Executive Summary
This strategy provides the direction required to ensure that Concern Worldwide meets the HIV and AIDS targets set out in the Concern Worldwide Strategic Plan 2006-2010. Whilst this strategy articulates a greater need for increased HIV and AIDS specific responses it is important to note that Concern Worldwide will continue to focus on mainstreaming a response to HIV and AIDS in all our work. It is only through this dual approach can we hope to halt and reverse the spread of HIV and AIDS.

Concern will work in coherence with in-country HIV and AIDS policy and strategy supporting nationally led responses of host governments and civil society.

Aim of the Strategy
Concern’s HIV and AIDS programme aims to lower HIV incidence and to minimise the impact of HIV and AIDS among people living in extreme poverty (Concern Worldwide Policy on Extreme Poverty and HIV and AIDS 2007).

Organisational Strategic Goal: Building Concern’s capacity for impact
Concern’s capacity to achieve impact in the response to HIV and AIDS is strengthened through greater coherence at all levels, continued mainstreaming practice (the “six step” process outlined in Annex 1) and by improved learning and sharing for greater influence on the global HIV and AIDS response.

Programme Strategic Goal 1: Stigma and Prevention
Individuals and communities demonstrate commitment, responsibility and capacity (knowledge, skills, means and options) to prevent the spread of HIV and to mitigate the causes of stigma against HIV and related issues, and to reduce discrimination.

Programme Strategic Goal 2: Care and Treatment
People living with HIV (PLHIV) and affected communities living in extreme poverty have increased and equitable access to (and uptake of) quality HIV related services as part of comprehensive health services, targeting in particular areas where Concern is supporting health programmes.

Programme Strategic Goal 3: Nutrition and Livelihood Security
Extremely poor HIV-affected communities and individuals especially women and children have improved levels of nutrition, food and livelihood security.

Programme Strategic Goal 4: HIV and AIDS in Emergency
People who are displaced or affected by an emergency are able to access (and take up their right to) quality HIV prevention, treatment, and care services.

Our strategic approaches
HIV programming and/or HIV-specific response refers to work focused on the four Programme Strategic Goals above. We must address underlying causes throughout all our work by mainstreaming an effective response to HIV and AIDS. There are occasions, when following programme analysis in other sectors, e.g. education, health, the response required is greater than HIV mainstreaming alone. The need to include HIV specific activities may be identified within a sector and this is referred to as integration.

No single sector can respond effectively to the HIV epidemic and this will mean close collaboration with Concern Health, Education and Livelihoods programmes. This strategy will build on progress made with a strengthened commitment to Greater Involvement of People Living with HIV (the GIPA principle) within the organisation and in our programme work. Concern will work in partnership with a range of actors at different levels in civil society and government to facilitate poorest people to realise their right to HIV prevention, care and treatment, and impact mitigation services.
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### Glossary

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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CCM</td>
<td>Country Coordinating Mechanism</td>
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<td>CTC</td>
<td>Community Therapeutic Care</td>
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<td>GBV</td>
<td>Gender Based Violence</td>
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<td>GIPA</td>
<td>Greater Involvement of People with HIV</td>
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<td>HAP</td>
<td>Humanitarian Accountability Partnership</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HQ</td>
<td>Headquarters</td>
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<td>HR</td>
<td>Human Resources</td>
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<td>IASC</td>
<td>Inter Agency Standing Committee</td>
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<td>IDP</td>
<td>Internally Displaced Person</td>
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<td>IDU</td>
<td>Injecting Drug User</td>
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<td>IEC</td>
<td>Information Education and Communication</td>
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<td>IFPRI</td>
<td>International Food Policy Research Institute</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>PCM</td>
<td>Project Cycle Management</td>
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<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
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<td>PLHIV</td>
<td>People Living with HIV</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PPMG</td>
<td>Programme Planning and Monitoring Group</td>
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<td>Regional Director</td>
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<td>RUTF</td>
<td>Ready to Use Therapeutic Food</td>
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<td>SBGV</td>
<td>Sexual and Gender Based Violence</td>
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<td>SMT</td>
<td>Senior Management Team</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>ToR</td>
<td>Terms of Reference</td>
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<td>UNAIDS</td>
<td>The Joint United Nations Programme on HIV and AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WAD</td>
<td>World AIDS Day</td>
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<td>WFP</td>
<td>World Food Programme</td>
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1.0 Introduction
This Strategy document provides the overall framework required to achieve the Concern Worldwide HIV and AIDS policy aims (2007) which are to:

- lower the incidence\(^1\) of HIV among our target group, our staff and partner organisations’ staff
- minimise the impact of HIV and AIDS on those within our target group who are infected and affected by it

While this document provides guidance to Concern Worldwide country teams, it does not replace National HIV and AIDS Strategic Plans and at all times Concern Worldwide will adhere to the “three ones”\(^2\) principle and work to support and to complement national plans.

This strategy was compiled through an extensive consultative and feedback process that drew from the experiences of a broad section of the organisation, including a review of the previous strategy and a week’s workshop with representatives from across the organisation.

Through this Strategy Concern Worldwide aims to enable poorest individuals and communities at risk of and/or vulnerable to HIV and AIDS, as well as government and partners, to overcome power imbalances, change harmful attitudes and behaviours so as to realise their rights and fulfil their responsibilities to maximise prevention, to achieve optimal treatment and care, mitigate the impact of HIV, and to enjoy healthy lives free of stigma and discrimination. In order to achieve this, there is one organisational strategy goal and there are four programme focused goals.

A country programme may decide to address one or a combination of the goals depending on the contextual analysis and their response plan. The goals are closely linked with other Concern sectors especially Health and Livelihoods. These Strategic goals are a direct response to the identified changes that are seen as necessary to stop the spread of HIV and AIDS. Each goal is presented with a set of objectives, actions and outcomes, to provide guidance and the actions outlined here are not an exhaustive list, and actions will be context-specific.

2.0 External and Internal Context

2.1 External Context

HIV and AIDS statistics are familiar yet staggering. More than 25 million people have died of AIDS since 1981. More than 33 million people are now estimated to be living with HIV and/or AIDS worldwide, including approximately 2.5 million people newly infected in 2007 alone. Children living with HIV (under 15 years old) total 2.5 million at the end of 2007 and there were 420,000 new HIV infections among children in 2007.

Even though we have greater understanding of the factors that determine transmission and vulnerability, the global epidemic continues to evolve and with more than 6,800 new HIV infections and over 5,700 deaths each day due to AIDS we must expand our efforts in order to significantly reduce the impact of AIDS worldwide (UNAIDS 2007). Sub-Saharan Africa remains the epicenter of the epidemic with Southern Africa being most affected. Although globally HIV prevalence has levelled off according to the latest UNAIDS report (2007), AIDS is still among the leading causes of death globally and remains the primary cause of death in Africa.

