will not seek counseling, testing, treatment and support if this means facing stigma, discrimination, and lack of confidentiality or other negative consequences. Discriminatory measures and other coercive actions drive away the people most in need of services. When human rights are protected, civil society organizations working on HIV are able to respond to the pandemic more effectively, fewer people become infected, and PLHIV and their communities can cope better.

It has become increasingly clear that national and community based responses to HIV will not work without the full engagement and participation of those infected with and affected by HIV (the 'GIPA principle'). The human rights of women and children must be protected if they are to avoid infection and cope with the impact of HIV. The human rights of poor people and marginalised groups such as IDUs, MSM and sex workers must be respected for the response to be effective.[2]

Among the most relevant international human rights standards related to HIV and AIDS are: the right to life: the right to liberty of movement; the right to work; the right to privacy; the right to marry and found a family; the right to non-discrimination and equality under law; the right to the highest attainable standard of health; the right to education; and the rights of women and children.

[1] Harvard University. (2004). HIV/AIDS and Human Rights in a nutshell.

[2] Open Society Institute (2007). HIV/AIDS and human rights: A resource guide. New York.
[3] Ofûce of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2006). International guidelines on HIV/AIDS and human rights. 2006 consolidated version. NewYork and Geneva.

Ofûce of the United Nations High Commissioner for Human Rights and the Joint United Nations Programme on HIV/AIDS (2007). Handbook on HIV and human rights for national human rights institutions. NewYork and Geneva.

[5] UNAIDS (1999)Handbook for legislators onHIV/AIDS, law and human rights.Action to combat HIV/AIDS in view of its devastating human, economic and social impact. Geneva.

[6] Open Society Institute (2007). HIV/AIDS and human rights: A resource guide. New York.
[7] UNAIDS. (2007). Reducing HIV stigma and discrimination: a critical part of national AIDS programmes. A resource f or national stakeholders in the HIV response. Geneva.
[8] IPPF (2008) The people living with HIV stigma index. London.

The UN has developed and updated international guidelines for human rights and HIV.[3] 12 guidelines are provided for States to implement an effective rights-based response. A handbook has subsequently been published by the UN on HIV and human rights for national human rights institutions.[4] It is designed to assist them to integrate HIV into their mandate to protect and promote human rights. It provides a basic overview of the role of human rights in an effective response to the epidemic and suggests concrete activities that national institutions can carry out within their existing work. It also presents possibilities for engaging with the national HIV response in order to protect and promote human rights, in the context of the **Three Ones Principles** (See below).

In addition, a range of resources are available to support human rights in national HIV responses. UNAIDS has published a handbook for legislators on HIV, law and human rights.[5] The Open Society has developed a resource guide on HIV and human rights.[6] UNAIDS has published a resource book for national stakeholders on reducing stigma and discrimination.[7] A stigma index has been developed for measuring stigma and discrimination experienced by people living with HIV.[8]

### 2.5 The GIPA Principle

The principle of the Greater Involvement of People Living with HIV/AIDS (GIPA) was formally recognised at the 1994 Paris AIDS Summit, when 42 countries agreed to support an initiative to "strengthen the capacity and coordination of networks of people living with HIV/AIDS and community-based organisations". They added that, "by ensuring their full involvement in our common response to the pandemic at all (national, regional and global) levels, this initiative will, in particular, stimulate the creation of supportive political, legal and social environments". In 2001, the United Nations Declaration of Commitment on HIV/AIDS endorsed the GIPA principle, which was further upheld in the Guiding Principles of the '3 by 5' Treatment Initiative. These guiding principles state that, "The Initiative clearly places the needs and involvement of people living with HIV/AIDS in the centre of all of its programming."

The GIPA principle aims to realize the rights and responsibilities of people living with HIV, including their right to participation in decision-making processes that affect their lives. GIPA aims to enhance the quality and effectiveness of the AIDS response and is critical to progress and sustainability. It seeks to ensure that people living with HIV are equal partners.

A range of resources is available to help realize the GIPA principle. UNAIDS has published guidelines[1] and a policy brief with recommended actions.[2] The International HIV/AIDS Alliance has published a good practice guide in collaboration with the Global Network of People Living with HIV (GNP+).[3]This includes standards for programming. A handbook for GIPA implementation has also been developed for NGOs and CBOs in India.[4]

**UNGASS Reporting**

In adopting the Declaration of Commitment on HIV/AIDS, Member States obligated themselves to regularly report on their progress to the General Assembly. The UN Secretary-General charged the UNAIDS Secretariat with the responsibility for developing the reporting process, accepting reports from member States on his behalf, and preparing a regular report for the General Assembly. Member States are required to submit Country Progress reports to the UNAIDS Secretariat every two years.

In collaboration with national governments, UNAIDS Cosponsors and development partners, the UNAIDS Secretariat developed a set of **Core Indicators for the monitoring of the Declaration of Commitment** for the first round of reporting in 2003. After each subsequent reporting round these indicators have been reviewed and, if necessary, updated, based on an analysis of indicator performance in previous reporting rounds, advice from partners and programmatic developments. Three rounds of UNGASS Reporting have taken place in 2004, 2006 and 2008. The UNGASS country response rate in 2004 was 54% of UN Member States submitted progress reports, which rose to 77% in 2008.

[1] UNAIDS (1999)Handbook for legislators on HIV/AIDS, law and human rights. Action to combat HIV/AIDS in view of its devastating human, economic and social impact. Geneva.

[2] Open Society Institute (2007). HIV/AIDS and human rights: A resource guide. New York.

In 2006 a **Political Declaration on HIV/AIDS** was adopted unanimously by UN Member States at the close of the United Nations General Assembly 2006 High Level Meeting on AIDS. It provides a strong mandate to help move the HIV response forward, with scaling up towards universal access to HIV prevention, treatment, care and support. It also reaffirms the 2001 Declaration of Commitment and the Millennium Development Goals.

### 2.7 The Three Ones Principles

On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves. They endorsed the "**Three Ones" principles**, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management: **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners. **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate. **One** agreed country-level Monitoring and Evaluation System.

As a result of action to implement the Three Ones principles, the overwhelming majority of countries have put in place national multi-sectoral strategic plans for HIV and AIDS. These are usually of 4/5 years duration and comprise the main framework for implementing the national response at all levels. This is usually coordinated by a National AIDS Commission (NAC) which is either located in the Ministry of Health or constitutes a separate entity.

The National HIV/AIDS Plan now includes a complex framework for monitoring and evaluation which is linked to UNGASS reporting. This is internationally agreed and includes a standard set of indicators with optional additional indicators. There are 25 core indicators. Guidance is provided by UNAIDS and regularly revised.[1] The national-level UNGASS indicators are divided into three categories:

i). **National commitment and action**. These indicators focus on policy and the strategic and ûnancial inputs for the prevention of the spread of HIV infection, the provision of treatment, care and support for people who are infected, and the mitigation of the social and economic consequences of high levels of morbidity and mortality due to AIDS. They also capture programme outputs, coverage and outcomes, for example, in preventing the transmission of HIV from mother to child, in providing treatment with antiretroviral therapy for those in need, and of services for orphans and vulnerable children.

ii). **National knowledge and behaviour**. These indicators cover a range of speciûc knowledge and behavioural outcomes, including accurate knowledge about HIV transmission, sexual behaviours and school attendance among orphans.

iii). **National-level programme impact.** These indicators, such as the percentage of young people infected with HIV, focus on the extent to which national programme activities have succeeded in reducing rates of HIV infection and its associated morbidity and mortality.

Most of the national indicators are applicable to all countries. For example, the knowledge and behaviour indicators related to the most-at-risk populations are relevant in countries with concentrated epidemics as well as countries with generalized epidemics if they are aware they have a concentrated sub epidemic occurring among a speciûc group. Similarly, countries with a concentrated epidemic are encouraged to collect data on general activities such as life skills education and sexual behaviours among young people as a means to track trends that could inûuence the nature of the national response in the future. International guidance has also been published for monitoring and evaluating the national response for children orphaned and made vulnerable by HIV and AIDS.[1]

UNAIDS. (2007). Reducing HIV stigma and discrimination: a critical part of national AIDS programmes. A resource for national stakeholders in the HIV response. Geneva.
[4] IPPF (2008) The people living with HIV stigma index. London.
[5] UNAIDS (1999) From principle to practice. Greater involvement of people living with HIV/AIDS. Geneva.
[6] UNAIDS. (2007). The greater involvement of people living with HIV. Policy brief. Geneva.
[7] International HIV/AIDS Alliance and GNP+. (2010) Greater involvement of people living with HIV/AIDS. Good practice guide. Hove and Amsterdam.
[8] International HIV/AIDS Alliance in India. (2004). Enhancing the Greater involvement of people living with HIV/AIDS in NGOs/CBOs in India. Delhi.
[1] UNAIDS (2009) Guidelines on construction of core indicators. Monitoring the UNGASS declaration on HIV/AIDS. Geneva.

## 2.8 Universal Access and the 3 by 5 Initiative

The "3 by 5" initiative, launched by UNAIDS and WHO in 2003, was a global target to provide three million people living with HIV/AIDS in low- and middle-income countries with life-prolonging antiretroviral treatment (ART) by the end of 2005. It was a step towards the goal of making universal access of HIV/AIDS prevention and treatment accessible for all who need them as a human right.

In 2005, leaders of the G8 countries agreed to work with WHO, UNAIDS and other international bodies to develop and implement a package for HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010. This goal was endorsed by United Nations Member States at the High-Level Plenary Meeting of the 60th Session of the United Nations General Assembly in September 2005. At the June 2006 General Assembly High Level Meeting on AIDS, United Nations Member States agreed to work towards the broad goal of 'universal access to comprehensive prevention programmes, treatment, care and support' by 2010. UNAIDS prepared an assessment of the processes and obstacle to be overcome in achieving Universal Access.[1] New international guidelines for intensifying HIV prevention under different epidemiological scenarios (low, concentrated and generalized epidemics) and for key target groups were developed.[2] An assessment of the investments needed was published in 2009.[3] This amounted to $19.8 billion in 2009 and $25.1 billion in 2010 for HIV services in low and middle-income countries.

The universal access initiative is complementary to the UNGASS Declaration of Commitment. It is the health sector that must play the lead role in coordinating the response at national and local levels, raising resources, administering health systems and delivering many of the most important interventions for HIV prevention, treatment, care and support through health services.
In many low- and middle-income countries, the chronically under-resourced health sector faces severe shortages of financial and human resources, and health systems are struggling to cope with the impact of the HIV epidemic. In some heavily affected countries in sub-Saharan Africa, people with HIV-related illnesses occupy more than 50% of hospital beds, and care and support services are overwhelmed by demand. At the same time as demand for health services increases, more health-care personnel are themselves dying or unable to work as a result of AIDS. Poor working conditions and low morale have also led many health workers to leave the sector or to migrate to countries offering better salaries and conditions.

Health infrastructure is very weak in many countries. Inpatient and outpatient facilities, laboratory capacity and systems to procure, manage and distribute drugs, diagnostics and other essential commodities such as disposable gloves and sterile needles and syringes, must all be strengthened if universal access is to be achieved. These constraints are contributing to low coverage of many of the major health-sector interventions against HIV/AIDS in many countries. Furthermore, stigma and discrimination against people living with HIV and most at-risk groups, including in health-care settings, continue to prevent people accessing the services they need.

Key challenges in achieving universal access include:[1]Scaling up HIV testing and counseling;Preventing sexual transmission; Prevention for people living with HIV/AIDS (positive prevention);Preventing transmission in health-care settings; Ensuring blood safety; Scaling up the prevention of mother-to-child transmission; Preventing HIV transmission through injecting drug use; Scaling up treatment and care; Overcoming major health systems constraints; Sustainable financing; and Monitoring the epidemic and the health sector response.

[1] UNAIDS. (2005). Guide to monitoring and evaluation of the national response for children orphaned and made vulnerable by HIV/AIDS. Geneva.
[2] UNGASS (2006). Scaling up HIV prevention, treatment care and support. New York.
[3] UNAIDS (2007). UNAIDS Practical guidelines for intensifying HIV prevention. Towards Universal Access. Geneva.
[4] UNAIDS (2009). What countries need. Investments needed for 2010 targets. Geneva
[5] WHO. (2006) Towards universal access by 2010. Geneva.

## 2.9 The Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund or GFATM) was established in 2002 as an innovative financing mechanism to raise and disburse funding to countries in need. As a partnership representing public and private stakeholders, the Global Fund uses a demand-driven, performance-based model. Countries can apply for grants to finance their response to HIV, whereas continued financing is dependent on achievement of targets. By March 2009, the Global Fund had committed $11.9 billion to 136 countries for HIV prevention, treatment, and care programmes. Significant efforts are also under way to develop and implement new prevention strategies and technologies.

At country level the Country Coordinating Mechanism (CCM) is a partnership composed of all key stakeholders in a country's response to the three diseases. It is responsible for submitting proposals to the Global Fund, nominating the entities responsible for administering the funding and overseeing grant implementation. The Global Fund signs an agreement with the Principal Recipient (PR) which is designated by the CCM. The PR either uses the financing directly or passes it on to other organisations (sub-recipients) for implementation.

It is highly unlikely that the Global Fund will be able to continue to expand its financing indefinitely. Much depends on the ability of the Fund to meet its funding targets through successive replenishments and to assure its donors that the governance and accountability measures are adequate to ensure that money is allocated and spent to the best effect.

## 2.10 The United States Emergency Plan for AIDS Relief (PEPFAR)

Launched in 2003 by President George W. Bush, PEPFAR is the largest effort by any nation to combat a single disease. In the first five years of the programme, PEPFAR focused on establishing and scaling up prevention, care and treatment programmes. It expanded access to HIV prevention, care and treatment in low-resource settings. During its first phase, PEPFAR supported the provision of treatment to more than 2 million people, care to more than 10 million people, including more than 4 million orphans and vulnerable children (OVC), and prevention of mother-to-child treatment services during nearly 16 million pregnancies.

As PEPFAR works to build upon its successes, it is focussing on transitioning from an emergency response to promoting sustainable country programmes. Future directions are as follows:**Sustainable programmes must be country-owned and country-driven.Sustainable programmes must address HIV/AIDS within a broader health and development context.** PEPFAR must be responsive to the overall health needs faced by PLHIV, their families, and their communities, linking the HIV response to a diverse array of global health challenges. As a component of the Global Health Initiative, PEPFAR will be carefully and purposefully integrated with other health and development programs. **Sustainable programs must build upon strengths and increase efficiencies.** To build upon the strengths of proven programmes, PEPFAR is scaling up effective interventions, particularly in prevention. It is working to ensure that increased access to coverage is accompanied by an emphasis on quality of services.

The abovementioned future directions apply in principle to all international development HIV interventions. They are highly relevant to AAI's future work.

## 2.11 The Gates Foundation

HIV is one of the top global health priorities of the Gates Foundation (GF), focusing on reducing the burden of HIV in developing countries. The Foundation strategy is to strengthen HIV prevention and helping ensure that HIV programmes are as efficient and effective as possible. To date, the Foundation has committed more than $2.2 billion in HIV grants to organizations around the world. It has also provided $650 million to support the Global Fund. To ensure that the investments have the greatest long-term impact, The Foundation has developed a highly targeted strategy for HIV that concentrates on three areas: Discovering and developing new tools; Maximizing the efficiency and effectiveness of HIV prevention and treatment programmes; Country demonstration projects.

This is an agenda that is in many ways similar to AAI's in that the organisation has invested in developing new tools (e.g. STAR, Mutapola etc). What has been less emphasised is the need for demonstration projects in country programmes. This needs to be considered in the next phase of HIV work.

## 2.12 Future Challenges in Addressing HIV

The challenges to be faced over the coming years include:

- Ensuring an appropriate balance between prevention, treatment and impact mitigation interventions;
- Sustaining the funding for treatment as increasing numbers require access to ART due to increasing numbers of people infected and rising demand for treatment services;
- Long-term financial sustainability of HIV programmes and ensuring that scarce resources are used optimally;
- Strengthening health systems to ensure that appropriate health services (VCT, ART, PMTCT, STI treatment etc) are available to all who need them;
- Addressing gender inequalities which increase vulnerability and risk of infection and which exacerbate the impact of infection;
- Maintaining HIV as a development priority and preventing donor fatigue in an environment in which there are new competing political priorities such as climate change and security; and
- Strengthening the rights-based approach to HIV.

A distinct challenge is maintaining a clear focus on HIV while ensuring a broader development or narrower health systems perspective. This requires a combination of HIV mainstreaming with the retention of specific 'vertical' programmed to address particular issues such as HIV-related stigma and discrimination.

## 2.13. Challenges for ActionAid International

AAI is a relatively small player on the international scene compared with the World bank, bilateral donors, the Global Fund and the Gates Foundation if measured in terms of financing capacity. This means that scarce funds must be used in a highly strategic way, catalytically in concert where possible with other partners. It means that AAI's work must be explicitly within the national HIV response framework and recognized by all stakeholders to be contributing to the achievement of its objectives. This in turn entails new forms of partnership with Government and civil society actors. A corollary of this approach is that AAI's work must in great measure be accountable in terms of the national HIV M&E framework which is part of the Three Ones Principles. These rules make it unacceptable for the organisation to operate on the basis of its own unique set of indicators and processes for M&E. These planning factors should be clearly reflected in country programme strategies and the international strategy on HIV and AIDS.

# CHAPTER- 3

## 3. HIV, Poverty and ActionAid International

### 3.1 Background

ActionAid International (AAI) is an international anti-poverty agency whose aim is to fight poverty worldwide. Formed in 1972, for over 30 years it has been growing and expanding its reach. Today it is helping over 13 million of the world's poorest and most disadvantaged people in 42 countries worldwide. For AAI HIV programming is a component of poverty eradication and not a stand-alone issue. Its HIV response is therefore part of broader approach to development. This is both a strength and a weakness. The main advantage is that while HIV is ultimately a health issue it has multiple social causes and results. A holistic response is necessarily multi-sectoral and broad in scope. The weakness is that the organisation's profile in HIV work may not be as clearly defined as those INGOs with narrower and more specific mandates such as the International HIV/AIDS Alliance or Family Health International. This may result in greater difficulty in obtaining funding for HIV work in contexts where AAI is not identified as an organization with a comparative advantage in this field.

The human rights-based or rights-based approach to poverty eradication and development lies at the heart of ActionAid's work.[1] Poverty is explained as a denial or a violation of human rights, though not all violations of human rights cause poverty. ActionAid's rights-based approach is best understood as having poor people fulfill their individual needs by claiming or securing their human rights. There are consistent principles that ensure that the process of securing rights is empowering and builds dignity. These are: Organizing and raising critical consciousness; Addressing people's needs as rights they can claim; Ensuring participation and actions of poor and excluded people; Paying attention to issues of power; and Holding state (and non-state actor) accountable.

**Key Components and Minimum Standards**. AAI has recently elaborated its RBA methodology.[2] There are to be three programming areas and 5 minimum standards. The key interlocking components are as follows:

- **Empowerment Component**. This concerns 'power within'. It involves work, such as capacity building, addressing immediate needs, organization building and rights consciousness programmes, with poor and excluded rights holders for enabling their collective analysis, identity and actions;

- **Solidarity Component**. This concerns 'power with'). It involves working with citizens, partners, coalitions and alliances for enlarging support to strengthen the power of poor and excluded people. Examples of activities include; alliance and platform building, networking with other rights holders, public awareness raising, mobilizing supporters and fundraising;

- **Advocacy and Campaigning Component**. This is targeted at duty bearers that violate or deny rights with the purpose of making changes in policies and practices, opening political space and building public opinion. Examples include: local and national campaigns; budget monitoring at all levels; advocacy and influencing processes, claiming of enjoying public policies.

The five minimum standards provide a framework to assess, support and provide strategic direction to local RBA programming. Programmes must have interventions related to each of the elements below or have a strategy that will build towards each of them. The minimum standards are: Building poor people consciousness as rights holders; Agency of the poor and excluded; Women's rights; Poor and excluded people critically engage duty bearers; and Changing the rules.

Addressing HIV necessarily involves taking a stance on human rights. This ought to be a significant advantage for AAI. However, it should be noted that AAI has not so far articulated a comprehensive rights-based approach that is specific to HIV within its broader mandate that can be used for programming, advocacy, policy dialogue or marketing. This is best seen as work in progress. Elements exist within the STAR approach and the Mutapola Framework for

[1] ActionAid (2008). Human rights-based approaches to poverty eradication and development
[2] AAI. (2010). Action on rights. June 2010.

Africa[1] and the Asian Framework on Women's Rights and HIV and AIDS.[2] What these do not include is any reference to the national HIV response architecture (e.g Three Ones; National Policy and legislation; UNGASS and Universal Access targets). It is recommended that AAI develop, on the basis of its HIV work, systematic guidance for a rights based approach to HIV and AIDS. This should also draw on existing resources for human rights and HIV, including GIPA. It would be helpful if such guidance also provided a framework for M&E. The guidance should be succinct and user-friendly.

AAI capacity to work in national HIV responses was given a huge boost through the implementation of the multi-country programme: Support to International Partnership against AIDS in Africa (SIPAA). It was a three-year initiative (2001-2004) funded by the UK Department for International development (DFID) and managed by the ActionAid Regional Office for Africa. The SIPAA programme was wholly constituted within the International Partnership against AIDS in Africa (IPAA) framework and principles. SIPAA interventions were designed to build capacity in 9 countries: Burundi, Ethiopia, Ghana, Rwanda, Lesotho, Swaziland, Tanzania, Cameroon, and Nigeria.

AAI has is a set of participatory tools or methods which can be used to harness a rights-based approach to HIV and wider development issues. The most widely known and applied of these is Stepping Stones. More recently, the STAR approach has been developed and implemented in a wide range of countries. These are discussed below.

### 3.1.1 Stepping Stones

Stepping Stones grew out of the need to address the vulnerability of women and young people in decision-making about sexual behaviour. Stepping Stones is a participatory training package that was originally developed in the mid 1990s to support the HIV prevention in sub-Saharan Africa.[1] It has been successfully adapted for use in Asia, North and Latin America and Europe (in over 40 countries). It has been used widely in the India response to HIV from 2003.[2] It is designed for use by a team of skilled people, ideally two male, two female, who work with peer groups of community members. The materials enable people to explore the huge range of issues which affect our sexual health, including gender roles, money, alcohol use, traditional practices, attitudes to sex, attitudes to death and our own personalities. Most sessions are designed for people in small groups of 10-20, of their own gender and age. Occasional sessions bring everyone together.

