Supporting community action on AIDS in developing countries

Strategic framework 2005–2007
Supporting communities to reduce the spread of HIV and meet the challenges of AIDS
The Alliance has country offices in:
The Caribbean, China, India, Madagascar, Mozambique, Myanmar, Ukraine, Zambia
and a representative office in the USA
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Chama Musoka talks to peer educators about his life with HIV/AIDS, Lusaka, Zambia
Our values
The International HIV/AIDS Alliance (the Alliance) builds on human rights, public health and socio-economic development approaches. Our work is underpinned by a set of shared values. We believe that:

• The lives of all human beings are of equal value
People’s vulnerability to HIV/AIDS is increased by unequal power relations. These arise, in particular, from poverty and the abuse of people’s human rights. Gender, religion, class, race, ethnicity and sexual orientation are all sources of vulnerability and unequal power in most societies.

• Everyone has the right to access the information and services they need
People should have access to accurate and complete information about HIV prevention, comprehensive prevention programmes, and initiatives that promote the self-determination, dignity and quality of life for people living with HIV, and for groups who are likely to affect, or be affected by, the spread of HIV/AIDS. People have the right to access AIDS care and treatment and appropriate health and social services, including treatment and palliative care for those with AIDS.

Our work is guided by our belief in the importance of:
- meaningfully involving all vulnerable people, particularly those living with HIV and AIDS, in all aspects of the response to the epidemic
- ensuring that communities play a central role in the response to the epidemic
- challenging dogma and discrimination
- making sure that our programming and policy efforts are driven by evidence of ‘what works’
- taking a gender approach to the epidemic that acknowledges the role of both women and men in meeting the challenges of HIV/AIDS
- reducing the vulnerability of children and young people, and involving them in planning, implementing and evaluating sex education, sexual and reproductive health, HIV/AIDS prevention and care programmes
- being accountable to the people we work to support, and to those who support our work.

The International HIV/AIDS Alliance is an initiative of people, organisations and communities working towards a shared vision by supporting effective community responses to HIV and AIDS. We do this by forging partnerships, sharing knowledge, accessing financial resources, and offering technical assistance. In fulfilling our mission, we contribute towards achieving the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session of June 2001 and to the Millennium Development Goals.
Part one Setting the scene

The International HIV/AIDS Alliance was established in 1993 in response to the evolving HIV/AIDS epidemic. Our work focuses on mobilising and strengthening communities so that they can respond to HIV/AIDS themselves. We have based this approach on the belief that those at the forefront of the struggle against HIV/AIDS need to have the resources to take on the challenges that the epidemic presents. In the next few pages, we set out the changing context of the past 11 years that has led to the new strategic framework.

A child-led consultation, Rambo village, Burkina Faso
1 Introduction and overview

The Alliance is made up of a system of linking organisations that reach out to work with communities where people are most vulnerable to HIV/AIDS, or where they are most affected by it. These include key non-governmental organisations in developing countries, local offices set up by the Alliance, and the Alliance secretariat in Brighton.

With over ten years’ experience, we now have a good track record in a significant number of countries, and a growing international profile through our global activities. By working with our partners and drawing strength from one another, we have become established as a leading player in the global response to the epidemic.

We are no longer referring to Brighton [the Alliance secretariat] as ‘donors’, but [as] partners. We do things together; it does not come from the top. The Alliance Strategic Framework is very good: we feel involved in building this initiative. We feel that it is ours.

Issam Moussaoui, Association Marocaine de Solidarité et Développement, at the Alliance’s 10th anniversary celebrations, Brighton, March 2004

About the framework

This strategic framework was written following extensive consultation with partners, donors and staff, and was endorsed by our board of trustees in November 2004. Because of the rapidly changing nature of the epidemic and the response, we decided on a three-year (2005–2007) framework rather than the more traditional four- or five-year time frame. This paper provides an overview of the aims and goals of all the Alliance organisations. Within the overall framework, each partner has its own strategic plan to contribute to our shared vision and mission.

The primary purpose of the framework is to give the individuals responsible for making strategic decisions at the Alliance secretariat some direction, and to offer guidance to our country-based partner organisations and Alliance offices, without imposing inappropriate priorities on them. The framework is also intended to communicate our shared strategy to the external partners that support our work. Finally, we hope it will be useful to other organisations that want to achieve our vision, such as governments, private businesses, and other non-governmental organisations.

2 Our history

Since late 1993, the International HIV/AIDS Alliance has worked with community organisations from over 40 developing countries. Ten years on, we were running long-term programmes in Brazil, Burkina Faso, Cambodia, Ecuador, India, Madagascar, Mexico, Mongolia, Morocco, Mozambique, Nigeria, Philippines, Senegal, Thailand, Ukraine and Zambia. We also had programmes emerging in China and the Eastern Caribbean, as well as project activities in Zimbabwe and Myanmar, and were reaching additional countries through our regional programme activities.

In that time, we have provided financial support to over 2,500 projects, which have been implemented by over 1,800 community and faith-based groups. We have offered technical support, including practical assistance, skills building and organisational development, to at least another 5,000 groups that had project financing from other sources. All of these community and faith-based groups were already working in their communities before they received our support, and most have continued working well after our assistance ended. Our involvement has enabled 70 per cent of these groups to take part in the local response to HIV/AIDS for the first time.

