AUSAID REGIONAL HIV/AIDS CAPACITY BUILDING PROGRAM 2007-2011

PROGRAM DESIGN

FINAL

September 2007

Contents

ACRONYMS

ACFID	Australian Council for International Development
ADB	Asia Development Bank
AHAPI	AusAID HIV/AIDS Partnership Initiative
APLF	Asia Pacific Leadership Forum on HIV/AIDS and Development
APPU	Annual Program Performance Update
ARHP	Asia Regional HIV/AIDS Project
ASHM	Australasian Society for HIV Medicine
ARV	Antiretroviral drug
AIPH	Australia Indonesia Partnership for HIV
ASA	Action to Stop AIDS (FHI Indonesia project)
CBO	Community based organisation
DFID	UK Department for International Development
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, TB and Malaria
HAARP	HIV/AIDS Asia Regional Program
IHPCP	Indonesia HIV /AIDS Prevention and Care Project
MCH	Maternal and child health
NCHECR	National Centre in HIV Epidemiology and Clinical Research
PCC	Program Coordination Committee
PMTCT	Prevention of Mother to Child Transmission
PRHP	Pacific Regional HIV/AIDS Project
SOTS	State of the Sector Reports
SPC	Secretariat of the Pacific Community
TAG	Technical Advisory Group

1. Program origin and context

Australian Aid: Promoting Growth and Stability (the White Paper) emphasises the need for regional approaches to trans-boundary threats, including HIV. The White Paper commits AusAID to strengthening capacity building linkages between Australian HIV organisations and their counterparts in the region. This commitment is intended to further implement *Meeting the Challenge: Australia's International HIV/AIDS Strategy (2004)*, which emphasises capacity building for HIV responses in Asia Pacific as a key priority of the Australian Government.

To provide a framework for implementation of this commitment, in 2006 AusAID developed an *HIV/AIDS Workforce Capacity Development Strategy 2007-2011* (Appendix 4) with four components:

(i) integrating HIV capacity building into bilateral and regional programs;
(ii) strengthening regional advocacy;
(iii) facilitating 'south-south' collaboration; and
(iv) linking Australian HIV organisations with in-country counterparts.

The HIV/AIDS Regional Capacity Building Program implements the last of these components. The Capacity Building Program will provide a flexible mechanism to fill gaps in the existing HIV response in the region. It will build on the achievements of and lessons learned from the AusAID HIV/AIDS Partnership Initiative (AHAPI), which linked six Australian HIV agencies to counterparts in the region in the period 2004-2008. AHAPI encompasses organisations working in the community, clinical and research sectors (Appendix 3).

The concept for the Program emerged as a recommendation of the *Analytical Report on HIV/AIDS* prepared to inform development of the White Paper[1]. A key message from the White Paper consultations was the importance of utilising Australian HIV expertise in a more coherent and strategic manner, to thereby enhance Australia's ability to respond to the workforce development needs of Asia Pacific countries.

After commitment was formalised in the White Paper, AusAID's Health and HIV Thematic Group began scoping the program through consultation internally and with members of the Australian HIV and development sectors.

Internal consultations highlighted the need for much closer coordination of the regional HIV partnerships with AusAID country programs and national priorities, so as to ensure that partnerships complement other AusAID programs, and are consistent with donor harmonisation and alignment principles.

In November 2006, the *HIV/AIDS Workforce Capacity Development Strategy 2007-2011* was distributed for comment to AusAID desks and posts, Australian HIV and development organisations and regional bodies including UNAIDS. A workshop to

[1] O'Keeffe A, Godwin J and Moodie R (2005) *HIV/AIDS in the Asia Pacific Region: Analytical Report for the White Paper on Australia's Aid Program* Commonwealth of Australia

discuss component (iv) of the Strategy was held with selected stakeholders in February 2007. The Program design was then developed by the AusAID Health and HIV Thematic Group, taking into account oral and written feedback received on the Strategy.

2. Situation analysis

2.1 Rationale for a focus on capacity building

There have been major advances in HIV interventions over the last decade. Antiretroviral therapy can dramatically improve the quality of life and increase the life expectancy of people living with HIV. PMTCT programs are highly effective in reducing mother to child transmission. Harm reduction approaches that encompass needle and syringe programs, drug substitution, access to condoms and sexual health services, primary care and peer education can prevent transmission of HIV through injecting drug use. Targeted education and condom promotion in the sex industry can help reverse an HIV epidemic, as has been demonstrated in Thailand and Cambodia.

Despite clear evidence of effective approaches to HIV prevention and care, the epidemic continues to spread across the Asia-Pacific region. The majority of poor people living with or vulnerable to HIV do not have access to prevention, testing, treatment, care and support services. For example, HIV prevention programs reach only 5.4% of injecting drug users in South and South East Asia, and treatment programs only 12% of people requiring ARVs in the Western Pacific.[2]

One of the major impediments to scaling up HIV related services is the lack of a skilled workforce.[3] Countries in the region can only mount comprehensive and sustained responses to the epidemic if supported to skill up key personnel to provide prevention, treatment, care and support services, build the evidence base of approaches that work in each particular country context, and advocate for an appropriate response to HIV.

The need to urgently scale up HIV responses to address unmet needs has been highlighted at numerous international fora, including the 2006 UN General Assembly Special Session on HIV/AIDS. At the Special Session, AusAID committed to the target of universal access to HIV prevention, treatment, care and support by 2010. This Program, together with AusAID's other regional and bilateral HIV programs, is a contribution to supporting our partner governments in the region to progress toward universal access.

2.2 Targeting of the program to address needs

During the design of the Program consideration was given to the workforce capacity needs identified by AHAPI partners in Australia and the region and AusAID's existing HIV programs in Indonesia, the Pacific and countries covered by the HIV/AIDS Asia

[2] UNAIDS (2005) *A Scaled Up Response to AIDS in Asia and the Pacific* UNAIDS/05.15E
[3] WHO (2006) *Taking Stock: Health Worker Shortages and the Response to AIDS* WHO/HIV/2006.05

Regional Program (HAARP) (Vietnam, Burma and southern China, to expand to Cambodia, Laos and Philippines).