All sessions use a participatory approach of adult learning through shared discussions. The exercises are all based on people's own experiences, and role play and drawing exercises enable everyone to take part. No literacy is needed. Participants discuss their experiences, act them out, analyse them, consider alternative outcomes, and then rehearse these together in a safe, supportive group. People feel safe because most sessions take place in groups of their own gender and age. Though designed with HIV in mind, the package covers many related topics such as gender-based violence and alcohol use. It should be noted that Stepping Stones has been widely adopted by other NGOs and is no longer part of AAI's distinct comparative advantage in HIV. For example, a detailed implementation guide for Stepping Stones has been developed by ACORD.[3]

A review of existing evaluations was commissioned by ActionAid International in 2006.[4] It was reported that the wide and changing range of purposes that the Stepping Stones approach had been used for rendered synthesis difficult. The main changes reported in the various evaluations were: Improvement in communication; Positive increases in knowledge and understanding of HIV and AIDS; Changes in behavior including greater uptake of condom use; reduction in gender based violence; Reduction in the number of sexual partners. Selected findings from the report on Stepping Stones implementation are presented in Box 2 below.

[1] ActionAid international (2007). Knowing Mutapola. A Resource and Action Guide for Women's Rights and HIV and AIDS in Africa. Nairobi.

ActionAid International. (Undated). The Asian Framework on Women's rights and HIV and AIDS. Bangkok.

[3] Welbourne. A. (1995). Stepping Stones. A package on HIV/AIDS, communication and relationship skills. Strategies for Hope Training Series no. 1. ActionAid. London.

[4] ICHAP and ActionAid India (2003). Report on the TOT on Stepping Stones. A training package on HIV/AIDS, communication and relationship skills.

[5] ACORD (2007) Implementing Stepping stones. A practical and strategic guide for implementers, planners and policy makers. London.

[6] Wallace, T. (2006). Evaluating Stepping Stones. A review of existing evaluation and ideas for future M&E work. ActionAid International.

**Box 2. Stepping Stones. Selected Implementation Findings.**

- Many people enjoy the Stepping Stones process;
- It provides space for discussion and reflection;
- It works well in community mobilisation;
- The experience changes the lives of many Stepping stones trainers;
- Special adaptations are needed for different groups and to ensure local relevance;
- There is often little follow up after the training;
- Appropriate selection of participants, trainer and facilitators is critical for success.

A number of recommendations were made mostly focusing on the need to strengthen monitoring and evaluation arrangements. There were strong caveats about the quality of some of the self-reported data concerning behaviour change in particular.

A cluster randomised-controlled trial was undertaken by the Medical Research Council of South Africa to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa.[1] The overall aim of the project was to study Stepping Stones scientifically in the rural Eastern Cape. The primary aim was to determine the impact of Stepping Stones on new HIV infections, and secondary aims were to determine the impact on new genital herpes infections, sexual behaviour and male violence. Qualitative research methods were used to understand how youth responded to it and made meaning from the programme in the context of their lives.

The research confirmed that Stepping Stones is an important intervention and, although not unequivocal, the findings provide evidence of success in bringing about changes that reduced sexually transmitted infections in study participants. It was also shown it to be effective in reducing sexual risk taking and violence perpetration among young, rural African men. The cluster of male behaviours transformed by the intervention are associated with ideas of masculinity that entail risk taking and anti- social behaviour, one that were shown be linked to perpetration of intimate partner violence (IPV), rape and participation in transactional sex. The findings confirm conclusions of smaller scale evaluations of Stepping Stones in many other countries that have shown a reduction in male perpetration of intimate partner violence.

Stepping Stones is the only intervention that has ever been subject to evaluation in a randomised controlled trial in Africa and shown to be effective in changing young men's sexual practices and perpetration of violence. These results are thus very important, but further research is needed. The qualitative research shows that Stepping Stones impacted on a range of different areas of participants' lives and in many different respects supports the argument that, particularly men changed who they were as individuals and how they related to others. The programme brought about changes in attitudes which could critically influence HIV risk through providing knowledge, generally raising awareness of personal risk and giving a much greater openness about HIV. In the process it seems to have provided general life skills, which made many of them better partners, friends, family members and citizens. These findings suggest that Stepping Stones can be seen as a broad-based programme of individual and, through this, relationship change, and it is the ability of Stepping Stones to impact on so many areas of young people's lives that was the key to its success. They provide considerable evidence that Stepping Stones is a useful HIV prevention intervention and successful in changing a range of different men's behaviours, and thus is deserving of further development and investigation.

In India, Stepping Stones has been localised and used with PLHIV, youth, sex workers, people with disabilities and injecting drug users. It has been translated into a number of Indian languages and a Braille manual has also been developed.

[1] Jewkes et al. (2007). Evaluation of Stepping Stones. A gender transformative HIV prevention intervention. MRC. Pretoria.
[2] Wallace, T. (2006). Evaluating Stepping Stones. A review of existing evaluation and ideas for future M&E work. ActionAid International.

### 3.1.2 Societies Tackling AIDS through Rights (STAR)

Societies Tackling AIDS through Rights (STAR) is a participatory approach for community mobilisation, empowerment and response to HIV. The STAR approach focuses on deepening community analysis and understanding of HIV and [1]The STAR approach is a product of joint partnership between communities in 19 countries across Africa and Asia, ActionAid International and Pamoja Africa Reûect Network to address the challenges of ûghting poverty and various issues that come with it especially HIV and AIDS.

STAR is operatationalised in the areas of gender, human rights and HIV, making it a unique approach that addresses an integrated response. STAR strengthens community capacity among people's organisations to demand rights and access basic services. STAR circles provides and/or strengthens social space and structure for PLHIV, women and girls, poor and excluded people through to voice their concerns and demand services from the duty bearers at household, community, local and national government levels. All this is geared towards ensuring a sustained and continuous build up of a people-centred community response to HIV.

STAR has not been as robustly evaluated as Stepping stones. There is a need to encourage its use in scientific research including in randomised controlled trials to obtain evidence as to its effectiveness in achieving HIV-related objectives. It is therefore recommended that efforts are made by AAI to encourage the scientific evaluation of the effectiveness of STAR in a selected country context.

### 3.1.3 Mutapola

Mutapola is the AAI framework for integrating women's rights in the HIV response. *Knowing Mutapola: A Resource and Action Guide for Women's Rights and HIV and AIDS in Africa* is a resource on issues that have an impact on the lives of women and girls in the context of HIV.[1] Intended for HIV programme managers, the guide has been written from a women's rights perspective, to serve as:

- A primary resource and action guide for ActionAid staff and partners who deal with HIV and AIDS issues;
- A tool for identifying policy issues with impact on women and girls in HIV programming,
- A quick reference for basic facts and statistics on the impact of HIV on women and girls in sub-Saharan countries.

The guide aims to assist programme managers in developing rights-based women-specific HIV interventions. Specific users include AAI staff and partners, community-level workers, policy makers, women's rights activists working on HIV issues, women activists living with HIV, media workers and service providers. The Mutapola framework includes 6 modules: Women's rights and HIV and AIDS: an overview; Women's rights dimensions of HIV prevention; Treatment of HIV and AIDS; Care and support; HIV and AIDS and sustainable livelihoods; and Policy and advocacy.

The Mutapola Framework has been adapted for use in India and across Asia.[1]

### 3.1.4 NGO Code of Good Practice and HIV Workplace Policy

AAI is a signatory to the NGO Code of Good Practice on HIV and AIDS.[1] This includes guiding principles which are subdivided into organizational and programming principles. The former stresses: involvement of PLHIV and affected communities; multi-sectoral partnerships; transparent governance and accountability; clear mission and strategic objectives; organizational capacity to support effective HIV responses; planning and M&E; advocacy, research and scaling up. The latter focuses on HIV as a cross cutting issue in development and its mainstreaming in humanitarian programming.

[1] ActionAid India (2007). Claiming Rights. Theme HIV and AIDS. 2006. Karnataka.
[2] Okello, L et al. (2008) Societies Tackling AIDS through Rights (STAR). A practitioner's guide. ActionAid International.
[3] ActionAid International (2007). Knowing Mutapola: A Resource and Action Guide for Women's Rights and HIV and AIDS in Africa. Nairobi.

AAI had put in place a workplace policy on HIV and AIDS in 2003.[1] The broad objectives of this policy include creating a supportive environment; ensuring all employees and their immediate families have all the information necessary for HIV prevention and access to affordable and appropriate medical care; reduction of HIV-related stigma and discrimination; to promote shared confidentiality and to comply with the ILO Code of Practice on HIV and AIDS.[2] The review was scheduled to be reviewed in 2005 and if necessary modified. This does not appear to have taken place. This would have been the responsibility of the International HR/OD Directorate and not the HIV Theme Team. It is recommended that the Workplace Policy be reviewed in the light of implementation and revisions made if necessary in terms of content and implementation arrangements.

### 3.2 AAI Strategic frameworks

AAI programming is informed by global, regional, thematic and country strategic plans. At the apex is the overarching global strategy on poverty eradication for 2005-2010. This is supplemented by 6 priority thematic strategies. These flesh out the details of the priorities established in the global strategy. There are regional strategies which contextualise the global and thematic priorities and set the directions for work in Africa, Asia and the Americas. The next level of planning is at the country level. Country programmes (CPs) develop strategic plans and operational plans. The main strategic frameworks are described below from an HIV perspective.

### 3.3 ActionAid's Global Strategy for Poverty Eradication (2005-2010)

The overarching strategic direction for AAI's work in the period 2005-2010 is set out in its international strategy to end poverty.[3] It is intended to guide the actions of staff by setting out clear priorities and a framework for accountability to the poor people with whom it works and its supporters and funders. The strategy aims to deepen the focus on poverty eradication by addressing unequal power relations and strengthening the rights-based approach and methods. Work on education, food, gender and HIV would be intensified. New priorities would be democracy, governance and human security in conflict and emergency situations.

Four poverty eradication goals are set as 'rallying points' for all AAI work. They also will apply fully to HIV programming. These are: Poor and excluded people and communities will exercise power to secure their rights; Women and girls will gain power to secure their rights; Citizens and civil society across the word will fight for rights and justice; and States and their institutions will be accountable and democratic and will promote, protect and fulfill human rights for all.

The strategy sets out six strategic rights-based themes that would drive AAI policies and programming. These are: i). Women's rights; The right to education; The right to food; The right to human security during conflicts and emergencies; The right to a life of dignity in the face of HIV and AIDS; and The right to just and democratic governance.

It should be noted that HIV is one of the strategic priorities of the organization during the period 2005-2010. It is therefore fundamental to the overall accountability of the performance of AAI and to the achievement of its stated goals and objectives. The strategy paper also recognizes that HIV is very much a cross cutting issue. In the section describing key actions, the links are made between HIV and the rights of women and girls; education, sustainable livelihoods and nutrition and governance. Attention is also given to strengthening the capacity of people living with HIV (PLHIV), especially the poor and excluded; the rights of orphans and vulnerable children (OVC)

[1] ActionAid International. (Undated). The Asian Framework on Women's rights and HIV and AIDS. Bangkok.
[2] NGO HIV/AIDS Code of Practice Project (2004). Renewing our voice. Code of good practice for NGOs responding to HIV/ AIDS. Oxfam publishing. Oxford.
[3] ActionAid International (2003). HIV/AIDS in the workplace policy.
[4] ILO (2001). Code of Practice on HIV/AIDS. Geneva.
[5] ActionAid International (2005). Rights to End Poverty. ActionAid International Strategy. 2005/2010. Johannesburg

### 3.4 Thematic Strategies linked to HIV

There are strategic plans for the period 2005-2010 for: women's rights, education, the right to food; human security during conflicts, HIV and just and democratic governance. Of these HIV is included in women's rights, education and just and democratic governance. It is not included in the right to food[1] or human security strategy.[2] This is surprising because food security and nutrition are widely recognised issues for poor people living with HIV, while HIV is often a major concern in emergency settings.

An important issue concerning implementation is how HIV work is coordinated across the different thematic teams. To be effectively co-ordinate HIV across themes would require a mechanism within country teams and at regional/ international levels. It would require staff whose roles include HIV coordination responsibilities. A consequence of integrating HIV within other thematic work is to increase the complexity of programming in this field and potentially to dilute the focus of activity. A different approach would have been to include the contributions of other thematic teams within the HIV theme work. This would have been easier to monitor and report on.

The components of those strategies which include HIV are summarised below. HIV has its own theme strategy (See 3.5).

#### 3.4.1 Women's Rights

The strategy for women's (2005-2010) rights includes HIV as one of four strategic priorities.[1] This is to increase attention and action on women's rights in relation to HIV and AIDS, in particular to: Enhance awareness, analysis and consciousness on HIV as it relates to women and girls; Strengthen advocacy and campaigns for laws and policies as well as implementation of those that already exist to promote and protect the rights of women in the context of HIV and AIDS; Build and strengthen movements and organizations focusing on the rights of women, in particular organizations of women living with/affected by HIV and AIDS; and Strengthen mainstreaming of women's rights in HIV responses.

The women's rights theme will play a major role towards implementation of the Mutapola Framework on women's rights and HIV. The key contribution would be the initiation of an international campaign on violence against women and its link with HIV. The expected outcomes are: Reduction of HIV incidence amongst younger women , Concrete legislative changes to protect women (violence, inheritance, property, marriage) ,Formation of strong networks of women living with HIV at all levels; and Reduction of violence against women (VAW), in particular sexual violence

The core countries would consist of all Southern African countries, India, China, Nepal and Haiti. However, it is clear that gender (in this context, Women's Rights should be mainstreamed in all country HIV programmes)

#### 3.4.2 Education

The education theme strategy includes as an operational goal building strong linkages to the other five priority themes of AAI, building at least one example of excellent collaboration at each interface.[1] In HIV, the linkages involve: Asserting the rights of both infected and affected children and teachers in mainstream education, pushing for legal protection and effective Ministry policies and procedures e.g. to include challenging stigma and discrimination; Opposing abstinence-only approaches to education and promoting comprehensive preventive education which place HIV in the context of sexual and reproductive health, which facilitate gender and power analysis, and which include participatory approaches and peer education; Maintaining a leading role for ActionAid in the Global Campaign for Education's work around HIV and Education, to strengthen partnerships between education and HIV coalitions and to take forward work with the Global Coalition on Women and AIDS, UNAIDS, UNICEF and the UNAIDS Inter-Agency Task Team (on Education) through the Accelerate Initiative in Africa, Researching the impact of different approaches to dealing with HIV in education.

[1] ActionAid International (2005) Right to food. Strategic Plan 2005-2010.
[2] ActionAid International (2005) Human security in conflict and emergencies. Strategic Plan 2005-2010.
[3] ActionAid International (2005) Women's Rights. Strategic Plan 2005-2010.
[4] ActionAid International (2005) Education. Strategic Plan 2005-2010.

### 3.4.3 Just and Democratic Governance

Addressing HIV is a governance issue. The fourth goal of the AAI Governance strategy is to strengthen inter-thematic work and deliver on agreed cross-thematic objectives. [1]This includes for HIV actions to:

- Support budget tracking and economic literacy work, especially around funding for treatment, care and support, and advocate for greater transparency in budget allocation mechanisms;
- Advocate for law reforms to include specific clauses under HIV and AIDS discrimination in education, employment (government and private sector) and other spheres of public life;
- Build advocacy skills of affected communities and support links with more experienced advocates;
- Work with HIV and AIDS affected groups to developing an agenda around rights over services and resources, and the right to information; and
- Encourage transparency by making data on national responses to HIV accessible.

## 3.5 The HIV and AIDS Strategic Plan 2005-2010

### 3.5.1. Process

The HIV Strategic Plan was developed through a lengthy consultative process, managed by a specially constituted Strategic Steering Group (SSG), involving internal and external stakeholders that lasted 9 months culminating in its endorsement by in mid-2005.

### 3.5.2 Problem analysis

The HIV strategic plan was informed by a problem analysis covering the international context of HIV and the global response. This was based on data in the UNAIDS 2004 Report.[1] The main conclusions were that HIV was perpetuating poverty and injustice. The situation was worst where poverty was extensive, gender inequality is pervasive and the rights of PLHIV were denied. The multiple impacts of HIV and AIDS on development was recognized, including on the family and children. Sub-Saharan Africa was worst affected with an estimated 28 million living with HIV. HIV was spreading rapidly in Asia.

The analysis of the global response to HIV concluded that while various commitments to address HIV had been made by governments such as the UNGASS Declaration of Commitment on HIV/AIDS and the UN Millennium Declarations, they had not kept their word. The challenge to be faced was in getting all governments to meet their commitments.
CSOs needed to work harder for mass mobilization in order to be able to do better coordinated prevention and advocacy. Links needed to be strengthened between PLHIV organisations and human righst movements in order to maximize political capital and space for advocacy as well as facilitate a better community level response.

### 3.5.3 The strategic niche of AAI in the HIV response

AAI had been involved in the international response for almost two decades. It had developed participatory tools such as Stepping Stones and Reflect, which aimed to empower poor people to assess their situations and determine the best ways to respond to HIV. It had supported the growth of CBOs and networks of PLHIV across Africa.

AAI had benefitted from the experience of its implementation of DFID funded Support for the International Partnership on AIDS in Africa (SIPAA), which involved interventions in nine countries. The Mutapola Framework was launched to promote the rights of poor women and girls living with and affected by HIV.

[1] ActionAid International (2005) Just and democratic governance. Strategic Plan 2005-2010.
[2] UNAIDS (2004). Report on the Global AIDS Epidemic 2004. Geneva.

### 3.5.4 Purpose of the HIV Strategic Plan

The stated purpose of the HIV Strategic Plan is:

***To implement the Rights to End Poverty strategy through actions that enhance the right to life and dignity for poor and excluded people living with, vulnerable and affected by HIV and AIDS, especially women and children in a focused, better coordinated, more effective international HIV and AIDS programme.*** [1]

The HIV Strategy identifies a number of characteristics of the global HIV response that is desired from both AAI and its partners. These are set out in Table 1 below. While it is clear that an expanded and more rights-based response to HIV is desired, the specific details are largely lacking. There are for example no indicators or benchmarks with which to track progress and the achievement of the intended response. This is a missed opportunity. Some of the language, such a *people's liberation war* may even be counter-productive.

**Table 1. Intended HIV response**

| Intended response | Comment |
|---|---|
| 1. Mobilises global commitment, a sense of outrage, urgency and non complacent action now | No indicators provided with which to assess commitment |
| 2. Moves from political commitments to real policy action now by all leaders at all levels, in all countries and regions | No policy indicators given |
| 3. Sets out a comprehensive rights based approach that enables poor and excluded people who are vulnerable to, affected by and living with HIV to demand actions from governments and other institutions at all levels | This is where AAI can add value |
| 4. Establishes simple, efficient and effective mechanisms to *Make the Money Reach and Work* for the poor and excluded people living with, vulnerable to and affected by HIV and AIDS | There is no exemplification of mechanisms or indicators |
| 5. Mobilises a long term people's liberation war with positive impact on PLHIV and their households | This is not a helpful metaphor. |
| 6. Promotes central role of the rights and leadership of women in an effective response | No indicators of women's leadership in the HIV response |
| 7. Promotes the rights and central role of PLHIV in planning, implementing and monitoring an effective response | This is GIPA |
| 8. Supports the critical engagement and space for CSO advocacy in government and inter-government institutions at all levels | A critical issue. A rights-based approach requires democratic space for its effectiveness. How CSO engagement can be broadened is an important issue, especially in countries with little tradition of civil society activism. |
| 9. Mobilises a stronger, better connected, better coordinated people's mass movement to demand their right to life and dignity in the face of HIV and AIDS | It is difficult to envisage how a mass movement can be supported in the context of HIV stigmatization and discrimination, unless it is by PLHIV themselves. |

### 3.5.5 Thematic Goals and Strategic Objectives.

The strategy sets 5 Goals each with a strategic objective. These are set out in Box 3 below. The framework is somewhat problematic from the outset. It is unusual to have so many goals in a strategy. It can be argued that one goal should be sufficient to provide clarity on the overall long-term outcome intended. The strategic objectives which serve each goal area are statements of activity or process rather than objectives, which can be measured or assessed in terms of their achievement. As a result accountability for the delivery of the objectives is severely constrained. Moreover, it is quite difficult to separate out the different goal and strategic objective areas as there is considerable overlap in content.

**Box 3. HIV Goals and Strategic Objectives**

i) **Goal 1**. People living with HIV (PLHIV) will increasingly claim and exercise their rights, including access to comprehensive treatment, care and social security. **Strategic Objective 1.** Advocate for and support meaningful involvement of people living with HIV (PLHIV) and affected communities in shaping and taking action on the HIV response.

ii) **Goal 2.** By exercising their rights, women and girls will measurably reduce their vulnerability to HIV and the impact of HIV on their lives including the burden of care. **Strategic Objective 2.** Support women and girls to claim their rights, reduce vulnerability and mitigate the impact of HIV on themselves.

iii) **Goal 3.** By exercising their rights, all those who are vulnerable to HIV infection will have the necessary information and skills to protect themselves from HIV infection. **Strategic Objective 3.** Support sustained comprehensive HIV prevention work to reduce vulnerability, especially women and children and high-risk groups.

iv) **Goal 4.** PLHIV and other citizens will have the necessary organisations and movements to create sustainable and effective responses and spaces for advocacy in the fight against HIV. **Strategic Objective 4.** Facilitate strong, flexible and dynamic partnerships that aim to deliver an effective response against HIV based on the rights of PLHIV and affected communities, especially women and girls.

v) **Goal 5.** States and other institutions will be accountable and responsive to their citizens, particularly by respecting and promoting the human rights of people living with and affected by HIV. **Strategic Objective 5.** Facilitate people-centred advocacy and campaigns that focus on supporting PLHIV and affected communities to claim their rights to life and dignity in the face of HIV and AIDS.

What is most obvious is the lack of explicit connection with the main trends at the time in the international HIV response, such as the Three Ones Principles, 3x5 and the implications of new funding arrangements such as the Global Fund and PEPFAR. The international agreements and new international guidelines connected with the movement towards Universal Access by 2010 (in 2006) arguably should have resulted in a revision of the strategy. It appears that the HIV Strategy has been insufficiently grounded in the international and national architecture for responding to HIV. This points to the need for AAI leadership in the field of HIV to be fully conversant technically with the main currents in policy making and programming. It requires a close working relationship with UNAIDS in particular, but also other important players such as GFATM, bilateral agencies and key INGOs such as the International HIV Alliance.

It is recommended that HIV leadership in AAI develop and maintain policy dialogue with UNAIDS in Geneva and other key players in the HIV field. A strategic approach is required.

### 3.5.6 Actions and Outcomes

The actions for each goal together with statements of outcomes are given for each goal/strategic objective in the strategy in Table 2 below. The list of actions provides examples of activities that might be supported at the country level alongside the sort of outcomes that might be achieved. This appears to have the result of pushing the detailed work down to country level programming. The activity list is likely to be a valuable planning tool as it provides clear illustrations of actions for the organisation to implement.