Table 2.1 gives an overview of the regions in which Concern Worldwide currently works.

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\(^1\) Incidence is the rate of occurrence of new infections. Prevalence is the percentage of the population who are infected. Prevalence depends on incidence and the mortality rate from the disease.

\(^2\) A UNAIDS initiative to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management:

- **One** agreed HIV and 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.
The main route of HIV transmission is unprotected sexual contact. In parts of Eastern Europe and South and South East Asia, sharing of contaminated injecting equipment is increasingly contributing to the spread of HIV. Injecting drug users (IDUs) infected with HIV also spread the virus to partners through unprotected sex. Approximately 35 per cent of infants born to HIV-positive mothers contract the virus through mother-to-child transmission (UNICEF 2006). Prevention of HIV transmission from mother to child is now very successful in many countries with well functioning health systems.

HIV infection remains incurable yet HIV transmission is technically 100% preventable and HIV and AIDS-related illnesses are increasingly treatable. There is still however an 80% unmet need for HIV treatment and resource poor countries are hardest hit, with less than 20% of people accessing their right to treatment in remoter locations. Effective HIV prevention services only reach 20% of those who need them most (Irish Aid 2007). The continuum of HIV prevention, treatment care and support to address the needs of both people at risk and those already infected with HIV is increasingly favoured as the best strategy to achieve universal access to essential life saving services.

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Effects of the Epidemic
The global HIV pandemic has had a profound, multi-sectoral impact on many countries, affecting their development and economic growth, communities, households, and individuals (UNAIDS 2007). The HIV and AIDS epidemic affects every aspect of human development, with short and long-term economic effects. In countries with high HIV prevalence and associated low fertility rates, population growth rates have been reduced to near zero. In some countries up to 60% of today’s 15 year olds will not reach their 60th birthday. Population pyramids are now showing a dramatic restructuring of the population, with decreasing numbers of children and middle-aged adults and more males than females.

The effect on communities and families is devastating as parents, children, income earners and leaders become ill and die. At household level, the epidemic undermines household economies, often pushing those directly affected into poverty, and reducing the incomes of all. Not only those living with HIV and AIDS, but also many individuals and households not directly affected, may see their incomes fall. The impact of the disease on affected households is cumulative, cutting incomes, depriving them of assets, undermining coping mechanisms and leaving them ever more vulnerable to extreme poverty.

Gender Dimension of the Epidemic
Women are disproportionately affected by HIV and AIDS mainly as a result of the disadvantaged social and economic status of women compared to men, but also by women’s biological and physiological vulnerability to HIV infection and their traditional gender role. In Southern Africa studies suggest that young women are two to seven times more likely to be infected than young men. The increasing number of HIV-infected women has led to the infection of nearly 700,000 infants each year. Just 11% of HIV-positive pregnant women in need of antiretrovirals (ARV) to prevent mother-to-child transmission of HIV (PMTCT) in low- and middle-income countries are receiving them in 2007 (WHO).
Cultural expectations about masculinity can influence the behaviour of men and this can heighten their vulnerability to HIV infection, but not all men put themselves at risk of infection. The involvement of men in HIV prevention programmes is critical to better address power inequalities and to reduce men’s vulnerability and that of women to HIV infection. Fathers need to be included in prevention-of-mother-to-child transmission programmes. Greater involvement of men can help to reduce the spread and impact of HIV and AIDS among women and men. Men and boys can be engaged to promote gender equality and to help address gender based violence associated with HIV transmission.

**Orphans and Vulnerable Children**

Among the most devastating consequences of the HIV and AIDS epidemic is the rapidly growing number of orphans and vulnerable children. UNAIDS (2007) estimates that a cumulative total of 14 million children in the world lost their mothers or both parents as a result of AIDS. It is expected that the number will double by 2010, of which 95% will be in Sub-Saharan Africa. Africa now has 12 million AIDS orphans.

In 2003 UNICEF called the effect of the AIDS epidemic on children a “crisis of gargantuan proportions” with the epidemic creating a cohort of children forced to endure the illnesses and loss of their parents and an uncertain future. Meeting the physical and psychosocial needs of these children is a great responsibility and increasingly it is older people who are shouldering this enormous emotional and financial burden. In Malawi, Tanzania and Zimbabwe, up to 60 per cent of orphaned children live in grandparent-headed households (HelpAge International 2005).

**People affected by Emergencies**

According to the United National High Commission for Refugees (UNHCR), in 2006 there were approximately 32.9 million refugees and Internally Displaced Persons (IDPs). It is estimated that between 8%-10% of this population is living with HIV and AIDS. Emergency conditions can increase or decrease vulnerability to the spread of HIV. In the areas hardest hit by political strife, natural calamity and hunger, AIDS is both a consequence of food emergencies and one of the drivers. In refugee and IDP settings, the situation is made worse by the break-up of traditional community structures destroyed during displacement (WFP 2006). In contexts where there is a high prevalence of HIV and AIDS, combined with increased vulnerability to and risk of HIV and AIDS, this can worsen the severity of the emergency, as well as undermine long-term prospects for recovery.

**Effects on health systems**

AIDS in sub-Saharan Africa imposes a huge burden on an already weak health infrastructure, while, at the same time, weak health systems are a major obstacle to effectively dealing with the health effects of HIV and AIDS. Some health systems are inadequate for ensuring the safe uptake of anti-retrovirals (ARVs) and treatment of patients who are HIV positive, especially with the rapidly rising incidence of tuberculosis (TB), fuelled by the HIV epidemic. Tuberculosis is the first manifestation of AIDS in over 50 percent of cases in the developing world. ‘We must act to ensure that health systems around the world have sufficient tools and workers to care for those in dire need of attention. When our health systems fail, individuals suffer’ (Mary Robinson 2007).