In our first 10 years, we channelled US$100 million to organisations across the world. In 2004, we expect to spend a further US$35 million.

Foundation

By the end of the 1980s there was clear evidence that HIV/AIDS was a global development crisis of enormous proportions, that its social and economic consequences were threatening attempts to address poverty in developing countries, and that it was inextricably bound to the challenges of poverty.

In 1991, a group of donor agencies and international organisations began a series of discussions about how to give more support to community groups in developing countries that were carrying out work around HIV/AIDS. Over the course of two years, the group commissioned needs assessments, project design activities, two country-level pilot projects and, eventually, a proposal for support in creating ‘the International Alliance Supporting Community Action on AIDS’ (later renamed the ‘International HIV/AIDS Alliance’).

The quotation overleaf, from the original proposal for support, captures much of the thinking that influenced the decision to establish the Alliance.
Changes in the HIV/AIDS epidemic
The growth and development of the Alliance since it was founded in 1993 has not taken place in a vacuum. In that time, HIV infections have risen by 400 per cent and, despite the best efforts of many, rates of infection are still on the rise. Young people (15–24 year-olds) account for nearly half of all new HIV infections.

Today, fewer than one in five people worldwide has access to HIV prevention services, only one in nine has access to voluntary counselling and testing, and in developing countries only 7 per cent of those who need it have access to anti-retroviral treatment. Over 20 million have died from AIDS since the first cases were identified in 1981 – almost 3 million in 2003 alone. AIDS has killed one or both parents of an estimated 12 million children in sub-Saharan Africa, and many of these orphans are not properly cared for. Our vision of a world where people do not die of AIDS remains a distant one.

Changes in the response
The global response is undoubtedly better funded than ever before. At just under US$5 billion in 2003, global spending on HIV/AIDS is now 15 times higher than the US$300 million in the early days of the Alliance. But it is less than half of what developing countries will need by 2005, according to UNAIDS.

Increasingly, donors, policymakers, and those involved in the HIV/AIDS global response have recognised the importance of involving civil society. We have all learned lessons about the importance of protecting, promoting and fulfilling human rights and the need for a combination of approaches for prevention, treatment and reducing the risk and impact of HIV/AIDS.

Civil society organisations have had a number of successes in:
- demanding that inactive governments take action
- taking the lead in initiating, planning and delivering responses
- setting the agenda at the international level
- calling pharmaceutical companies to account.

There has also been a growing realisation that to halt – and begin to reverse – the spread of HIV/AIDS, we all need to do more, and do it faster. This change of pace has created challenges to keep the work of donors harmonised and to maintain quality control in rapidly expanding programming.

Funding arrangements are changing, both in terms of the scale of the funding and the impact that the funding has. The Global Fund and World Bank are both increasing their levels of funding for HIV/AIDS, increasing possibilities in individual countries. However, this also raises issues about the capacity of countries to absorb and use this extra money, and the nature of the relationships between governments and civil society organisations themselves.

While new money means that civil society organisations can make a much larger contribution, it brings a greater risk of non-governmental and community-based organisations losing their ability to mobilise support and simply becoming implementing subcontractors. One way to avoid this is by having national intermediaries in each country, along the lines we set up when the Alliance was established.

More recently, anti-retroviral treatment has become increasingly available, and this has led to a shift in the general approach taken to programming. For example, there has been increased pressure for short-term results, sometimes at the expense of taking a capacity-building, developmental approach. The nature of HIV/AIDS as a chronic emergency has increased the need for a dual approach: addressing immediate HIV/AIDS-specific needs, while carrying out more long-term work on underlying factors and contexts.

Civil society needs to engage with and challenge the policies and programmes of other bodies, including government and health organisations, in the struggle against the epidemic.
Changes in society
Since the birth of the International HIV/AIDS Alliance, the wider social, political and economic context has changed dramatically – particularly over the past few years. On the negative side, the growing income gap between rich and poor (both within individual countries, and between one country and the next) has increased migration and mobility. Meanwhile, an increase in fundamentalism in many religions and the ‘war against terror’ has impacted negatively on health, human rights and development issues. On the positive side, some aspects of globalisation have created enormous opportunities for global networking and activism.

Gender inequalities, and stigma and discrimination based on sexual orientation or expression, continue to have a significant influence on the course and impact of the epidemic. One of the clear lessons that we are learning from the global HIV/AIDS response to date is that human rights, public health, and development frameworks are critical – both in understanding the key problems that impact on the epidemic, and in building the alliances that are needed to address them.

Impact of these changes on the Alliance
The changes and developments described above have impacted on the direction and emphasis of the Alliance. In 1993, our emphasis was on a technical, project-driven approach. We offered a vision and a way of working that would put communities at the centre of the response by enabling them to understand and respond to HIV/AIDS.

Our original goal was ‘to provide an effective multilateral channel for donors to support a cost-effective and speedy international non-governmental response to the HIV/AIDS epidemic’.

The central goal of our first strategic plan (1993–1996) was to transfer funds from northern donors to southern NGOs. To achieve this, we aimed to:
- significantly increase the quantity of non-governmental organisation activity on HIV/AIDS
- improve the quality, concentration and sustainability of non-governmental organisation activity on HIV/AIDS
- make sure non-governmental organisations had better access to flexible funds and technical skills.