The summary below highlights aspects of the current HIV response that confirm the need for a program of capacity building support for the health, community and research sectors in these countries. Careful targeting of the program will be important to ensure that it complements AusAID's other HIV capacity building efforts funded through country and regional programs (including in relation to health systems strengthening and child and maternal health), and to avoid duplicating the capacity building activities of other donors and the UNAIDS Technical Support Facility for South East Asia and the Pacific (which sources short term technical inputs at the request of governments and organisations).

In addition to assessment of country and regional needs, consideration was given to the importance of supporting Australian organisations to coordinate in the planning and delivery of a targeted program of assistance through strategic partnerships. Enabling Australian HIV organisations to collaborate in development and delivery of a coherent program is essential for efficiency and to maximise Australia's contribution to addressing regional capacity development needs.

Indonesia

Indonesia's HIV epidemic is concentrated among marginalized populations, particularly injecting drug users, sex workers, transgender populations (waria) and men who have sex with men. An exception is the generalised epidemic in Papua and West Papua provinces. Both the concentrated and generalised epidemics are expanding and capacity in insufficient to respond to needs. Epidemiology indicates that HIV needs are greatest in Java and Papua/West Papua.

A new National HIV/AIDS Strategy 2007-2010 sets out the Government of Indonesia's priorities. Planning of any new capacity building support needs to occur under the leadership of the National AIDS Commission, and in close consultation with the AusAID bilateral health and HIV program. Planning will also need to take into account capacity building activities funded by USAID (eg FHI/ASA project), the Indonesia Partnership Fund (supported principally by DFID) and the GFATM.

AusAID is designing a program of support to assist the Government of Indonesia to implement the new National AIDS Plan. Capacity building needs in Indonesia were considered during the design of the new Australia Indonesia Partnership for HIV (AIPH) which is a new program of support commencing in 2008 to replace the existing AusAID bilateral project, the Indonesia HIV/AIDS Prevention and Care Project (IHPCP). The new bilateral program will have a narrower technical and geographic focus than the IHPCP, and will primarily focus on the generalised epidemic in Papua, the epidemic among drug users in Java, and the national prisons system.

IHPCP has worked to develop national networks of people living with HIV groups, and has provided grants to NGOs and CBOs, including support to the national organisation Spiritia since 2001. It is unclear the extent to which the new bilateral program will be

able to continue this work and it is considered important that an assessment occur as to how the Regional Capacity Building Program will be able to play a role in contributing to this work. The FHI/ASA project (primarily funded by USAID) has supported a wide range of NGOs and CBOs including sex worker groups and it will be important to liaise with FHI/ASA when planning any new work to develop the capacity of the community sector.

There have been clinical capacity elements within the existing AusAID IHPCP project, delivered in partnership with WHO, FHI/ASA and Australian clinical experts (including Albion Street Centre, Burnet Institute, and ASHM (funded by IHPCP and the AHAPI program)). Capacity building has included pre-service and in-service training for health care workers, supporting referral hospitals to act as training centres and models, working with medical faculties and teaching hospitals, addressing laboratory and pharmacy issues and building community health centre capacity. ASHM has active partnerships with Indonesian health care worker groups including the Indonesian Medical Association which has been assisted in developing an accreditation program for HIV clinicians.

Under the new bilateral program it is unlikely that support will be available to build clinical capacity outside the geographic and technical focus areas of the new program (ie in Papua/West Papua, and treatment services for people who use drugs and prisoners). The Clinton Foundation with support from AusAID has commenced scoping a potential program of activities to build treatment capacity with a focus on Papua.

It is important that an assessment occur as to whether the Regional Capacity Building Program will be able to offer a new program of support for national clinical capacity building eg, by working in partnership with national groups and the key referral hospitals.

Research capacity building has been identified as a priority under the National AIDS Plan 2007-2010 with an emphasis on inter-sectoral and multidisciplinary approaches through developing research networks, establishing technical working groups, and promoting collaboration between research centres, universities and experienced researchers. A research working group of the National AIDS Commission is setting priorities.

Under the new AusAID bilateral program, AusAID will largely withdraw the current support provided by IHPCP to Bali's HIV response except in prisons. The rationale for this is so that the resources of the bilateral program can focus on HIV in Papua, among drug users in Java and in prisons. AusAID is keen however for regional initiatives including the Capacity Building Program to offer new support to Bali province in recognition of the special relationship between Bali and Australia. The Government of Indonesia has indicated enthusiasm for AusAID to continue to support HIV interventions with all risk populations in Bali.

Pacific region (excluding PNG)

HIV prevalence remains low across the Pacific region (apart from PNG) and the epidemic appears to be spreading slowly. Nevertheless, a youthful, mobile population, high rates of sexually transmitted infections and low rates of condom use indicate the

need to ensure a workforce capable of supporting expanded prevention efforts as well as offering care for those diagnosed. Fiji has a relatively high HIV case load compared to other islands states, acts as a regional hub and may require a special focus for capacity building efforts. HIV is primarily transmitted through sex in the Pacific as injecting drug use is rare. A key issue therefore for all Pacific Island countries is integration of HIV responses with efforts to build capacity in addressing sexual and reproductive health needs.

The Pacific Regional HIV/AIDS Strategy is a key reference point for donors and country partners planning new HIV activities.

HIV capacity building activities have been funded primarily through AusAID's Pacific Regional HIV/AIDS Prevention Project (PRHP) (2003-2008), the GFATM and the regional ADB project (ADB Prevention and Capacity Development in the Pacific Project). PRHP is focused on implementing the Pacific Regional HIV/AIDS Strategy and strengthening country capacity to implement National HIV/AIDS Plans. A PRHP grants scheme funds local NGOs and Capacity Development Organisations. The Capacity Development Organisations support smaller, local NGOs and CBOs to implement the grants they receive through the project.