**Effects on Education**

Michael Kelly S.J. has long spoken of education as the ‘social vaccine’ against HIV (2002), but it is itself threatened by the epidemic. The spread of HIV and AIDS is compromising the potential to attain “Education for All” and furthermore, threatens gains that have already been made in the capacity to deliver high quality education. The disease not only causes illness and death of teachers and teacher-trainees, but also impacts on the demand for education in terms of the numbers and composition of the school-age population. Even though young people (10 to 24 years) are estimated to account for up to 60% of all new HIV infections worldwide school children in the worst affected countries still have the lowest rates of HIV infection of any age group and are being seen by many as the ‘window of hope’ for a virus-free generation.
**Effects on Livelihoods**

Research has shown that livelihood insecurity is a cause as well as an effect of HIV and AIDS, and policy recommendations include preventive strategies that address livelihood vulnerabilities and building on people’s resilience (Edstrom et al 2007). There is evidence that HIV and AIDS-affected households suffer from loss of income, loss of assets that must be sold to cover the costs of illness, and loss of skills as household members with knowledge of farming succumb to the disease (FAO 2006). A decline in the available household labour due to AIDS mortality and morbidity has a significant impact on household agricultural productivity resulting in increasing hunger in poorest households (IFPRI 2007). The disease, combined with food and nutrition insecurity can lead to severe malnutrition and deepened poverty. Food insecurity may drive people to livelihood strategies including migration for seasonal work that increase the risk of contracting HIV and AIDS. “Food is often cited by people living with and affected by HIV and AIDS as their greatest and most important need,” said Elizabeth Mataka, the UN Secretary-General’s Special Envoy for AIDS in Africa recently (Rome 2007). The United Nations in 2006 declared that access to food should be part of a comprehensive plan to fight HIV and AIDS (UNGASS Declaration of Commitment, Article 28).

**The response**

Even as we recognise the devastation of AIDS during the two-and-a-half decades since HIV was first identified, it is important to note that there has been remarkable progress in our understanding of various aspects of the global HIV and AIDS epidemic. Advancements have been made in the science surrounding HIV, and there is greater recognition of the interrelated factors of the epidemic, all leading to a greater understanding of the holistic interventions required to make an impact. Governments across the world have committed themselves to accelerating their responses to the epidemic at the

- 2001 United Nations General Assembly Special Session on HIV and AIDS
- The United Nations World Summit 2005
- The June 2006 and 2008 UNGASS High-level Meetings on AIDS

There have also been increasing initiatives to address HIV within each sector. Globally there has been an increase in donor funding which is estimated to need to continue and grow from $18 billion in 2007 to $22 billion in 2008 and is set to reach up to $23 billion by 2010. Table 2.2 provides a breakdown of global funding.

**Table 2.2: Global funding for HIV and AIDS (Irish Aid Issues Paper 2007)**

<table>
<thead>
<tr>
<th>Estimates of External Global Funding</th>
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<tr>
<td>Global Fund to Fight AIDS, TB and Malaria</td>
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<tr>
<td>World Bank/UNAIDS</td>
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<tr>
<td>President’s Emergency Plan for AIDS Relief (PEPFAR)</td>
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<td>Bilateral Organisations</td>
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<td>Private Sources</td>
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Governments and supporting organisations are increasingly implementing behaviour change programmes that include social mobilisation, skills building, intensive interpersonal counseling and HIV testing. The number of people using HIV testing and counselling services quadrupled in the past five years in more than 70 countries surveyed, from roughly four million persons in 2001 to 16.5 million in 2005 (UNAIDS 2006). Providing counselling and voluntary testing services identifies those who need treatment, helps to reduce mother-to-child transmission and is also an entry point for education to prevent further transmission.

The responses to the care needs of People living with HIV and AIDS (PLHIV) in highly affected and resource-constrained settings have been diverse. However in the last few years, armed with greater knowledge and resources there has been an expansion in the provision of quality care and treatment. Comprehensive packages of care are now available that includes the provision of ARV in optimal care settings and food assistance and food supplements.
The problem in 2008

Despite an improved global understanding and response many challenges still remain at individual and community level. Increasingly people are responding to widespread and consistent education messages about HIV and AIDS prevention and care. However, it is evident that there is still a significant gap between knowledge and practice. The epidemic is aggravated by stigma and discrimination. Stigma cuts across all aspects of society; it can be seen in the workplace, in health care settings, in school, in communities and in families. Self-stigma can be even more devastating than the disease as people feel shame, self doubt, and guilt causing withdrawal from society. It prevents many people from getting tested and telling their partners the result. In Africa a growing trend is the violence associated with disclosure. Tackling the myths and misunderstandings surrounding HIV and AIDS remains one of the biggest tasks for grassroots organisations.

Even with the increased financial commitments, the global response to HIV and AIDS is in no way commensurate with the currently reality and daily human tragedy. Pledged contributions are not always realised in disbursement of the funding to the Global Fund and other funding mechanisms. UNAIDS estimates that there was a global funding gap of $8bn in 2007 to tackle HIV and AIDS. Health systems are particularly underfunded. Many developing countries do not meet the basic health and nutrition needs of their populations.

More children are being born with HIV worldwide due to weak prevention of mother-to-child transmission programmes. No child should be born with HIV now that we know how to prevent HIV transmission from mother to child. The provisions of the TRIPS agreements (opening the door for cheaper anti-retroviral drugs) are not benefiting those who most need access to essential medicines. Mitigation interventions are just being initiated in worst impacted countries in East, Central and Southern Africa.

In recognition of the relationship between extreme poverty, inequality and HIV and AIDS, in-country leadership, coordination and a commitment to action by all are critical to reduce the spread of HIV and AIDS globally. External support is necessary to support national efforts in poorest countries. Donor fatigue, invisibility of poorest people living with and affected by HIV and AIDS, complacency, and competing global issues including food and fuel crises and climate change now diverting response efforts contribute to increased and unnecessary preventable deaths.

2.2.3 Concern Worldwide response

HIV and AIDS was the original focus of Concern Uganda's work in the late 1980’s. Concern Ireland is mentioned by the Government of Uganda/Ministry of Health with respect to it’s Community Based Home Care Programme in a UNAIDS Review - Collaboration with traditional healers in HIV and AIDS prevention, documented examples of collaboration in sub-Saharan Africa (1987 - 1999).

Concern was supporting HIV and AIDS prevention through education work with Khmer refugees in the Thai border camps from the mid 1980’s. HIV and AIDS projects were being implemented in more than 15 countries in 2003, either as explicit projects or as components of larger programmes. Over the past 20 years Concern Worldwide has been addressing various issues of the HIV epidemic and in 2003 increased its commitment with the launch of the first HIV and AIDS policy with the first strategy document following in 2004. Concern’s Human Resources Illness Policy (incl. HIV and AIDS) and Implementation Guidelines were finalised in September 2004.