Palmyrah Workers Development Society (PWDS) is the Alliance lead partner in Tamil Nadu (India). PWDS sees the HIV/AIDS epidemic as a development issue and aims to integrate it into existing development programmes. Through a non-governmental organisation called the Society for Rural Development and Protection of the Environment it supports the handful-of-rice scheme. Women in the Theni district of Tamil Nadu throw a handful of rice into a bowl each time they prepare a meal for their families. The rice is distributed to those who need it, often those who are living with HIV/AIDS.

The Theni District Network of Positive People (TDNP+)
By 1997, these goals had developed into a new strategic framework that emphasised our roles in strategic activities, such as building capacity, enhancing quality, learning and disseminating lessons, and using our influence to make more resources available, rather than simply channelling funds.

Key features of the 1997–1999 strategy included:
• an emphasis on technical support (including skills building and organisational development), rather than financial contributions
• an emphasis on acting as a catalyst for activities to expand, rather than directly sustaining them
• a commitment to experiment with new ways of working, such as developing and testing tools, research and advocacy, in order to influence practice.

This new strategy took into account the fact that most donors were not simply looking for a way of channelling funds from around the globe into local communities. Donors and multilateral agencies were also developing a growing appreciation for our significant body of knowledge and practice about influencing and improving the ways communities respond to HIV/AIDS.

By 2000, the Alliance had helped bring about a greater recognition of the role of civil society. The following year, the way that international funding for HIV/AIDS was set up changed too, as more money went directly to southern countries and non-governmental organisations through mechanisms such as the World Bank Multi-Country HIV/AIDS Programme (MAP) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). This had a big impact on the next phase of our development.

Our third strategic plan (2001–2004) proposed that we intensify our efforts, with a stronger focus on making an impact on the epidemic by:
• reducing the spread of HIV and reducing its impact
• contributing to sustainability and scaling up activities
• making a concrete impact on the policies and programmes of other key stakeholders in the struggle against the epidemic.

As the organisations within the Alliance learned valuable lessons from their experience on the ground, our strategy as a whole evolved, and our direction strengthened and clarified. The idea at the core, however, remained the same.

The central strategy
Community-level responses are at the core of our strategy. From the beginning, we realised that local community groups need to have access in their own countries to resources and technical assistance that matches what local people need, and networks that enable them to learn from and influence their peers.

We decided to identify existing non-governmental organisations that could act as linking organisations to support other non-governmental and community-based organisations within their own countries. We would assist these linking organisations by giving them financial and technical resources. In turn, they would provide financial and technical resources to help inspire local groups to begin responding to HIV/AIDS for the first time, and to encourage community-based organisations already working on HIV/AIDS to expand their work.

In some countries, the need for urgent action and short-term results meant that there was no time to select, support and build the type of relationship that would enable a linking organisation to be truly independent from the very beginning. Instead, we introduced an interim solution in the form of country offices that were initiated by us but were led and staffed by nationals.

Where they have been set up, these offices have spearheaded our activities, allowing interventions to get going in the short term while establishing a basis for independent linking organisations in the longer term. We are committed to helping them evolve from externally controlled, project-oriented offices into sustainable, nationally led linking organisations, as quickly as possible.

Hope and Salvation is a project that was set up in 1997 by two colleagues at the Simferopol AIDS Centre in Crimea [Ukraine]. When the Alliance decided to open a country office in Ukraine, in 2001, it supported the Hope and Salvation project and helped it to shift the focus of its work more towards safe sex skills and professional training. The Alliance also encouraged the project to hire women who sell sex as co-workers. Now the project employs five outreach workers – three young men and two women from the sex industry.

*Hope and Salvation*, *Living Proof*, the Alliance, 2004
The Alliance – shaped and shaping

We have become one of the leading organisations responding to HIV/AIDS globally, with the ability to influence the context and respond to changing demands within it. One of our strengths is that we work with non-governmental and community-based organisations whose core work is not necessarily specific to HIV/AIDS, but involves broader health, development or human rights activities. We help these organisations integrate HIV/AIDS considerations into whatever they are doing. This adds an extra dimension to the response: addressing the complex reality of an epidemic that is so bound up with other social and economic challenges.

An additional strength lies in our ability to help national organisations compile, analyse and share their knowledge and expertise, and disseminate innovation and lessons that have been learned.

Because of the way in which we operate, we are rooted in community experience. We benefit from our local proximity to the issues, the work and the population groups that are likely to affect, and be affected by, the spread of HIV/AIDS (key populations). Our capacity is multiplied by the efforts of thousands of local non-governmental and community-based organisations, which we in turn support with professional technical input and finances.

At the same time, we provide a link between our local organisations and communities and the international level. This enables us to harmonise everyone’s efforts without stunting their innovation and creativity.

The way our organisation is set up is innovative and powerful, but it brings its own challenges. How can we balance diversity and consistency? How do we maximise and share learning? How can we form partnerships with government at different levels, so that we have a greater impact on the epidemic?

Alliance organisations include many faith-based organisations amongst their partners. While this presents its own set of challenges, it also creates exciting opportunities. In Cambodia, the Khmer HIV/AIDS NGO Alliance (KHANA) has a community-based model which supports children orphaned by AIDS to remain in the community where they live with siblings, relatives, or foster families. Buddhist monks have been mobilised to establish hospices for people living with HIV/AIDS and child-care centres for orphans within the pagoda, building on the Khmer tradition of the pagoda as an educational resource for the community.