Some work has also been conducted by PRHP in partnership with WHO to build the capacity of health care workers to provide HIV care; however, fundamental services such as ART provision, clinical monitoring, surveillance, PMTCT services and voluntary counselling and testing are still in their infancy. SPC has received support from AusAID, ADB and the Government of France for building surveillance capacity. Under AHAPI, ASHM has provided technical assistance to the Fiji School of Medicine as a regional institution and arranged HIV clinical placements for health care professionals from Pacific Island countries to Australia and NRL has conducted laboratory training in Fiji. ASHM has also supported the establishment in 2007 of the Oceania Society for Sexual Health and HIV Medicine (OSSHHM). PRHP has provided some support for improving epidemiological surveillance capacities.

AusAID is funding a new Australia Pacific Technical College which will provide vocational training in Fiji, Vanuatu, Samoa and Papua New Guinea.

CBOs are poorly developed in the Pacific for people living with HIV, gay men/men who have sex with men, transgender/fa'fafine populations and sex workers. This makes it difficult to develop community based participatory approaches to HIV prevention and sexual health promotion. Sex work is often indirect and transactional rather than brothel based, presenting challenges for reaching women who sell or trade sex with prevention messages, peer education and support.

A review of HIV social research priorities was conducted in 2006-2007 for SPC that made the following observations in relation to research capacity building needs[4]:

[4] Holly Buchanan-Aruwafu *An Integrated Picture: HIV Risk and Vulnerability in the Pacific. Research Gaps, Priorities and Approaches*. (PhD) February 2007

- an approach that allows for local ownership and sustainability is needed
- the University of the South Pacific (USP) and the Fiji School of Medicine (FSM) are institutions identified as requiring support, as well as NGOs/CBOs as partners in community based research
- it would be useful to have a New Zealand or Australian University and their expertise in HIV related research involved in research capacity building.

Planning for the future of AusAID's support to the Pacific region's HIV response is occurring in close collaboration with SPC and it is anticipated that from 2008 SPC will lead planning and delivery of capacity building efforts aligned with the Pacific Regional HIV/AIDS Strategy.

Solomon Islands is considered particularly vulnerable to HIV given the proximity to PNG, high STI rates, gender inequalities and the poor state of the health sector. AusAID conducted a situation analysis on HIV in Solomon Islands in 2005 which recommended capacity building support targeted at community based prevention responses addressing the HIV and STI needs of vulnerable populations, particularly sex workers and their clients. Planning for any new support for capacity building in Solomon Islands will need to take into account support for prevention and community development already being provided by AusAID through mechanisms such as PRHP, the Australian NGO Cooperation Program and Solomon Islands Community Sector Program. Any new capacity building support for the health sector will need to complement the work being funded through the AusAID/World Bank/Solomon Islands Government Health Sector Support Program which commences in 2007.

Greater Mekong region and the Philippines (HAARP countries)

HIV is rapidly expanding in the Greater Mekong Region due largely to risk behaviours associated with injecting drug use and sex work. Sex between men is also emerging as a key factor driving escalation of the epidemic. HIV related needs are particularly high in Burma, Cambodia and Vietnam. Cambodia has a generalised epidemic which means that married women are increasingly vulnerable to HIV in addition to risk populations such as sex workers and their clients and men who have sex with men. Laos PDR has relatively low HIV prevalence although is at risk of an expanding epidemic as mobility increases across the region and drug use escalates. Philippines also has low HIV prevalence although there are concerns that low rates of condom use and growth in injecting drug use may kick start the country's nascent epidemic.

Australia's current regional HIV program for Asia, the Asia Regional HIV/AIDS Project (ARHP) has undertaken work in China, Vietnam and Burma, focusing on HIV prevention and harm reduction approaches among people who use drugs. ARHP is due to finish in 2007, and a new activity called the HIV/AIDS Asia Regional Program (HAARP) is to commence in July 2007.

HAARP continues the focus on HIV and drug use both at the regional level and at national levels within six countries: Vietnam, Burma, Laos, Cambodia, Philippines and Guangxi Autonomous Region and Yunnan Province of China.

HAARP aims to create a framework that promotes regional cooperation and addresses cross-border issues among AusAID activities, international agencies and NGOs. It also supports the locality-specific and technical aspects of work on HIV associated with drug use within national programs.

A new HAARP Regional Technical and Coordination Unit based in Bangkok is responsible for managing regional activities. The Unit works with multilateral agencies that work on HIV and drug use such as UNODC and WHO, and promotes coordination between donors to maximise effectiveness of efforts to address the HIV related needs of people who use drugs. The Unit provides high-level support and technical inputs as required by AusAID's programs in the six focus countries.

Situation and needs assessments are planned in 2007-2008 to inform the country level activities of HAARP. The findings of these assessments may inform ways in which the Capacity Building Program could offer strategic assistance both through country level and regional activities.

HAARP primarily targets the Government sector and will also provide training of community based out-reach workers. There is scope for the Capacity Building Program to complement HAARP by supporting research capacity relevant to HIV and drug use, focusing on building capacity to deliver HIV treatment and care to people who use drugs, and by targeting the capacity of drug user community sector organisations in peer education and advocacy for policy change and regulatory reform relating to harm reduction and drug use issues.

HAARP focuses its activities on HIV and injecting drug use and not other at risk populations. To mount a comprehensive response to HIV, capacity building activities are required to support responses to the needs of populations such as sex workers and men who have sex with men, and people living with HIV groups. It should be noted that support from other donors is often available targeting these populations. Liaison with other donors particularly USAID and DFID will be important to avoid duplication.

Some community organisations receive capacity building support from regional HIV organisations (such as APCASO and APN+), however these regional organisations are small and their reach is limited due to resource constraints and the breadth of their geographic mandates. The International HIV/AIDS Alliance provides capacity building support for CBOs in Cambodia (in relation to men who have sex with men and people living with HIV), Burma (in relation to sex workers, men who have sex with men and people living with HIV), has a project in Yunnan, and is developing a new Indonesia project and a regional program of support for CBOs through member organisations which act as hubs for regional technical support.