The outcomes box is weakly conceptualized and lacks technical rigour. Many of the outcomes specified are difficult to measure without substantial investment in M&E inputs and close partnership with other agencies working in the same fields. . There is no explicit linkage made with the interventions proposed, anticipated outcomes and the national M&E framework or indicators for HIV that each country has as part of its commitment to the Three Ones principles. This seems to be a wasted opportunity to strengthen the monitoring of AAI's contribution to national HIV responses. No specific indicators are given for any of the outcomes, many of which would be difficult to qualify even if a base line study and data were available. Together with the Box 3, this is the closest approximation to a monitoring and evaluation framework for the HIV strategic plan and it will be utilized in the next chapter to discuss results. However, it falls far short of a technically robust and useful M&E plan.

It is recommended that a specific rights-based M&E framework be developed by AAI to monitor HIV work in country programmes in line with national HIV frameworks for M&E. Therefore, such a framework should be aligned with internationally agreed core and additional indicators. The HIV M&E framework should be linked to existing M&E arrangements such as ALPS.

**Table 2. Actions and outcomes**

| Goal | Actions | Outcomes |
|---|---|---|
| 1 | Support the effective roll out of the HIV Workplace policy at all levels within AAI and partner organisations<br><br>Advocate for legal reforms that protect and support PLHIV to utilize laws against stigma and discrimination.<br><br>Promote community level HIV prevention, treatment and care literacy and awareness of the negative impact of stigma and discrimination on the rights of PLHIV and affected communities<br><br>Advocate for, mobilise and support meaningful action for the central participation of PLHIV and affected communities at different levels, including planning, implementing, monitoring and evaluation, including financial resources and timely access to information | Increased uptake of testing, treatment and care by staff members<br>Reported increase in utilisation of anti-stigma laws by PLHIV especially women and girls<br><br>Increase in improved household and community level love, care and support for PLHIV<br><br>Increase in active advocacy and participation of PLHIV organisations in decision-making processes<br><br>Increased uptake of voluntary counselling and testing especially by women and youth |
| 2 | Advocate and support women to use policies, practices and laws that protect their sexual and reproductive health and land, income and other assets rights<br><br>Advocate for and support programmes that reduce and or eliminate the burden of AIDS care for women and girls | Increase in number of women and children reporting legal protection of land and assets rights<br><br>Reduction in violence and abuse of women and girls |

| | | |
|---|---|---|
| | Advocate for expeditious research on and availability of microbicides, female condoms and other female-controlled prevention tools | Reported reduction in the burden of home based care for on women and girls<br><br>Reported increase in access to affordable women-friendly prevention tools such as microbicides. |
| 3 | Facilitate community analysis and social mobilization actions using empowerment tools, such as Stepping Stones and Reflect (STAR), for prevention including informed decision making and challenge gender and power relations that underscore vulnerability to HIV infection<br><br>Support empowerment of communities to claim their right to comprehensive HIV prevention, voluntary counselling and testing and care programmes, including accurate information on condoms and sterile injecting equipment<br><br>Advocate for and support resources to household and community level preparedness through community based treatment literacy, care and peer support tools and skills.<br><br>Support school based programmes that integrate HIV prevention, sexual and reproductive health rights education into the school curriculum. | Reported reduction in HIV infection rates especially amongst women and youth.<br><br>Reported increase in access to voluntary counselling and testing, treatment, care and support especially for women and girls<br><br>Reported reduction in stigma and discrimination of PLHIV<br><br>Increase in reported community based treatment care and support |
| 4 | Invest in building partnerships based on trust, shared values, transparency, complementary capacity and credibility with PLHIV and affected communities<br><br>Advocate for and facilitate a sustained long term support including funding and learning to strengthen capacity of the response especially at community level<br><br>Identify capacity requirements and provide support through training, placements, mentoring, and learning exchanges, documentation of working experiences in the HIV response for staff and partners.<br><br>Research and develop effective community based “state of the art” social mobilisation and monitoring tools, including resource tracking that can effectively contribute to halting the spread of the HIV epidemic especially amongst women and girls | Reported increase in access to treatment, nutrition and care for PLHIV<br><br>Reported increase in number of community based organisations scaling up high quality coverage of community level programmes<br><br>Increase in reported improvement in quality of HIV programming in AAI and partners organisation in areas such as conflict and emergencies settings, cost effective home based care, and family nutrition for PLHIV especially women and girls.<br><br>Increased evidence that voices, perspectives and lived experiences and realities of PLHIV especially women and girls are actually influencing policy decisions effectively. |

| | | |
|---|---|---|
| 5 | Mobilise global political dialogue to investigate why the epidemic has been controlled in North America and Western Europe but getting out of control in Africa and Asia.<br><br>Mobilise global outrage against the failure of all governments at national, regional and international level to fulfilling their obligations and commitments set out in the UNGASS<br><br>Declaration of Commitment on HIV&AIDS, the UN Millennium Declaration and relevant regional declarations such as the Abuja Declaration<br><br>Mobilise CSO and organisations of PLHIV at all levels to demand that governments to better coordinate and strengthen policies, practices, structures and systems that improve decentralised response, especially at the primary health care, based on lived experiences of people affected by HIV from the grass roots and effective referral mechanisms<br><br>Advocate for international trade rules that enhance the right to universal access to free, sustainable, comprehensive, treatment, care and support, especially for women and girls | Increase in transparent, predictable, sustainable, mobilisation, equitable allocation, disbursement, utilisation, and accountability of HIV resources to poor and excluded PLHIV especially women and girls<br><br>Increase in access to free, quality treatment (including generics), care and support by PLHIV and affected household levels<br><br>Increase in active CSO and PLHIV organisations, mobilisations and advocacy for the right to life and dignity in the face of HIV and AIDS. |

### 3.5.7 Programme focus and advocacy strategy

The core country approach would involve a focus on:*New wave countries* (e.g. countries with large economies such as China, India, Nigeria and South Africa which had a large potential for the spread of HIV);*Countries emerging from conflict* (e.g. DRC; Rwanda, Burundi; Uganda, Liberia, Sierra Leone, Guinea, Ethiopia and Haiti; *Advocacy centres in the north* (e.g. USA; UK and Belgium -EC).

The core programmatic focus would be: Focus on the right to life and dignity for women and PLHIV. The empowerment and meaningful involvement of PLHIV would be supported; Strengthening decentralized community-based programming; and Advocacy that draws from programme realities and lessons on the ground.

### 3.5.8 Implementation Arrangements

The HIV strategy would involve a major scaling up of HIV work in AAI. It would be implemented through the following arrangements:

- **International HIV and AIDS Secretariat.** This would provide oversight, guidance and support to regions and country programmes.
- **Regional HIV Programmes.** The strategy steering group would be set up to monitor the implementation direction of the strategic plan. HIV operational plans would be developed and support given to country programmes.
- **Country Programmes.** Priorities for responding to HIV would be set in line with the strategic plan. HIV work would be focused or mainstreamed. The country programmes would design key activities to contribute to the achievement of the goals of the strategy.

Staffing of the International HIV and AIDS Secretariat would include 11 members, incuding the International Director Africa, an International Thematic Head and 4 Regional HIV and AIDS Advisors. At the Country level, there would be theme Heads or Programme managers supported by 2 programme officers (1 for policy and 1 for programme support).

Resource mobilisation would be supported by the fundraising unit. HIV proposal would be aggressively marketed on the basis of AAI's unique approach to HIV.

### 3.6 Regional Strategies

In addition to the global HIV strategy HIV was included in regional strategies for Africa, Asia and the Americas. This results in a multiplicity of strategies which are imperfectly aligned. It would have been preferable for the Global Strategy to have included separate sections for the three regions where relevant. It is recommended that in future only one strategic plan be prepared for HIV work which includes the inputs from all contributing thematic and regional teams.

The regional perspectives on HIV are described below.

#### 3.6.1 Africa

The overarching strategy and its six priority themes was applied to the Africa region.[1] It was noted that the HIV epidemic presented a unique burden and challenge for the continent. Over 70% of global HIV infections were in Africa and the second largest cause of death on the continent. In particular, there was an urgent need for treatment. HIV impacts were falling disproportionately on women and exacting a toll on the many children whose parents were infected with HIV, with large numbers becoming orphaned.

HIV would be a thematic priority. The HIV focus of the strategy would promote and protect the rights of African people to access HIV prevention, comprehensive treatment and support. A goal of the strategy would be to reverse rising rates of HIV infection and the impact on people and their development. Eight key actions were set out (See Box 4). Planned HIV allocations and expenditures would average 15% of the total indicative budget.

**Box 4. Key Actions for Africa**

- Expand implementation of the Mutapola framework in 75% of our Africa programmes to reduce the burden of care for women and girls and the epidemics impacts;
- Advocate for downward accountability of international and African institutions and leaders to deliver HIV related commitments including universal access to anti-retroviral drugs;
- Mobilise, strengthen and promote leadership and organisations of civil society at sub-regional and regional level, especially PLHIV to engage and advocate on issues of rights;
- Develop an interactive public data base of key sub-regional and regional state and non state actors and movement to promote partnership development and shared learning;
- Establish an institutional mechanism for sharing Africa's experiences of combating HIV with new
- epicentres of the epidemic in Asia and the Americas;
- Advocate nationally and regionally for policies that ensure an appropriate number of health professionals are trained and retained;
- Advocate for policies that strengthen health delivery services aimed at achieving universal access to good nutrition, services and comprehensive care; and
- Support and enhance quality of programme delivery at country level.

### 3.6.2 Asia

The Asia region strategic plan for 2005-2010 clearly identified the links between poverty, exclusion and HIV.[1] Some 8.2 million people were estimated to be living with HIV. Access to treatment was very limited. The severity of epidemics across the region varied. The worst affected included Cambodia Myanmar and Thailand with growing epidemics in Indonesia, Nepal and Vietnam.

HIV was selected as one of the six thematic areas for the Asia region strategy. The focus would be on promoting and protecting the rights of people in the 'face of HIV'. Key actions were listed (See Box 5 below)

**Box 5. Key Actions for Asia**

- Support Country Programmes (CPs) to understand design programmes linked up with Women's rights issues and advocate for appropriate policies and resources from government and other actors. Awareness and deeper analysis of links with women's rights including power to make decisions on safe sex;
- Work with parliamentarians, promote and mobilize organisations, alliances and movement of PLHIV e.g. APACHA and other agencies at regional level to fight and remove the stigma attached to their lives and status and for their rightful representation in decision making fora;
- Advocate and work towards increased resource mobilisation and allocation for the response to the threat of the epidemic, both regionally and internationally;
- Promote access of PLHIV to health and social care, treatment and rehabilitation;

Establish mechanisms to learn from Africa's significant experiences of combating HIV to enact effective programmes to counter it in Asia.

### 3.6.3 Americas

The Americas region strategic plan for 2005-2010 recognised that some 1.7 million people were living with HIV in Latin America, with the highest rates of infection in Guatemala and Honduras and Brazil the largest number of PLHIV.[1] In the Caribbean, an estimated 440,000 were living with HIV, with Haiti having the highest rate of prevalence. People living with HIV were frequently being excluded from employment and healthcare.

HIV was not accorded the status of a separate theme in the Americas regional strategy. It was included under the thematic priority of women's rights. The focus of HIV programming would be working with women's groups, especially in Central America and the Caribbean. HIV would remain on the political agenda and support would be given to campaigns and networking on access to affordable medicines. At the country level, the main focus would be Haiti. The projected costs of HIV work would amount to around 5% of the budget for achieving strategic objectives.
The strategy acknowledged constraints in the region, which included a limited presence (5 countries), limited resources (funding and staff) and a historical lack of focus in strategically investing scarce resources.

[1] ActionAid International (2005). Asia Region Strategic Plan. 2005-2010.
[2] ActionAid International (2005). Rights to Poverty. Aatemericas regional strategic plan 2005-2010.

### 3.7 Country level strategies

It is observed that AAI country programmes selected objectives from the various strategies. Objectives were obtained for 15 country programmes through the questionnaire and related documentation (See Table 3). This approach is likely to ensure that the work is best tailored to the country context. However, it means that the strategy is more of a cafeteria of options that a commitment to achieving organizational objectives. Detailed programmatic guidance on RBA and HIV might be more productive than the guidelines provided in the current thematic strategy.

What is very apparent from the available objectives is the strong focus on PLHIV. These suggest a narrower agenda than that proposed in Table 2. On the basis of the proposed objectives, it is concluded that PLHIV represent the core constituency for AAI work in HIV. It is recommended that PLHIV and their families be identified by AAI as the core constituency in any future HIV-related programming. Enabling PLHIV to claim their rights should be the prime focus.

**Table 3. Selected Country HIV Objectives**

| Country | HIV Objectives |
|---|---|
| **Afghanistan** | 1. Advocate for and support meaningful involvement of PLHIV and affected communities in shaping and taking action on the HIV response;<br>2. To strength deeper understanding of HIV, through establishment of short term courses on HIV prevention, care and treatment for Afghan professionals and working with staff of NGOs in the field of HIV;<br>3. To work with most vulnerable groups such as truckers and women by empowering and educating as well as by providing HIV prevention services. |
| **Bangladesh** | 1. To make government more responsive and proactive for positive people;<br>2. To work with several likeminded organizations for the betterment of people living with HIV and AIDS;<br>3. To organize several groups of positive people to establish positive people's organizations and provide support to strengthen those organizations. |
| **Cambodia** | 1. Building and strengthening livelihood self-help groups among PLHIV;<br>2. Campaign against stigma and isolation of women living with HIV;<br>3. Campaign for the right of the poor countries to produce generic medicines including the generic ARVs for HIV treatment. |
| **China** | 1. To improve the living standard of positive groups (livelihood for them, support groups) and network establishment and further linking with the APACHA at Asia regional level;<br>2. To promote STAR approach for community development and linking with violence with women in rural areas;<br>3. To reduce the discrimination and stigmatisation thorough HIV/AID Positive Photo exhibition to the groups like youth in universities and migrants and general public at large |

| | |
|---|---|
| **DRC** | 1. Facilitate people centered advocacy and campaigns that focus on supporting PLHIV and affected communities to claim their rights to life and dignity in the face of HIV;<br><br>2. To intensify work on the protection of women and girls against violence and HIV . |
| **Ethiopia** | 1. To ensure that people are able to prevent the spread of HIV and mitigate its impacts<br><br>2. To enable PLHIV to claim and secure the right to ART, care and support and be free from discrimination in the enjoyment of their rights. |
| **Gambia** | 1. To contribute to the stabilization and reduction of the prevalence of HIV in the Gambia<br><br>2. To facilitate the empowerment of PLHIVs through training, networking, campaigning and lobbying<br><br>3. To mobilize communities through participatory methodologies (Stepping Stones and STAR) to generate knowledge and skills to advocate and lobby for political will and commitment to HIV |
| **Lesotho** | 1. To empower women and girls to demand and exercise their rights in the fight against HIV and AIDS.<br><br>The objective was approached through partnerships with community based HIV and AIDS support groups that provided treatment, care and prevention interventions to the affected members of community. |
| **India** | Same as International Theme Strategy. |
| **Malawi** | 1. To support the creation of a just and enabling environment where the infected and affected especially the poor and socially excluded can demand and realize their rights to information, and access to quality HIV prevention, treatment, care and support services. |
| **Pakistan** | 1. Lobbying and advocacy with Government to finalize the country's HIV policy and hold government accountable to its commitments to allocate funds and meaningful flow of expenses against HIV.<br><br>2. Strengthening and supporting PLHIV especially women & children, FSWs, HBSWs and other excluded/vulnerable people to assert for their rights to access care, preventive, and treatment facilities against HIV & AIDS.<br><br>3. Mobilizing & supporting organizations, networks and associations of PLHIV to demand and exercise their rights by focusing on universal access. |
| **Sierra Leone** | 1. Facilitate peopled-centered advocacy and campaigns for meaning involvement of women living with HIV.<br><br>2. Sustain a comprehensive HIV prevention programme to reduce vulnerability and mitigate impact of HIV, especially on women and girls. |

| | |
|---|---|
| | 3. Promote and facilitate partnership to effectively respond to the rights of women living with HIV. |
| **Tanzania** | 1. Promote organisations of PLHIV.<br>2. Support to PLHIV and their organisations in advocacy, research, campaigns and networking.<br>3. Support initiatives of PLHIV to contribute in prevention, behaviour change, and in addressing stigma and discrimination. |
| **Uganda** | 1. To reverse the trend of HIV spread and support the development of a continuum of care and support and effective policy environment for scaling up the national response to the disease. |
| **Vietnam** | 1. To ensure that people are able to prevent the spread of HIV and mitigate its impact through raising their knowledge and understanding about modes of transmission and ways to avoid HIV infection.<br>2.To enable PLHIV to claim and secure the rights to comprehensive care, support, and related information on international and national policies, and be free from discrimination in exercising their rights, especially for women and children.<br>3. To advocate to government policy makers and community leaders for effective enforcement of responsive policies on rights to health care and support for PLHIV at all levels. |

The HIV Theme strategic plan was generally felt by respondents to be useful for country-level planning purposes. It was valued and performed the following functions: Provided strategic focus and planning framework; Acted as a road map: Guided country level programming; Helped identify most at risk populations; Placed emphasis on women; and Enabled links with international, regional and country levels.

### 3.8 Key Issues

**3.8.1 Complexity.** It is concluded that the strategic framework for HIV involving multiple interlocking and overlapping strategies is complex and difficult to operationalise. The different strategies with their different perspectives are not particularly well aligned.

**3.8.2 Technical content**. The different strategies are generally weak from a technical perspective. There is very little detailed discussion of issues in the key technical issues in HIV prevention, treatment and care at the national level which might inform country level programming;

**3.8.3 Lack of M&E plan for HIV**. The lack of clear monitoring and evaluation framework effectively hobbles this strategy from the point of view of accountability. Inadequate guidance is given to country level HIV teams in respect of selecting appropriate indicators (e.g. coverage, process and outcome) and assessment processes (e.g. quantitative and qualitative research. This needs to be included within AAI guidance on RBA and HIV.

### 3.9 Recommendations

It is therefore recommended that consideration be given to:

- Enhancing the coordination mechanisms for effective interdisciplinary, cross-thematic work at international and country levels in particular;
- Strengthen the technical content of the international and country strategies on HIV. This indicates a need for stronger technical oversight by HIV team leaders and more investment in capacity building within the organization;
- Ensuring that future strategies on HIV have well worked and technically sound M&E arrangements including the selection of appropriate indicators and means of assessment;
- Internalizing the Three Ones Principles in that AAI should have at international and country levels one HIV action framework, one coordinating mechanism and one M&E plan.

# CHAPTER - 4

## 4. The Main Findings of the Review

### 4.1. Mapping the Response

A mapping was undertaken of the AAI HIV response using a number of sources. These include internal and published reports on HIV activities, AAI website information, and a survey questionnaire which was sent out to country offices which were known to be implementing HIV activities. The response rate to the questionnaire was only moderate. A number of country offices did not submit a return, a theme that is also observed in internal reporting on HIV. Similarly, it needs to be stated that AAI websites at the country are very variable in the content they provide. There may be no policy or it exists, but it is not followed. In particular, the Country Plan is not often available for external scrutiny, which is a substantial shortcoming in the accountability of the organisation. Thus, the information is limited to what is currently available and there may be significant gaps.

The purpose of the mapping was first to determine whether the HIV was being implemented in all countries. HIV had been identified as one of AAI's six rights-based themes that would *drive policies and programming*,[1] as well as being explicitly included within the strategic plans of three other themes. The presence of HIV work can be considered as a litmus test, not only of the organisation's commitment and capacity to respond to HIV, but also to implement its global strategy for poverty eradication.

#### 4.1.1 Country focus. Which country programmes are implementing the HIV theme?

The mapping of country programme specific responses is presented in Table 4 below. As discussed above, due to data limitations and the lack of response from a few country offices, it is difficult to complete the mapping the response. Nevertheless, the following trends are discernable:

- Not all country programmes consider HIV to be a thematic priority;
- Appropriation of the HIV theme as a priority for country action is variable. Country epidemiological status is not a good predictor of activity;
- The AAI response to HIV is strongest in sub-Saharan Africa, though focused in 12 countries (See Annex 1);
- The Asia response shows that most country programmes are involved in HIV work. Some countries include it as thematic priority, some include it under another priority theme (e.g. Women's rights) and some omit it altogether.
- The HIV response is very weak in the Americas region;
- There is move in a few countries to include HIV under the Right to Health (NB. Not a thematic priority in the global strategy) or to merge it with other health issues (e.g. malaria);
- There is little evidence of a specific focus on 'new wave countries' or countries emerging from conflict, although HIV work is taking place in DRC and Sierra Leone;
- AAI country progarmme websites vary considerably in the attention they give to HIV, including the details of the country strategy/programmes.

The AAI Thematic Strategy for HIV provides no guidance on responding to HIV in different epidemiological scenarios. This is surprising as it would be expected that the response would be proportional to the scale of the epidemic and its impact on poor people and their human rights. It is therefore surprising to find that a number of Country Programmes where there is a generalised HIV epidemic (i.e. >1% adult HIV prevalence) appear to have little or no HIV activity or thematic work. For example, Thailand, which has the highest adult HIV prevalence rate in Asia, has no HIV thematic work. There appears to be little or no HIV related work in Burundi, Cameroon, Rwanda and Senegal. It is also possible that the table over-represents HIV activity. The returned survey for Mozambique indicated that little work was being currently undertaken on HIV.

