Corporate Strategy on

HIV and AIDS

2006-2010

Supporting Universal Access to HIV/AIDS Prevention, Care and Treatment in sub-Saharan Africa

Foreword

This strategy is a result of an extensive consultative process within AMREF and its partners. It is also a reflection of national priorities articulated in the various national strategic frameworks as well as AMREF's own involvement in the HIV/AIDS response in the different countries of operation. The strategy takes into account global frameworks outlined in global agendas such as the Millennium Development Goals, the 3 by 5 initiative and the 3-Ones strategy as well the opportunities that present in working alongside communities, civil society and government institutions. The strategy is informed by past and plausible future trends of the epidemic in sub Saharan Africa and the current responses at national and international level.

The strategy concerns itself with the persistent gap between communities and health delivery systems particularly at the periphery in health care planning and implementation. Marginalized populations that are also vulnerable to HIV/AIDS are the ultimate focus of AMREF's HIV/AIDS work. Interventions are aimed towards prevention as well as care, support and treatment delivered in a congruent manner to maximize impact and synergy. This is in pursuit of the AMREF position that neither prevention nor care and treatment are sufficient on their own to make a long lasting impact on the epidemic but rather that both prevention and treatment are necessarily interdependent and therefore must be addressed simultaneously. In addition, the strategy embeds itself within public health and human rights contexts as equally essential and therefore to be harnessed in the response to HIV and AIDS.

The implementation arrangement recognizes HIV/AIDS as a development issue that can most effectively be addressed through effective partnerships within a multisectoral framework at every level, taking into account factors such as gender discrepancies, social exclusion and household poverty that underlie the vulnerability of marginalized populations to HIV and AIDS. It also recognizes the interaction of HIV and AIDS with other diseases of poverty such as TB and malaria and therefore a need for a comprehensive development oriented approach.

Director General

"A war against disease requires not only financial resources, sufficient technology, and political commitment, but also a strategy, operational lines of responsibility and the capacity to learn along the way".

Quoted from "Macroeconomics and Health: Investing in Health for Economic Development" a report of the Commission on Macroeconomics and Health.

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical and Research Foundation
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavioural Change Communication
CBHC	Community based health care
CSO	Civil Society Organisations
DHS	Demographic and Health Survey
GFATM	Global Fund to fight AIDS, TB and Malaria
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
MAP	Multi-country AIDS Program
MTCT	Mother-to-Child Transmission
MDG	Millennium Development Goals
NGOs	Nongovernmental Organisations
OSP	Organisational Strengthening Program
PEPFAR	Presidential Emergency Plan for AIDS Relief
PJMS	Project Management System
PLHA	People Living with HIV
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
SW	Sex Workers
T&C	Testing and Counselling
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

1 INTRODUCTION

1.1 The HIV/AIDS epidemic in Sub Saharan Africa

According to the UNAIDS 2006 report on the Global AIDS epidemic, 24.5 million of the 38.6 million people living with HIV worldwide in 2005 were in sub-Saharan Africa (www.unaids.org/en/HIV_data/2006GlobalReport/default.asp). In the same year, 2.7 million new infections occurred in sub Saharan Africa while 2 million died from AIDS related illness. AIDS remained the leading cause of premature death among adults in most of Sub-Saharan Africa. There have been claims that the rise in death rates beginning in the 1990s partly explained some of the decline in HIV prevalence recently seen in some communities (www.retroconference.org/2005/abstracts/25775.htm). Nonetheless, increased uptake of preventative measures in an increasing number of countries including Uganda and Kenya explains much of the decline in prevalence.

In the wake of rising AIDS mortality is the increasing number of orphans in sub Saharan Africa estimated at 12 million in 2005 and projected to reach 18 million by 2010, should the current death rates be sustained. Devastation is not felt at the family level alone but also at national economies, with a rate of decline in annual per capital growth (or GDP) estimated at 0.5-1.2% per annum and projected to reach up to 20% by 2020 in some of the most affected sub Saharan Africa countries[1]. The loss of healthcare workforce to AIDS related illness and the increasing demand for AIDS care on the health delivery systems have further weakened an already weak healthcare infrastructure. As the social infrastructures break down at the community level and healthcare systems weaken, so is the gap between communities and the healthcare systems widening further thereby making populations that are vulnerable to HIV and AIDS less able to access and utilise health services.