Concern Worldwide had a good track record in working with poorest communities and more recently this includes increasing numbers of the extremely poor who are infected and affected by HIV and AIDS - partnering with Mekdim in Ethiopia, and supporting Home Care Associations in Uganda and anti-AIDS Clubs in Rwanda. Concern works with CBOs and local NGO and government service providers responding to HIV and AIDS in Afghanistan, Angola, Haiti, India, Kenya, Laos, Liberia, South Sudan, Somalia, Mozambique, Zambia and Zimbabwe. Concern focuses on mainstreaming a response to HIV and AIDS in Bangladesh, Pakistan and in Tanzania.
For Concern Worldwide HIV and AIDS is both a sectoral programme area and a cross cutting issue. In the last four years strategies and strong internal capacity for the process of mainstreaming has been established and the majority of Concern Worldwide programmes are being examined through a HIV lens. A number of processes and documents have assisted in achieving these gains:

- 2003 HIV and AIDS Policy
- 2004 Concern’s Illness Policy (under the HR Policy)
- 2004 Programme Participant Protection Policy
- 2005 Equality Policy
- 2007 Concern Worldwide Policy on Extreme Poverty and HIV and AIDS

Concern Worldwide has now an emerging organisational competence in HIV mainstreaming and many areas of HIV programming that through our increasing advocacy is being recognised by our peer organisations.

Concern Worldwide now supports over 90 partners to implement prevention, treatment and care interventions in specific response projects in 15 countries working towards the targets set out in the Concern Worldwide Strategic Plan. Additionally Concern is supporting integrated HIV and AIDS interventions within livelihoods, education and health programmes. Concern works in partnership with a range of actors at different levels in civil society and government to ensure that poorest people are facilitated to realise their right to HIV prevention, care and treatment services, and for impact mitigation.

Whilst it is important to recognise the work which is being carried out it is also important to note some findings from the external review that was conducted in 2007 – “There is some excellent work happening – but it seems to be happening in pockets where Concern has staff who have the knowledge, skills and understanding of the issues, and it is not being built on or linking up between levels to add up to anything greater than the individual interventions”.

The review also made the significant point that “Programmes often carried embedded assumptions that increased knowledge and awareness about HIV and AIDS will lead to behaviour change, without critically examining or developing strategies to counter the social, cultural and economic pressures that work against this, except in a fairly superficial manner”. Building on both the experience to date and the findings of the external review has assisted greatly in the development of this strategy.

2.3 Targeting
The Concern Worldwide Policy Statement (2005) states that Concern will work “so that those living in extreme poverty benefit to the greatest possible extent”. To achieve this, we will work with those who can best ensure positive impacts for our target population of extremely poor people. At times we may work with people outside our target group, including people with high risk behaviours who may increase the vulnerability to infection of our target populations including women and children, youth, refugees, migrant workers and the displaced.

To strengthen national efforts countries are being encouraged to “know your epidemic” by identifying the behaviours and social conditions that are most associated with HIV transmission. This can provide the basis for countries to ‘know your response’ and to “tailor your prevention plans” to meet the needs of the populations with highest rates and highest risks of HIV (UNAIDS 2007).

In regions/areas with a concentrated epidemic Concern may need to target specific groups including intravenous drug users, migrant and sex workers, aiming to interrupt the spread of HIV and AIDS. In a generalised or hyper endemic context we may need to target prevention activities towards youth - 15 to 24 year olds. The target group may differ from context to context and according to the nature and stage of the epidemic. The key principle of ultimately benefiting or reducing the vulnerability of people living in extreme poverty should be applied in all contexts.
3.0 Strategy Aim, Goals and Objectives
In the next five years Concern Worldwide intends to continue its contribution to the achievement of the HIV and AIDS Millennium Development Goal by building on past achievements and expanding our response to 20 countries by 2010 in accordance with the Concern Worldwide Strategic Plan. Concern Worldwide aims to reach 500,000 people directly and 4 million people indirectly through scaling up HIV and AIDS services and continued HIV mainstreaming in all our sectoral programmes.

3.1 Aim of the Strategy
Concern’s HIV and AIDS programme aims to reduce HIV incidence and to minimise the impact of HIV and AIDS among people living in extreme poverty.

The goals set out below are necessary to deliver a holistic and comprehensive response to HIV and AIDS. A country programme may address one or a combination of the goals depending on the contextual analysis, Concern’s capacity, and in-country capacity and gaps in the response.

3.2 Goals and Objectives

**Organisational Strategy Goal**

**Organisational Strategic Goal: Building Concern’s capacity for impact**
Concern’s capacity to achieve impact in the response to HIV and AIDS is strengthened through greater coherence at all levels, continued mainstreaming practice (the “six step” process in Annex 1) and improved learning and sharing for greater influence on the global HIV and AIDS response.

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<th>Objectives</th>
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<td>1. Document and facilitate cross country and regional learning on the mainstreaming process that allows Concern and partners to have a greater understanding on the relationship of HIV to our organisations, programmes, and the impact of HIV on poorest communities and individuals.</td>
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<td>2. Synthesise lessons learnt, promising practices, and knowledge sharing on effectiveness on all aspects of HIV and AIDS programming.</td>
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<td>3. Develop an organisational culture of implementing programmes that are evidence informed by building the capacity of Concern and Partners in continually documenting and evaluating practices and adopting proven initiatives into their programmes.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mainstreaming a response to HIV and AIDS is a recognised competence of Concern.</td>
</tr>
<tr>
<td>• Documentation of mainstreaming will support to inform the mainstreaming process for other cross-cutting issues in Concern.</td>
</tr>
<tr>
<td>• All HIV and AIDS programmes are evidence–informed and use proven international best standards and practices.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Devise templates and standards for documenting case studies.</td>
</tr>
<tr>
<td>• Ensure that staff and/or partners have opportunities to participate and learn at international conferences and meetings on HIV and AIDS, and to present Concern experiences as appropriate.</td>
</tr>
<tr>
<td>• Adopt international standards to be relevant to Concern’s work and develop guidance to be followed by all HIV and AIDS programmes and HIV and AIDS activities that are integrated into non-HIV programmes.</td>
</tr>
<tr>
<td>• Continue to ensure that all fields and offices implement internal mainstreaming.</td>
</tr>
</tbody>
</table>

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3 Goal 6: Combat HIV and AIDS, Malaria and other Diseases, Target 7 Halt and begin to reverse the spread of HIV and AIDS
Programme Strategic Goal 1: Stigma and Prevention
Individuals and communities demonstrate commitment, responsibility and capacity (knowledge, skills, means and options) to prevent the spread of HIV and to mitigate the causes of stigma against HIV and related issues, and to act to reduce discrimination.

Although often overshadowed by the focus on treatment, prevention remains the highest priority for controlling HIV. Preventing HIV is a complex, and often elusive, process that requires individual behaviour change, an enabling environment redressing societal power imbalances, reducing stigma and discrimination, addressing gender and economic inequalities, and ensuring equitable access to prevention services.

Stigma, and accompanying discrimination, is a primary barrier to preventing the transmission of HIV, ensuring appropriate and high-quality medical care, and permitting PLHIV and those affected by HIV to live productive and secure lives. Concern will put special emphasis on identifying and addressing the attitudes and values that underlie stigma in order to improve the lives of extremely poor PLHIV, their families, and affected communities.