**Table 4. Mapping of AAI country programme HIV thematic responses**

| Country | HIV Situation<br><br>(Adults aged 15 to 49 prevalence rate)Source: UNAIDS 2008 Global Report | AAI HIV Theme | AAI HIV strategy/ Country Strategic Plan (CSP) | Website features HIV | Submitted response to HIV survey |
|---|---|---|---|---|---|
| **East and Southern Africa** | 2% (1.8% - 2.2%) | Yes | Included in CSP (2005-2009) | Yes | YesCountry case study |
| Ethiopia | N/A (7.1% - 8.3%) | Yes | Included in CSP (2006-2010) under HIV and Right to Health Theme | Yes | Yes |
| Kenya | 23.2% (22% - 24.5%) | Yes | CSP not obtained | No | Yes |
| Lesotho | 11.9% (11% - 12.9%) | Yes | Included in CSP (2005-2010) | Yes | Yes |
| Malawi | 12.5% (11% - 14.7%) | Yes | Included in CSP (2007-2011) | Yes | Yes |
| Mozambique | N/A | No | CSP not obtained | No | No |
| Somaliland | 18.1% (15.4% - 20.9%) | Yes | Included in CSP (2006-2010) | Yes | No |
| South Africa | 6.2% (5.8% - 6.6%) | Yes | Included in CSP. | Yes | Yes |
| Tanzania | 5.4% (5% - 6.1%) | Yes | Included in CSP (2006-2010) | Yes | Yes |
| Uganda | 5.4% (5% - 6.1%) | Yes | Included in CSP (2006-2010) | Yes | Yes |
| Zambia | 15.2% (14.% - 16.4%) | | CSP not obtained | No | No |
| Zimbabwe | 15.3% (14.6% - 16 %) | Yes | Included in CSP (2007-2011) | Yes | No |
| **Central and West Africa** | | | | | |
| Burundi | 2% (1.3% - 2.5%) | No | CSP not obtained | No | No |
| Cameroon | 5.1% (3.9% - 6.2%) | No | CSP not obtained | No | No |
| DRC | 4.1% (PNLS, 2007) | No | CSP not obtained. HIV does not appear to be a thematic priority from website | No | Yes |
| Gambia | 0.9% (0.4% - 1.3%) | Yes | Included in CSP with malaria (2008-2012) | Yes | Yes |

| | | | | | |
|---|---|---|---|---|---|
| Ghana | 1.9% (1.7% - 2.2%) | Yes | Included in CSP (2005-2009)HIV is a thematic priority and also mainstreamed | Yes | Yes |
| Liberia | 1.7% (1.4% - 2%) | Yes | CSP not obtained | No | No |
| Nigeria | 3.1% (2.3% - 3.8%) | No | Included under Right to Health in CSP (2009-2013) | Yes | Country case study |
| Rwanda | 2.8% (2.4% - 3.2%) | No | No. 5 thematic areas selected. HIV is omitted | No | No |
| Senegal | 1% (0.7% - 1.4%) | No | CSP not obtained | No | No |
| Sierra Leone | 1.7% (1.3% - 2.4%) | Yes | Included in CSP (2007-2011) | Yes | Yes |
| **Asia** | | | | | |
| Afghanistan | N/A | Yes | CSP not obtained. | Yes | Yes |
| Bangladesh | 0% (0% - 0%) | No. | No. HIV is included under Rights and Social Justice (Social Inclusion theme) | No | Yes |
| Cambodia | 0.8% (0.7% - 0.9%) | No. | No. HIV is included under Women's Rights and Governance in CSP (2008-2012) | Yes | Country case study |
| China | 0.05%. | No. | No. Not included in CSP 2008-2012 | No | Yes |
| India | 0.36%. (2006) | Yes | Yes. Included in CSP 2005-2010HIV and Operational Strategy 2006-2010 | Yes | Country case study |
| Nepal | 0.5% (0.4% - 0.7%) | Yes | No. HIV is not a separate theme (Included under Right to Health) | Yes | No |
| Pakistan | 0.1% (0.1% - 0.2%) | Yes | HIV included in CSP (2008-2012) | Yes | Yes |
| Sri Lanka | 0% (0% - 0%) | Yes | Included in CSP (2005-2008) | Yes | No |
| Thailand | 1.4% (0.9% - 2.1%) | No | No. Not included in CSP | Yes | No |
| Vietnam | 0.5% (0.3% - 0.9%) | Yes | HIV included in CSP (2006-2010) | Yes | Yes |
| **Latin America and Caribbean** | | | | | |
| Brazil | 0.6% (0.5% - 0.8%) | No | No. Not a theme in CSP. | No | No |
| Dominican Republic | 1.1% (0.9% - 1.2%) | ? | CSP not obtained | No | No |
| Guatemala | 0.8% (0.5% - 1.1%) | Yes | Included in CSP (2006-2010) | Yes | No |
| Haiti | 2.2% (1.9% - 2.5%) | ? | CSP not obtained | No | No |

**4.2 Country Action. Which HIV interventions are country programmes implementing?**

A rapid mapping was undertaken of the HIV activities that various country programmes are implementing in relation to thematic work. These are tabulated below separately for Africa and Asia (See Tables 5 and 6).

The tables show the strong focus across country programmes on empowering PLHIV, largely through building the capacity of their organisations and their leadership. There has been a prioritisation of women living with HIV. There has been an important contribution from the intersection with Women's Rights. In general, this appears to have been the most effective cross-thematic work and is significant in many country programmes. The contributions from education and governance thematic work are far more patchy. There is a strong thread of community based intervention whether for Stepping Stones, STAR or REFLECT along with capacity building of CBOS and some FBOs. There has been a considerable amount of influencing work involving lobbying, campaigning and research.

HIV-related activities can be organized into the following categories: Support for people living with HIV; Support for orphans and vulnerable children (OVC);Gender-based interventions focused on women and girls; Community based interventions; Capacity building of Local Government, NGOs and CBOs; and Advocacy.

**Table 5. HIV Interventions in Africa**

| Country | PLHIV rights and GIPA | Reducing vulnerability of women and girls | Comprehensive HIV prevention and mobilisation | Partnership development | Advocacy, dialogue and campaigns |
|---|---|---|---|---|---|
| **DRC** | Capacity building of PLHIV organisations Income generating activities for (women) PLHIV | Violence against women | STAR circles | CSO capacity building/ mobilizationGovernment capacity building | GAWAPLHIV law advocacy |
| **Ethiopia** | Capacity building of PLHIV organisations (including women a focus on PLHIV) | | STAR circles Commity Based AIDS Programme (CBAP)HIV mainstreaming | CSO capacity building/ mobilizationGovernment capacity buildingEnhancing the role of mediaBusiness coalition | PLHIV policies |
| **Gambia** | Capacity building of PLHIV organisations Establish positive women's network (Mutapola) | OVC supportStrengthening women's networksMutapola | STAR circles Stepping StonesGFATM prevention programme (principal recipient) | Coalition building of CSOs | Care and treatment for PLHIV |
| **Ghana** | Capacity building of PLHIV organisations<br><br>Positive living<br><br>Nutrition support for PLHIV | Violence against women | Strengthening community capacity<br><br>Training of religious leaders<br><br>Engagement with District assemblies | CSO capacity building/ mobilization<br><br>Enhancing the role of media<br><br>Engagement with District Assemblies | Stigma and discrimination<br><br>WAD/GAWA<br><br>Research on violence against women |

| | | | | | |
|---|---|---|---|---|---|
| **Kenya** | Capacity building of PLHIV organisations Support for PLHIV networks and support groupsPositive prevention | OVC support/birth registration and property rightsChildren and Women Support Project | STAR CirclesStepping StonesSocial Mobilization of Youth (GFATM) | CSO capacity building/ mobilizationLinking communities to primary health care | Stigma index reportPediatric treatment Campaigns for pro-poor health policiesSupport demand for VCT and PMTCT services |
| **Lesotho** | Support for PLHIV organisations/support groups | Empowerment of women and girlsHome based care (HBC) training for women in HBC groupsIncome generating activities | REFLECT circles | Capacity building of grass roots organisationsHIV mainstreaming | Promotion of VCT and PMTCT servicesCampaign against stigma and discrimination |
| **Liberia** | Networks of women PLHIV | Women's empowerment networkViolence against women | STAR circles for women | | Involvement in National HIV Plan developmentGAWA |
| **Malawi** | Capacity building of PLHIV organisations Coalition building (e.g. women living with HIV)STAR PLHIV circles | Addressing GBVCapacity building of women's organisationsStepping StonesMutapola | Treatment literacySTAR circles | | Advocacy for access to prevention, treatment and careStudy on home based care referralHIV Bill lobbying |
| **Nigeria** | Capacity building of PLHIV organisations STAR PLHIV circles | Gender mainstreaming in State level HIV responsesCapacity building for women-led support groups and HIV networks | Peer Education Plus (PEP)STAR circles with traditional and religious leadersEssential sexual and reproductive health services programmeHealth systems strengthening (GFATM)Peer Education Plus (PEP) | Capacity building of traditional leadersNGO/ CBO capacity buildingCapacity building of SACAs and LACAsHealth systems strengthening | Study of PHC in HIV responseAnti-stigma law in Enugu StateHIV policy by FBOsHIV resource tracking capacity building |

| | | | | | |
|---|---|---|---|---|---|
| **Sierra Leone** | Support for PLHIV organisations | Violence against womenGender mainstreamingSTAR circles for women living with HIVMutapola | STAR circles for poor communities | Coalition building | Study of PHC in HIV responseWomen PLHIVGAWA/ WADPrevention and Control Act |
| **Tanzania** | Support for PLHIV organisationsCapacity building of PLHIV organisations | Girl's education | STAR circles for local communitiesCommunity Forums to address stigma and discrimination | CSO capacity building/ mobilization | Study of PHC in HIV responseGAWA/ WADReview of National HIV policyDebate on HIV/SIDS Act |
| **Uganda** | Capacity building of PLHIV organisationsPositive preventionAAI workplace policy | MutapolaResearch on burden of care on women and girlsDirect support for OVCWidows and affected womenWomen and children in conflict areasViolence against women | STAR PLHIV circlesHIV mainstreamingFishing communitiesSchool HIV clubs | Coalition building | Action researchHIV and AIDS BillUNGASS commitmentsHIV and school absenteeismPHC in HIV responseTelevision programmes on HIV and violencePolicy briefs |
| **Zimbabwee** | Capacity building of PLHIV networksSocial protection programme for PLHIVPositive preventionPMTCTTreatment literacy | Mutapola | STAR circles for PLHIV, adolescent schoolgirls and community mobilisation | NGO/CBO capacity buildingTechnical and financial support to self-help/support groups | Advocacy for rights of OVC and Research on HIV and violence and women's burden of care |

**Table 6. HIV Interventions in Asia**

| Country | PLHIV rights and GIPA | Reducing vulnerability of women and girls | Comprehensive HIV prevention and mobilisation | Partnership development | Advocacy, dialogue and campaigns |
|---|---|---|---|---|---|
| **Afghanistan** | Research with PLHIV | | Strengthening provincial HIV ProgrammeTruckers | BPHS capacity buidingCSO capacity building | Documentary filmsResearch on PLHIV |
| **Bangladesh** | Capacity building of PLHIV organisationsWorkplace policy | | STAR circles | CSO capacity building | PLHIV policy lobbyingParliamentary Caucus on HIV |
| **Cambodia** | Capacity building of PLHIV organisations | Strengthen sex worker's organizationIntegrated care and support programmeStrengthening leadership of women living with HIVOVC home based care/ART and educationMutapola | STAR Circles for PLHIVStepping StonesHIV mainstreaming | | Action research on entertainment and sex workersCampaign on public health with PLHIVUniversal Access campaignStigma and discrimination |
| **China** | Capacity building of PLHIV organisations | Violence against women | STAR Circles for PLHIVAwareness raising with migrant workersPeer education in vocational schools and colleges | NGO capacity building | Photo exhibition |
| **India** | Capacity building of PLHIV organisationsMutapola training (Fellowship Scheme) | Ripples of Learning (sex workers)Violence against women and girls | STAR circles for CSW and villagesStepping StonesLink Workers scheme and Mainstreaming in Orissa (NACP III) | HIV mainstreaming/ NGO capacity building | Study of PHC in HIV responseBudget tracking in 3 statesPublic Hearing on OVCHIV and AIDS BillGAWA |
| **Nepal** | Capacity building of PLHIV organisations | Women's Rights and HIV | STAR circles for migrant spouses | | Child marriage and trafficking |
| **Pakistan** | Capacity building of PLHIV organisations | Violence against women | STAR circles for CSW and community mobilisation | CSO capacity buildingEnhancing the role of media | Study of PHC in HIV responseHIV and AIDS policyART for PLHIVBudget tracking |
| **Vietnam** | PLHIV capacity buildingPositive living | | HIV integrated in DA workSTAR Circles | INGO network building | WAD |

### 4.2.1 Support for People living with HIV (PLHIV)

Support for PLHIV takes many forms.

**i) Capacity building of PLHIV organisations.**

Building the capacity of PLHIV organisations is a critically important component of any national response to HIV. This is one important way in which the GIPA principle can be realised. This is an intervention area that could be better documented. UNAIDS best practice collection includes case studies from Ukraine[1] and Thailand.[2] The International HIV/AIDS Alliance has documented case studies internationally[3] and in India.[4] It is recommended that AAI invest in developing a best practice report based on its wide-ranging experience on capacity building of PLHIV organisations.

PLHIV organisations have many forms, though their functions are broadly similar: to enforce rights; to empower and protect; and to address immediate and longer term needs. HIV policy issues include access to effective treatment, care and support; positive prevention and PMTCT: promotion of positive living and addressing marginalisation, stigma and discrimination. Such organisations typically provide a forum for meetings and exchange of experience; a means of providing support, solidarity and building social capital; a vehicle for capacity building; a platform for PLHIV issues to be raised through advocacy and lobbying; and a means of empowerment for members both individually and collectively.
Types of PLHIV organisation that AAI works in partnership to build capacity include:

- **Umbrella networks of PLHIV**: e.g. Network of networks of HIV positives in Ethiopia (NEP+);
- **National PLHIV organisations**: e.g. National Association of People Living Positively (NAP+) in Ghana; India Network of Positive People (INP+); National Empowerment Network of PLHIV in Kenya; Lesotho Network of PLHIV; National Council of PLHIV in Tanzania; Zimbabwe National Network of PLHIV (ZNNP+)
- **Regional PLHIV organisations**: e.g. South India Positive Network (SIP+); Gujarat State Network of Positive People (GSNP+) in India; Zanzibar Association of PLHIV (ZAPHA+) in Tanzania;
- **Specialised PLHIV networks** e.g. Malawi Network of Religious Leaders Living with HIV; Young Positives in Uganda;
- **Family support network of PLHIV**: e.g. MILANA in Bangalore (Karnataka, India);
- **Alliances of PLHIV** e.g. KAPOP: (Kebbi Alliance of Positive People, Kebbi State, Nigeria);
- **HIV forums** e.g. Bangalore HIV and AIDS Forum (India) and similar fora in Orissa and Tamil Nadu. These broad-based organisations may include PLHIV orgnaistions and non-HIV CSOs.;
- **Women living with HIV** e.g. National Network of positive women in Ethiopia (NNPWE); Gujarat State Women's Forum in India; Coalition of Women Living with HIV and AIDS in Malawi; Voice of Women in Sierra Leone;
- **Community-Based PLHIV networks** e.g. Network of People Living with AIDS in Nyakach (NYANEPHA) in Kenya; Uwambaba, Mwavium, Mwavinne, Awaviutta and Uwavvu in Bagamayo, Mkuranga, Newala, Tandahima and Liwale Districts, respectively, in Tanzania;
- **Grass roots support groups** (e.g RipKei PLHIV support group in Kenya.

[1] UNAIDS. (2007). A non-governmental organisation's national response to HIV; the work of the all-Ukranian network of people living with HIV. Geneva.
[2] UNAIDS. (2007). The positive partnerships program in Thailand: empowering people living with HIV. Geneva.
[3] International HIV/AIDS Alliance (2003). The Involvement of People Living with HIV/AIDS in Community-based Prevention, Care and Support Programs in Developing Countries

[4] International HIV/AIDS Alliance (2003). The involvement of people living with HIV/AIDS in the delivery of community-based prevention, care and support services in Maharashtra, India

**ii) Leadership training**

In India, Fellowships to PLHIV is a three-year period flagship venture to build leadership, communication and advocacy skills. Through this AAI has reached out to women, men and persons from sexuality minorities. The Fellowship programme has resulted in the formation of networks of PLHIV across the country in collaboration with state and national networks of positive people. This is an innovative approach and it is recommended that it should be documented as a best practice (See Section 4.7.3). PLHIV leadership training within PLHIV associations has been a strong area of work for AA Ethiopia.

**iii) Solidarity with sexual minorities**.

In some countries, the work with PLHIV involves working with sexual minorities (e.g. men who have sex with men, gay and transgenders) as these are typically highly vulnerable to HIV infection and strongly stigmatised in their own right. Involvement with PLHIV who are sexual minorities includes issues of their human rights, legal status as well as HIV prevention and treatment interventions. It is a broad field of policy work, which still remains largely outside the mainstream of development.

AAI's work with sexual minorities appears to be stronger in Asia, where there is more civil society space to advance their rights and provide solidarity. The countries where such work is taking place include Cambodia, India and Pakistan. In Orissa, India, AA is a member of Sampark a civil society coalition to build the capacity of sexual minorities and PLHIV.

It is recommended that sexual minorities be included under within a broader conceptualisation of gender and rights.

### 4.2.2 Support for orphans and vulnerable children (OVC) and children

There are relatively few organisations and interventions that were identified which specifically targeted children. This may be a gap area. It is far from clear that PLHIV organisations also effectively represent the interests of children. Examples include:

- **School based interventions**; School Anti-AIDS clubs were supported in Ethiopia;
- **Birth registration of OVC** e.g. in Kenya with WOFAK and KELIN (Comic Relief Project);
- **Children of sex workers**. Mentoring centres for children of sex workers have been supported in Chennai, India. They provide part time foster care for these children;
- **OVC support organisations e**.g. Partnership with Hope of Children in Cambodia. OVC support is integrated in the project to strengthen the leadership of women living with HIV in Cambodia;
- **Family-support organistions** e.g. Partnership with MILANA in India.

### 4.2.3. Gender-based interventions focused on women and girls

Gender in HIV in AAI programming is driven by a women's rights approach as exemplified by the Mutapola Framework. It is clear that women PLHIV are a priority constituency for the organisation. Examples include:

**Mutapola.** In Africa, *Mutapola* (HIV and Women's Rights) is being implemented in Gambia, Malawi, Sierra Leone and Uganda. In Asia, it is being implemented in Cambodia in selected areas to address the needs and rights of women living with HIV. In India the women's Universal Access (Mutapola) Project is being implemented in Gujarat and Orissa. The key highlight of the Project in both the States is that it is led by Positive Women. In Gujarat, the project is being implemented by Gujarat State Network of Positive People (GSNP+) and primarily works towards advocating food, livelihood and property rights for women and children. It promotes outreach education as a strategy for awareness and knowledge among women and men on the linkages between Violence against Women and HIV and AIDS. In Orissa, the project is implemented by SHRADHA Network and has resulted

- **Women's groups.** AA supports the Women and Aids Support Network (WASN) in Zimbabwe; Women's Initiatives (WINS) in Andhra Pradesh in India; Urban Poor Women Development (Cambodia); Uganda Women Network (UWONET);

- **Sex workers**. In India the training programme called **Ripples of Learning** has been helping sex workers in AAI projects to deal with the epidemic, equipped with practical knowledge and skills. Sex worker support groups have been formed in three States;[1]

- **Women and children**. In Kenya, AAI is partnering with Women Fighting AIDS in Kenya (WOFAK), who are implementing a five year 'Children and Women Support Project' supported financially by Comic Relief in the UK. This aims to provide women and children infected and affected by HIV and AIDS across all WOFAK centres with HIV prevention and care services, and influence government policy and legislation to prioritise the rights of PLHIV. In Cambodia, the Children and Women Development Centre of Cambodia is working with PLHIV in 7 villages;

- **Women's support Groups**. AA Nigeria is involved in providing institutional support and strengthening for women's support groups under the 6-year integrated institutional strengthening, governance and HIV prevention programme.

- **Women's rights and HIV.** In Nepal a project was implemented focusing on educating women and the wider community about the linkage between gender-based violence, discrimination and vulnerability to HIV infection, building cross-district networks of HIV positive groups to mainstream the issue into the larger women's rights movement, creating a community support group (comprising multiple stakeholders), providing psycho-social, health and livelihood counseling and viable alternative livelihood training and opportunities.

- **GBV Organisations**: e.g Embakasi GBV Survivor's Organisation in Kenya.

It is recommended that AAI document its work with women PLHIV in Africa and Asia to bring out rights issues and promising solutions in different country contexts. This would help develop gender the conceptualisation of gender, HIV and rights for the organisation but also provide a platform for policy dialogue at national and international levels.

### 4.2.4 Work with Most at Risk Populations

In Asia (Cambodia, India and Pakistan), AAI works with commercial sex workers (CSW), men who have sex with men (MSM), transgenders (TGs) and injecting drug users (IDU). Such work is very much in line with the policy guidance provided by the Commission on AIDS in Asia.[1]

- **CSW:** CSW support groups have been set up in three States in India to address their rights and exclusion from mainstream society.

- **MSM:** MSM have been organised in Karnataka, India to address stigma and discrimination and drop in centres (DiCs) have been set up.

- **IDU:** Support for the Akimbo Society in Nagaland, India to reduce HIV vulnerability and risk among IDUs. This involves a harm reduction programme and the use of Stepping Stones.

In Africa, work with most at risk populations has been focused on sex workers. Work with MSM is highly problematic due to the very high levels of stigmatisation in society that they face. This is a clear challenge to AAI as a rights-based organisation. IDUs are an emerging high-risk group in coastal settlements in particular where there is increasing access to injectable drugs.

[1] ActionAid India (2010). Theme HIV Annual Report 2009. Bangalore.
[2] ActionAid India (2007). Claiming Rights. Theme HIV and AIDS. 2006. Karnataka.

### 4.2.5 Community based interventions

Community based interventions have long been recognized as a critically important component of the national HIV response, especially in Africa. They are integral, for example, to a district level approach. [1] They are important for HIV prevention[2] as well as for reducing stigma, increasing awareness of treatment options and facilities. UNAIDS has developed guidance on community-based interventions for HIV, TB and malaria.[3] The International HIV/AIDS Alliance has developed guidance on expanding community action.[4]

AAI supported community-based programmes include:

- **HIV mainstreaming in DAs**. HIV work is being integrated in the work of partners in development areas. For example in Cambodia, HIV is being mainstreamed with AAI's15 partners with a focus on PLHIV and their families. It also involves promoting the GIPA prinvciple (Branded as 'MIPA' – the meaningful involvement of People with HIV and AIDS by AAI. It is recommended that the internationally accepted GIPA be used rather than MIPA).

- **STAR and Stepping Stones**. (See section on 'Best Practices'). Some 20 AAI country programmes report implementing STAR;

- **CBAP.** The Community Based AIDS Programme (CBAP) in Ethiopia which was adapted from Uganda and is implemented in partnership with Regional HAPCOs, CSOs and FBOs in 5 regions;[5]

- **Link Workers Scheme.** This is carried out in partnership with UNDP and the National AIDS Control Society (NACO) in 6 category A districts of Orissa. It is a part of the National AIDS Control Programme (NACP III). The goal of this project is to create a district-level replicable model of prevention, care, support and treatment programme to halt and reverse the epidemic in India during 2008–2012;

[6]

- **Support for home-based care.** AAI Cambodia is providing support for comprehensive home based care for women living with HIV and OVCs. It also includes positive prevention, access to education and livelihood opportunities.