Sexual transmission accounts for the vast majority of HIV transmission in Africa[2] although other means of transmission such as intravenous drug use (IDU) and transmission in healthcare settings are believed to play an increasing role. Therefore, sexual behavior patterns such as early sex debut, multiple sex partners, unprotected sex and the high incidence of other sexually transmitted infections drive the high HIV incidence observed in Africa. Underlying sexual transmission are social, cultural, economic and political contexts that make some populations such as women, young boys and girls and poor people in rural and urban settings more vulnerable. The same contexts determine the degree of impact HIV infection has on individuals and communities. During 2004, at least 60% of new infections in SSA occurred among young boys and girls between 15 and 24 years of age while women constituted at least 57% of people living with HIV. Young girls are 3 to 6 times more likely to become infected than young boys of the same age while the HIV prevalence tends to peak at 5 to 6 years younger among women. In addition to the

1 UNAIDS, Report of the Global HIV/AIDS Epidemic, July, 2004

[2] "Expert group stresses that unsafe sex is the primary mode of transmission of HIV in Africa," WHO/UNAIDS statement, March 14, 2003. www.who.int/mediacenter/statements/2003/statement5/en

observed differences in social groups, different countries and even locations within the same country experience the epidemic differently such that there is no one single epidemic across SSA. For example, while the HIV prevalence in some districts of Nyanza province in Kenya is close to 40%, it is under 7% in several other districts in the same country *(Kenya Demographics and Heath Survey, 2005).*

The table below is a summary of the HIV and AIDS data in five AMREF countries of operation:

Country	Population	PLHAs (all ages and sex)	Adult rate % (15-49)	Women	Children	AIDS Deaths (adults and children)	AIDS Orphans
Kenya	31,916,000	1,300,000	6.1	740,000	150,000	140,000	1,100,000
South Africa	45,294,000	5,500,000	18.8	3,100,000	240,000	320,000	1,200,000
Uganda	24,780,000	1,000,000	6.7	520,000	110,000	91,000	1,000,000
Tanzania	35,889,000	1,400,000	6.5	710,000	110,000	140,000	1,100,000
Ethiopia	68,613,000	1,300,000		730,000	220,000	130,000	870,000
SSA		24,500,000	6.1	13,200,000	2,000,000	2,000,000	12,000,000

Source: UNAIDS/WHO 2006 Report on the global AIDS Epidemic

1.2 HIV/AIDS and other diseases of poverty

Tuberculosis has re-emerged and reinforced the HIV epidemic. At its August 2005 meeting in Maputo the WHO Regional Committee for Africa declared tuberculosis an emergency in the African region. In poor communities of Africa TB has become the commonest cause of death among people infected with HIV (www.stoptb.org). Current TB-control measures are failing, largely as a result of the HIV epidemic. According to the WHO, up to 70% of patients with sputum smear positive pulmonary TB in several SSA countries, are co-infected with HIV. The annual incidence of TB has more than quadrupled in most African countries since 1990. And yet, TB has been observed to accelerate the progression of HIV infection to AIDS. Co-infection with HIV has made laboratory diagnosis of TB less certain and antiretroviral AIDS treatment more complex. TB co-infection with HIV is also responsible for accelerating the emergence of multiple drug resistant (MDR) TB, a condition that if unchecked is likely to reverse successes in TB control in Africa. Worldwide, 4% of TB cases are believed to be resistant to at least one drug in the DOTS treatment regimen. This figure could be as high as 20% in high TB prevalence contexts. While MDR-TB could rapidly be growing (estimated at 400,000 cases each year according to the TB alliance – www.tballiance.org) the picture is remains fuzzy as most affected

countries also have poor infrastructure to diagnosis and report trends. All AMREF countries of operation exhibit high TB prevalence with South Africa reporting a prevalence rate of close to 500/100,000 population.