Objectives
1. Support comprehensive prevention services, tailored to the needs of specific populations
2. Influence a policy environment where international and national policies, covenants, laws and treaties are respected, observed, and implemented by all stakeholders.
3. Support communities to accept PLHIV and their families to participate at all levels, in all areas of community and public life.

Outcomes
• People living with HIV and AIDS, those vulnerable or at risk, and communities recognise and are able to act on their responsibilities to protect themselves and others from HIV re-infection or primary infection HIV and have access to the appropriate services.
• National policies and laws ensure individuals can access their right to HIV prevention services and treatment of HIV and AIDS and actively reduce stigma and discrimination against people living with HIV and AIDS, women, youth, children, and those who practise risky behaviours.
• Reduction in stigma, discrimination and violence towards PLHIV and affected households.
• Reduced incidence of HIV.

Actions
• Conduct a comprehensive situational analysis of the policy environment, at-risk and vulnerable populations and design advocacy and prevention interventions to address specific needs, risks, and vulnerabilities.
• Incorporate good practices that emphasise individual rights and responsibilities for sustained behaviour change into intervention design.
• Link all activities to relevant referral services, e.g., condom distribution, needle and syringe exchange, medical care, VCT, drug treatment/addiction services, PMTCT, etc
• Sensitise government and facilitate community discussions on values and attitudes that stigmatise HIV and AIDS and on the means to counteract this.
• Build the capacity of CBOs and PLHIV support organisations to enable them to address power imbalances and inequalities affecting extremely poor people, including between young and old.

Programme Strategic Goal 2: Care and Treatment
PLHIV and affected communities living in extreme poverty have increased and equitable access (and uptake) to quality HIV related services as part of comprehensive health services for all, targeting in particular areas where Concern is supporting health programmes.

4 Comprehensive HIV prevention includes sexual transmission, early diagnosis and treatment of STIs, PEP, PMTCT, injection and blood safety and health-care precautions, harm reduction, BCC and VCT.
Despite extraordinary advances in antiretroviral treatments to control HIV and extend the lives of those infected, many people living with HIV do not have access to these and other health and HIV related services. Concern recognises that HIV related services alone are not sufficient and that all areas of the health care system need to be addressed.

Where on assessment the health services are deemed to be sufficient and Concern is not working in the health sector, a HIV Programme focusing on this Strategic Goal will support the delivery of HIV related services. Where the formal health services are also in need of strengthening, this may be considered under the Concern Health Programme. Informal HIV and AIDS services can be supported under this Strategic Goal.

### Objectives

1. Improve the capacity of health services and systems (formal and informal) to deliver HIV related services as part of comprehensive health care including ARV treatments.
2. Advocate and make linkages for the provision of services and the allocation of resources in underserved areas.
3. Promote the uptake of HIV and AIDS-related services amongst youth, PLHIV and affected poor communities.
4. Support a stigma-free environment and one that addresses knowledge, financial, age, gender and geographical barriers and facilitate improved health-seeking behaviours of poorest people living with HIV and AIDS and affected communities.

### Outcomes

- PLHIV are aware of their right to quality and sustainable health services.
- PLHIV and affected communities living in extreme poverty, including young people enjoy improved access to HIV related services.
- Health systems are delivering HIV related services as part of a comprehensive health care package.

### Actions

- Assess access of those in extreme poverty to HIV related services.
- Provide training and support for improved quality and delivery of HIV related services.
- Advocate for and target underserved areas for improved HIV related service delivery and resource allocation.
- Mobilise communities to support HIV and AIDS home based care services.
- Improve coordination between HIV and health programming.

### Programme Strategic Goal 3: Nutrition and Livelihood Security

Extremely poor HIV-affected communities and individuals especially women and children have improved levels of nutrition, food and livelihood security.

Food and nutrition security play an important role in keeping those who are infected and affected well for longer. A person who is well nourished is less susceptible to infection including HIV.

Once a person becomes HIV positive, nutrition security can play a role in delaying the onset of AIDS defining illnesses. Food and nutrition security can also help with adherence to antiretroviral therapy (ART). HIV treatment outcomes are improved and lives are extended with nutritional support.

Targeting responses appropriately will be critical, and given the sensitivity of targeting PLHIV, chronic illness can be used as a proxy indicator for HIV and AIDS. Concern is committed to implementing the principles of the Humanitarian Accountability Partnership (HAP).

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5 It is Concern's preferred option not to be directly operational, but to collaborate and work alongside implementing partners, building their capacity for service delivery (Concern Worldwide's Policy on Health 2002).
## Objectives

1. Ensure that PLHIV and affected communities have sustainable food and nutrition security.
2. Build a base of evidence on HIV and food and nutrition security to influence programmes and policy.

## Outcomes

- PLHIV and affected communities have increased access to food, increased production capacity and food quality at a household and intra-household level.
- Vulnerable households, individuals and young people are empowered to abandon livelihood strategies that increase their risk of contracting HIV.
- Concern Worldwide programme experience influences policies both nationally and globally on nutrition and food security for people with HIV and affected communities.

## Actions

- Facilitate linkages between food providers (e.g. WFP) and severely vulnerable households.
- Explore further development of CTC and Ready-to-Use Therapeutic Food (RUTF) appropriate for HIV affected adults and children.
- Support nutrition education for ‘positive living’ and people affected by HIV and AIDS.
- Develop the Concern IFPRI programme of action research on the interconnections between HIV, nutrition, food and livelihood security.
- Establish national and international links based on documentation, learning and evidence and develop advocacy action plans to influence policy change.

## Programme Strategic Goal 4: HIV and AIDS in Emergency

People who are displaced or affected by an emergency are able to access (and take up their right to) quality HIV prevention, treatment, and care services.

Disruption of family support structures, societal norms, and social networks, sexual violence, coercive sex and psychological trauma can increase the risk and vulnerability of people affected by emergencies to HIV and AIDS. Yet a recent Lancet study finds that conflict does not necessarily increase HIV transmission and that each situation must be analysed individually (Spiegel et al 2007).

Gaps in available services are however often greater in conflict affected settings. Concern will, therefore, put special emphasis on ensuring that all emergency responses address issues of risk for HIV infection and support access to prevention, treatment and care services.

Concern is a signatory to the Code of Good Practice for NGOs respond to HIV and AIDS since 2004 and staff follow the IASC Guidelines for responding to HIV in emergencies.

## Objective

1. Support communities affected by an emergency to adopt behaviours that prevent HIV infection, and empower them to care for people living with HIV and to access appropriate treatment.