Philippines has a well developed community sector HIV response and opportunities to share lessons regionally on issues such a education and advocacy strategies relating to marginalised populations could be explored.

In Burma a new four year program of capacity building support for HIV and sexual and reproductive health is being funded through AusAID's Program for Humanitarian Assistance in Burma 2007-2012. This will be delivered by Care Australia, Burnet Institute and Marie Stopes International and will address the needs of drug users, sex workers and other vulnerable populations. Burnet Institute and Care have been supporting a range of community organisations and faith based groups to develop skills and expertise in HIV responses targeting vulnerable communities for a number of years.

AusAID has provided some clinical research capacity building support to NCHECR for an ARV research project in Cambodia. HIV research capacity building receives significant support from other donors delivered for example through FHI's country programs and the TreatAsia network of HIV clinical research sites.

Although AusAID has supported some important HIV work in Thailand (eg, through support to Albion Street Centre projects) Thailand will not be a focus for future AusAID support due to its relatively advanced state of economic development. There may however be advantages in including Thailand in program activities to promote learning from the successful aspects of the Thai national HIV response.

East Timor

East Timor has low HIV prevalence and the HIV response is in its infancy. There is a significant level of sexual partner change, high rates of STIs particularly among sex workers, and condom use is low across the population. There are concerns that the epidemic may expand given the very low levels of national capacity to provide basic health and education services and to address HIV and broader sexual and reproductive health needs.

The *National HIV/AIDS and STI Strategy 2006-2010* identifies workforce capacity development needs and recommends that specific training plans be developed on:

- Prevention and education
- VCT
- Clinical Services
- Surveillance
- Strategic Information
- Program Management.

The Strategy notes that immediate needs include sentinel surveillance and behavioural monitoring to inform prevention. Given the low prevalence, prevention is a priority.

AusAID supports development of East Timor's health services particularly for rural populations and has also provided some capacity building support for the HIV clinical response and peer support for people living with HIV under AHAPI. ASHM has collaborated with the National Hospital in Dili and convened a working group on clinical

services as part of the development of the National Strategy. Ongoing clinical capacity development needs can be identified in liaison with the Ministry of Health and the HIV Interest Group formed within the East Timor Medical Association.

The community sector HIV response is very fragile and there is an almost total absence of peer education and support services for people living with HIV and marginalised populations, particularly since the USAID supported FHI HIV project ended in 2006. Capacity building support should focus on CBOs with potential to undertake HIV and STI prevention work with most at risk groups that are defined by the National Strategy as sex workers and their clients, men who have sex with men and mobile populations. There is no apparent injecting drug use issue in East Timor.

Papua New Guinea (PNG)

Mounting an escalated response to PNG's generalised HIV epidemic is an Australian Government White Paper priority. The new AusAID-PNG HIV Program 'Sanap Wantaim' has its own Capacity Development Strategy that supports PNG National HIV/AIDS Strategy priorities and targets individuals, organisations, government and civil society, and with a particular focus on building the capacity of the National AIDS Council Secretariat.

Significant resources are available through the PNG program for capacity building support to the health, research and community sectors. AusAID's partnership with the Clinton Foundation provides some capacity building support for HIV treatment and laboratory services.

The PNG program will build NGO networks and support twinning with Australian agencies involving staff exchanges, training partnerships between institutions and establishment of mentoring relationships. AHAPI partnerships have been established to develop capacities in social research, peer education and advocacy for sex workers and people living with HIV, health policy, clinical and laboratory skills. At the end of the AHAPI projects, AHAPI partnerships may be integrated where appropriate into the PNG program.

It is not intended that the Capacity Building Program will fund activities in PNG directly, however services provided by the Capacity Building Program may attract supplementary funding from AusAID's PNG program to support activities that benefit PNG individuals and organisations including PNG participation in regional conferences and training events organised by the Capacity Building Program.

Technical Support Facility for South East Asia and the Pacific (TSF)

The TSF was established in 2006 to support countries in Southeast Asia, the Pacific Islands, China and Mongolia. At the request of countries, business or donors, the TSF sources consultants in the following fields:

- Planning: Strategic and operational planning (situation analysis, response analysis, strategic plan formulation); costing and budgeting
- Communications: Campaigns, media, education, social marketing

- Resource mobilisation and tracking: Global Fund and other proposals; writing, evaluating, crisis management
- Monitoring and Evaluation: M&E design, assessment and problem solving
- Management: Implementation/execution; procurement; financial management; organizational development
- Work with key populations: People living with HIV; women and young people; injecting drug users; men who have sex with men; sex workers; transgender; migrants and mobile populations.

The Facility is managed by the International Planned Parenthood Federation's East & South East Asia and Oceania Region, and AusAID sits on the Facility's Inter-agency Reference Group. TSF also:

- Strengthens country partners' capacity to manage technical assistance
- Offers professional development activities for consultants.

2.2 Lessons learned

The Capacity Building Program incorporates lessons from the substantial capacity building work of AusAID's HIV/AIDS programs in PNG, the Pacific, Indonesia, China, Burma and Vietnam. The design of the Capacity Building Program is also informed by lessons learned from AHAPI, funding for which ends in 2008. AHAPI supports eight projects that involve capacity building partnerships between Australian HIV organisations and similar bodies in the region (see Appendix 3). Lessons learned from AHAPI, identified in consultation with AHAPI partners, ACFID and ASHM's HIV network, include

- Effectiveness of capacity building efforts will be enhanced by coordinating and better targeting efforts where impact will be greatest
- AusAID must utilise Australian expertise in a more strategic and coherent way to complement its existing programs, rather than funding ad hoc, stand alone projects.
- Australian HIV organisations working in the region should align more closely with country priorities and coordinate more closely with other AusAID programs
- The need for flexibility in program design and delivery to match the pace and need of in-country partners
- The need to promote cross sectoral work through linking community organisations, researchers and health professionals, particularly in developing capacity to conduct community based operational research in areas such as adherence support
- The increased willingness of Australian organisations working in HIV in the region to collaborate and coordinate
- The need for a continued focus on areas where Australia has a comparative advantage, including HIV medicine, peer education, social and epidemiological research, advocacy and policy development.