- **Support for Community Based Development Organisations:** e.g. Wuli Association for Development in Gambia;

- **Support for AIDS Support Societies**: e.g. Gambia Network of HIV and AIDS Support Societies (GAMNAS); Network of AIDS Support Societies (NASO, Gambia); Uganda National AIDS Services Organisations; The AIDS Support Organisation (TASO in Uganda);

### 4.2.6 Capacity building of Local Government, NGOs and CBOs

- **HIV mainstreaming.** The largest project specifically to mainstream HIV is the UNDP-funded project in Orissa State, India. The Mainstreaming Resource Unit has the goal of enhancing the capacities of government departments, CSOs, and public and private sector organisations on the concept of mainstreaming HIV in their work. The major expected outcome is a change in policies of 6 Ministries to include PLHIV issues;

- **Capacity building of State Agencies**. AA Nigeria is involved in strengthening the capacity of state agencies to address the increased demand for services following successful community mobilization. This work is focused in Benue, Kaduna, Cross River, Nassarawa and Lagos States. AA Nigeria is also a partner in the 6-year integrated institutional strengthening, governance and HIV prevention programme managed by the Society for Family Health in 27 States. This involves capacity building of State agencies for HIV prevention and control as well as support for gender mainstreaming.

- **Capacity building of CBOs**. AA Nigeria is a partner in the 6-year integrated institutional strengthening, governance and HIV prevention programme managed by the Society for Family Health in 27 States.

- **Coalition and Alliance building**. Examples of coalition and alliance building include: Sexual Health Action Network (SHAN) in Gujarat, India involving over 80 organisations including trades unions, women's groups and health groups; **Alliances**. The Citizen's Alliance was set up in Uttar Pradesh (UP), India and includes NGOs, trusts and the UIP Network of positive people (UPN+). The Manipur Alliance (India) involves 8 district level PLHIV networks; The Cambodian Alliance for Combating HIV and AIDS is a joint engagement of 18 local and international NGOs, which was envisioned in order to fill in the gaps affecting the poor in responding to HIV. It brings together important stakeholders and actors, such as activists, PLHIV networks, MSM, sex worker's unions, trade unions, NGOs, broadcasters, parliamentarians and student associations to become a wider alliance. CACHA was conceived as a catalyst to influence state governments, politicians, policy makers, planners, administrators, implementers and the UN that basically politicise the response to HIV. The Orissa AIDS Solidarity Forum was established in Orissa, India, and comprises 15 organisations (NGOs, CBOs and PLHIV networks) and AIDS activists. The Tamil Nadu Solidarity Action (India) is an alliance of NGOs, CBOs and collectives. The Africa Civil society Coalition on HIV/AIDS, TB and Malaria (ACSC) and Asia People's Alliance for combating HIV and AIDS (APPACHA) both played an important role in mobilization at the Global Citizen Summit.

- **Health systems strengthening**. AA Nigeria is involved in supporting health systems strengthening funded by GFATM in 14 States;

### 4.2.8 Advocacy

There are multiple strands to HIV-related advocacy work. These include:

i) **Public Hearings:** Public Hearings have been held in India to provide legal support and protection to PLHIV. The public hearing in Tamil Nadu on transgenders led to the formation of a Welfare Board for the transgender community in that State. A national public hearing on children living with HIV was held in Hyderabad, followed by a series of regional public hearings.[1]

ii) **Call for Action.** A call for action on AIDS orphans was published by ActionAid India as preparation for the National public Hearing and Consultation on the rights of children affected by HIV and AIDS[2]. This paper included a discussion of criticval issues such as inadequate PMTCT services and provided examples from the life experiences of children orphaned by AIDS. A call for integrating nutrition in HIV programming was published in India.[3]

iii) **Advocacy brief**
AAI has published advocacy papers which aim to arise awareness of specific issues and to mobilise action These include:

- **Gender.** Papers include those aimed putting women's rights at the heart of the HIV response[4]; at empowering women to address HIV in India;[5] access to treatment for women living with HIV in India[6]; violence against women and HIV in India[7];

- **Access to treatment.** A booklet was published in India on ARV drugs and patents.
[8]

- **Women living with HIV.** A booklet presenting the lives of women living with HIV in Andhra Pradesh, India.[9]

- **The Rights of Children in the context of HIV.** A paper was published in India exploring the rights and realities of children in the context of HIV.
[10]

- **Stigma and discrimination.** A paper was published by ActionAid Nigeria on HIV-related stigma reduction and which included a situation assessment and recommendations for action.
[11]

- **Social protection.** A series of papers around the theme of social protection in urban settings were published by ActionAid Zimbabwe.[12] These were based on experiences from the DFID-funded Protracted Relief Programme. They include papers on home-based care, cash transfers, vouchers for food and nutrition support and urban social protection.

### iii) Research

AAI country programmes have commissioned research in policy issues to provide data for evidence-based advocacy with policy makers and civil society pressure groups. The range of topics is broad. Examples include:

- **Public Health Care (PHC) Services.** Studies have been conducted on PHC in Jharkhand (India);[1] the health status of the urban poor in Bihar (India)[2] and why it is important for tackling HIV;[3]
- **HIV related knowledge, attitude and practice (KAP).** A KAP survey was conducted with support from AA India in the urban setting of Patna, Bihar State.[4]
- **Community Based HIV Programming.** In Ethiopia, an evaluation was conducted of the Community-Based AIDS Programme (CBAP) to identify the results in terms of rights, attitude and behaviour change, impact mitigation, capacity building and sustainability.[5]
- **Sex workers.** Research papers include a study of Self-Regulatory Boards and sex workers' lives in West Bengal (India);[6]
- **Nutrition for PLHIV.** Action research was undertaken in Cambodia focusing on food requirements for PLHIV particularly women and children;[7]
- **Vulnerability of Women.** A study was published on women in resource poor communities in six districts of Karnataka, India;[8]
- **The Cost of Home-Based Care.** An exploratory study, supported by UNIFEM, on the cost of home-based care in Southern Africa was published by ActionAid South Africa.[9] It attempted to estimate the overall cost of home based care in 6 study countries and provided policy and programmatic recommendations.
- **Access to treatment.** Bangalore HIV and AIDS Forum was commissioned to undertake a study assessing VCT, PMTCT and ART services in Bangalore India;[10]
- **Rights of Sex Workers**. Action research was published on the policy environment regarding Universal Access and the Rights to Work of Entertainment workers and Sex Workers in Cambodia;
- **Stigma**. The Stigma Index study report was published in Kenya. This study, funded by Comic Relief, attempted to measure the extent and impact of HIV-related stigma and discrimination on women and children using the Stigma Index.[11]
- **HIV budget tracking**. A study was undertaken in 3 states in India. It showed that most agencies focused their funds on targeted interventions for HIV prevention.

[1] ActionAid India (2010). Theme HIV Annual Report 2009. Bangalore.
[2] ActionAid India. (2009). AIDS Orphans calling for action. Bangalore.
[3] ActionAid India (2008). A call for integrating nutrition in HIV and AIDS programming. Bangalore.
[4] ActionAid International and VSO (Undated). Walking the talk. Putting women's rights at the heart of the HIV and AIDS response. London.
[5] ActionAid India. (Undated). Enabling women to fight HIV/AIDS.
[6] ActionAid India. (Undated). Access to a distant dream. Women living with HIV and AIDS demand accountability from civil society and world leaders. Bangalore.
[7] Jadavpur University. (2007). Understanding violence against women and its implications for our struggles against HIV and AIDS. Action Aid India. Kolkata.
[8] ActionAid India (Undated) Fight WTO. Reject patents on ARV drugs.
[9] ActionAid India (2007). Claiming Rights. Theme HIV and AIDS. 2006. Karnataka.
[10] ActionAid India. (2009). Exploring the rights and realities of children in the context of HIV. Bangalore.
[11] ActionAid Nigeria (2008). HIV and AIDS related stigma reduction in Nigeria.: collaborating to fight the third epidemic. Abuja.
[12] ActionAid Zimbabwe. (Undated). Social protection in urban Zimbabwe. Harare

[1] Rahman, S. (Undated). Study on performance of primary health care services in Jharkhand. Action Aid India.
[2] Rahman, S. (Undated) Cities of despair. A study on the health status of urban poor in Bihar. CHARM. Patna.
[3] ActionAid International (2009 ) Primary concern. Why primary health care is key to tackling HIV and AIDS. Johannesburg and London
[4] CHARM. (Undated). Study on knowledge, awareness, attitude, attitude and practice on HIV/AIDS/STD. A report. AA India.
[5] Action Aid Ethiopia. (2008). ActionAid-Ethiopia Community-Based AIDS Programme (CBAP) value addition to Regional and Woreda level HIV and AIDS response. Addis Ababa.
[6] ActionAid India. (2009). SRBs and its impact on the lives of sex workers- an assessment. Kolkata.
[7] ActionAid Cambodia (2007). Action research focus on food for all people living with HIV/AIDS particularly women and children. Phnom Penh.
[8] ActionAid India (2007). Claiming Rights. Theme HIV and AIDS. 2006. Karnataka.
[9] ActionAid South Africa. (2008). Women bailing out the states: an exploratory study on the cost of home-based care in Southern Africa in 2007. Johannesburg.
[10] Bangalore HIV and AIDS Forum

It is recommended that a complete list of AAI research publications relating to HIV be drawn up and put on the main website with hyperlinks to PDF versions.

**iv)** **Participatory Plan Development.** AA India was involved in the multi-partner preparation of a draft plan for urban PHC in Bihar State, focusing on the health issues of the urban poor.[1] This is an innovative advocacy instrument.

**v)** **Project specific publications.**
AAI has published papers which arise out of specific projects. They are intended not only for the project audience, but also for wider consumption. Such papers include:

- **HIV Mainstreaming.** Papers on the mainstreaming initiative in Orissa (India).[2]
- **STAR.** Papers were published on empowering communities using STAR[3] and a review of the project in different countries.[4] Briefs were also prepared on individual country interventions and sustainability;
- **Lessons Learned**. A series of 6 papers focusing on lessons learned from the SNR programme in Nigeria were published by DFID in 2009. The topics included: gender mainstreaming; co-location, LACA Stakeholders' Forum: Concept Note; and M&E.[5]

**vii)** **Global Week of Action (GAWA) and World AIDS Day (WAD)**

GAWA and WAD have been used to mobilize support for PLHIV and raise the profile of important HIV issues in society. Candle Light Memorials have been held in India to show support for PLHIV and remember the dead.

**viii)** **Documentary Films**

Films produced include *Suffering in Silence* (PLHIV in India) and *Candles of Tuensang* ( HIV in Tuensang, Nagaland, India).

ix) **UNGASS Shadow Report**.

AA Cambodia supported the preparation of an UNGASS Shadow Report by PLHIV and Most at Risk Populations (MARPs) in 2010. This provided perspectives on the current HIV situation in the country, human rights achievements and challenges, institutional support, progress against Universal Access targets. Key challenges are outlined together with recommendations for action.

**x)** **Policy dialogue.**

In a few countries, AAI is part of the National technical Team on HIV and has participated in the development of the National Strategic Plan for HIV e.g Kenya and Liberia. AAI has been significantly involved in the implementation of National HIV Strategies on HIV in Gambia, Kenya, Nigeria, India and Uganda. This involvement helps provide a platform for policy dialogue.

### 4.3 Country case studies

Detailed case studies were prepared for Ethiopia and India (See Annexes 2 and 3) on the basis on filed visits and available literature. The main findings from each are summarized below.

[1] ActionAid India (2007). Claiming Rights. Theme HIV and AIDS. 2006. Karnataka.
[2] Charm and AA India(2009). Plan for urban primary health care. Patna
[3] ActionAid India. (2009) Understanding HIV for an integrated response. Mainstreaming initiative in Orissa. Bangalore and Bhubaneswar and UNDP, NACO, OSACS and AAI (Undated). Mainstreaming: an opportunity to respond to the challenges of HIV and AIDS. Bhubaneswar.
[4] ActionAid International, Pamoja and EU. (Undated) Empowering communities in the face of HIV/AIDS. Nairobi.
[5] ActionAid International (2008). Community mobilization to end AIDS: the STAR approach in action. Nairobi.
[6] DFID (2009). Strengthening Nigeria's response to HIV/AIDS Program. Lessons Learnt Series. Volumes 1-6. Abuja.

### 4.3.1 Ethiopia

**Overview**

The HIV epidemic in Ethiopia highlights some of the pertinent challenges that AAI faces in working in this complex field of development. The national epidemic has evolved over thirty years and continues to provide fresh challenges to policy makers and planners. While the adult prevalence rate appears to have stabilised at just over 2%, the impacts are considerable and long-term, especially on poor households in a context of pervasive rural and concentrated urban poverty. Almost a million children are estimated to have been orphaned. The urban epidemic is now under control and it is some rural settings, particularly in Gambela region that the prevalence rates are highest. The advent of affordable treatment has increased the importance of strengthening the health system to provide quality services across the country to ensure that there is access for all. Given that Ethiopia is a large and mostly mountainous country with significant infrastructure problems, this is an ambitious agenda.

ActionAid Ethiopia (AAE) has played a very significant role in developing capacity to tackle HIV in Government, NGOs and perhaps most importantly among people living with HIV (PLHIV). The period of DFID-funded SIPAA activities (2001-5) was arguably when AAE had most influence in the national HIV response. However, since then AAE has worked with over 400 PLHIV organisations which is close to 100% of the national total. It has helped build credible capacity in the national umbrella network of PLHIV (NEP+) with the result that it has become the Principal Recipient for GFATM Round 7 funding. AAE has also successfully piloted 2 models of community-based intervention (CBAP and STAR). The challenge is now to take these to scale within the national response framework.

A fundamental challenge for AAE is to use its scarce resources to best effect where substantial funds are available for the HIV response through the Global Fund, PEPFAR and the World Bank as well as bilateral support. Although for a short period AAE (2001-2005) had a significant source of funding through the SIPAA project, this is no longer the case and the approach must necessarily be strategic, focused and catalytic in a context of reduced resources. It is therefore important to define the niche of the organization of the organization and capitalise on its comparative advantages.

The democratic space within which AAE can operate has been severely curtailed by the introduction of legislation to register and regulate charities in 2009.[1] Under the terms of Proclamation No 621, NGOs which spend more than 10% of their funding from international sources are classified as *Foreign Charities.* These are prohibited by the law from taking part in activities to advance human and democratic rights, promote gender equality, conflict resolution as well as the rights of the disabled and children. This presumably covers both direct and indirect support for such activities. Providing support for the advancement of education and health, however, are permissible, but not through a rights-based approach. International organizations, such as the UN or bilateral agencies, are not included in this legislation.

It is clearly important that AAE undertakes a comprehensive situation analysis in order to help position itself in a crowded field of development actors. This involves assessing the policy environment, the strategic plan, the M&E framework and the national coordinating mechanism. There is a good fit between AAE's strengths and the thematic areas of the national HIV strategic plan 2010-2014.

**Focus**

The Ethiopia visit indicated that was a need for a stronger and clearer focus on HIV. Universal Access will not be achieved without health system strengthening in rural Ethiopia.[2] The main challenge is to provide access to quality health services at decentralized levels and in particular through primary health care.[3] A major issue is the weak and underfinanced state of the health system. The great majority of the population still use traditional medicine and self- or lay care. In 2005, modern health care services covered only about 60% of the population, with low levels of access in rural, nomadic and border areas.[4] Lack of and costs of transportation are major barriers to access. Most hospital facilities are under-utilised and under- or inappropriately staffed. There is a lack of trained staff and a high turnover. Service delivery is often of poor quality. Child health and antenatal care services are limited.

[1] Federal Republic of Ethiopia. (2009). Proclamation No 621/2009. Proclamation to provide for the registration of charities and societies. Addis Ababa.

[2] ActionAid Ethiopia. (2007)HIV/AIDs Sub-Strategy Plan 2007-2009. Addis Ababa.

AAE programme work needs to be focused on grass-roots levels. However, AAE has been seriously hobbled by new legislation on charities/NGOs which forbids INGOs to become involved in any rights-related activities. This is a major operating constraint for the organisation.

**Engagement with PLHIV**

AA Ethiopia has played an important role in establishing and building the capacity of organisations and networks of PLHIV. 378 local PLHIV associations have benefitted from AA support, particularly in terms of training. The Network of Networks of HIV Positives in Ethiopia (NEP+) is playing a key role in influencing the state and non-state actors to realize the GIPA principle. It has a seat on the Country Coordinating Mechanism (CCM) for the Global fund and has been selected as the Principal Recipient for Round 7 ($25 million) to implement GIPA. The Association of Positive Women-Ethiopia (NAP-WE) has formed a National Network of Positive Women Ethiopians (NNPWE) to deepen engagement on advocacy. 23 Associations have been supported. These networks are leading on advocacy for the expansion of VCT services and the achievement of Universal Access. A total of 1232 leaders of PLHIV Associations have been trained in leadership, project cycle management, advocacy, mainstreaming and networking.

It is observed that female PLHIV are worst affected. However, research is needed, which goes beyond 'stories of the poor' to provide more robust evidence concerning their disempowerment and vulnerability.

There are persistent skill gaps in care and support services for PLHIV and OVC. Increased demand for services such as VCT are not being met on the supply side. PLHIV lack sufficient food and nutrition, this is especially true for women. This undermines ART adherence and efficicy.[1] Safe water and sanitation are also important for PLHIV.[2] Together, these demonstrate the importance of taking a multi-sectoral approach to HIV in general and PLHIV in particular.

Stigma and discrimination have reportedly been reduced, but still remain a problem. There is need for a fresh look at the problem and to devise innovative solutions. Continued dialogue and leadership training is crucial for moving PLHIV associations to a rights-based approach.[3] Also important is the promotion of *positive living* and the provision of PLHIV leadership training. Finally, PLHIV associations value an ongoing partnership with AAE and expect this to continue.

**CBAP and STAR**

The Community Based AIDS programme (CBAP) involves a means by which the community can openly discuss HIV, its impact and the response required. Local structures (*idirs*) are utilized to identify problems in their respective localities. Youth are organized and mobilized. As a result of the programme community support for PLHIV and OVC has been strengthened. Demand for services is increasing (VCT, condoms etc) and social norms are changing. HIV testing is becoming the norm prior to marriage and for returning male migrant workers. The traditional practice of wife inheritance is increasingly becoming unacceptable. AAE feels that the CBAP model has been demonstrated to be effective and should now be scaled up.

Ethiopia was one of the countries elected for the rolling out of the STAR programme in 2007. This involved a partnership with Government, focusing on regional and *woreda* HAPCOs. STAR was scaled up in AAE's DAs to ensure sustainability. A total of 46 STAR circles were initiated and established and 82 Community STAR Facilitators were trained. 7 manuals/guides were developed.

[1] ActionAid Ethiopia. (2009). HIV/AIDS CSP Mid-Term Review report. Addis Ababa.
[2] Kitaw, Y. et al (2006). Ethiopia. In Beck, E at al (eds). 2006. The HIV pandemic. Local and global implications. Oxford University Press.
[3] ActionAid Ethiopia. (2009). HIV/AIDS Annual Report. Addis Ababa.
[4] Action Aid International Ethiopia. (2010). ActionAid Ethiopia Interim Country Strategic Plan 2010-2011. Addis Ababa.
[5] ActionAid Ethiopia. (2007). Capacity-building for scaled and multisectoral HIV/AIDS response. Annual report. January – December 2006. Addis Ababa.

The STAR approach demonstrates the importance of a participatory approach for community ownership and problem solving. It was observed that STAR Circle members started to see the synergy of HIV with development. Stigma towards PLHIV was being reduced and more positive people were disclosing their status. Circle members were being provided with a small grant to support livelihoods and links to horticulture, micro-credit and women's groups. Demand for VCT has increased as a result of STAR. There is however, a need for a more robust approach to proving the effectiveness of STAR as a community based HIV intervention. This is lacking.

HAPCO at regional and woreda levels are reluctant to adopt CBAP and STAR models as the *Community Conversation (CC)* has been adopted by Government as the preferred community-based intervention (and which is highly politicised).[1] There is a lack of understanding about complementarity between CBAP and the CC. This appears primarily to be an issue of alignment with the national HIV response where the CC approach has been selected for national implementation. It is therefore advisable to label SATR or CBAP as variants of CC to promote their acceptance by key stakeholders.

**Capacity building and partnerships**

AAE has provided important capacity-building support to PLHIV organisations. This has been the primary focus of partnership activity. It has also worked in partnership with Government to decentralize the HIV response through regional HAPCOs.[1] Six HAPCOs have been strengthened.[2] A number of local NGOs have had capacity building partnerships. These include: Dawn of Hope, Information and Development for Persons with Disability (IDPDA), Mary Joy, OPRAH and Redeem the Generation. AAE has alos worked with the business sector providing support for the Ethiopian Business Coalition and the Ethiopian Employee Federation.

**Key HIV issues**

A number of key issues emerge for the HIV response. These include:

- Primary Health Care strengthening;
- Addressing HIV-related stigma and discrimination;
- Improving access to treatment for PLHIV;
- Nutrition support for PLHIV;
- Strengthening PMTCT services;
- Addressing gender-based violence (GBV) and harmful traditional practices; and
- Decentralisation of the HIV response.

**Support, staffing and funding**

- Support has been weak from AAI; communications have been limited;
- Shortage of technical HIV staff (only 1) and staff turnover is high;
- There is a continuing need for AAI to have a strategic plan on HIV;

Long-term funding arrangements are required and resources are dwindling.

### 4.3.2 India

**Background**

The Government of India estimates that in 2007, about 2.31 million Indians were living with HIV (1.8 – 2.9 million) with an adult prevalence of 0.34 percent. India's highly heterogeneous epidemic is largely concentrated in six states—in the industrialized south and west and in the north-eastern tip. On average, HIV prevalence in those states is 4–5 times higher than in the other states. HIV prevalence is highest in the Mumbai-Karnataka corridor, the Nagpur area of Maharashtra, the Nammakkal district of Tamil Nadu, coastal Andhra Pradesh, and parts of Manipur and Nagaland. [1]

The Indian epidemic continues to be concentrated in populations with high-risk behavior characterized by unprotected paid sex, anal sex, and injecting drug use with contaminated injecting equipment. Several of the most at-risk groups continue to have high HIV prevalence in 2007: injecting drug users (7.2%), men having sex with men (7.4%, female sex workers (5.1%), and attendees of sexually transmitted disease clinics (3.6%). According to India's National AIDS Control Organization (NACO), the bulk of HIV infections in India occur during unprotected heterosexual intercourse. Consequently, and as the epidemic has matured, women account for a growing proportion of people living with HIV (39% in 2007), especially in rural areas. The low rate of multiple partner concurrent sexual relationships among the wider community seems to have, so far, protected the larger body of people with 99% of the adult Indian population being HIV negative. However, although overall prevalence remains low, even relatively minor increases in HIV infection rates in a country of more than 1 billion people could translate into large numbers of people becoming infected.