_Looking back to move forward_, a report on the 10th Anniversary workshop and roundtable meeting, the Alliance, April 2004.

The International HIV/AIDS Alliance – Madagascar is doing pioneering work in linking up with local/municipal government AIDS Committees known as Comité Local de Lutte contre le SIDA. The impetus behind this work has been to support the development of a national vision and greater multi-sectoral collaboration through technical support to these committees at district and commune levels. The work is intended to ensure participatory planning and multi-sectoral work at local levels. The learnings from this work have been considerable and have raised a whole new range of challenges around the meaning of ‘local leadership’.

_Adapted from Looking back to move forward_, and a personal communication from a staff member in Madagascar, in their input towards the strategic framework.

Preparing feedback for a stakeholder meeting after a participatory assessment in Ste Marie, Madagascar. The assessment included, among others, groups of tourism workers, migrant workers and night club clients.
Part two Mission, strategy and new priorities

In this second part of the strategic framework, we look at our plans to build on our values, history and strengths as we take action to address the changes in the HIV/AIDS epidemic and, more broadly, in the world around us over the coming three years.

A scene from Rambo village school, Burkina Faso, where one-third of the children are orphans
Our mission is to reduce the spread of HIV and meet the challenges of AIDS.

We are committed to preventing HIV infection; facilitating access to treatment, care and support; and lessening the impact of AIDS.

The most successful responses to HIV/AIDS and other development challenges are built on local leadership, commitment and responsibility, and are supported by knowledge, learning and resources drawn from local and external sources. Local governments and non-governmental and community-based organisations are particularly well placed to encourage responses from local communities, and to match health and development efforts with the needs and capacities of poor people and poor communities.

Building on its core values, the Alliance is committed to:
• meaningfully involve people living with HIV/AIDS in all aspects of our response to the epidemic. We are committed to the Greater Involvement of People Living with or Affected by HIV/AIDS – the GIPA principles of the Paris Declaration of December 1994
• reduce vulnerability, stigma, violence and discrimination
• strengthen the capacity of communities to respond to HIV/AIDS and other health, development and human rights priorities.
• work (in high- and low-prevalence countries alike) with ‘key populations’ – groups that are likely to affect, or be affected by, the spread of HIV/AIDS. These include people who sell or buy sex, people living with HIV/AIDS, men who have sex with men and injecting drug users.

These groups are not always the poorest, but in developing countries they are usually found among the poor and marginalised. Our emphasis is on developing partnerships with them and strengthening their ‘social capital’ – the processes that enable them to establish networks, norms and social trust – to help them co-ordinate and co-operate so that they can address the epidemic and other challenges. We do this by enabling them to organise, manage and sustain their own community-based organisations so that they themselves can carry out HIV work with other people in their communities.

Working together
We will aim to determine the impact of our own work and results, and the value that we add, by linking organisations, disseminating innovation and lessons learned, brokering new partnerships and helping community groups get involved in taking action on HIV/AIDS. However, the most important measure of performance is the success of the overall response. No matter how good our results are, on their own they will not be enough to make a lasting impact on HIV/AIDS. So our 2005–2007 strategic framework thinks beyond individual projects, and looks to open up to larger partners and coalitions, and to make a more direct contribution towards creating enabling environments.

We link HIV/AIDS to the broader issues of health, development and human rights. In fulfilling our mission, we will contribute towards achieving the Declaration of Commitment on HIV/AIDS of the United Nations General Assembly Special Session of June 2001 (UNGASS) and the Millennium Development Goals. Goal 6 specifically focuses on HIV/AIDS but HIV/AIDS is also relevant to the first five goals (see over).

Goal 1: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 a day
There will be no continuous 7 per cent annual growth rate in the 25 countries where the prevalence rate of HIV is above 5 per cent unless the pandemic is defeated. In fact, it is virtually certain that several of those countries will experience a negative rate of growth, year over year, under present circumstances. There will be no cutting poverty in half by the year 2015 unless the pandemic is defeated. Poverty exacerbates the pandemic, but the reverse is equally true.

Goal 2: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Goal 3: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015
There is certainly no chance of putting every eligible child in school, especially the girls, unless the pandemic is defeated.

United Nations Educational, Scientific and Cultural Organization (UNESCO) has very recently released a study showing that four out of every ten primary school age children are now not in school in sub-Saharan Africa. Young girls are regularly pulled out of classrooms to look after ailing parents. There are 13 million orphans in Africa, the numbers rising inexorably, huge cohorts of them living on the streets, or attempting to survive in child-headed households after the extended family is gone and the grandmothers are dead. These kids have nothing – they certainly have no money to afford school fees, or books, or uniforms.

And it’s not just the children – it’s the teachers. I was in New York last month for the Children’s Summit, sharing a panel with Peter Piot, head of the Joint United Nations Programme on HIV/AIDS (UNAIDS), when he used the startling figure that last year alone, one million African children lost their teachers to AIDS... As I travel, when I speak to ministers of education, they haven’t the faintest idea how they’re going to replace the teachers that are gone, or how they will ever find trained or adequate substitute teachers to fill in for the regular classroom teachers who are off sick for extended periods of time.