The interaction between HIV and malaria in adults is now well documented. In areas of stable malaria transmission, infection and fever rates among HIV infected adults increase. In areas of unstable malaria transmission, HIV co-infection is associated with severe forms of malaria and death. Anti-malarial therapy also appears less effective among HIV-infected adults. Pregnant women are especially vulnerable to HIV and malaria co-infection, suffering more episodes of malaria and adverse birth outcomes *(van Eijk et al, AIDS 2003)*. Furthermore, acute malaria episodes result in elevated HIV viral loads. This relationship is of particular concern in sub-Saharan Africa where both diseases show a significant degree of geographical overlap.

1.3 Plausible trends of the HIV/AIDS epidemic in sub-Saharan Africa

HIV prevalence appears to be stabilizing or even declining in an increasing number of SSA countries. However, in the absence of an effective vaccine and cure, it is unlikely that the declining tend will be sustained. Uganda where prevalence rates declined from a high of 30% in the early 1990s to 4.1% in 2001/2 and now the recently reported 7% *(Uganda HIV/AIDS sero prevalence and behaviour survey; Ministry of Health 2005)* demonstrates the challenge that SSA countries face in sustaining a declining HIV prevalence. Nonetheless, while progress towards an effective vaccine remains a long way away, progress has been fast towards an effective microbicide agent that could become available in the near future. Access to an effective microbicide agent is likely to reduce risk and accelerate prevention particularly among marginalized women and girls. Preliminary results of research on male circumcision and Herpes Simplex Type II suppression indicate these strategies could also play a role in preventing new HIV infections. Besides, aggressive pharmaceutical research continues to bring new and more effective antiretroviral therapies. Progress in clinical management will sooner than later turn AIDS into a chronic and manageable illness, similar to diabetes and others. Similarly, the rapid progress towards new TB pharmaceuticals, vaccines and diagnostics will help to control the commonest cause of death among people living with HIV in Africa. HIV as a chronic infection could also transform attitudes and help to overcome stigma, a major constraint facing prevention, care and treatment and mitigation. Nevertheless, new clinical and social management approaches will become necessary as HIV infection becomes a chronic condition. Besides, the severe and drawn-out consequences of the epidemic on families, healthcare systems and national economies will continue to be felt over the long term.

1.4 The Global Response

During the 20+ years of the epidemic, the world has gained a better understanding of factors that fuel the HIV/AIDS epidemic. On the other hand, effective approaches and technologies have been tested and developed to combat the epidemic. Countries such as Uganda that have experienced a significant reduction in HIV prevalence or those such as Senegal that have sustained a low prevalence have important lessons to offer. For

example, significant changes in sexual behaviour such as abstinence, reduction of sex partners, faithfulness, delayed sexual intercourse and increased condom use are all possible but must be offered as a package to provide the wider choice for adoption. The world is also aware that it is only through multiple and multisectoral approaches that engage communities and health systems that the epidemic will be halted and reversed.

Noteworthy are the changes in global attitudes and commitment to fight the epidemic. The denial that characterised HIV/AIDS during the initial two decades has given way to acceptance and increased political and financial commitment by governments in Africa and the world community. UNAIDS has played a key role in raising not only the profile but also the resources necessary to fight the epidemic. Consequently, funding for HIV/AIDS has increased globally from $300 million in 1996 to more than $8 billion in 2005[3]. The UN General Assembly Special Session to AIDS (UNGASS) with its Declaration of Commitment (DoC) and the Millennium Development Goals (MDG) has helped to focus action on a global level. MDG 6 aims to halt and begin to reverse the spread of HIV/AIDS, malaria, and other diseases, including tuberculosis (TB) although the other MDGs also impinge on the HIV/AIDS epidemic. The WHO "3by5" initiative and the UNAIDS supported "Three-Ones" framework have provided further impetus towards increased access to care and treatment and better coordination of national responses respectively. During its three years of existence, the Global Fund to fight AIDS, TB and Malaria (GFATM) has realised more financial resources than any other prior initiative while bringing to the fore the link between the three diseases of poverty. Other initiatives such as the US Presidential Emergency Fund (PEPFAR), the Bill Clinton Foundation, the Bill and Melinda Gates Foundation, the World Bank Multi Country AIDS Programs (MAP) and various bilateral and multilateral agency initiatives are providing additional financial and technical resources.