## Outcomes

- People affected by an emergency and the aid community are aware of the vulnerability/pre-disposing factors to HIV infection and how to prevent it.
- People affected by an emergency are aware of Sexual Gender Based Violence (SGBV) in such contexts and know how to reduce the risk, and are empowered to act upon that knowledge.
- STI/HIV and AIDS related stigma and discrimination is addressed.
- Emergency medical services include quality HIV-related treatment and care, and provide treatment for STI and post exposure prophylaxis (PEP)
**Actions**

- Support sensitisation activities on HIV and AIDS and related stigma and discrimination among Internally Displaced Persons (IDPs), refugees and host communities affected by the emergency and the aid community, particularly in the preparedness phase if possible.
- Advocate for a supportive environment to facilitate behaviour change and ensure that target populations and young people especially, have access to Voluntary Counselling and Testing, STI and quality HIV-related services and the means of protection (e.g. condoms, PEP).
- Ensure that in all Concern supported activities, the potential risk for sexual violence and exploitation are minimised (e.g. layout of camps, location of facilities, during distributions, and when people are accessing services).
- Advocate that all emergency responders implement the Inter Agency Standing Committee (IASC) Guidelines for HIV and AIDS interventions in emergency settings and other guidelines on HIV assessments and response in emergencies.

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**4.0 Our Strategic Approaches**

**4.1 HIV and AIDS Programming and Mainstreaming**

Concern Worldwide aims to support host countries to scale up strategies proven to work in the prevention, treatment and care of HIV and AIDS. HIV-specific responses alone are not enough to stop the drivers of the epidemic. We must also address the underlying causes throughout all our work by mainstreaming an effective response to HIV and AIDS.

**4.1.1 HIV and AIDS Programming**

The term HIV programming and/or HIV-specific response refers to work which is focused on the four Strategic Goals above – HIV related stigma and prevention, care and treatment, nutrition and livelihood security and HIV and AIDS in emergency. All HIV programming will be based on a sound contextual analysis of the nature of the epidemic and the existing services, the role of key stakeholders and gaps in the response. Concern Worldwide works in many contexts and settings and, given the considerable differences in the HIV epidemic across the regions where we work, the response will depend on the stage of the epidemic, whether it is a low, concentrated or a generalised epidemic. For example in a low prevalence area the response may take the form of HIV prevention focusing on groups with high-risk behaviours whereas in a high prevalence area interventions may span the whole spectrum from HIV prevention to treatment and impact mitigation. Some activities may be undertaken within other sectors.

**Integration**

There are certain occasions when programme analysis in other sectors, e.g. education, health and livelihoods is carried out and the response required is greater than HIV mainstreaming alone. The need to include HIV specific activities may be identified within a sector. This is referred to as integration. For example HIV awareness raising in an education programme. The main focus of the programme is education but there is some HIV-specific work integrated into the activities. This work should be staffed by appropriately qualified experts or utilising a qualified partner.

**Programme Linkages**

No single sector can respond effectively to the HIV epidemic in isolation. A comprehensive response to HIV and AIDS will, in the majority of cases require a multi-sectoral approach. This has two implications for our work. Firstly Concern Worldwide cannot respond to all needs identified in a situational analysis and therefore will need to collaborate with a wide range of stakeholders including civil society, government and private sector in order to ensure an effective response.

In terms of Concern Worldwide HIV interventions, this will mean close collaboration with Health, Education and Livelihoods programmes in all aspects of planning, implementing, monitoring and evaluation.
4.1.2 Mainstreaming
Concern Worldwide sees HIV and AIDS mainstreaming as a process to minimise the impact of HIV and AIDS on the organisation, its programmes and the communities where Concern works and to maximise the impact of Concern’s work on HIV and AIDS. Therefore mainstreaming remains a major organisational goal for this strategy.

It views programmes and projects through an HIV lens and refocuses them to take into account both causes and consequences of HIV and AIDS, i.e. external or programmatic mainstreaming. To support country programmes a “six step” process has been developed to show exactly what mainstreaming means.

The steps do not necessarily constitute a chronological progression and activities from different stages may occur concurrently. However, experience since 2005 shows that internalising the process among staff, i.e. internal or organisational mainstreaming, greatly enhances the success of the programmatic mainstreaming. Ref. Annex 1.

4.2 Greater Involvement of People Living with HIV (GIPA)\(^6\)
This strategy will build on progress made with a strengthened commitment to the Greater Involvement of People Living with HIV within the organisation and in our programme work. To reach this commitment Concern will strive to make the organisational workplace an open safe and supportive place for people who are infected and affected at all levels. We will ensure that poorest people living with HIV will be involved in all aspects of planning, monitoring, implementing and evaluating of all our programmes. Ref. Annex 2.

Concern is committed to supporting organisations and networks of people living with and affected by HIV and AIDS, where such partnerships will allow gains to be made to achieving HIV and AIDS targets and goals for those living in extreme poverty.

4.3 Partnership
Concern works in partnership with a range of actors at different levels in civil society and government to facilitate poorest people to realise their right to HIV prevention, care and treatment, and impact mitigation services.

Where there are no local organisations or institutions of sufficient quality or experience with which to partner, Concern will work directly at community level but will seek opportunities to support and strengthen local capacity to take on the implementation role in the long-term.

Concern’s Capacity Building Policy and partnership Guidelines in all aspects of our partner relationships (Policy on Concern’s Relationships With Other Institutions (Partnership Policy 2007) will guide us.

4.4 Aligning Approaches
During the life of this strategy HIV and AIDS programmes will continue to draw together Concern’s cross–cutting issues of equality, rights based approaches, HIV and disaster risk reduction together more coherently in all aspects of programming, ensuring a coherent context analysis and ultimately responding to the root causes of extreme poverty.

HIV and AIDS programmes will be based upon approaches that are holistic, rights–based, culturally appropriate, promote gender equality, and involve poorest people living with HIV and AIDS. Programmes will seek to work in partnership and will consider the adoption of social protection, and disaster risk-reduction measures when they are an appropriate response to the situation within a given context.

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\(^6\) Whilst recognising the importance of the GIPA principle it is essential to note that it is not a substitute for Concern’s targeting policy but a strategy for working within the targeted population.
4.5 Learning, Research and Advocacy

In this strategic period, there will be increasing emphasis on improving our capacity to learn from our programme work, to improve work across countries as a result of this learning, to modify our international policy and practice accordingly and to link this learning to our advocacy work and establish best practice throughout all our programmes.

Strategic relationships will be built and sustained with key stakeholders that can support Concern to deliver on our four programme focused strategic goals. These include:

- Alliance2015 partners
- The IASC
- IFPRI
- Valid International

Concern will identify an appropriate institution to support us improve efforts in our HIV prevention and behaviour change interventions, aiming for sustainable behaviour change.