Goal 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate
There will be no reduction in infant mortality by two-thirds unless the pandemic is defeated. How can there be? Two thousand infants a day are currently infected... a certain death warrant... maintaining or elevating the already impossibly high infant mortality rates.

Goal 5: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio
There will be no reduction in maternal mortality rates unless the pandemic is defeated. How can there be? We’ve learned over the years that maternal mortality is one of the most intractable health problems throughout the developing world. In a situation where the health systems are under assault, where hospitals and community clinics can’t cope, there’s no chance of reducing maternal mortality by three-quarters. Seldom has the word ‘pipedream’ been more applicable.

(Note on Goal 6: To combat HIV/AIDS, malaria and other diseases – To halt and begin to reverse the spread of HIV/AIDS and to halt and begin to reverse the incidence of malaria and other major diseases.)
This section outlines the strategic directions that we have agreed as part of our strategic framework. It shows the direction and emphasis that we intend to take in our work during the 2005–2007 period.

Our strategic directions address what we will do, and how we will do it. It is this combination of what we do and how we do it that makes us distinct. ‘What’ we do is to enable communities to help reduce the spread of HIV and lessen the impact of AIDS. ‘How’ we do that is by developing a system of national linking organisations, supported by our secretariat in the United Kingdom, which has global and community outreach. Together, the organisations and initiatives within our system combine to create something far greater than the sum of our parts.

Our four strategic directions are to:
- increase coverage of effective community-focused HIV/AIDS action
- strengthen the leadership and capacity of civil society to enable it to participate effectively in national responses to HIV/AIDS
- influence the national and international policy and financial environment to enable more effective civil society responses to HIV/AIDS
- build up an alliance of national linking organisations working effectively together.

The first three of these directions are about what we do, while the fourth is about how we do it. These four strategic directions are explained below.

**Strategic direction 1: Increase coverage of effective community-focused HIV/AIDS action**
Because of the magnitude of the epidemic and the need for action on a wider scale, we are committed to reaching more people, in more areas, with more comprehensive responses. We will prioritise for expansion those countries and areas that are particularly hard hit, working with populations most likely to affect, or be affected by, the spread of HIV/AIDS.

Positive prevention and community-driven treatment schemes are among the new areas of intervention that we plan to advance. We will pay special attention to the newest generation to be affected by AIDS, especially children orphaned by AIDS.

**Strategic direction 2: Strengthen the leadership and capacity of civil society to enable it to participate effectively in national responses to HIV/AIDS**
We commit to continue strengthening the leadership and capacity of civil society organisations to take action on HIV/AIDS by providing them with technical and financial resources, such as practical assistance, skills building and organisational development.

As well as our core work enabling communities to take action on HIV/AIDS, we will put particular emphasis on supporting non-governmental organisations to participate effectively in national co-ordination mechanisms. We will act as a catalyst to enable them to participate meaningfully in public–private partnerships, work with health systems to develop creative interventions for community-driven HIV/AIDS treatment, and make use of new technologies, while remaining accountable to the communities they represent.

**Strategic direction 3: Influence the national and international policy and financial environment to enable more effective civil society responses to HIV/AIDS**
We are well placed to link global policy institutions to the work that local organisations are carrying out across the world. The pooled experience and understanding of our organisations is an invaluable body of knowledge. We commit to using this knowledge to shape national and international policies, creating a policy and financial environment in which community responses can thrive.

**Strategic direction 4: Build up an alliance of national linking organisations working effectively together**
The vision of a stronger Alliance of national linking organisations is the one we believe best fits the demands of the current response. The combination of our UK secretariat, with strong international links, and a shared vision, mission, values and strategic framework, will ensure cross-country learning, quicker responses and economies of scale. We will, however, need strong investment for our governance, policymaking and corporate identity to evolve accordingly.
This section explains in detail the implications of each of the four strategic directions outlined in the previous section.

**Strategic direction 1: Increase coverage of effective community-focused HIV/AIDS action**

The challenges of the epidemic are enormous, and we urgently need to increase the scale of initiatives that are proving effective. This means reaching not only more countries, but also more geographical areas within larger countries where there has been only limited coverage so far. We also need to make sure the interventions are of high quality and evidence based.

In countries where the epidemic has not yet spread to all sections of the population, there is a compelling rationale for focused investment in HIV prevention, and we will continue to invest technical and financial resources in these countries. However, hard-hit countries and provinces will be our top priority for expansion during 2005–2007. We have set ourselves a global target for expanding our work: by the end of 2007, we expect to be making a significant difference to the HIV/AIDS situation in at least the following additional countries:

- two in Latin America and the Caribbean
- two in Eastern Europe
- one in Asia
- five in Africa.

This will expand our operation from 20 to 30 country programmes. We will also set priorities for expanding in the countries where we are currently operating.

In many high-prevalence countries, we have seen food crises, poverty and HIV/AIDS combine to create major, complex emergencies. There is much evidence that food insecurity increases the likelihood of HIV/AIDS being transmitted, while HIV/AIDS increases food insecurity at both the individual and social levels through exclusion, stigma and resource drain. Specialists have agreed that food aid can play a positive role in reducing the impact of HIV/AIDS among households and communities, but it remains a sensitive issue. Nutritional care and support is crucial to people living with HIV/AIDS, as well as to their families and communities. Food needs to be seen as an essential part of treatment.