**Focus**

AA India recognizes in the Country Strategy Paper (CSP) for 2005-2010 that PLHIV are a core constituency.[2] They live with discrimination, deprivation, exclusion and the denial of their rights. Women in particular experience blame, stigma and discrimination. Children comprise around 35% of PLHIV and are considered to be the most vulnerable. To realize basic rights such as to education, health, food and livelihoods entails transforming governance. This means promoting active citizenship and sustaining democratic practices and institutions. Thus the HIV response is mainstreamed in the following strategic objectives: Building alliances of the marginalized; Facilitating just and democratic governance; Enforcing rights of women and girls; Addressing immediate poverty needs; and Diversifying the resource base.

AA India developed a detailed HIV and AIDS operational plan for the period 2006-2010.[3] This is a very well presented document which sets out the rights-based approach to HIV and strategies and actions to realise them as well thematic structures and roles for implementation. The core constituencies include PLHIV, women and girls, sexual minorities, women in sex work, trafficked women, migrants, youth and AIDS orphans, drug and alcohol users, people affected by disasters and persons with disabilities. The HIV operational plan retains the original strategic objectives of the AAI HIV Thematic Strategy 2005-2010,[4] but include a different set of actions and outcomes for each. The weak point of the strategy is its lack of connection with the national HIV response in general and the National AIDS Control Programme (NACP), in particular. NACP is now in its third phase (NACP III).

AAI works in 22 States of India. The HIV response varies considerably across these as result of the heterogeneity of the epidemic and differing levels of political commitment and technical capacity. Similarly, AAI India's response is also varied. In terms of scale, the work by AAI India in Orissa State stands out. This is because it is involved in implementing a key component of the NACP, the community based link worker scheme, which has been adapted to an AAI approach using STAR. Important work has been carried out in a number of states e.g. Bihar, Gujarat and Karnataka with PLHIV organisations.

[1] World Bank (2009). HIV in India. New Delhi.

[2] ActionAid International India. (2005). Rights first. Working together to end poverty and patriarchy. New Delhi.
[3] ActuonAid International India. (2006). HIV and AIDS Operational Strategy. New Delhi.
[4] ActionAid International. (2005). HIV and AIDS. Strategic Plan 2005-2010

**PLHIV**

A number of important lessons can be drawn form AAI's work with PLHIV. These are:

- A rights-based approach is effective in enabling PLHIV successfully to put pressure on State Governments to improve their entitlements (e.g. widow pensions, below poverty line entitlements);
- Platform politics through mechanisms such as public hearings on policy issues such as children living with HIV can be effective in exerting pressure on the Federal and States Governments;
- The work with PLHIV is a long-term endeavour. There is persistence of severe stigma and discrimination (based on fear and moral judgment) in family, schools and health care facilities. Poverty is the biggest problem and lack of family support. There is a need for Treatment Literacy and continuing education for PLHIV and to promote positive living;
- Meeting the immediate needs of PLHIV (as well as their strategic needs) is a significant challenge. They need multi-sectoral support. Livelihoods are important for PLHIV (including alternative livelihoods for those who can no longer undertake manual labour).
- Family support is needed for PLHIV and support groups. PLHIV are not isolated individuals. They are family members;
- A holistic approach to gender is needed which includes men and TGs. A women's rights approach alone is inadequate to address issues of masculinities;
- Children with HIV have special needs e.g. adolescents and sexuality;
- Access to treatment is far from easy for many PLHIV. There are issues of distance, mobility, accommodation, costs etc). There is a widespread lack of provision for OI treatment and few CD4 count machines. Nutrition support for PLHIV is required. PLHIV are increasingly needing 2nd line ART (may not be available in some states e.g. Haryana). Women and children living with HIV (and OVC) are a low priority in some states (e.g. Haryana)
- There is an urgent need for health systems strengthening (especially PHC). The quality of care in ART centres is often poor. PMTCT service provision is poor.
- Gender inequality is exacerbated by HIV. There is extreme marginalistion of widows living with HIV. Married women are highly vulnerable to HIV infection if married to a husband with risk behaviours. There is a need for Positive Prevention among discordant couples;

**Challenges**

- Corruption and misuse of funds in the national HIV response;
- Slowness in the national HIV Bill approval process (since 2006);
- Insufficient resources; and
- Limited number of technical HIV staff in AAI.

### 4.4 What is AAI's Niche in HIV Programming?

The picture obtained of AAI's strategic niche in HIV programming was complex, comprising multiple inter-locking elements. They involve the organisation's approach to development; its target groups or partners; its methods; its capacity and its advocacy**.**

### 4.4.1 Approach to development

The Rights-Based Approach (RBA) is clearly fundamentally important in AAI's HIV work. This is strongly evident in the programme focus on vulnerable and marginal populations who are most likely to experience human rights violations. The focus on people living with HIV (PLHIV) is particularly strong. The AAI RBA also involves specific methods which involve the promotion of empowerment, participation, protection and accountability. Non-discrimination is an important feature of a RBA to HIV and AIDS. AAI has developed resources for a human rights-based approach to development,[1] but nothing specific to the HIV response has been published. A RBA guide to HIV programming was being prepared in 2008, but appears not to have been completed.[2]Such a product, would be immensely useful for both AAI staff and for external partners.

AAI respondents reported that the RBA enabled PLHIV and most at risk populations (MARP) to be aware of their rights and to demand and access services from duty bearers. It therefore helped raise demand and uptake of health-related services. The approach promoted the participation of PLHIV and poor households in all activities. Rights abuses were 'easily identified' through STAR and REFLECT circles. The RBA approach has built civic competence to challenge unequal power relations. It has promoted respect for PLHIV rights at a grass roots level. PLHIV have been able to act as role models and been given space to present their priorities in planning at sub-district and district levels.

### 4.4.2 Social Groups

The selection of core constituencies or target groups is related to the RBA and to AAI's strategic niche. The organisation's mission is to work with poor and excluded people to eradicate poverty and injustice. People living with HIV constitute a particularly vulnerable group. They are generally subject to stigma and discrimination, sometimes severely so. Without access to effective treatment, their lives are dramatically cut short. Promoting Positive Living and Positive Prevention are important programme interventions. Women living with HIV, including widows, are especially at risk. Women and girls are a priority group for AAI in general and in particular with regard to HIV. This is for HIV prevention and treatment. For HIV-positive pregnant women, access to PMTCT services is essential, but a major challenge in resource poor settings where most child deliveries occur at home and antenatal care is lacking. Children affected by and living with HIV are two key groups for social and health services. These include orphans. Other vulnerable groups in HIV responses include ethnic minorities, people with disabilities, mobile populations and sexual minorities, such as men who have sex with men and transgenders.

### 4.4.3 RBA Tools

AAI has a set of tools and processes that have been built up over the years in the HIV response. These are being adapted in response to lessons from the field. Among the key tools that are most often cited are: STAR (Societies Tackling AIDS through Rights); Stepping Stones; and. REFLECT.

The methods that are commonly mentioned are: creating an effective community level response; community and social mobilization; PLHIV capacity building; CSO capacity building; and network and coalition building.

### 4.4.4 Technical Capacity

An important facet of AAI's HIV niche is its technical capacity in HIV prevention and working with PLHIV. The skills set involve capacity building at the community level and supporting networks of PLHIV.

### 4.4.4 Advocacy and accountability

Respondents mention the importance of AAI's work in advocacy and accountability. These include strengthening HIV programming accountability and evidence-based policy advocacy (at national, regional and international level) and local campaigning to raise the profile of HIV issues. Particularly important is policy advocacy for PLHIV.

[1] ActionAid. (2004). A human rights approach to development. Resource book.
[2] ActionAid International. (2008). HIV and AIDS Theme. Participatory Reflection and Review process. Nairobi.

## 4.5 Outcomes

### 4.5.1 Did the strategy achieve its intended response?

The Strategy sets out the HIV response it hopes to leverage. However, it is extremely difficult to evaluate the impact of the Thematic Strategy on the HIV response at the international level or at regional levels. This is partly due to the lack of indicators and means of assessment and also to the difficulty of attribution (See Table 7). It is concluded that the strategy contributed to the enhanced international and national response to HIV and that AAI was a significant actor.

The following conclusions are drawn:

- The HIV Strategic Plan period saw a substantial scaling up of the HIV response, including a rapid expansion of access to treatment. There is no baseline from which to track progress. However, it is clear that there has been a significant expansion of HIV programming in Asia, while in Africa, the loss of SIPAA funding has been a challenge but programming is now taking place in 12 countries. This represents a very substantial portfolio of HIV intereventions.

- Policy action has taken place in some countries. New HIV-related policies have been put in place in some countries. However, the UNAIDS 2010 Outlook report[1] indicates that in many countries there is a lack of clarity and agreement between government and civil society as to which policy areas have been addressed concerning stigma and discrimination, sex work, MSM and IDUs. It appears that many countries have yet to put in place adequate policies, to disseminate and to implement them. It is noted that AAI currently has no methodology at the country level for assessing the laws/policies and linkage to rights within its rights-based approach;

- While AAI has made progress in developing its RBA in HIV work, it cannot yet be described as comprehensive. It needs further articulation particularly in line with the increased emphasis on treatment and the commitment to Universal Access;

- It is far from clear that national HIV funding is being used most efficiently and effectively in all country contexts, benefiting those most in need, people living with HIV and populations most at risk. There is much informal mention of corruption and wastage of resources. Much more work is needed to enable rights-holders to hold duty-bearers to account through community audit and budget tracking processes, though this is an area of extreme sensitivity for many governments (e.g. Ethiopia) and a politically cautious approach is required;

- The mention of along term liberation war on HIV is in conflict with UNAIDS guidelines on language to be used to describe HIV. Conflict and war metaphors are to be avoided (even 'fighting HIV');

- AAI has worked hard to promote the rights of women in the HIV response. Significant work has been carried out with women living with HIV in a number of country programmes. Further work is needed. There is a need to evaluate the Mutapola Framework. It appears that women are still far from central in the HIV response;

- AAI has taken the GIPA principle seriously in many country programmes as reflected by the work in strengthening PLHIV organisations and leadership;

- The issue of space for CSO advocacy is critically important in the HIV response and the empowerment of PLHIV. This is an area of considerable political sensitivity which varies from country to country in terms of democratic traditions and culture. PLHIV empowerment needs to be carefully strategised;

- Mass movements on HIV have not arisen. This is partly a result of stigmatization and 'silent epidemics.' It would be more appropriate to consider the potential for developing effective PLHIV organisations and coalitions that support them.

[1] UNAIDS. (2010) Outlook Report 2010. Geneva.

**Table 7. Intended Response from HIV Thematic Strategy**

| **Intended response** | **Findings** |
|---|---|
| 1. Mobilises global commitment, a sense of outrage, urgency and non complacent action now | No indicators provided with which to assess commitmentInternational HIV response has been substantially scaled up |
| 2. Moves from political commitments to real policy action now by all leaders at all levels, in all countries and regions | No policy indicators given AAI has no means of assessing HIV policy and legal frameworks from a RBA perspective |
| 3. Sets out a comprehensive rights based approach that enables poor and excluded people who are vulnerable to, affected by and living with HIV to demand actions from governments and other institutions at all levels | AAI has yet to set out comprehensive RBA in HIV work |
| 4. Establishes simple, efficient and effective mechanisms to *Make the Money Reach and Work* for the poor and excluded people living with, vulnerable to and affected by HIV and AIDS | There is no exemplification of mechanisms or indicators |
| 5. Mobilises a long term people's liberation war with positive impact on PLHIV and their households | Not occurred |
| 6. Promotes central role of the rights and leadership of women in an effective response | No indicators of women's leadership in the HIV responseWork in progress. Mutapola Framework needs to be reviewed |
| 7. Promotes the rights and central role of PLHIV in planning, implementing and monitoring an effective response | GIPA continues to be important principle |
| 8. Supports the critical engagement and space for CSO advocacy in government and inter-government institutions at all levels | A critical issue. A rights-based approach requires democratic space for its effectiveness. How CSO engagement can be broadened is an important issue, especially in countries with little tradition of civil society activism. |
| 9. Mobilises a stronger, better connected, better coordinated people's mass movement to demand their right to life and dignity in the face of HIV and AIDS | PLHIV becoming a policy community in some countries |

### 4.5.2. Did the strategy achieve its intended outcomes (goals and objectives)?

**Goal 1.** ***People living with HIV (PLHIV) will increasingly claim and exercise their rights, including access to comprehensive treatment, care and social security.***

**Strategic Objective 1.** ***Advocate for and support meaningful involvement of people living with HIV (PLHIV) and affected communities in shaping and taking action on the HIV response.***

This goal has been achieved. PLHIV are in a stronger position in many countries, in particular through AAI support to PLHIV organisations, to claim their rights and entitlements in health care and welfare provisions. This is most clearly the case in India, where PLHIV organisations have become pressure groups in several states and are in the process of emerging as a policy community, one which is able to influence government policy-making. A major contributory factor is the use of 'platform politics' to advance the agenda of PLHIV.[1]

There is little room for complacency, however. In all contexts, PLHIV remain a stigmatized group. The severity of the stigmatization and accompanying discrimination varies from culture to culture. There has been progress in reducing HIV-related stigma as a result of multiple interventions, but in many contexts their rights are still violated. In some countries health facilities remain contexts of discrimination. Governments have been slow to put in place policies and laws that are anti-discriminatory and support PLHIV.

In this context, AAI's work with and for PLHIV is important. It needs to be continued and better documented. The approach is distinctive, probably unique and is likely to be effective. Unfortunately, the work with PLHIV organisations has not yet been robustly evaluated in any country programme. This is urgently needed for the effectiveness of AAI's methods to be proven and the case made for activities to be scaled up and sustained.

It is recommended that evaluations of support for PLHIV organisations be carried in out selected country programmes and a multi-country study assembled to showcase AAI's innovations and lessons learned in working to fulfill the rights of PLHIV.

Objective 1 is to be met through a range of activities (See 3.5.6) including workplace policy; legal reform; community-based programmes to reduce stigma and discrimination and the application of the GIPA principle. A number of outcomes are suggested in the HIV Theme Strategy. As can be seen in Table 8, these are difficult to assess in part due to the lack of baseline data and the absence of measurable indicators. A number of conclusions can be drawn, however:

**Workplace policy**. This has not been systematically implemented. Some countries e.g. Cambodia have included activities to enforce the policy. However, commitment to the policy is not strong in all offices. This is attributed to the perceived costs of implementation. Resources do need to be allocated where HIV is an issue. Greater activism around the policy is required. A review is needed of implementation and revision of content and practices may be required as a result. Not all staff are aware of the policy. Not all those entitled to benefits are claiming or obtaining them. This suggests that a process of awareness raising, internally, is urgently needed. Staff-training sessions are also recommended. The workplace needs to be included in regular staff induction programmes. There also needs to be stronger commitment to GIPA in the workplace. Some country offices have hired PLHIV and are to be commended for this.

**Legal reform**. There is a need to strengthen AAI's work in policy development and legal reform. Tools need to be made available for country team members to undertake legal and policy analysis. At present no country team appears to have carried out any comprehensive policy or legal situation analysis from a rights-based perspective.

[1] Action Aid International. (2005) Rights First. India Country Strategy Paper III. (2005-2010). New Delhi.

There are a number of success stories:

- **Nigeria**. In 2009, AA mobilised civil society organisations to work with the House Committee on Health to draft the national anti-stigma bill. AA Nigeria also facilitated the development and dissemination of national Islamic HIV/AIDS policy in the year. This policy is to guide HIV interventions within the Muslim community.
[1]

- **Sierra Leone**. A HIV and AIDS bill was passed to promote the rights of PLHIV. Through this, the government committed to promote public awareness on causes, consequences, and means of prevention and control of HIV. With the passage of the bill discrimination against PLHIV is an offence. A network of women living with HIV was also launched to engage national and sub regional responses to HIV.

- In **Uganda, Nigeria, Zimbabwe,** and **Malawi** PLHIV circles lobbied and accessed ART and opportunistic infection treatments.

**Community-based programmes.** AAI has a toolkit of widely recognised community-based methods such as Stepping Stones, Reflect and STAR for addressing HIV-related stigma and other HIV issues. These, however, need to be more robustly evaluated as most evidence that is available is anecdotal and in individual narrative (story) form.

**GIPA**. AAI is working through is support for PLHIV organisations to put the GIPA principle into wider practice. It is ultimately the PLHIV activists themselves who will best placed to achieve GIPA through their own skills and commitment. Fellowship Training for PLHIV in India is an innovative way of supporting GIPA implementation and is recommended as a 'Best Practice'.

**Table 8. Intended outcomes for Strategic Objective 12.**

| **Intended Outcome** | **Actual Outcome** |
|---|---|
| 1. Increased uptake of testing, treatment and care by staff members | Not measurableIssue of confidentialityWorkplace HIV policy not consistently implemented |
| 2. Reported increase in utilization of anti-stigma laws by PLHIV especially women and girls | Some progress in legal reform e.g. DRC: promulgation of a law protecting PLHIVNo means of assessing utilisation of anti-stigmatisation laws by PLHIV |
| 3. Increase in improved household and community level love, care and support for PLHIV | No means of assessment |
| 4. Increase in active advocacy and participation of PLHIV organisations in decision making processes | No quantitative data or qualitative studies available.PLHIV in some countries are increasing their participation in advocacy and decision making. |
| 5. Increased uptake of voluntary counseling and testing especially by women and youth | No data available. Problem of attribution to AAI interventions |

**Goal 2.** ***By exercising their rights, women and girls will measurably reduce their vulnerability to HIV and the impact of HIV on their lives including the burden of care.***

**Strategic Objective 2.** ***Support women and girls to claim their rights, reduce vulnerability and mitigate the impact of HIV on themselves***.

It is far from clear that vulnerability reduction among women and girls is taking place and if this is attributable to exercising their rights. Some success stories have been reported:

- **India**. The key achievement of the Mutapola project is that it has helped in reaching out to more than 5000 women in 24 districts of Gujarat resulting in more women seeking available health services and taking collective action to address issues related to Violence Against Women and HIV. The project has helped nearly 100 women obtain benefits under the widow pension scheme and Antyodaya cards.

- **Lesotho**. Reported reduction of violence against women and girls;

- **Malawi**. Strategic partnerships built at national level with Coalition of Women Living with HIV (COWLHA)/ Women Forum have influenced decisions to improve access to treatment through mobile centers and have spoken out on malpractices in ART administration and nutrition supplementation.

- **Malawi.** GBV is being addressed through improved access to justice by survivors of violence through training in Prevention of Domestic Violence act; linkages created with victim support unit of the police; training of paralegals who support survivors to access justice through chiefs and the formal courts.

- **Malawi.** Women have been trained in Treatment Literacy and are making a difference in educating others about ART drugs and how to promote drug efficacy.

- **Gambia**. Establishment of a strong and vibrant positive women's network that is taking a central role in the national HIV response;

- **Tanzania.** AA is managing a transforming education for girls' in northern Tanzania (TEGINT) project to address the underlying gender inequality which is keeping girls out of school and making them highly vulnerable to HIV infection and gender discrimination. The project targets girls, teachers, parents, school management committee, boys and policy makers in the project area. This project is implemented through a partner Maarifa Ni Ufunguo in six districts. This project aims to help 30,000 girls to be enrolled, retained and complete their studies;

- **Uganda.** Through the Women Wont Wait Campaign development organizations have adopted the intersectional issues as their operational mechanism with TASO taking leadership. The experiences have also been used in documenting the Mutapola multicountry experiences for the development of a model programme for strengthening women's rights in HIV/AIDS. A positive prevention model is being developed by AAU and TASO capturing the good practices.

The main approach has been the Mutapola Framework. There have clearly been implementation difficulties, although there are some success stories too. It is recommended that the Mutapola Framework be comprehensive reviewed and if necessary revised or incorporated into a broader human rights framework for HIV.

The outcomes that are suggested in the AAI HIV Theme Strategy are incapable of assessment. (See Table 10). The following activities are suggested.

**Support for programmes that protect women's reproductive health, land income and other assets.**

In Malawi AA has been supporting community based organizations, civil society organizations and district-level coordinating structures in policy formulation, interpretation and implementation to advocate for sexual and reproductive health rights for women and HIV care and support services. Campaigns were conducted to address cultural practices such as early and forced marriages with bye laws enacted at community level to protect girls and keep them in schools.

**Programmes that reduce the burden of care on women and girls.**

In order to reduce the burden of caring for their young, AA in Sierra Leone supported the children of members of the VOW in Bombali with learning materials and set up a skills training centre where lessons in various livelihood skills such as sewing, gara-tye dyeing and soap making are held three times a week for four hours a day. About 80% of the 40 women in the network have acquired new skills and are engaged in gainful pursuits, earning a decent living and can now take care of their children. With support from the Government Voluntary Counseling and Confidential Testing (VCCT) Unit, a group of five members was set-up to monitor how members in the network are engaged in their various business activities and how their lives are being impacted by the business. In Gambia, AA facilitated access to education for over 800 OVC through provision of financial support resource mobilization advocacy

**Advocacy for female controlled prevention tools.** There is no evidence of advocacy or success to date in developing effective female controlled prevention tools.

**Table 9. Intended outcomes for objective 2.**

| Intended Outcome | Actual Outcome |
|---|---|
| 1. Increase in number of women and children reporting legal protection of land and assets rights | Not measured |
| 2. Reduction in violence and abuse of women and girls | Not measured |
| 3. Reported reduction in the burden of home based care for women and girls | Not measured |
| 4. Reported increase in access to affordable women-friendly prevention tools such as microbicides | Not measured |

**Goal 3.** ***By exercising their rights, all those who are vulnerable to HIV infection will have the necessary information and skills to protect themselves from HIV infection.***

**Strategic Objective 3.** ***Support sustained comprehensive HIV prevention work to reduce vulnerability, especially women and children and high-risk groups.***

It is far from clear the extent to which the exercise of rights is reducing vulnerability to HIV. An assessment is needed to see how in practice this is contributing to empowerment and protection in the context of HIV prevention and impact reduction.

Most of the work taken place towards achieving this objective has been through the implementation of STAR and Stepping Stones. In all STAR countries, circle members have benefited from a number of income generating activities which include poultry, piggery, vegetable growing, cash crop sale, and various micro/informal businesses such as grinding and selling maize flour. Both STAR and Stepping Stones are identified as best practices. The intended outcomes for this objective are all broadly positive, however they are beyond the capacity of AAI to monitor and measure.

Some success stories:

- **Bangladesh**. 126 STAR circles were established with, 126 community leaders (facilitators) and finally 10 CBOs were formed out of this 126 circles;
- **Gambia.** Created strong partnerships with relevant government agencies, CSOs and privatesector for the national response. Facilitated in ensuring access to regular treatment, home based care and support for about 2000 PLHIV in the country.