Though improving, the current responses at national and global levels remain far from adequate in size and scope to halt and reverse the HIV/AIDS epidemic in the next 10 years. Health systems are weak and national responses are often inadequately coordinated. Disagreements persist on strategy at national and global level, thereby compromising the positive impact that increasing resources could have on the epidemic. Prevention efforts are far from adequate as new infections escalate in Africa and other parts of the world. The disproportionate vulnerability to HIV especially among women and young girls and boys is a concern. Less than 1 in 10 adults in SSA are aware of their HIV status while 1 in 3 children born to HIV positive mothers is likely to become infected, a rate that has been reduced to under 2% in high income countries[4]. Although access to AIDS treatment in sub Saharan Africa increased from under 100,000 to over 800,000 between 2003 and 2005 as a result of the 3by5 campaigns, only 50% of the targets were reached and in only a handful of the most affected countries. Nonetheless, the 3by5 campaign raised universal access to treatment on the global agenda and also mobilised additional resources. UNAIDS and the WHO estimate that overall, 72% of unmet need for treatment remains in SSA.

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[3] *UNAIDS/WHO 2006 Report on the global AIDS Epidemic* www.unaids.org/epi2006/doc

[4] De Cock. KM et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice. American Medical Association, 2000, 283(9)

1.5 HIV/AIDS/TB, a priority intervention area for AMREF

Founded in 1957 as the Flying Doctors Service of East Africa, AMREF has grown to become the largest Africa-based, international nongovernmental health development organization in sub Saharan Africa. AMREF's mission is to improve the health of disadvantaged people[5] in Africa as a means for them to escape poverty and improve the quality of their lives. The AMREF mission is challenged by the HIV/AIDS epidemic that has increased the vulnerability of women, men, girls and boys in sub Saharan Africa and threatened to reverse the social and economic development of many African countries. AMREF recognises the interrelationship between disease including HIV/AIDS and poverty and has set an agenda to focus its mission on the common diseases of poverty articulated in its six priority intervention areas that comprise: HIV/AIDS/TB; Malaria; Water and basic sanitation; Training; Family health and Clinical outreach.

AMREF's response and leadership in HIV/AIDS programming span the duration of the epidemic. While initial interventions focused on raising awareness, AMREF quickly integrated research and human resource training by the late 1980s. Some of AMREF's work over the past 20 years has included among others:

i. The development of behavioural change communication models using a wide range of methods including social marketing that has resulted in the rapid scale up of services such as VCT[6].
ii. Collaborative research that established the link between STIs and HIV infection, followed by models for the syndromic management of STIs, which were later adopted by the WHO for global application in poor settings
iii. Psychosocial lifeskills education models for adolescent sexual and reproductive health that have increased sex debut among adolescents and improved reproductive health knowledge and other sexual practices among young people in and out of school.
iv. Health systems research and capacity building tools and models that have improved HIV/AIDS management within multisectoral frameworks and helped to engage the civil society and the private sector in HIV/AIDS programming.
v. Operational research on social contexts that underpin the high incidence of HIV/AIDS among vulnerable populations and applying the results to influence policy and practice through capacity building of actors in the public, private and nongovernmental sectors.

In the past five years, AMREF has further reaffirmed its commitment to target HIV/AIDS as one of its priority intervention areas. Through the Organisational Strengthening Programme (OSP) that has been implemented since 2003, AMREF identified HIV testing and counselling, prevention of mother to child transmission, behaviour change communication, treatment, care and support and adolescent sexual and reproductive health as key areas of the HIV/AIDS programme focus.

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[5] People who suffer high prevalence and impact of major health problems and challenges like malaria, HIV and AIDS, poor reproductive health, water and sanitation related diseases and have poor access to health care.