Concern will engage the services of qualified and appropriate partners for action research and institutional strengthening / capacity building of partners and for advocacy support as necessary.

4.6 Monitoring and Evaluation

Indicators of achievement for this strategy will be developed, and outcome indicators are necessary at programme outcome level.

Concern will work with partners to monitor and evaluate all HIV and AIDS programmes, the quality and effectiveness and progress towards agreed goals and outcomes on individuals and communities.

HIV and AIDS programmes will follow the Concern Programme Cycle Management (PCM) system and each programme should have an M&E work-plan that ensures that the M&E process is participatory, and enables evidence-informed decision making and learning to improve future programmes. Each work-plan should include objectives and indicators at output (activity), outcome and impact level and show how these indicators will be gathered and used starting with baseline data.

In understanding the difficulty of measuring the reduction in prevalence or incidence of HIV the recommendation is to focus on outcome level indicators (e.g. changes in reported knowledge, attitudes and behaviour, access to, uptake and quality of services). Where there is robust data for a number of outcome indicators, together these can serve as a proxy (alternative) to impact indicators and help to make the case for likely changes at impact level.

5.0 Organisational Implications

5.1 Organisational issues

Recent internal and external reviews showed that despite the considerable progress that is being made, a number of issues and challenges were highlighted concerning the previous strategy and its implementation, and some organisational issues were also raised. These include:

- the importance of making strategic linkages between local, national and international work;
- holistic programming design to address gender, equality and rights dimensions alongside risk and vulnerability analysis to HIV and AIDS;
- supportive organisational management systems;
- improved mechanisms for learning what others are doing and what others and Concern have learnt;
- development and retention of staff skills and organisational capacity;

All of the above are aimed at improving programme quality and impact and inform our organisational strategic goal as outlined below.
5.2 Structure and Staff

Concern’s Global HIV and AIDS programme will be staffed and structured so as to maximise on the key strengths of Concern: field presence, extreme poverty-focussed targeting, commitment to evidence-informed advocacy, dedication to constantly seeking to improve programme quality, and documentation and sharing experiences for advocacy and policy influencing.

To do this, the programme must be globally holistic and connected. Coherent support for effective HIV and AIDS policy and strategy implementation from Concern HQ Dublin and supporting offices in London, New York, Belfast, Glasgow and Chicago will be necessary.

The Programme Planning and Monitoring Group (PPMG) will continue to guide the development and progress of Concern’s global HIV and AIDS response with technical assistance from HQ and regionally based HIV and AIDS Advisors in Africa and Asia. The primary focus of the Advisors is to provide technical assistance to our countries of operation. Programme proposals will be supported to include HR and technical assistance plans during the programme design phase. External technical assistance may be sought as necessary.

HIV and AIDS Advisors will guide the PPMG technically and support the development of advocacy issues, research and learning within the organisation and will also coordinate with Technical Advisors in Education, Health and Livelihood support units (e.g. HSU) and with other Advisors on cross-cutting issues and approaches (partnership, DRR, RBA, equality) supporting holistic programming.

In-country national Advisors, Managers and/or Coordinators will continue to support work on the ground in all countries where Concern works. Skills and capacities of HIV staff required in-country will depend on whether the epidemic is just emerging, concentrated among groups with high risk behaviours or HIV prevalence is already generalised among the population. Where the emphasis is on prevention, staff with skills in social and behavioural change methodologies will be critical. In high prevalence areas, staff with health system experience will be important to support the development of local health systems for safe and sustainable quality treatment services. In high impact areas, those with experience in impact mitigation and working with child and elderly headed households will be necessary. In locations where it is difficult to find staff with relevant skills and experience, capacity development plans will be agreed with national HIV and AIDS staff and supporting staff. Career paths and promotion opportunities for national staff will be supported by HR at all levels of the organisation.

5.3 Financing and resource mobilisation

Annual planning and budgeting for HIV and AIDS programme strategy implementation will be necessary. HQ and country management teams will need to consider organisational and programmatic mainstreaming costs in their financial planning, budgeting and financial reporting. Research, training and learning, country / regional exchange visits and conference / workshop participation will need resourcing to develop staff and partner staff and organisational HIV and AIDS competence.

HIV and AIDS expenditure was just 4.9% (€5.3 million) of the total overseas programme spend (excludes expenditure on mainstreaming effort) in 2007 (Concern Annual Report). According to the Strategic Plan we will to aim for a 10% spend on programming by 2010 and further growth thereafter.

The Council of Concern continues to support our HIV and AIDS work and planned expansion in line with the organisational Strategic Plan 2006 – 2010. However to reduce dependency on internal funding countries will be supported to seek out opportunities within the increasing amount of funding available in the HIV and AIDS sector. Increasingly Concern’s role is to support partners in resource mobilisation by engaging with donors and funding bodies like the Global Fund, PEPFAR and the World Bank. More applications are now being requested from consortia rather than from single agencies/ NGOs and partners will need support in preparing joint applications for funding, e.g. with CCMs. Global and Regional Advisors will support the strengthening of key donor relationships.
6.0 Accountability and Responsibilities

6.1 Internal accountability
All levels of the organisation from Concern Headquarters and senior management to field staff and partners are accountable for global HIV and AIDS programme outcomes.

Visionary leadership has been identified as a critical ingredient for an effective HIV and AIDS response and organisational leadership demonstrated by Senior Management Team commitment will strengthen staff responsibility and accountability.

Table 6.2 Roles and Responsibilities:

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>CEO / SMT</td>
<td>Leadership and management for effective delivery of the organisational Strategic Plan and approval of the HIV and AIDS Strategy</td>
</tr>
<tr>
<td>Overseas Director / Regional Directors</td>
<td>Strategic and managerial responsibility for implementation of the HIV and AIDS programme strategy in countries of responsibility</td>
</tr>
<tr>
<td>HR Director</td>
<td>Development and roll out of all Human Resource policies, including the Illness Policy and the Programme Participant Protection Policy</td>
</tr>
<tr>
<td>HIV and AIDS PPMG</td>
<td>Strategy dissemination, and planning and monitoring implementation of the global HIV and AIDS programme strategy</td>
</tr>
<tr>
<td>HIV and AIDS Technical Advisors</td>
<td>Technical guidance to the PPMG, quality control and standards maintenance and will also coordinate with Technical Advisors in Education, Health and Livelihood PPMGs and other Advisors on cross-cutting issues supporting holistic programming.</td>
</tr>
<tr>
<td>Country Directors</td>
<td>Strategic and management responsibility for implementation of the HIV and AIDS programme strategy and agreed organisational programme approaches in-country</td>
</tr>
<tr>
<td>Country Focus Groups</td>
<td>Support to in-country HIV and AIDS projects with partners and / or other sector projects with integrated HIV and AIDS work. Supporting the HIV and AIDS mainstreaming response and with partners as agreed with / requested</td>
</tr>
<tr>
<td>National / Local Advisers</td>
<td>Support to HIV and AIDS programme development and mainstreaming response in-country with Concern staff and partners in line with the global HIV and AIDS Strategy</td>
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</table>

7.0 Monitoring the Strategy
Annual ‘milestones’ towards meeting the objectives in the strategy will be developed by the PPMG and accounted for in the annual programme report as part of the annual review and planning process. These milestones will focus on the operational (e.g. Concern capacity to do HIV, roll-out of strategy) rather than programmatic (e.g. access to services, behaviour change) objectives.