We are committed to viewing HIV/AIDS in a broader framework that looks at people’s livelihoods. At the programming level, we and our national partners mobilise and involve local non-governmental organisations in HIV/AIDS work, encouraging them to link their income generation and socio-economic development projects with HIV prevention and HIV care work. We plan to explore issues such as how households and communities can adapt their coping strategies to incorporate HIV/AIDS, and how home-based care programmes can best make sure that people living with HIV/AIDS get adequate and suitable nutrition.

Policymakers must realise that the broader poverty reduction strategies provide a tremendous opportunity to deal with the link between poverty, HIV/AIDS and food security. We will work with our national and international partners to explore social protection strategies that involve providing long- (or longer-) term safety nets through governments.

Expanding our coverage does not only mean reaching more people; it also means reaching people with more comprehensive responses that address HIV/AIDS in an integrated way. We will continue to provide direct financial and technical assistance to enable a broad range of community responses and services offering prevention, treatment, care and support, as well as reducing the impact of HIV/AIDS. In doing so, we will be guided by our stated values and scientific evidence of what works. We pay particular attention to marginalised people who are most likely to affect or to be affected by the spread of HIV/AIDS.

The key populations that we prioritise in our work include:

- people who sell or buy sex
- people living with HIV/AIDS
- men who have sex with men, and injecting drug users, wherever they are identified as significant to the dynamics of the epidemic.

Our work involves enabling these groups (and communities more generally) to:

- become aware of the risks of HIV and sexually transmitted infections, and of risks and risk reduction strategies
- express hope or desire to avoid becoming infected with HIV or sexually transmitted infections, and to avoid infecting others
- develop skills to reduce risk of transmission of HIV and sexually transmitted infections
- become motivated to use health services and commodities when they need them

The Association d’Insertion d’Aide aux Orphelins (AIAO) supports village-based work with AIDS orphans in Burkina Faso. In one village where there are 300 orphans, a spokesperson who has been organising a football tournament for the children says: “If these children are abandoned today, they will become highway gangsters. There are people in the village who are sceptical of our work and think we are wasting our time. But tomorrow they will see the results and they will know we are right.”

*Child to child, Living Proof*, the Alliance, 2004
• gain a satisfactory level of support in reducing the risk of HIV and sexually transmitted infection through their peers.

Drawing on evidence of HIV/AIDS programming around the world in the past 20 years, we also emphasise the importance of making sure there is an environment that is conducive to HIV prevention, and that appropriate services and commodities are available.

Over the last four years, we have developed significant experience working with key populations. Two issues present priority challenges for our work in the 2005–2007 period. One is working with drug users. The second is the anticipated dramatic increase in the number of people who become aware that they are living with HIV/AIDS and require support and services.

We commit to:
• Expanding our work on primary HIV prevention and helping drug users to access a range of options (including detoxification, medical care, psycho-social support and HIV prevention) to help them take control of their lives and avoid harm. More specifically, we commit to:
  - building further technical skills on harm-reduction where needed
  - increasing participation of drug users
  - developing links between HIV/AIDS programmes and detoxification services
  - strengthening advocacy strategies
  - strengthening life-skills education
  - integrating drug use and HIV within current HIV sexual health projects.

Also, in linking HIV prevention to care efforts, we will consolidate and share experiences of care and support for positive drug users.

• Strengthening our positive prevention initiatives, including a range of activities led by and for positive people, in their efforts to reduce risk and maintain the best possible physical and psychological health. As more people become aware of their status and start accessing treatment, these activities will become a crucial element in the response. Positive prevention is very cost-effective, and is designed to complement other prevention initiatives rather than to replace them.

• Making sure access to treatment builds on, and contributes to, increased social capital. This means supporting affected groups to engage with, organise, manage and sustain health systems.

• Paying special attention to the newest generation affected by HIV/AIDS – especially to children and young adults whose parents are living with HIV, or who have been orphaned by AIDS.

Increasing our coverage will mean working with more linking and community-based organisations, either directly or through the consortiums we form part of:
• Communities Responding to the HIV/AIDS Epidemic (CORE) – the CORE Initiative is a United States Agency for International Development (USAID) funded consortium whose mission is to respond to the causes and consequences of HIV/AIDS by strengthening the capacity of community and faith-based groups worldwide. The initiative is led by CARE International
• the Health Communication Partnership (HCP) – a collaborative partnership led by the Center for Communication Programs at Johns Hopkins Bloomberg School of Public Health, Baltimore, aiming to promote health-competent societies by advancing the field of health communication
• Horizons – a global HIV/AIDS operations research project directed by the Population Council under a co-operative agreement with USAID.

Our first priority will be to do more of what we know how to do best. However, we may also need to identify new, larger partners, such as some working in international development and humanitarian aid and others with whom we have not worked traditionally, including multiplier organisations such as trade unions and other membership organisations. Exploring the best ways of sharing our expertise, and ways of working with these types of partners, will be a secondary priority for the 2005–2007 period.