- **Pakistan**. Enhancing the role of media through mobilizing to address the issue of victimization of vulnerable and disadvantaged sections of society e.g. FSWs, transgender etc.

**Table 10. Intended outcomes for Objective 3.**

| Intended Outcome | Actual Outcome |
|---|---|
| 1. Reported reduction in HIV infection rates especially among women and youth | Taking place in most countries |
| 2. Reported increase in VCT, treatment care and support especially for women and girls | Data unavailable from country programmesTaking place in most countries |
| 3. Reported reduction in stigma and reduction of PLHIV | No means of assessmentReportedly taking place in most countries |
| 4. Increase in reported community based treatment and care | No means of assessment |

**Goal 4.** ***PLHIV and other citizens will have the necessary organisations and movements to create sustainable and effective responses and spaces for advocacy in the fight against HIV.***

**Strategic Objective 4.** ***Facilitate strong, flexible and dynamic partnerships that aim to deliver an effective response against HIV based on the rights of PLHIV and affected communities, especially women and girls.***

The establishment and capacity building of PLHIV organisations is one of AAI's most important contributions to the international HIV response. This appears to be taking place in almost all countries where AA is implementing HIV activities. Some success stories:

- **Afghanistan**. Strengthening the capacity of basic package of health care services staff in order to support PLHIV by ensuring their rights;
- **DRC.** Restoration of dignity, self confidence and reinsertion of PLHIV in society through psychosocial support and income generation activities;
- **Nigeria.** AA Nigeria contributed to establishing and strengthening 54 of the ward health committees in Delta, Kogi, Bayelsa, Nasarawa and Plateau states. The strengthened committees will facilitate access to primary health care within their wards and reduce the burden on secondary and tertiary health care providers;[1]
- **Nigeria.** HIV mainstreaming capacity building. AA Nigeria trained the State Agencies for the Control of AIDS (SACA) in Cross River, Akwa Ibom, Nasarawa, Kaduna and Benue states to enhance their capacities to mainstream gender within state HIV/AIDS policies and strategic frameworks.[2]
- **Malawi.** The capacity of local NGO / CBO partners, networks and alliances in programming and service delivery and advocating for increased resources to support grassroots responses have been strengthened.

**Table 11. Intended outcomes for Objective 4.**

| Intended Outcome | Actual Outcome |
|---|---|
| 1. Reported increase in access to treatment, nutrition and care for PLHIV | Taking place |
| 2. Reported increase in number of community based organisations scaling up high quality coverage of community level programmes | Taking place |
| 3. Increase in reported improvement in quality of HIV programming in AAI and partner organistions in areas such as conflict and emergency settings, cost effective home based care and family nutrition for PLHIV especially women and girls | Taking place |
| 4. Increased evidence that voices, perspectives and lived experiences and realities of PLHIV especially women and children are actually influencing policy decisions directly | Taking place |

**Goal 5.** ***States and other institutions will be accountable and responsive to their citizens, particularly by respecting and promoting the human rights of people living with and affected by HIV.***

**Strategic Objective 5.** ***Facilitate people-centred advocacy and campaigns that focus on supporting PLHIV and affected communities to claim their rights to life and dignity in the face of HIV and AIDS.***

It is not clear what the overall trend is in respect of states accountability and responsiveness in relation to HIV and rights. This needs to be reviewed at a country level. There is no evidence of AA undertaking any reviews or analytical work in this regard.

Some success stories:

- **China**: Over 10,000 persons took part in the photo exhibition, covering 5 provinces. It improved basic knowledge on HIV;
- **DRC**: Awareness raised on World AIDS Day and during GAWA;
- **Kenya. Advocacy on stigma and discrimination**. AA Kenya in partnership with Women Fighting AIDS in Kenya published a study on stigma (The Extent and Impact of HIV and AIDS Related Stigma and Discrimination on Women and Children). The study documents cases where fear, stigmatization and discrimination of PLHIV has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected by the disease. 60% of those interviewed feared disclosing their status to anyone in the community and as a result travelled long distances to access care so as to conceal their status. 48% of respondents expressed fear of contracting HIV from non-invasive contact with people living with HIV. 55% of the respondents would not be willing to share a meal with someone they knew of their HIV positive status.
- **Malawi**. Conducted campaigns to address cultural practices like early and forced marriages with bye laws enacted at community level to protect girls and keep them in schools
- **Pakistan**. Lobbying at districts level for the functioning and straitening of Basic Health Units and allocation of trained staff at few is the achievement. Advocacy, networking and liaison to combat rights based HIV related issues with policy makers, INGOs and NGOs to act as a pressure groups and concerned authorities.

- **Tanzania**. Conducted 2 policy research studies on community access to health services in remote areas and Primary Health Care facilities which influenced operational policies and frameworks.

**Table 12. Intended outcome for Objective 5.**

| Intended Outcome | Actual Outcome |
|---|---|
| 1. Increase in transparent, predictable, sustainable mobilisation, equitable allocation, disbursement, utliisation and accountability of HIV resources to poor and excluded PLHIV especially women and girls | No means of assessmentTaking place |
| 2. Increase in access to free quality treatment including generics, care and support by PLHIV and affected household levels | Taking place |
| 3. Increase in active CSO and PLHIV organisations, mobilisations and advocacy for the right to life and dignity in the face of HIV and AIDS | Taking place |

### 4.8 Lessons Learned

Lessons learned are divided into success factors and challenges, constraints and limitations.

#### 4.8.1 Success Factors

The survey questionnaire invited respondents to identify which the factors which have facilitated success in AAI HIBV thematic work. The results are broadly consistent across country programmed and are largely predictable. They are presented in Table 13. The key success factors include the following:

**Rights-Based Approach**. This is now AAI's way of working. The organisation has deepened its approach to rights-based development especially at the country level. It is a political approach[1] and is likely to be most effective in countries with democratic space for rights holders to exercise pressure on duty bearers e.g. India;

**Well-developed policies, strategies and effective prioritization**. Country teams need to be able to prioritise effectively. AAI has limited resources for HIV activities. It is a relatively small player in most country contexts. It is therefore critically important that scarce resources are used to optimal effect. Without effective prioritization, there is the real risk of too wide a spread of activity and dilution of resources;

**Teamwork.** Effective teamwork is an obvious success factor in any organization. There is a great deal of reference to teamworking which involving enthusiasm and , commitment for the mission of AAI. This needs to be sustained;
**Ability to be flexible and innovate**. There is recognizable pride in AAI's ability to innovate. This is an important aspect of its comparative advantage. The capacity to innovate however must be matched by the ability to demonstrate scientifically the results of such innovations in achieving objectives more efficiently or effectively than other methods;

**Leadership and support from central and regional levels**. HIV work is fast-moving and requires that organisations working in the field stay abreast of developments in the scientific aspects and the international development modalities. There is a strong demand for high quality technical leadership from the centre;

[1] Chapman, J. (2005). Rights-based development: the challenge of change and power. GPRG and ESRC.

**Good relationships with Government**. This would appear to be an obvious point. However, in some contexts AAI has the reputation of being adversarial towards the government. In order to advance the rights agenda it may be necessary to work in partnership with government in implementing appropriate components of the national HIV strategic plan. This is taking place in Nigeria and India for example. Working explicitly within the national HIV architecture (Three Ones) appears to be an important success factor;

**Strong partnerships**. It is no exaggeration to suggest that the foundation of AAI's work lies in the strength of its partners. There are many PLHIV and community-based organisations that owe their foundation and capacity to AAI support. This agenda requires judicious selection of partners according to robust and transparent criteria in line with achievement of policy objectives. It also involves the use of capacity building approaches and tools. This should involve means of assessing institutional capacity needs and the supply of high quality training and resources for effective programme implementation. It should also involve development of M&E in partner organisations. In conclusion, partnership development needs a strategic approach and best practices need to be documented for national and international audiences;

**HIV mainstreaming**. Mainstreaming is way of ensuring that HIV is addressed in all relevant activities. At best this involves systematic capacity building in the AAI team such as implemented in Cambodia. Mainstreaming is a cost-effective approach if well planned and coordinated;

**PLHIV organisations.** The main strength of AAI's work in HIV appears to be its solidarity with and support for PLHIV organisations. They represent a core constituency for a rights- based approach. By focusing on PLHIV organisations, AAI can develop a better understanding of the epidemic and the national response as it is experienced by those most affected. This is an extremely powerful lens which has yet to be adequately documented and utilised by the organisation for advocacy and policy dialogue.

**DA presence**. The development area presence is fundamentally important for working with poor and marginalized people. The DA presence constitutes the roots of the AAI development understanding and process. DA work on HIV, however, in general needs to be better documented.

**Availability of donor funding**. Access to external financial resources is a key success factor. There is a clear relationship between scale of activity, impact and project financing. Nigeria and India stand out in terms of the scale of activity attained through the ability of the local office to obtain funding through Government programmes (including GFATM resources).

**Table 13. Success factors**

| Country | Success Factors |
|---|---|
| Afghanistan | Effective community participationRights based approachEvidence based information |
| Bangladesh | Team enthusiasm to work on the human rights of PLHIVInternal facilitating environment Well-developed country strategies as well as AAI strategies on HIV Interest of all party parliament members to work on the respective issueCommunity people's eager participation in promoting human rights of PLHIV |
| China | Good relationship with Government partners Good team workMobilized local NGOs, Good methods of AA |
| DRC | The existence of organizations of PLHIVThe availability of government structure in charge of HIV work at Provincial levelThe dialogue between CSOs and government in fighting HIVThe promulgation of the law of PLHIV by the government The availability of donors in the countryThe existence of AAI HIV policy and strategy |

| | |
|---|---|
| Ethiopia | **Internal:** Good governance of AAE, good leadership, committed staff, sufficient budget allocated from AAE sponsorship fund **External:** Strong and committed partners, particularly PLHIV networks and their constituencies; excellent image and reputations of AAE at community level, commitment of a government at all levels to work with AAE and excellent relationship with CSOs |
| Gambia | Strong partnership relations between AAI and its partnersCommitted staff both at AAI and partner levelsClarity of purpose on most issuesStrong commitment to resource mobilization |
| Lesotho | Commitment from staffTargeting the needy sectors of the communityResponding to priority needsConsistent funding from the affiliatesWorking through partnershipsMainstreaming HIV work with Education, Women's Rights, Governance and Food Rights |
| Malawi | Political will to fight HIV in Malawi Availability of donor funds especially GFATM. It enabled the government to procure drugs for treatment that is given free of charge to patients. AAI rights based approach The availability of alternative funding from donors like Irish Aid, DFID among the many others. |
| Nepal | Working with local partners, building their capacity, close support to the partners on understanding and use of the methodologyPeriodical review and learning on improving the quality of the local level engagementThe support from the regional and international level to the country team. |
| Pakistan | Efficient and determined team Organised and moblized civil society to support AA interventionsCommitment and vision of leadership within AA |
| Sierra Leone | Our presence in all communities where DAC has mandate.Our unique Human Rights Based ApproachesOur VAW networks, which are now growing in strength, would eventually emerge as a movement of empowered women and girls living with HIV. |
| Tanzania | Existence of Country policies and strategies and AA Strategies on HIV.Experience sharing during HIV international Meetings.Participatory Reflection and Review Processes (PRRP)Joint Country programme planning and progress reporting.Existence of community structures which deliberate issues and solutions in their context with regard to HIV. |
| Uganda | Internal management that was keen on delivery of HIV services both for staff and affected women, girls and menStrong civil society in Uganda mobilized into coalitions and networksAvailability of minimal resources to implement proposed interventionsFlexibility in piloting innovations internallyMobilized PLHIV and STAR groups for local advocacy and identification of contextualized policy issues |
| Vietnam | Having AAI support in building our capacity (through Stepping Stones training, APACHA workshop, exposure trips to Indian SHGs of PLHIV, International conferences) Having clear and practical country strategic plansApplying appropriate approaches: RBA, STAR, positive living approach |

### 4.8.2 Challenges, constraints and limitations

The survey questionnaire elicited responses from AAI country team respondents on challenges to implementing the HIV thematic work. A range of issues was obtained. These are presented in Table 15 and discussed below.

**Funding.** Inadequate funding to achieve plan objectives and to implement programmes is a frequently cited challenge. The issue appears to be complex. There are multiple competing priorities as well as competing organisations for funds. It is clear that AAI has experienced a declining resource envelope for HIV over the period 2006-2009 as revealed in annual reports and accounts. The funds for HIV are given in Table 15 below in thousands of Euros. The downward trajectory is clear in absolute terms and a s a proportion of AAI's total programme spending. At the same time financial resources for the international response to HIV have been increasing in low and middle-income countries. In 2008, some $13.6 billion was raised. In this context, AAI's financial share of the total resources available for HIV work is decidedly modest. However, at country level it may be significant, especially in the areas where AAI is targeting its scarce resources. Moreover, some country teams have been able to obtain substantial external funding e.g. India and Nigeria.

**Table 14. AAI Funding and HIV Thematic Work**

| **Financial Year** | **2006** | **2007** | **2008** | **2009** |
|---|---|---|---|---|
| HIV funding | 15,915 | 12,922 | 12,086 | 10,696 |
| Total AAI funding | 123,244 | 144,992 | 136,504 | 159,171 |

The implications are clear enough. AAI needs to reexamine its fund-raising capability for HIV work. Secondly it needs to reflect on whether the organisation is sufficient committed to addressing HIV and thirdly, if it is providing enough technical leadership at global and regional levels. Fourthly, AAI needs to reflect on its niche and comparative advantages in this field and exploit these in resource mobilisation. The conclusion is drawn that AAI needs to be strategic at all levels in how it plans and allocates its scarce resources for HIV work. It is recommended that a more strategic approach be taken towards fund raising.

**Staffing constraints.** Staffing constraints are frequently mentioned. These include staff shortages, high staff turnover rates and lack of continuity, lack of HIV focal point or theme head and lack of training and expertise both internally and in partner organisations. Lack of internal understanding of HIV issues is also cited.The impact of staff changes and losses in the international team are easy to discern. There appears to have been a loss of direction and commitment at a central level. The technical needs of AAI country teams are not being met adequately. There is an urgent need for high quality technical leadership at the international level within AAI and the space and support for this to function effectively.

**Management issues.** There is a hint of country programme management difficulties in the responses and documentation. These imply some difficulties in priority setting, human resource management, follow up and monitoring and evaluation. There is report of weak internal coordination across themes as well as a fragmentation of effort when HIV is mainstreamed. It would be helpful if thematic coordination mechanisms which are in place could be compared and the best practices promulgated.

**Development environment constraints.** The difficulty of operating in HIV where political will is lacking and health infrastructure is weak is mentioned. High levels of stigma and discrimination continue to make this a difficult area for development workers, especially where there are competing and more comfortable policy areas for attention. It seems that HIV work needs continued activism, leadership and support from senior managers to be sustained. It appears that where HIV activism is strong within AAI, there is more likelihood of a stronger programme being developed and implemented. It may also be that AAI HIV programmes are more likely to be successful where there is greater space for NGO/CSO activity, including the ability to support pressure groups and advocacy by PLHIV.

**Table 15. Challenges, constraints and limitations**

| Country | Challenges, constraints and limitations |
|---|---|
| Afghanistan | Security situation, Lack of funding |
| Bangladesh | Fund reduction in the context of global economic recession |
| Cambodia | Lack of necessary financial resources to deliver HIV plan, Staff not taking up HIV workplace entitlements, Inadequate human resources, Lack of space for HIV mainstreaming;Lack of coordination by NAC |
| China | Staff mobilization, Not enough opportunity to improve staff capacityStructure changed in organization, HIV not set up as independent themeFinancial crisis. |
| DRC | Absence of HIV focal pointLack of funds (both flexible and donors project funds) both for HIV direct work and in HIV mainstreaming Lack of capacities of PLHIV to engage well with government representatives who are well informed and have the necessary skillsLack of security due to the on-going conflict in most parts of countryDonor fatigueLack of understanding of HIV |
| Ethiopia | Structure changes in regional HAPCOs (high turn over of government staff)Lack of understanding about CBAS and STAR models by governmentFinancial constraints/ limited budget (small budget allocation after SIPAA)Restrictive legal environment and lack of democratic spaceHigh staff turnoverCompeting priorities |
| Gambia | Inadequate fundingIlliteracy especially among PLHIV groups and networksHigh material expectations by the intervention communities |
| Ghana | Inadequate fundsHIV not being a main theme in the CP |
| Kenya | Insufficient fundingToo many NGOs working in HIV fieldLack of balance between RBA and service deliveryHigh levels of stigma and discriminationPoor health infrastructure |
| Lesotho | Lack of external fundingMyths about HIV and AIDSStigma and discriminationLack of theme head (staffing)Lack of verifiable data from the NAC |
| Malawi | Resource constraintsThe Theme was not implemented as a stand-alone but mainstreamed into other themes, which is a good approach but it tends to scatter attention and resources instead of focusing them.The theme had remained vacant for a considerable period in the past year after the death of theme lead in a fatal accident.Some conflicts resulting from group dynamics within the Coalition of Women Living with HIV&AIDS robbed the group of the unity that initially propelled it to greater height in the AIDS fight.Access to treatment has been a successful programme that has benefitted PLHIV but this is undermined by lack of attention to adequate nutrition. |
| Nigeria | Parallel and uncoordinated HIV interventions across ThemesDifficulties in partners taking on AAI's core valuesSustained fundingHigh staff turnoverWeak political will on HIV response |
| Pakistan | Political will and political priorities in the country always plays vital role in the National response to upscale HIV and AIDS |
| Sierra Leone | Funding: small budgetStaffing: small team Negative traditional norms and practices.Weak political will |

| | |
|---|---|
| Tanzania | Development areas staff turnover.Non-responsive fund raising initiatives.Staff capacity and exposure, especially in the development areasCompetition for funds. |
| Uganda | Dwindling resource basket verses targeted number of beneficiaries.Inadequate implementation of the policies that relate to HIV and AIDSDrug stock outs affecting the treatment cycle for PLHIV on treatmentLack of CD4 count machinesGender based violence as a result of HIVControversial HIV Bill |
| Vietnam | Strictly national political regulations made difficulties for AAV advocacy activities.With limited budget and interventions, AAV is not a strong NGO working on HIV. This made difficulties for AAV to make networking with NGOs, CBOs, SHGs in advocacy on HIV. AAV staff have not had training on advocacy and have less experience on this aspect. |
| Zimbawe | Limited resources |

### 4.9 Conclusions

**Key Components and Minimum Standards**. The AAI recently elaborated RBA methodology[1] in which there are three programming areas and 5 minimum standards provides a framework for making some conclusions. It is clear that the HIV thematic work that has been undertaken in the period 2005-2010 fits in well with the new RBA approach.

**1. Empowerment Component**. (This concerns 'power within'. It involves work, such as capacity building, addressing immediate needs, organization building and rights consciousness programmes, with poor and excluded rights holders for enabling their collective analysis, identity and actions;)The Empowerment Component of the HIV thematic work has been especially strong. There has been an impressive contribution to the development of PLHIV organisations involving capacity building and leadership training. A range of PLHIV organisations has been established at national and decentralized levels. There has been a strong focus on establishing networks and organisations for women living with HIV. The women's rights contribution has been clearly observable. While there has been good work with children living with and affected by HIV (OVC), this constituency does not appear to have been so important to AAI. In a number of countries, the empowerment processes have enabled PLHIV to put pressure on national, state and local government to obtain better entitlements in health care, nutrition and welfare. The clearest examples of change arising from empowerment appear to be in India.

**2. Solidarity Component**. (This concerns 'power with'). It involves working with citizens, partners, coalitions and alliances for enlarging support to strengthen the power of poor and excluded people. Examples of activities include; alliance and platform building, networking with other rights holders, public awareness raising, mobilizing supporters and fundraising).The Solidarity Component is present in most country-level HIV thematic work in the form of NGO/CBO partnerships, capacity building of local government institutions, HIV mainstreaming and coalition building. Through these activities a constituency that is conducive to change and to providing better support to PLHIV is emerging. There appears to be lower priority to solidarity-related interventions. This may be fully appropriate as empowerment is arguably a more important are for driving change. It appears necessary to develop a clearer strategy linking empowerment with solidarity activities to bring about change for PLHIV and their families.

**3. Advocacy and Campaigning Component**. (This is targeted at duty bearers that violate or deny rights with the purpose of making changes in policies and practices, opening political space and building public opinion. Examples include: local and national campaigns; budget monitoring at all levels; advocacy and influencing processes, claiming of enjoying public policies).A great deal of advocacy and campaigning work has taken place involving a wide range of activities, some routine, others more innovative. There has been a wide spread of issues addressed by such work. What is less clear is the success rate as M&E arrangements are rudimentary across the organisation for this purpose. Changes have been brought about in law on HIV (in DRC and Sierra Leone) and influence brought to bear in developing national HIV strategy (e.g. Liberia and Kenya). This area of activity needs to be closely linked with the empowerment component and driven by PLHIV as much as possible.

**Minimum Standards**

The five minimum standards provide a framework to assess, support and provide strategic direction to local RBA programming. Programmes must have interventions related to each of the elements below or have a strategy that will build towards each of them. The minimum standards are met in most countries in HIV work. They :

1. **Building poor people consciousness as rights holders:** This is a standard component involved in working with PLHIV.

2. **Agency of the poor and excluded:** This is a standard component of PLHIV capacity building.

3. **Women's rights:** Women's rights have become integral to PLHIV work.

4. **Poor and excluded people critically engage duty bearers:** This is a standard component involved in working with PLHIV.

5. **Changing the rules.**Many country programmed are attempting to change the rules for PLHIV. This needs to be more carefully strategized at international and country programme levels within a stronger M&E framework.

# CHAPTER 5. – THE WAY FORWARD

## 5.1. Future objectives

Country programme teams were asked to identify objectives for future programming. These are presented in Table 18 below. They broadly point to continuity in programming terms. Constant factors are: PLHIV and rights; Gender and rights/addressing GBV and HIV; and STAR and community-based interventions.

New areas of emphasis include life skills education. The recommended future directions indicate that there is a commitment to continuing and strengthening work on HIV at country level. There is a trend towards including HIV with Health system strengthening (primary health care). This is an important shift, made necessary by the international commitment to achieve a rapid increase in access to affordable treatment. Universal access cannot take place without the health system playing a stronger role.[1] However, HIV is not simply about health and there are multi-sectoral impacts which need to be addressed such as widow/family support. *For details refer to Table 17 in Annexures*..

It is possible to unpack some of the key decision areas for future strategic planning on HIV. It is necessary that the organisation develop a successor HIV strategy for 2010-2015 to support effective country planning. The key issues appear to be: HIV conceptualized in a broad development framework including health system strengthening; PLHIV and their families as a core social group; HIV thematic priorities include: GIPA, addressing stigma and discrimination, gender equality, community-based prevention, impact mitigation for PLHIV and OVC, legislation and policy, positive living, local-level capacity-building and demand-raising social mobilization around access to services including treatment , Scaling up STAR methods; Advocacy and campaign work; and a higher priority given to M&E.