The strategy will be reviewed after five years, or sooner if a need to do so is identified. It is anticipated that the strategy review will focus more on the strategy itself rather than on programme results. A cross section of people involved in implementing the strategy will be involved in the review plus key external stakeholders. Key questions for the review can be developed at the first stage of the review but might include for example:

- How far has the strategy been implemented? Reasons why / why not.
- Has there been a change in the programming approach as a result of it?
- Was the strategy an appropriate response to implementing the policy (e.g. best practice, internal / external context…etc)

Action Plan with M&E Framework
A time-bound action plan and M&E framework will be developed to facilitate the effective implementation and monitoring of this HIV and AIDS Strategy.
Meta Evaluation 2009
Mid-term strategy review due mid 2010.
Impact evaluation 2013

### 8.0 Major Risks and Assumptions

<table>
<thead>
<tr>
<th>Aim / Strategic Goals</th>
<th>Risk - Assumption</th>
<th>Risk Management by Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDG 6, Target 7</td>
<td>The HIV epidemic continues to expand</td>
<td>Adapt our strategy as appropriate based on informed evidence and policy change</td>
</tr>
<tr>
<td>Aim of Strategy</td>
<td>Government leadership to the HIV response is strengthened and sustained</td>
<td>Advocate for and support the ‘three ones’ in all countries of operation</td>
</tr>
<tr>
<td>Org. Strategic Goal:</td>
<td>Adequate HR and technical capacity for effective strategy implementation</td>
<td>Recruit personnel as per HR/Budget plan and engage with supportive institutions</td>
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<tr>
<td>Building Concern’s</td>
<td></td>
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<tr>
<td>capacity for impact</td>
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<tr>
<td>Prog. Strategic Goal 1:</td>
<td>Stigma remains a barrier to effective HIV prevention and VCT access (In 2007, 1 in 10 PLHIV know their status)</td>
<td>Adhere to the GIPA principle wherever possible and promote the benefits of knowing one’s HIV status</td>
</tr>
<tr>
<td>Stigma and Prevention</td>
<td></td>
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<tr>
<td>Prog. Strategic Goal 2:</td>
<td>Health systems are not strengthened rapidly enough to meet expanding care and treatment needs</td>
<td>Concern will prioritise the strengthening of health systems in health programming and advocacy work</td>
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<tr>
<td>Care and Treatment</td>
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<tr>
<td>Prog. Strategic Goal 3:</td>
<td>The livelihood and poverty impacts of HIV and AIDS will increase in worst affected countries at least up to 2012</td>
<td>The Concern – IFPRI action research work will inform practical programming responses and favourable policy change</td>
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<tr>
<td>Nutrition and Livelihood Security</td>
<td></td>
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<tr>
<td>Prog. Strategic Goal 4:</td>
<td>The humanitarian sector will increase responses to HIV and AIDS among emergency affected populations. GBV will continue in emergency areas</td>
<td>Engage in the revision of the IASC Guidelines and support implementation. Continue to engage with the Joint GBV Consortium and advocate on GBV issues</td>
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<tr>
<td>HIV and AIDS in</td>
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<tr>
<td>Emergency</td>
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9. Appendices

Annex 1. “Six step” roadmap for HIV mainstreaming in programmes and at the work place

1. Laying the Foundation - Create understanding & commitment within the organisation
   • **Actions** –
     - Creating a HIV focal group at country level that oversees the mainstreaming process and that includes senior management, HR, finance and technical programme staff.
     - Establishing an ongoing staff education programme

2. Organisational mainstreaming - Adaptation and introduction of improved policies and practices to provide a safe and supportive environment of staff and their families
   • **Actions** –
     - Developing a HIV workplace policy
     - Ensure HIV is addressed in all organisational policies and strategies

3. Programme assessment and analysis - Developing an understanding of where our target communities are at risk and vulnerable to the impact of HIV and AIDS and modifying our activities to **reduce** that risk and vulnerability
   • **Actions**
     - In all programmes conduct a HIV community risk analysis or KAP study.
     - Using the results conduct a stakeholder analysis to modify the intended activities without adding any HIV activities.
     - Examine proposed activities to ensure they are not inadvertently increasing risk or vulnerability
     - Develop a mainstreaming response plan

4. Implementation of mainstreaming response plan based on the principles of equality, participation, inclusion and accountability.
   • **Action**
     - Reassess impact (current or potential), and risk and vulnerability at least annually as contexts change both in the external environment and internally within the project. Modify the mainstreaming response plan as appropriate.

5. Monitoring and Evaluating the process- continual assessment and analysis of our programmes and projects for risk and vulnerability
   • **Action**
     - Each country will continually monitor and evaluate the mainstreaming process utilizing the global framework that is now available.

6. Learning and Documentation-.To promote learning across the organisation and for our peer organisations.
   • **Action**
     - Countries will document the outcome, challenges and barriers in the mainstreaming process for cross country learning.
Annex 2.

GIPA or the Greater Involvement of People Living with HIV is critical to halting and reversing the epidemic; in many countries reversing the epidemic is also critical to reducing poverty.

GIPA is not a project or programme. It is a principle that aims to realise the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. In these efforts, GIPA also aims to enhance the quality and effectiveness of the AIDS response.

The GIPA Principle was formalised at the 1994 Paris AIDS Summit when 42 countries agreed to “support a greater involvement of people living with HIV at all…levels…and to…stimulate the creation of supportive political, legal and social environments.

The 2006 Political Declaration on HIV and AIDS unanimously adopted by 192 Member States at the 2006 High Level Meeting on AIDS also advocated the greater involvement of people living with HIV.

The figure above shows how people living with HIV can be involved in policymaking, programming, advocacy, prevention education and treatment rollout.

Ref. UNAIDS 2007 Policy Brief – The Greater Involvement of People Living with HIV (GIPA)