Key lessons learned regarding effective approaches were identified through consultations with Australian HIV agencies experienced in capacity development, analysis of the previous capacity building programs of AusAID and other donors, and drawing from

AusAID's statement of *Capacity Development Principles and Practices* (November 2004).[5] These lessons include:

- It is critically important that programs are needs led. Programs that are supply driven are too often unresponsive to locally defined needs and priorities. Participants in capacity building should be involved in defining needs and priorities and capacity mapping.
- The importance of culturally appropriate responses adapted to local contexts and which work through national systems.[6]
- That capacity building is most effective when it takes place through *long term* partnerships, rather than merely providing short term technical assistance. Follow-up support to organisations and individuals should be factored into programs. Maintaining contact can help those who encounter difficulties in introducing changes in their workplaces, a situation reported particularly by women.[7] This, too, calls for a long-term commitment by the donor.
- Local leadership and ownership of the change agenda is critical. Leadership should be visible, not just agreements with donors.
- Holistic approaches work best, with attention paid to management and organisational change, not just technical fixes.
- Mobilising existing capacity is often the key challenge for organisations – applying existing capacity in different, more productive ways. There are often under utilised capacities in individuals, organisations and systems that can be used productively. Programs should be informed by capacity mapping to identify strengths as well as gaps and needs[8]
- The need to build on local systems and knowledge, and avoid importing complex, sophisticated systems.
- The pace of change must be in the control of the partner agency, attempts by donors to force the pace undermine ownership and sustainability.
- Planning, coordination and sequencing of activities is important, which should be based on an analysis of the problems, mapping of capacities and coordination of donor efforts.
- Training is important but is maximised when embedded within a broader program of change, and most knowledge for work is best acquired in the workplace by 'doing', hence the centrality of ongoing programs of coaching and mentoring.
- The importance of establishing a participatory process through which the key stakeholders can be involved in strategic decisions about capacity development and the necessary changes, the change process, its impact, the risks and the responsibilities of all involved.

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[5] Summarised in *AusAID's Capacity building: Lessons learned* (Oct 2006) and *AusAID Internal Brief on Capacity Building* (Oct 2006)

[6] OECD (2006) *The Challenge of Capacity Development: Working Towards Good Practice* DCD/DAC/GOVNET(2005)5/REV1

[7] Lessons from USAID's African Graduate Fellowship (AFGRAD) and African Training for Leadership and Advanced Skills (ATLAS) programs were evaluated over the period 1962-2003: see World Bank Capacity Development Brief No 15 Feb 2006 (World Bank Institute)

[8] AusAID (2004), *PNG Health Services Support Program, Capacity building plans annual review 2003*

- Identifying positive incentives that foster and maintain commitment to the capacity development effort is critical to success. Incentives may come in various forms:
    - official recognition or certification
    - access to personal development and networking opportunities
    - improved workplace conditions
    - support for performance based human resource management practices.

The program also integrates the following lessons learned by AusAID relating to sustainable training approaches[9]:

- Too often training is an exercise in transferring technical knowledge without giving enough attention to ensuring that the methodologies used will be effective in ensuring sustainable learning outcomes. Approaches to training have often ignored expertise in educational psychology and adult learning. Sustainable learning, and the effective application of this learning in the workplace, will occur where the initial focus has been on the establishment of an effective and consistent training method that can be applied to any content. Training will succeed not because of the technical content but because the training has been built around a training method that is grounded in the principles of adult learning.
- The need for training programs to be multifaceted, involving preparation, follow-up, and action plans by which participants in training or other activities commit to transfer the skills or practices they have learned to their own workplace or community.

In terms of clinical capacity building, the following lessons from AHAPI and other donor projects have been taken into account:

- the importance of supporting health care workers to form networks and organisations which allow them to share experiences, discuss training and support needs, and facilitate engagement with policy development processes.
- acknowledging that training efforts require ongoing support, mentoring and infrastructure
- use of targeted work plans based on HIV clinical training needs assessment
- the need for a multi-disciplinary effort[10]
- the mutual advantages of fostering partnerships between professional associations in different countries in the region.

2.3 Options considered: Rationale for a Consortium model

The following options for implementing the Program were considered:

[9] Lessons learned as documented by the AusAID *Indonesia-Australia Specialised Training Project*

[10] International HIV clinical capacity building: lessons learned from the US AIDS education and training centers. Reyes EM, Downer AE. *Int Conf AIDS.* 2004 Jul 11-16; 15: abstract no. E10369

Option 1: AusAID provides supplementary funding to key posts to contract technical expertise as and when required.

Under this option, supplementary funding could be provided to AusAID's posts in Indonesia, East Timor and the Pacific, and to the Bangkok post in respect of the Asia regional program. Guidelines could be prepared as to use of the funding for procuring technical assistance for capacity building. Posts would ensure that capacity building priorities complement AusAID's other bilateral and regional health and HIV programs, reflect local needs and are aligned with national priorities. The new Health Resource Centre being established by the Health and HIV Thematic Group would provide advice as to where to source appropriate expertise, or posts could access the UNAIDS Technical Support Facility to procure assistance.

An advantage of this model is that it puts control over decision regarding allocation of the funding with the posts. Disadvantages are that:

- fails to focus on further building the relationships established over 4 years through the AHAPI partnerships. There is a risk that instead of promoting long term institutional partnerships, funds would be used in an ad hoc way, or for short term consulting assistance only. This would not be consistent with the policy thrust of the White Paper, which is to provide greater impetus to Australia's response in the region by supporting linkages between Australian HIV organisations and their counterparts in the region.

- this model has no oversight mechanism to ensure that the program as a whole is coherent and strategic from a regional perspective and coordinates efforts to make best use of Australian expertise.