[6] Bukenya D: Enhancing Voluntary Counselling and Testing; AMREF Technical Briefing Paper

Among the lessons that AMREF has learned are that:

a) Households and communities play a crucial role in HIV/AIDS prevention, care, treatment and mitigation. Therefore their efforts need to be strengthened and harnessed alongside those of peripheral health systems so the two could work as partners in an integrated response that takes into account local solutions to local needs. AMREF experience in Africa has shown that persons affected by HIV/AIDS and communities, whether in conflict, post conflict or politically stable environments have been able to provide basic services in HIV/AIDS prevention, care, treatment and mitigation if trained, facilitated and supervised. Recognition of the community as a resource and bridging the gap that exists between communities and healthcare systems is what is likely to generate a sustainable impact on the spread and impacts of the epidemic in SSA.
b) A multisectoral approach is essential at every level for scaling up the response. Barriers to multisectoral collaboration and engagement such as those between public sector departments and others between the public and non-public sectors must be overcome as a matter of priority.
c) Marginalised populations including those in states of poverty, disempowerment and exclusion such as women, young people, poor men and women and people living with HIV suffer most from the impacts of the epidemic. They must specifically be targeted with interventions that also address the socioeconomic and cultural contexts that underpin marginalisation and vulnerability in order to have a larger and sustainable impact on the epidemic. On the other hand, AMREF experience shows that when mobilised, assisted to acknowledge the HIV/AIDS challenge and empowered with skills and resources, marginalised groups such as sex workers, youths, women or indeed PLHAs could be the most effective resource in addressing the epidemic in s sustainable way.
d) Economic inequalities, social exclusion and stigma inhibit efforts at every stage of HIV/AIDS prevention, care, support, treatment and mitigation and further entrench and worsen vulnerability and marginalisation.

AMREF's sub-Saharan Africa base and working alongside both communities and governments to strengthen capacity, generate new knowledge and influence policy and practice gives it the edge to contribute to HIV/AIDS prevention, care, treatment and mitigation in Africa. Besides, AMREF working alongside other research institutions has conducted operational research on HIV/AIDS since the late 1980s in the areas of sexually transmitted infections, adolescent sexual and reproductive health, microbicide and workplace programs. AMREF has also been engaged with evaluating and testing models in its field projects and applying the results for capacity building and advocacy. AMREF membership on national, regional and global HIV/AIDS networks and technical and policy committees such as the Technical Working Group on HIV/AIDS of the East African Community, the Global Business Council and Country Coordinating Mechanisms in several countries provide an opportunity to advocate, influence policy and practice and provide technical assistance in the region. AMREF has recently been appointed by UNAIDS to provide short term HIV/AIDS technical assistance in eastern Africa, a role with a potential to expand to other regions of SSA.

2 THE AMREF CORPORATE HIV/AIDS STRATEGY FOR 2006-2010

2.1 Goal, Purpose and Outcomes

The goal of the AMREF HIV/AIDS programme is to achieve universal access to HIV/AIDS and TB prevention, care and treatment for vulnerable groups in Africa's poor rural and urban settings. In attaining this goal, AMREF is concerned with the gap that continues to persist between communities and health care systems, especially at the periphery in prioritising and implementing action. Therefore, **the purpose** of the strategy is to guide AMREF's action towards closing the gap as a means towards the achievement of universal access. AMREF's contribution focuses on marginalized and vulnerable populations[7] among whom HIV/AIDS and TB transmission and their impacts are also highest.

The strategy will achieve the following **results** over the next five years:

1. The ABC strategies are adopted by vulnerable populations to prevent new HIV infections
2. Awareness of HIV/AIDS individual status is increased among vulnerable populations as a means of preventing new HIV infections
3. Competence of communities, community groups and organised public and non-public institutions including the peripheral health systems is strengthened to manage the HIV/AIDS and TB epidemics and their impacts.
4. Access to effective HIV/AIDS and TB care and treatment is scaled up for adults and children in poor settings

Capacity building that strengthens and empowers communities and health systems, operational research that provides answers to challenges facing vulnerable communities and health systems and advocacy that influences policy and practice change shall be the overarching strategies that AMREF will apply in an integrated and synergistic manner to achieve the outcomes.

2.2 Priority interventions and results

The following are the key program development priorities that will achieve the outcomes:

2.2.1 Result 1: ABC[8] strategies adopted

Behaviour change remains essential in preventing new HIV infections. AMREF shall influence behavioural change through repackaging skills based HIV/AIDS information on

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[7] People with an increased likelihood of becoming HIV infected as a result of biological or environmental factors such as the socioeconomic and cultural status and context. Among these are poor women, young girls and boys, children and people living with HIV and AIDS in poor settings

[8] A= Abstinence; B=Being faithful; C=Condom use

the ABC strategy, specifically targeting vulnerable and high risk populations. Appropriate models for communicating behaviour change information that build on, rather than disrupt cultural contexts in which vulnerable populations live will be designed, tested and disseminated for adoption.