## 5.2. Country Team Recommendations

Country programme teams were asked to identify objectives for future programming. These are presented in Table 18 in Annexure. They broadly point to continuity in programming terms. Strong themes are: A broader approach to HIV and health (SRH, Primary Health Care); Continuity with PLHIV; GIPA; STAR: GBV; and MARPs, Strengthen HIV mainstreaming; and Increase funding for HIV;

## 5.3. Key recommendations

AAI is an important actor in HIV work. AAI has a unique niche in HIV programming. In particular, it plays an important role in empowering and protecting PLHIV. It is also active in addressing gender issues and community-based HIV prevention. Many of its staff are highly committed in this field. They are a valuable asset and need to be further empowered through training and exposure visits. AAI is a strong and valued supporter of PLHIV and their families. Accordingly, AAI needs to strengthen its strategic approach to HIV and prioritise work with PLHIV and their families.

**The following key recommendations are made:**

- AAI to develop a new 5-year strategic framework for HIV which includes equity and primary health care and closely aligned with international and national frameworks for addressing HIV;
- The primary focus of HIV work should be the empowerment and realising the rights of PLHIV and their families;
- Gender should continue to be mainstreamed within the HIV strategy and should be broader in concept to include men and transgenders/sexual minorities. A strong focus on Women's Rights should be maintained;
- A focus should be on the empowerment of individual PLHIV leaders; community based groups and national networks to bring about measurable change for PLHIV;
- Community-based work should continue in particular through STAR and Stepping Stones with the focus on Universal Access. This is an area of comparative advantage for AAI;

- AAI to develop comprehensive and user-friendly RBA guidance for HIV programming;
- AAI technical leadership on HIV to be strengthened and empowered at central and regional levels;
- A high priority to be given to strengthening M&E within the AAI strategic plan framework for HIV;
- AAI staff working on HIV to be given appropriate technical training on a regular basis;
- AAI to renew its voice on HIV and AIDS.

**5.4. Specific Recommendations**

It is recommended that

- AAI work with PLHIV organisations be comprehensively reviewed and in selected countries in order to showcase the rights- based approach and identify the characteristics of effective interventions. AAI should invest in developing a best practice report based on its wide-ranging experience on capacity building of PLHIV organisations including documenting its work with women PLHIV in Africa and Asia to bring out rights issues and promising solutions in different country contexts;
- Efforts be made by AAI to encourage the scientific evaluation of the effectiveness of STAR in a selected country context(s);
- The HIV Workplace Policy to be reviewed and revised. It should be implemented consistently across the organization;
- HIV leadership in AAI develop and maintain policy dialogue with UNAIDS in Geneva and other key international players in the HIV field;
- A specific rights-based M&E framework be developed by AAI to monitor HIV work in country programmes in line with national HIV frameworks for M&E;
- In future only one strategic plan be prepared for HIV work which includes the inputs from all contributing thematic and regional teams;
- Consideration to be given to enhancing the coordination mechanisms for effective interdisciplinary, cross-thematic work at international and country levels in particular;
- The technical content of the international and country strategies on HIV should be strengthened. This indicates a need for stronger technical oversight by HIV team leaders and more investment in capacity building within the organization;
- The Three Ones Principles in that AAI should be internalized by AAI have at international and country levels one HIV action framework, one coordinating mechanism and one M&E plan.
- The Fellowship Programme in India should be documented as a best practice;
- The internationally accepted ‘GIPA’ be used rather than AAI’s ‘MIPA’;
- A complete list of AAI research publications relating to HIV be drawn up and put on the main website with hyperlinks to PDF versions;

# CHAPTER 6

# Best Practices and Annexures

## 6.1 Best Practices

A number of best practices were recommended by country teams. These are presented in Table 16 below. The frequency with which STAR is mentioned is important. This is a promising approach and it is recommended that investments are made in high quality research similar to that in South Africa used to assess the effectiveness of Stepping Stones.

**Table 16. Country Team-Identified Best Practices**

| Country | Best Practice |
|---|---|
| Afghanistan | Religious and culturally sensitive approach |
| Bangladesh | STAR approach |
| China | Photo-exhibition |
| DRC | Involvement of PLHIV in advocacy and campaigns |
| Ethiopia | "Balageru" Radio programmeFM radio programme called "Yebekal" (enough with HIV/ AIDS) Community-Based AIDS Programme (CBAP) |
| Lesotho | Working with grass roots agencies (support groups)Mainstreaming other thematic interventions into the HIV and AIDS work.Linking CBOs with Members of Parliament for conducive policy environment |
| Malawi | Treatment Literacy The movement of Women living with HIV STAR approach |
| Nepal | STAR Methodology |
| Nigeria | Peer Education Plus (PEP)STAR methodologyCapacity building of CBOs |
| Pakistan | STAR approach |
| Sierra Leone | Rights Based Approaches in the communities.STAR |
| Tanzania | Use of community development facilitation circles to link policy and campaign issues from grass-root to national and international levels.Documentation of grass-root experience and national level policy work Use of community development facilitation circles as a source for community resource card analysis on health budget and other social services. |
| Uganda | STAR. Responding to violence as part of the HIV response. |
| Vietnam | STAR approach Positive living approach |

## 6.2 Highlighted Best Practices

The following are identified as promising practices requiring further research and documentation.

**6.2.1 Stepping Stones.** This is already a recognized best practice. More research on Stepping Stones is needed in different contexts.

### 6.2.2 STAR (Societies Tackling AIDS through Rights)

In 2005, the European Commission (EC) provided grant funding to ActionAid to implement the STAR Project for three years (2005-2008) under the rubric of Empowering communities in the face of HIV and AIDS through STAR. AAI implemented the project in collaboration with Pamoja Africa Reûect Network as a lead partner and 21 implementing partners at the country level. The project was designed with the overall objective of '*developing an integrated approach to individual and community empowerment in the face of HIV and AIDS in diverse countries'*. The project was implemented in 19 countries. The key project outcomes that were reported were:[1]Acquisition of knowledge and skills that enabled the poor and marginalised people to claim their sexual and reproductive health rights among other rights; Enhanced ability of the poor and marginalized people to engage in HIV-related policy and practices at local and national levels; Increased access to quality and appropriate reproductive and sexual health, and HIV-related services by poor and vulnerable groups and capacity of positive living persons to respond to all aspects of HIV and AIDS.

Country level findings are presented in Table 17 below.[2]

**Table 17. STAR Project Outcomes**

| Country | Implementation area | Outcomes |
|---|---|---|
| Bangladesh | Silheyt district | HIV awareness and mobilisation among poor communities e.g. tea plantation community |
| India | Orissa and West Bengal States | HIV prevention among migrant labourers, their families, community members and youth groupsOrissa PLHIV networks have influenced the opening of CD4 count centresInclude PLHIV widows under Madhuban pension scheme |
| Malawi | Phalombe district | Services demanded such as mobile VCT centres and under 5 clinics27 communities opened Child Care Centres for OVCs in 40 villagesMobilisation of FBOs, CBOs and government to address rights of OVCsIGAs to support OVCsPLHIV circles lobbied for ART and OI treatment |
| Nigeria | Kebbi State (Kebbi alliance of positive people) and Niger State | Circle representatives collect ART for registered PLHIV, reducing financial burdenPLHIV circles lobbied for ART and OI treatment |
| Sierra Leone | Border areas with Liberia | Circle members have formed credit schemes. Condom use has increased. |
| Tanzania | Liwale District | Decentralised development funding influencedPLHIV better organizedReduction of stigma against PLHIV |
| Uganda | Mitiyana and Kalangala districts | Star circles provide opening for PLHIV group conselling PLHIV circles lobbied for ART and OI treatmentSTAR circles able to obtain support from National Agriculture Department and Development Services PLHIV circles reduce stigma and discriminationPLHIV able to obtain CD4 counts at district hospital |
| Zimbabwe | Four locations | School-based circles mobiles teachers and students for HIV preventionDelay in sexual debut and better informed about sexual issues and rightsPLHIV circles lobbied for ART and OI treatment |

Other organizations have started using the STAR approach. They include Concern Universal in Malawi and Zimbabwe, UNICEF in Zimbabwe, UNHCR in Sierra Lone, and FHI in Nigeria. Circles have assisted adjacent communities to initiate STAR in their locality. Some of the project partners have started using STAR approach in their work. In a number of countries (Uganda, Malawi, Zimbabwe and Nigeria) local governments have started working with circles. It is recommended that research be undertaken to establish scientifically the strengths and limitations of the STAR approach.

### 6.2.3 Fellowship Programme in India

Actionaid India's Fellowship programme was initiated in September 2005 and 40 Fellows from 10 states (Delhi, Uttar Pradesh, Bihar, Orissa, Nagaland, Gujarat, Maharashtra, Andhra Pradesh, Karnataka, Tamil Nadu), have since been part of the project. There is an element of continuity and sustainability in the program as Fellows after completion of between 1 to 3 years move on to other opportunities and new Fellows are recruited in their place. The programme upholds the right to dignity of PLHIV and commits to meaningful involvement of positive people by: Providing a Fellowship to PLHIV for leadership development and community work, Training Fellows for both knowledge and skills for rights based work in HIV and AIDS with public speaking, peer counseling, networking and communication, advocacy etc, Mentoring fellows constantly "on the job", Linking local issues to national and global issues as well as larger development issues through information gathering and dissemination, Facilitating participation in national and international platforms for experience sharing, enhanced learning and advocacy for rights.

### 6.2.4 CBAP in Ethiopia

The Community-Based AIDS Programme (CBAP) is an adopted model from the experience of the AIDS Support Organization (TASO) in Uganda. It was implemented by AA Ethiopia and its local partners to integrate HIV, as a component, into already existing programmes or structures such as Community-Based Health Care (CBHC). CBAP was designed to address six key objectives with the notion that each community can set up its own additional objectives around local priorities.

### 6.2.5 UNAIDS Technical Support Facility (TSF), South Asia

The UNAIDS Technical Support Facility - South Asia (TSF SA) was set up in Kathmandu, Nepal. on 1 March 2009. The rapid establishment of the facility within 8 months was achieved using the AAI partnership model. The partners in the consortium are Tata Institute of Social Sciences, Mumbai and International Centre for Diarrheal Diseases Research centre, Bangladesh and the Country Programmes of Bangladesh, India, Pakistan, Nepal and Afghanistan.

The TSF has brought more visibility, recognition and acceptance of ActionAId by national governments as it succeeded in providing technical support to 3 national governments (India, Nepal, and Bhutan,) which included taking up 7 national assignments in the three countries. The uniqueness of the TSF SA resides in the Rights Based Approach for empowering Most At Risk Populations (MARPS).

### 6.2.6 Platform Politics

The use of various platforms to engage with duty bearers on policy issues e.g children living with HIV needs to be documented. India in particular presents many innovative examples such as public hearings but there may be other innovations elsewhere.

### 6.2.7 Capacity Building of PLHIV Organisations

There are many examples of AAI support for PHIV organsitions which could be documented to provide lessons learned, inform policy dialogue and enhance programmatic guidance. This should examine modalities for capacity building and results in terms of addressing key policy issues such as stigma and access to treatment/services.

## 6.3 Tools for RBA Programming on HIV and AIDS

A number of tools have been developed for RBA and HIV. A full inventory needs to be made and tools with widespread applicability need to be made available online. Examples include:

**6.3.1 The Asian Framework on Women's Rights and HIV and AIDS.**[1] This detailed resource guide is an adaptation of the Mutapola manual as a result of a joint effort between the Women's Rights Thematic team and the HIV Thematic Team. AAI staff and partners in Bangladesh, Cambodia, India, Nepal and Pakistan were involved in its development. Composed of 6 modules, its purpose is to serve as a quick reference on basic facts and statistics on HIV, women and girls in Asia, the primary resource for AAI staff and partners and a reference tool for policy makers, women's rights activists, media workers and service providers. The content includes: vulnerability of women to HIV infection; the rights of women and challenges as a result of HIV; treatment; care and support; food security and sustainable livelihoods and advocacy.

**6.3.2 HIV and Life Skills Education Manual**. A manual for teacher education institutions, adapted from on a manual prepared for India, was prepared by UNESCO and published by ActionAid Gambia with finance from GFATM.[1] Supplementary reading materials were also prepared for 10-12 year olds.[2]

**6.3.3 Peer Education Guide.** A peer educator's guide for school-based peer education was prepared in Gambia in collaboration with UNESCO and UNICEF.[3] ActionAid Nigeria has prepared tools for peer education (Peer Education Plus).

**6.3.4 Trainers' Manual on Advocacy and Social Mobilisation.** This resource was prepared by ActionAid Nigeria to provide community groups with a 'how to' tool for organizing social mobilisation for integrated HIV, TB and malaria interventions.[4]

**6.3.5 Field Guide on Working with CBOs in the HIV response**. A field guide for programme managers to initiate, facilitate and nurture the emergence of CBOs was prepared by Action Aid Nigeria within the Promoting sexual and Reproductive health for HIV and AIDS reduction (PSRHH) programme, funded by DFID and USAID.[5] A strategy for engagement with faith-based organisations was also prepared.[6]

**6.3.6 Field Guide on Behaviour Maintenance.** A field guide for CBO programme managers was prepared by ActionAid Nigeria for promoting behaviour maintenance among high-risk populations as a component of the PSRHH programme. [7]

**6.3.7 Partnership Assessment and Development Framework**. The partnership and development framework (PADEF) was prepared by ActionAid Nigeria as an output of PSRHH. This is a manual on partner selection and participatory organizational assessment and development.[1]

**6.3.8 Technical Brief on Strengthening Institutions for Improved HIV Prevention Service Delivery**. This briefing document was prepared on the basis of lessons learned in implementing the Strengthening Nigeria's Response to HIV/AIDS (SNR) programme, funded by DFID;[2]

**6.3.9 A Practitioners Guide to STAR**. This is a resource that is organized in 5 main sections including about the approach, getting started, policy and advocacy and M&E. [3]

[1] ActionAid India. (Undated). The Asian Framework on Women's Rights and HIV and AIDS. Bangalore.
[2] Republic of the Gambia. (Undated). HIV/AIDS and life skills education. Manual for teacher educators in teacher training institutions. Department of State for Basic and Secondary Education. Banjul.
[3] Republic of the Gambia. (2007). Life skills supplementary reading materials for 10-12 years old. HIV/AIDS and life skills education. Department of State for Basic and Secondary Education. Banjul.
[4] Republic of the Gambia. (Undated). Mam Haddy Peer Educator's guide. Department of State for Basic and Secondary Education. Banjul.
[5] ActionAid Nigeria. (Undated). Trainers' manual on advocacy and social mobilisation for integrated HIV and AIDS, tuberculosis and malaria response. Abuja.
[6] ActionAid Nigeria. (2008). Working with community based organisation in HIV and AIDS response. Abuja
[7] ActionAid Nigeria. (2008). Partnering with faith-based organizations on HIV and AIDS response in Nigeria. Abuja
[8] ActionAid Nigeria. (2008). The behaviour maintenance intervention framework. A field guide for programme managers to initiate, facilitate and manage behaviour maintenance activities. Abuja

**Table 18. Future HIV Objectives**

| Country | Objectives |
|---|---|
| **Afghanistan** | Holistic approach |
| **Bangladesh** | Establishing human rights of PLHIV and government ownership of the issue |
| **China** | Decrease stigma and discriminationSpread and practice STARSummarise experiences and share them |
| **DRC** | Facilitate people-centered advocacy and campaigns that focus on supporting PLHIV and affected communities to claim their rights to life and dignity in the face of HIVIntensify work on the protection of women and girls against violence and HIV |
| **Ethiopia** | To ensure that people able to prevent the spread of HIV/AIDS and mitigate its impacts (CBAP&STAR)To enhance GIPA principle |
| **Gambia** | To advocate for high quality prevention programmes including provision access to comprehensive care and social security |
| **Malawi** | Protect Women and Girls from Gender Based Violence and provide support if they suffer violence i.e. support to justice and move quickly to intercept HIV infection in rape cases i.e. through provision of PEP.Work with PLHIV Orphans and Vulnerable Children to secure their rights to livelihoods, education, shelter, care and property inheritance.Ensure that treatment services are available and comprehensiveCreate awareness for and promote consequences for law enforcement officers who ignore regulations that promote women's rights. Provide assertiveness and life skills programmefor girls (and youth) |
| **Nepal** | The focus on HIV and AIDS, women and Primary Health Care are interlinked and a programme focus enables to the desired outcome that will have a bigger impact on AIDS.Tested approaches' like STAR can be used for mobilization and galvanize movement for prevention and treatment as well as accountability on HIV and AIDS commitment as a right agenda. |
| **Pakistan** | Lobbying for legal reforms to combat against fight against criminalization of aids Promoting and strengthening regarding integration of HIV and AIDS into primary health care systems in the country and to accelerate achievement of universal access 2010 targetsSocial mobilization of MARPS through STAR approachRights based programming for MARPs especially for women |
| **Sierra Leone** | Same as 2005 – 2010 |
| **Tanzania** | Focus on Aid Effectiveness to hold accountable National and Donor governments as per National goals.Policy Advocacy and campaign on rights of PLHIV with regard to Acts and policies which are put into laws but violate human rights.Policy and campaign linkage from grass-root which enable cases building-up at national and international levels.Capacity building of structures at local levels to hold accountable local governments service delivery (primary healthcare and quality health system strengthening) |
| **Uganda** | All the past objectives are still relevant. |
| **Vietnam** | Apply STAR approach in mobilization of community in response of HIVIntegrate HIV prevention and SRH rights and life skills for youth and teenagersPromote Positive living approach among PLHIVStrengthen HIV theme capacity in doing evidence research, advocacy and policy influencing |

**Table 18. Country Programme Recommendations**

| Country | Recommendations |
|---|---|
| **Afghanistan** | HIV should be in combination with Reproductive Health Country level organizational structure should maintain |
| **China** | Decrease stigma and discrimination, spread STAR, focus on marginal people, e.g. sex-workers, children etcHIV should be a separate theme. |
| **DRC** | Putting effort to HIV mainstreaming can help to address HIV quickly especially in awareness raising Linking with national level for advocacy and campaign at international level (addressing countries cases which needs international mobilization, such as donors phase out, etc) Supporting CPs to fundraise, targeting mainly those with low capacities to fundraise for HIV related work |
| **Ethiopia** | Revisiting the HIV Thematic goal, strategic objectives and key intervention activities from PHC perspective Focusing on programme work at grass root levels by introducing innovative approaches, building the capacity of government & different actors engaged on PHC programmes (SRH, water & sanitation and hygiene, nutrition, positive prevention, etc)Use CBAP/STAR models Work in partnership with key strategic partners (Networks), government and CSOs in line with the new legislationHIV/AIDS should be a separate theme, |
| **Gambia** | HIV should remain as a theme/issues pursued by AAI but in tandem with Health Systems Strengthening (HSS) to address other disease like malaria as well as PHC, |
| **Lesotho** | Strong targeted messages to youth and malesFacilitation of ongoing dialogues between communities and duty bearersPushing government to relax funding opportunities to CSOs.Promoting workplace policies and interventions.It cuts across all spheres of life and it is ideal to have it integrated with others with strong emphasis on key milestones. |
| **Malawi** | Let us join hands with others to make sure that resources for HIV&AIDS are sustained and not diminished as in the current scenario. If the current trend continues it will have devastating consequences for millions of poor people on life sustaining drugs that are sponsored by donor resources.Countries in Africa should develop mechanisms for sustainable domestic funding for HIV as an exit strategy from exclusive donor funding.We should enhance efforts to address gender-based violence.Advocate for early diagnosis and early treatment when CD4 count is 500 taking into account the studies showing that individuals who have such interventions have been less infectious. We should join hands to stop the passing on any legislation that will increase stigma and marginalization of PLHIV like some components of HIV bills (mandatory testing, criminalization of infection or deliberate exposure etc) in certain countries like Malawi are likely to do.HIV should be a separate theme but working closely with themes like education themes because of the focus on the girl child that is among the vulnerable groups in the country. Besides young people need special targeting because of their need for information to shape behaviors that are risk free while they are still young. |
| **Nepal** | More staffing for better results and capacity support to countries. |
| **Pakistan** | In the country context, there is a dire need for SRHR interventions for young people. Strategic interventions regarding sexual and reproductive health and rights especially for young girls and women in a country like Pakistan would definitely help reducing their vulnerability towards HIV. Therefore, Pakistan CP along with AAI work together in research and community level initiatives using participatory approaches to create impact through integrated approach. |

| | |
|---|---|
| **Sierra Leone** | HIV should be a separate theme |
| **Tanzania** | Researches indicate subsistence of poor governance on financial resources and mostly not reaching poor people at the grass root levels. AA needs to facilitate capacity of CSOs in tracking of AIDS financial resources.Some of enacted Acts violate human rights. We need to continue facilitating knowledge of acts and Laws which violate human rights. Rights of PLHIV and women should be a continuous struggle. Participatory approaches have brought people together to discuss and shared experience on prevention, care, treatment and support. Need to continue with support of local structures which instill ideas of change in policy practices and follow-up of government plans and actions.When we commit to work on HIV with our partners, we need to plan and work better forI suggest HIV/AIDS remains separate for the purpose of maintaining its leverage and being focused. I am afraid that if it is integrated with others concentration will be reduced and will lose required attention. HIV still has social stigma attachments and unfinished business like stigma and discrimination, people living with HIV who are still not accessing services due to distance and costs of opportunistic infections treatments. |
| **Uganda** | Health financing is key area of interventionResponding to violence as part of HIV responseProgramming for high-risk populations.Strengthening social mobilization using the already proven STAR methodologyPromotion of positive preventionBuilding, strengthening and support PLHiV organizations in advocacy for policy reforms and implementation. |
| **Vietnam** | Continue with STAR approach in mobilizing community in HIV responses Promote the positive living of PLHIV, including appropriate nutrition, positive thinking, positive prevention, regular exercise and good individual, food and environmental hygiene.Integrate HIV prevention with SRH, life skills for teenage and youthBuild capacity of staff on advocacy and policy influencing, research and abstract writing skills Contribute/introduce AAI activities to worldwide community through participating in international conferencesHIV theme should be a separate theme. HIV theme should do integrate activities with other themes, such as o<br>With WR theme in training on domestic and sexual violence for community people in STAR circleso<br>With education theme in addressing sexual abuse in teenage and youth, by raising their awareness on life skills, sexual reproductive health and prevention of sexual abuse,With FR theme in technical support on sustainable agriculture model, integrated in positive living approach for PLHIV |