Summary
Given the magnitude of the epidemic and the need to support scaled-up responses, we are committed to reaching more people, in more areas, with more comprehensive responses. We will prioritise those people who are most likely to affect, or be most affected by, the spread of HIV/AIDS, and will expand our operations to include some additional countries and areas that are especially hard hit. We will also seek new partners. New areas of intervention that we plan to advance include positive prevention and community-driven treatment schemes.
Strategic direction 2: Strengthen the leadership and capacity of civil society to enable it to participate effectively in national responses to HIV/AIDS

The organisations that make up our Alliance support community responses by offering technical and financial assistance to local non-governmental and community-based organisations. Because of the evolving dynamics of the epidemic, we need to expand our technical support significantly. We commit to continue working with civil society organisations and their leaders to make sure that they are able to take part in responding to HIV/AIDS. We will do this by ensuring they have access to technical and financial resources.

In addition to our core work – supporting communities to take action on HIV/AIDS – we will put particular emphasis on enabling civil society organisations to:

- Participate meaningfully in public – private partnerships. The need to increase the size, range and reach of HIV/AIDS programming, and the fact that new donors are emerging, such as the Global Fund and the World Bank Multi-Country HIV/AIDS Programme, present urgent challenges to the responses of community-based and non-governmental organisations. One of the most pressing of these is the capacity of community organisations to organise and participate in what are designed to be nation-wide public – private partnerships.

We will enable civil society co-ordinated action to:
- inform one agreed HIV/AIDS action framework that provides the basis for co-ordinating the work of all partners
- participate actively and meaningfully in one national AIDS co-ordinating mechanism
- contribute to an agreed country-level monitoring and evaluation system.

One important priority in our strategic framework is to strengthen the leadership, capacity and co-ordination of civil society organisations so that they can engage with initiatives working to rationalise their countries’ responses. Another is helping them to access the available resources in an effective way.

- Work with health systems to develop creative interventions for community-driven HIV/AIDS treatment. As HIV treatment becomes more widely accessible, and as significant proportions of the population in some locations become dependent on life-long anti-retroviral treatment, health systems will become an even more crucial element of the response to the epidemic.

Civil society needs to play an active role in planning and implementing not only health systems, but also the broader social support systems of which health systems are a part. Without doing this, they will lose out on the benefits of mutual accountability, and will not be able to build on shared information and experience. For this reason, we will invest in supporting the interaction between communities and health and social systems, particularly at the local level.

- Engage constructively with new technologies. The scientific world has taken up the challenges of HIV/AIDS, and new technologies and developments are emerging all the time. The central pillar of our strategic framework is the need to involve communities in all aspects of the response to the epidemic.

This means we have an obligation to support civil society organisations and their leaders so that they can be actively involved in the scientific and technological issues that impact on them, whether in the form of vaccine trials or the Global Campaign for Microbicides. Both of these fields of research require considerable work to ensure that communities are prepared for their long-term impacts.

A priority for technical support to linking organisations is to build their capacity in working ‘upstream’. There was a clear recommendation from mature linking organisations at the Directors’ Retreat about the need for technical assistance to help them in influencing national strategic thinking and planning and creating space for non-governmental organisation participation in national forums. In addition, the Alliance needs to more clearly define its niche at the national, regional and global level in Global Fund and World Bank funding mechanisms.

Looking back to move forward, a report on the 10th Anniversary workshop and roundtable meeting, the Alliance, April 2004
The UK Consortium on AIDS and International Development is a group of UK-based international development non-governmental organisations, academic institutions, government agencies and other political and civil society organisations working together to understand and lessen the impact of HIV/AIDS in developing countries. It provides opportunities for these organisations, with their many diverse concerns and interests, to come together on a regular basis to discuss issues raised by the impact of the HIV/AIDS epidemic. Each agency brings its own experience and knowledge to share it and use it to help the other members improve their response to the epidemic.

www.aidsconsortium.org.uk

Summary

We commit to continue strengthening the leadership and capacity of civil society organisations so they can take part in the response to HIV/AIDS. We will do this by making sure that they have access to the technical and financial resources they need. In addition to our core work, supporting communities to take action on HIV/AIDS, we will put particular emphasis on supporting NGOs so that they can participate meaningfully and effectively in national co-ordination mechanisms.

Chama Musoka, aged 26, was diagnosed with HIV in 1999. He is the co-ordinator for the outreach programme of Kara Counselling and Training Trust, Lusaka, Zambia, which provides counselling and support for people living with HIV/AIDS. He is also Vice President of the Young Ambassadors of Positive Living, a Commonwealth peer education programme.

‘We use our own life stories to change other people’s views and behaviour. But we also do a lot of general educational work. We talk about human rights issues and clear up the many misconceptions that people have about HIV. It is for the negative and the positive ones. We talk about the kind of lifestyle you need to have to avoid catching the virus – or if you are already positive, to delay the onset of AIDS. This is very important.

There is this gulf between behaviour and knowledge. Today, everyone knows about HIV, but it’s just as if they can’t connect what they know to their behaviour. It’s like this medical doctor who is a secret smoker… So our stories are there to bridge that gulf; our stories are the solution.

We are winning this one – oh yes, we are winning. But stigma is still there… it is still roaring like thunder in Zambia.’

Young Ambassador, Living Proof, the Alliance 2004
Strategic direction 3: Influence the national and international policy and financial environment to enable more effective civil society responses to HIV/AIDS

Because of the way we work, we are well placed to document lessons learned, analyse them, and use them to inform policy and advocacy work at national and international levels.

The pooled experience and understanding of Alliance organisations constitutes a valuable body of knowledge that must be used to impact on national and international policies, to create a policy and financial environment in which community responses can thrive. We work to make sure that civil society organisations are properly represented by providing technical and financial support that enables them to influence their environment (see strategic direction 2), and by working as an alliance to directly advocate for greater support or changes in policy.