Building on its experience working alongside high risk and vulnerable groups, AMREF shall test, document and disseminate for adoption models that empower communities, community groups and vulnerable and high risk populations to play a role in HIV/AIDS and TB prevention.

AMREF shall evaluate current applications of the ABC strategies on various groups of vulnerable and high risk populations and use the results to influence policy and practice.

AMREF shall participate in partnerships to evaluate other preventative approaches and commodities including barrier methods (male and female condoms), microbicides, Herpes Simplex Type II (HSV II) suppression therapy, male circumcision and vaccines. AMREF shall focus on operational research that could help accelerate access and utilisation of preventative tools in poor settings. In this regard, models to scale up access and uptake of available microbicide, HSV II suppression, circumcision and vaccines (when they become available) in poor settings will be tested, documented and applied to influence policy and practice

2.2.2 Result 2: Awareness of HIV/AIDS individual status increased

Available data appear to suggest that knowing one's HIV status is beneficial for behaviour change especially among HIV positive individuals and couples[9].

AMREF shall overcome barriers to HIV individual status awareness through designing and testing models of routine and voluntary HIV testing and counselling established in different settings in the public and non public sectors as a means to scale up access and utilisation for vulnerable populations.

AMREF shall develop and test tools for training providers of HIV testing and counselling in formal and informal settings as a means of increasing access to information and services by vulnerable populations

The increasing occurrence of discordance among couples is a concern. Barriers to HIV individual status disclosure shall be evaluated and models to increase disclosure among concordant and discordant couples tested. Tools that enable tracking of discordant couples shall also be tested and integrated into current HIV testing and counselling protocols.

Models that bring to scale parent to child transmission prevention (PMTCT) while engaging families and men and linking to long term antiretroviral treatment in poor settings

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[9] Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. The Voluntary HIV-1 Counseling and Testing Efficacy Study Group: Lancet. 2000 Jul 8;356(9224):103-12.

as a better approach to integrated HIV prevention and long term care and treatment shall be tested and applied to influence policy and practice.

Testing and counselling and PMTCT services that integrate other reproductive healthcare such as family planning and maternal and child healthcare shall be tested and evaluated for their effectiveness in poor settings.

2.2.3 Result 3: Community and health systems competence to manage HIV/AIDS and TB epidemics strengthened

Bottlenecks in scaling up HIV/AIDS prevention, care and treatment including socioeconomic, cultural and other factors that underpin the vulnerability of marginalised population to HIV/AIDS and prevent their effective utilisation of available services shall be evaluated and lessons applied to influence policy and practice for HIV/AIDS service delivery in the public and non public sectors

AMREF shall prepare communities for readiness to participate and strengthen the capacity of civil society organisations including those of high risk groups and people living with HIV through management and technical skills training and technical assistance to enable them interface effectively with and bridge gaps between them and peripheral health systems. For example, AMREF shall develop tools that enhance ART literacy and adherence and use them to train civil society organisations and groups of people living with HIV to strengthen their services.

Models for training facility and community based workers in multidisciplinary skills shall be developed and tested as a means of expanding capacity for service delivery and strengthening integrated services. AMREF shall test and promote models that engage households, communities, men and people living with HIV in the delivery of prevention, care and treatment interventions

HIV/AIDS service quality assurance models including laboratory quality assurance shall be designed, tested and applied to train healthcare providers and managers of interventions at the periphery and influence relevant authorities at local, national and international levels for their adoption

Harmonisation of policy and practice shall be promoted within and across countries through testing and documenting best practices and advocating for their adoption into national, regional and international strategies and plans

The strategic management capacity of central and peripheral health systems shall be strengthened to apply effective multisectoral partnerships that engage public and non public sector actors and communities in a comprehensive HIV/AIDS response. Capacity strengthening shall include designing and making available disaggregated strategic information, developing planning and management tools and training and providing technical assistance for their application. Models of successful multisectoral partnerships shall be documented and used to influence policy and practice.

AMREF shall design and test models of HIV/AIDS programming in organised settings such as the workplace and schools and use them to develop the capacity of the public and private sectors for their adoption.