Option 2: AusAID develops an overall workplan in consultation with the Australian HIV sector, then contracts with individual organisations to implement particular activities.

Under this option, the Health and HIV Thematic Group would work with key posts and Australian HIV organisations to identify capacity building priorities. Individual contracts would be entered with Australian organisations that have the expertise in these priority areas, and these organisations would then work with in-country counterparts to prepare annual workplans for approval. A program oversight group would be established to provide advice on coordination and strategy.

This model is informed by AusAID's PNG Church Partnership Program, a collaboration whereby seven Australian faith based organisations strengthen the institutional capacity of their counterparts in PNG. The Australian organisations operate under a broad Charter which articulates the purpose of the program and guiding principles. Implementation is guided by a Charter Group; however each Australian organisation has a separate contract with AusAID and develops its own annual workplan in conjunction with its PNG counterpart.

The advantage of this option is that it maintains some of the flexibility of the approach of individual contracting (as used in the AHAPI program), while enabling strategic planning of activities through the Charter Group or equivalent. Disadvantages are the administrative burden it imposes on AusAID and the fact that it does not encourage Australian HIV organisations to market their skills to the region and other donors in a coherent way.

Option 3: Contract implementation of the HIV/AIDS Capacity Building Program to the UNAIDS Technical Support Facility, AusAID's proposed Health Resource Centre, or similar entity.

An option considered was implementation of the Program through an existing entity, such as those named above. This approach was decided against as the emphasis of the program is on *long term* capacity building and supporting institutional partnerships between Australian agencies and regional counterparts. In this way it is conceptually different from the proposed AusAID Health Resource Centre (which is concerned with knowledge management and providing technical expertise to AusAID) and the UNAIDS Technical Support Facility (which sources short term technical inputs delivered by consultants at the request of partner country governments and organisations, rather than long term institutional capacity building partnerships, twinning and mentoring relationships).

Option 4: AusAID enters a funding agreement for implementation of Program to a Consortium of agencies, working to an agreed workplan.

This option involves AusAID funding a consortium of Australian HIV organisations. A precedent exists in DFID's consortium on "Research and capacity building in reproductive and sexual health and HIV/AIDS in Developing Countries".[11] In 2005, DFID called for expressions of interest from consortia with the following features:

- Comprised of 4-6 institutions, but headed by a single organisation;
- Include at least 3 institutions from a developing country and 2 institutions which are well established;
- Have a director who is responsible for management of the Consortium; and
- Advised by an inter-disciplinary Consortium Advisory Group which is independent of the managing institution.

The effectiveness of the consortium approach is dependent on establishing a sound governance structure, working principles and a work plan that are acceptable to all members. A disadvantage is that these processes could be time consuming and detract from the implementation of activities.

In considering options for the formation of a consortium for the AusAID program, the functions required for the program as a whole to work were identified as follows:

[11] http://www.dfid.gov.uk/research/rpc-guidance.pdf accessed 15 February 2007

(1) A Program Coordination Committee to oversee implementation of the Program, the primary role of which is to agree a joint workplan for the Consortium, and provide ongoing advice on strategy, program priorities and emerging issues.

(2) A Secretariat that provides a central coordination point for the Program, enters contracts for implementation of activities, monitors progress and supports the Program Coordination Committee and meetings of the Consortium.

(3) A financial function that independently audits the finances and monitors contracting arrangements, and feeds this information to the Program Coordination Committee through the Secretariat.

(4) A Consortium group, which is responsible for collaborative planning and the implementation of activities through its members and partners.

Identifying separate bodies responsible for each of these functions is considered necessary to avoid conflict of interest. Conflicts of interest issues may arise given that the Secretariat is likely to be housed within a member of the Consortium, which could result in a service provider both accounting to and monitoring itself. To address this, it is considered important that financial functions be carried out by another management entity.

As a quality control measure, this option would be enhanced by including capacity for technical review of the workplan by independent HIV experts with knowledge of AusAID policies and programs (e.g a Technical Advisory Group contracted by AusAID).

The Consortium approach is preferable to administering individual grants because it:

- Promotes cross-sectoral collaboration and showcases the Australian partnership approach to planning and delivering HIV services

- Builds on the AHAPI model with enhanced capacity for strategic planning to inform the targeting of effort

- Encourages the HIV sector's participation and ownership of strategic planning for an entire program of work, rather than funding a series of stand alone, ad hoc activities

- Provides Australian HIV organisations with greater flexibility and autonomy in implementing and managing the program, placing less of a burden on the Health and HIV Thematic Group

- Builds on the existing regional relationships of Australian HIV organisations developed through AHAPI and through their other programs supported by private foundations and other donors

- Recognises the increased enthusiasm of Australian HIV organisations that are working in Asia Pacific to work more collaboratively and strategically and to coordinate the use of the resources that they receive from a variety of sources

- Recognises that a consortium is in a much stronger position than small individual organisations to leverage funds from other sources in a competitive international market. Australian expertise has unique strengths and AusAID seeks to establish a sustainable structure through which the sector's capacity building services can be provided to the region.

3. The Program

3.1 Principles

In recognition of the need to address workforce development as a priority to support scale-up for universal access, AusAID will implement an HIV/AIDS Regional Capacity Building Program targeting segments of the workforce critical to a strengthened response.

The Program will work alongside other AusAID programs, other donors, partner country governments and multilateral institutions to bolster the ability of individuals and organisations to respond to HIV. The emphasis is on building the skills and expertise of *people* and *organisations*, rather than providing additional infrastructure or equipment.

The Program will work within the following principles:

- **Alignment** with AusAID programs and national priorities, as defined by national and regional HIV/AIDS strategies, in keeping with the UNAIDS "Three Ones" principles[12];

- **Sustainability** through long term partnership approaches rather than short term "parachuting in" of experts, by fostering local ownership and leadership and using partner systems and processes as the entry point;

- **Partnerships** including facilitating collaboration between partners in low and middle income countries across the region, encouraging cooperation across disciplines and the participation of people living with HIV/AIDS and other affected communities.