This involves documenting the organisations’ practice, analysing how communities can interact and influence global policy, and assessing what type of support they need to represent themselves more effectively – particularly those working with vulnerable populations.

At the international level, our specific development areas include:

- assessing global financial architecture for HIV/AIDS funding and how appropriate it is for supporting community action on AIDS
- harmonising new funding mechanisms, such as the Global Fund and World Bank Multi-Country HIV/AIDS Programme (MAP), to make sure they are easy for civil society to use and access, and that they address issues around the capacity of civil society to absorb funds
- using our documentation and analysis to inform policy development and to feedback on implementation to UK, European Union and US policymakers, as well as the World Bank, the Global Fund and UNAIDS
- working to galvanise civil society leaders around the new Code of Good Practice for NGOs responding to HIV/AIDS.

At the national level, we will focus on the activities listed above, as well as on documenting and analysing the effects of the legal and regulatory environment on civil society responses and, in particular, their impact on key populations.

Finally, we will work to raise awareness and knowledge of the relationship between HIV/AIDS, health and development issues, particularly looking at how HIV/AIDS programmes impact on broader health systems and community development. We will develop an advocacy agenda focusing on these relationships and, because of this, our policy agenda will need to engage more strongly with political leaders at national and international levels. We will also need a stronger presence and visibility in the domestic and international media.

Summary
We are well placed to provide a link between global policy and local responses. The pooled experience and understanding of the Alliance is an invaluable body of knowledge. We commit to using this body of knowledge to inform national and international policies in order to create a policy and financial environment in which community responses can thrive.
The clear view of the Directors who came together at the retreat [in Brighton, March 2004] was that the promise of a powerful future for the Alliance rests on a vision of powerful internationally linked organisations that are governed, led and managed nationally. Alliance country offices are intermediate steps toward this vision. This is not to say that there is one model of linking with the Alliance – this is not a one-size fits all approach. There will be different types of relationships with the secretariat and with other national organisations in the Alliance structure.

Looking back to move forward, a report on the 10th Anniversary workshop and roundtable meeting, the Alliance, April 2004.

Strategic direction 4: Build up an alliance of national linking organisations working effectively together

At the centre of our strategy is a commitment to work through strong national linking organisations, with strong international connections. This relates to ‘how’ we work, rather than what we plan to achieve through this way of working. However, unless we get the ‘how’ right, we will struggle to achieve the ‘what’.

Our vision of a stronger Alliance of national linking organisations, with strong international connections and a shared vision, mission, values and strategic framework, is the one that we believe best fits the demands of the current response to HIV/AIDS. However, we will need strong investment for our governance, policymaking and corporate identity to evolve accordingly.

At this stage in our development, we need to explore how the system of linking organisations can develop stronger national identities while also strengthening international links. The organisations that make up our Alliance are committed to strengthening mutual co-operation, assistance and learning, and co-ordinating policy action and programme implementation. To achieve this effectively will involve:

- Evolving country offices towards nationally governed and managed organisations. Some situations need quick action and quick results, and in some locations we have needed to help urgently scale up community action on HIV/AIDS, and develop local support for non-governmental and community-based organisations. In these situations, we ourselves have established (and will continue to open) offices in countries. However, this is not a first-choice option, and we will work towards these offices becoming independent organisations that are governed and managed nationally, rather than an extension of the Alliance secretariat.

- Further developing opportunities for exchange and joint programme and policy work across the national organisations within the Alliance. This involves enabling our organisations to share good practice.

- Identifying and working jointly, as an Alliance, on a number of policy issues.

6 Taking the strategic framework forward

We intend to put in place a comprehensive system to monitor how we implement our interventions over time so we can make sure we have a good understanding of the progress we are making towards achieving the four strategic directions outlined in this document.

We will also continue to invest strategically in high quality, rigorous evaluations and operations research into selected interventions to assess our contribution towards our strategic directions and programme objectives.

Through this work, we will increase our understanding of what works and what does not. This will enable us to make a significant contribution towards designing new interventions (and mobilising increased funds for proven interventions). It will also help indicate the best way to implement these interventions so that we can reduce the momentum and impact of the HIV epidemic.

The strategic directions present a number of daunting challenges. We can only meet them if we continue to work together to make this strategic framework a reality.

Sign outside the Kalomo District Hospital, Zambia
Acknowledgments
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Captions:
Front cover:
(top) HIV/AIDS educator, Fernanda Hernandez, demonstrates the correct way to use a condom in the market place in Chimoio, Mozambique
(bottom) The Theni District Network of Positive People (TDNP+) holds regular social events to provide support and comfort

Inside front cover:
(top) Mark rehearses a play about stigma with a drama group, which they will perform for traditional leaders
(bottom) Fabiana advises other transgenders about safer sex and HIV at a nightclub in Guayaquil, Ecuador

Back page:
Six orphans walk through the bush from their school to their grandfather’s home near Rupisse, Mozambique

Inside back cover:
(top) All family members benefit from the care of Seva Nilayam’s outreach workers in Tamil Nadu, India
(bottom) Ivan Shekker advises a young drug user on preventing HIV at a mobile needle exchange in a busy Kiev shopping area.