2.2.4 Result 4: Access to effective HIV/AIDS care and treatment scaled up

Recognising that though desirable, universal access to antiretroviral therapy (ART) will take many years to be achieved, AMREF shall develop non ART home and community based comprehensive care packages and develop the capacity of community based care providers to apply them to prevent opportunistic infections and improve the nutrition and psychosocial wellbeing of people living with HIV.

Models to scale up access, uptake and adherence to available antiretroviral therapy in poor settings will be tested, documented and applied to influence policy and practice

AMREF shall work towards normalising HIV and AIDS care and treatment through testing models of integrated management of adulthood illnesses (IMAI) for HIV and AIDS care and treatment at facility and community levels. Integration of paediatric AIDS care into national IMCI programs shall also be promoted.

Models that integrate HIV and AIDS management with other diseases of poverty, especially TB, malaria and reproductive health conditions shall be designed, tested and the lessons learned used to influence policy and practice. For example, AMREF shall test models of settings that integrate TB and HIV testing, counselling and treatment; malaria and parent to child HIV transmission prevention (PMTCT), family planning, VCT and PMTCT and others.

AMREF shall evaluate HIV/AIDS diagnostics that are appropriate for poor settings, influence relevant authorities in the public and non public sectors for their adoption and train providers on their use. For example, new rapid tests shall be evaluated for their effective application in poor settings and recommendations made for their inclusion on national standards.

The role of traditional health care systems and alternative medical practices and therapies shall be evaluated and models developed for their integration into formal healthcare systems.

Barriers to treatment adherence and compliance in different contexts such as among poor people, mobile populations and children shall be investigated and lessons used to influence policy and practice.

In recognition of HIV becoming a chronic infection, AMREF shall test models that normalise antiretroviral therapy and community/home based care. In this regard, AMREF shall develop the competences of those on treatment to sustain treatment adherence and effectiveness.

2.3 Implementation principles

2.3.1 Poverty, stigma and gender:

The interplay between poverty and HIV/AIDS drives the AMREF strategy. AMREF also recognizes that HIV and AIDS related stigma underlies much of the challenge in scaling up prevention, care and treatment for marginalised and vulnerable populations. Both these conditions also have gender based dimensions including gender based violence that further exacerbates vulnerability. Therefore, poverty, stigma and gender inequities are going concerns that will be addressed in every intervention under this strategy. In addition to targeting interventions towards those in poor settings, AMREF shall evaluate the understanding of gender, poverty and stigma dimensions and use the knowledge to inform project design and implementation. Project monitoring and evaluation shall also attempt to evaluate the impact that a project may have had on gender, poverty and stigma.

2.3.2 Community based health care and a development approach to HIV/AIDS:

A community based health care (CBHC) approach shall be applied in testing and rolling out models of community interventions as a means of fully engaging communities in their own health development and responding to HIV and AIDS from a development perspective.

2.3.3 Promoting a learning agenda:

Learning from what we do and sharing it with others to influence policy and practice is integral to all AMREF interventions. Therefore, documentation and dissemination of knowledge generated through AMREF interventions and those of other partners will be regularly carried out.

2.3.4 Building partnerships and linkages:

A development approach to HIV and AIDS calls for establishing and harnessing partnerships. AMREF shall therefore be a major actor and play a facilitatory role in partnerships that aim to strengthen health systems and communities, generate new knowledge and influence policy and practice.

2.3.5 Integrating a public health and human rights focus:

In designing interventions, AMREF shall balance human rights and public health perspectives as essential and mutually beneficial in addressing the HIV/AIDS challenge.

3 Monitoring and Evaluation

3.1 Indicators of Performance

A set of critical performance indicators accompanies this strategy (Annex I). AMREF will utilise input, process and output indicators to monitor progress towards the intended strategic results. Input indicators such as the financial and human resource investments on HIV/AIDS and TB shall be regularly monitored at country and corporate levels through the AMREF financial and human resource management systems that have been established and synchronised across the organisation. Process indicators such as the degree to which the project portfolio represents the strategic results and program development priorities will be monitored through AMREF's Project Management System (PJMS) at country and corporate levels. Outputs indicators will constitute an analysis of project outputs disaggregated by social economic class, rural/urban settings, age and gender. The lessons learned out of the projects, their documentation and dissemination will also form part of the output indicators of program performance.