The Program adopts AusAID's definition of capacity building as the process of developing competencies and capabilities in individuals, groups, organisations and sectors which will lead to sustained and self generating performance improvement. The approach of the Program will acknowledge that capacity exists within partners, and that the program's role is to help identify, strengthen and maintain capacities. Consistent with

[12] One national HIV/AIDS coordinating authority, one national HIV/AIDS plan, one national HIV/AIDS M&E framework

AusAID's gender policy,[13] the Program will be informed by gender analysis and respond to different issues faced by men and women so that gender equality is promoted.

3.2 Goal, purpose and objectives

The overarching goal of this Program is:

> Strengthened capacity of organisations and individuals in the Asia – Pacific region to respond effectively to HIV/AIDS.

The Program's purpose is:

> To foster strategic partnerships and linkages between Australia and the Asia Pacific region that will enable sustained performance improvement for individuals and organisations working in HIV/AIDS health care, research and community responses.

The Program objectives are:

1. to develop the capacity of health care workers and their organisations (e.g. health services, professional associations) to scale up and manage HIV services;

2. to develop the capacity of researchers and research institutions to develop and maintain a local evidence base on HIV and effective responses, including through social, behavioural, economic, epidemiological and clinical research;

3. to develop the capacity of community organisations and community sector workers to scale up and manage community and peer based HIV services;

4. to establish and maintain sustainable capacity building partnerships across the region to support improved HIV responses of health care, research and community sectors.

Sectoral priorities

The focus is on three segments of the workforce critical to scale-up of HIV responses: health care, research and the community sector. Collaboration between health, research and community sectors will be encouraged. The Program will work across the community/NGO, private and public sectors. Some individuals and agencies with technical roles in the public sector will benefit from the program (eg clinicians and laboratory technicians in the public health system, research institutes, community health centres, STI clinics). However the Program is targeted at improving technical capacity and not intended to focus on Ministerial staff or AIDS Councils/Committees as these are already receiving support from other sources, including AusAID's bilateral and regional programs.

[13] *Gender Equality in Australia's Aid Program: Why and How*, AusAID 2007.

Geographic priorities
Priorities are as follows:

- First order priority will be accorded to activities in **Indonesia** and activities with a regional focus for the **Pacific**.

- In addition to regional Pacific activities, in-country work in the Pacific may include at least Fiji (given the scale of the emerging epidemic and its potential to act as a regional source of assistance) and Solomon Islands (due to the proximity to PNG and under-developed capacities).

- Second order priority will be given to activities that support or complement the activities of the HIV/AIDS Asia Regional Program (HAARP) in **Vietnam, Burma, Laos, Cambodia, Philippines, and Guangxi Autonomous Region and Yunnan Province of China**. Special written permission must be sought by the Secretariat from AusAID prior to engaging in planning or implementation of activities in Burma.

- The Program should at a minimum offer capacity building activities at the regional level for Mekong countries (Vietnam, Burma, Laos, Cambodia), in addition to addressing the first order priorities of Indonesia and the Pacific.

- Consideration will also be given to supporting activities:
    - in HAARP countries, where the activities fall outside the focus on injecting drug use, and
    - in **East Timor**.

This list is not exhaustive and may change over the life of the Program in response to emerging needs.

It is expected all activities in **Papua New Guinea** will be funded through the bilateral HIV/AIDS program, rather than this Regional Capacity Building Program. The provider for the Capacity Building Program will be expected to liaise with the bilateral PNG program to determine whether the latter wishes to contract any services, including involvement in regional activities such as conferences and training events where appropriate.

3.3 Program management

The Program structure comprises five elements:

- a Consortium of Australian HIV organisations;
- a Program Coordination Committee (PCC);
- a Secretariat led by a Program Director;
- an independent Financial Manager and
- a Technical Advisory Group (TAG).

The structure is illustrated in **Figure 1** (see below).

Consortium

The primary role of the Consortium is to collaboratively plan and deliver HIV capacity building activities in the Asia-Pacific region that address gaps in the HIV response, with reference to the priorities agreed between AusAID, other donors and national governments. The Consortium will comprise Australian organisations with expertise in HIV and must include members from the health care, research and community sectors. Consortium members must be not-for-profit organisations that do not pay dividends or distribute profits to shareholders, owners or members.

Figure 1: Program Structure

Members of the Consortium must have capacity to work in collaboration with partners in Asia and the Pacific in the health, research and community sectors. It is expected that most activities will be implemented by Consortium members, although some may be sub-contracted to other agencies or individuals with specialist expertise in a particular area.

In addition to implementing the Program's workplan of activities, Consortium members will be engaged in an ongoing process of reviewing performance of the Program and monitoring achievements against the Program Goal, Purpose and Objectives and the overarching Strategy. Consortium members will be invited to provide feedback on draft performance reports prepared by the Secretariat, and will be expected to comment on the achievements and problems identified by the Secretariat and any recommendations that the Secretariat wishes to put to the PCC for consideration. Members will be expected to share information that will be of common benefit to the Consortium. This may include strategic information on emerging issues that may impact on the effectiveness of the Program, which should be shared with other members and provided through the Secretariat to the PCC, including identification of new risks, anticipated threats/problems or strategic opportunities for maximising Program impact such as new regional partnerships.

The Program's Secretariat will work with the Consortium members to develop a four year outline workplan and detailed annual plans. The collaborative planning process will require Consortium members to engage in dialogue with a variety of stakeholders including partners in the region, AusAID country programs, national HIV/AIDS coordinating authorities and HIV/AIDS projects supported by other donors.

Program Coordination Committee (PCC)

Members of the PCC will be appointed by AusAID. The PCC will comprise:

- no more than three representatives of Consortium members
- independent experts in HIV/AIDS and development, including a Chair who may be drawn from the Asia Pacific region
- a person living with HIV/AIDS
- an AusAID representative
- the Program Director (ex officio, with no voting rights).