Measurement of achievements on the strategic outcomes will provide data on the degree to which AMREF has contributed to increasing universal access to prevention, care, treatment and mitigation by vulnerable and marginalised populations. Due to the inherent problems associated with measuring and attributing impact results such as morbidity and mortality on a population basis, AMREF will primarily utilise outcome indicators for measuring medium term population level results such as change in behaviour with regards to the ABC strategy or HIV status awareness. Such change could easily be attributable to AMREF contribution. Special studies, evaluations and surveys will be conducted where appropriate to give further meaning to outcomes and to answer questions pertinent to HIV/AIDS prevention, care and treatment in SSA.

Health management information systems shall be established at project, country and corporate levels and linked to the AMREF Project Management Systems (PJMS) to monitor progress on the strategy achievements but also to indicate AMREF's contribution towards national HIV/AIDS strategies and international agendas and commitments such as the MDGs and the 3by5.

3.2 Communication and evidence based advocacy

AMREF shall continue to implement its HIV and AIDS programme activities to seek answers to key operational research questions and to use the evidence to inform policy and practice. Consequently, monitoring and evaluation activities are inextricably linked with those relating to communication and evidence based advocacy. A set of key operational research questions on different aspects of the AMREF areas of focus accompanies this strategy and will be updated from time to time. The operational research questions shall appropriately be embedded in relevant HIV/AIDS projects. In addition, all substantive projects shall have baseline and final evaluations to inform policy and practice as well as further project development.

Wide ranging approaches shall be used to communicate results of interventions. Such approaches include inter alia:

- Documentation and sharing through technical briefing papers, publications and the website
- Participation at national, regional and international conferences and web-based networks to communicate evidence and AMREF position on key themes
- Technical discussions shall regularly be organised to share results and debate emerging issues in HIV/AIDS programming
- AMREF shall use results of its interventions to mobilise resources

4 Further Reading AND Useful Websites

i. UNAIDS, Report of the Global HIV/AIDS Epidemic, July, 2004
ii. World Health Organization, 2004 WHO, A guide to monitoring and evaluation for collaborative TB/HIV activities. (WHO/HTM/TB/2004.342, WHO/HIV/2004.09
iii. Grosskurth H, Mosha F, Todd J, et al. A community trial of the impact of improved sexually transmitted disease treatment on the HIV epidemic in rural Tanzania: AIDS 1995;9(8):927-34.
iv. Anderson S.R. and Dermont M, 2001: An analysis of interaction between TB and HIV/AIDS Programmes in sub Saharan Africa, Stop TB Department WHO Geneva
v. van Eijk et al, AIDS 2003
vi. Katabira E. Epidemiology and measurement of diarrhoeal disease in HIV –infected patients. International Journal of Infectious Diseases also cited in Millennium Water Alliance 2004; Quality of life: Exploring the links between living with HIV/AIDS and safe water and sanitation
vii. Uganda HIV/AIDS sero prevalence and behaviour survey; 2005
viii. Global Fund report, March 1, 2005, Pledges and contributions
ix. Hogle J, Green EC, Nantulya V, Stoneburner R, Stover J. What happened in Uganda? Declining HIV prevalence, behavior change and the national response. Washington, D.C.: USAID, 2002. http://www.usaid.gov/pop_health/aids/Countries/africa/uganda_report.pdf
x. UNAIDS Policy Position Paper: Intensifying HIV Prevention (UNAIDS/PCB(17)/05.3 29 June 2005)
xi. UNAIDS: AIDS epidemic update, December 2005 www.unaids.org/epiupdate/doc
xii. *Guidelines for the* management of drug-resistant tuberculosis. Geneva, World Health Organization, 1996 (WHO/TB/96.210 (Rev. 1)).
xiii. Lawn SD, Bekker LG, Middelkoop K, Myer L, Wood R.: Impact of HIV infection on the epidemiology of tuberculosis in a peri-urban community in South Africa: the need for age-specific interventions (Clin Infect Dis. 2006 Apr 1;42(7):1048-50.)