The PCC will provide strategic oversight of the Program and approve annual workplans. It will provide guidance to the Consortium members and the Secretariat, advise on emerging priorities and issues, agree workplans having regard to Program goal, purpose and objectives, and endorse performance reports and financial reports to be submitted to AusAID. AusAID will prepare Terms of Reference for the PCC. The PCC will meet at least annually so as to approve each year's annual plan, and more often if required. In the first six months it will meet to approve the four year outline workplan and first year's detailed annual plan.

Secretariat *(see Appendix 6 for role description)*
AusAID will enter into a Funding Agreement with an organisation to engage a Secretariat to deliver the Program. The Funding Agreement will require the Secretariat to enter contracts to ensure implementation of annual plans agreed by the PCC. The Secretariat's responsibilities will include:

- administrative support to the PCC;
- administrative support to meetings of the Consortium group;
- contracting the provision of independent financial management services for the program by a Financial Manager;
- negotiation, monitoring and management of contracts with Consortium members or other providers (e.g. external technical agencies or regional partners) to deliver activities and achieve outcomes described in agreed annual plans;
- working with the Consortium members to develop joint annual plan proposals for submission to the PCC for endorsement;
- cooperation with the TAG including ensuring that draft annual plans and other relevant reports are provided in a timely fashion to the TAG;
- working with the Consortium members to consider and respond to TAG recommendations in consultation with Consortium members;
- support to resolve problems and maximise effective collaboration between partners.

An initial Funding Agreement for the Secretariat will be entered into for the period from signing the contract until the end of the second year of the Program. An extension of the Funding Agreement until the end of the fourth year of the Program may be entered into subject to the findings of a mid-term review (see below) and agreement by AusAID.

The Secretariat will be based within one of the Consortium members or a third party (as agreed by AusAID) and will be managed by a Program Director.

Financial Manager *(see Appendix 7 for role description)*
The Secretariat will be required to appoint an independent Financial Manager to monitor contracting arrangements and to audit financial reports. Contracts will include specific monitoring and evaluation requirements. Consortium members and other contractors funded to implement activities will be required to provide regular financial reports to the Financial Manager, who will report to the PCC through the Secretariat.

Consideration should be given by the Secretariat to retaining services of a financial management firm that has demonstrated a commitment to HIV/AIDS as a community issue and which may be willing to provide a percentage of services on a pro-bono basis or as an in-kind contribution to the Program.

Technical Advisory Group (TAG)
For each year of the Program, AusAID will contract a TAG to consider the draft annual plan prior to the plan being submitted to the PCC. The TAG will comprise technical experts with knowledge of AusAID policy and programs, and may include an AusAID representative. Draft annual plans and any other documents requested for review (e.g.

performance reports, reports on changes to the risk environment) should be submitted to the TAG by the Secretariat at least four weeks prior to the date of the next scheduled PCC meeting. The TAG will report to the Secretariat and may request information relevant to the workplan from the Secretariat and individual Consortium members, and may recommend alterations to the annual plan prior to the submission of the annual plan to the PCC. TAG reports will be made available by the Secretariat to the PCC. If the annual workplan is not altered in accordance with TAG recommendations, the Secretariat should provide a statement to the PCC explaining the reasons for this.

Consortium Proposal

AusAID will invite the Australian HIV organisations identified in Appendix 8 to form a Consortium and submit a joint proposal for AusAID support under this Program. The Consortium may comprise all or any subset of the listed organisations. These organisations are domestic HIV organisations with expertise in health, research and community based or peer led HIV responses. The list includes but is not limited to all of the current AHAPI partners.

AusAID is seeking to support only one Consortium group through this Program.

The Consortium Proposal must identify which of the organisations listed in Appendix 8 have agreed to form the Consortium and demonstrate that members have the expertise, experience and partnerships required to deliver HIV capacity building activities in line with the Program's purpose, objectives, principles and priorities.

The Consortium may define different tiers of membership (e.g. associates) if this clarifies roles. The proposal should describe the Consortium's decision making processes including in relation to membership issues. It is expected that the organisations that are founding members of the Consortium will remain its core members, ensuring that the focus of the program is on regional partnerships formed by domestic HIV organisations with technical expertise in health, research and community sector responses. If the Consortium decides to invite other Australian organisations to be invited to join the Consortium, then a case should be presented to the PCC as to how the organisations' inclusion will enhance the Consortium's overall capacity to deliver the Program. The PCC will then decide whether membership should be expanded as proposed.

A detailed workplan will not be required in the joint proposal. The joint proposal must:

- describe the overarching approach and strategy to be adopted in achieving the Program goal and objectives over the four year life of the Program;
- include a brief outline of the types of activities that Consortium members will engage in, and how the proposed activities will help achieve the Program goal and objectives;
- describe the management requirements of the Consortium including:
    - establishment of a Secretariat (including staffing and operational costs);
    - financial management and administrative systems.
- provide a budget for the Secretariat and any other management costs for the period of the initial Funding Agreement i.e. to 30 June 2009;

- identify the legal entity with which it is proposed that AusAID will enter into a funding agreement (this entity will engage the Secretariat and contract with the implementing organisations); and
- define the process for appointment of the Financial Manager

A Funding Agreement will be entered with the entity hosting the Secretariat to fund costs associated with the Secretariat, Financial Manager and the development of an initial Consortium workplan.

ACFID will have observer status to attend meetings of the Consortium. It is expected that the Consortium will liaise with ACFID as to opportunities for collaboration and avoidance of duplication with its members' activities in the region.

Consortium Four Year Workplan

The Secretariat will work with the Consortium to develop an outline workplan that provides an indication of the activities to be implemented by Consortium members over the four year period. Once this is approved by the PCC, more detailed annual plans will be developed. To guide development of workplans, Appendix 5 contains an outline of factors that AusAID considers to be important for effective implementation.

The initial workplan development process will entail:

(i) Consultation with AusAID regarding activities Consortium members and partners could implement to address gaps in the HIV response of priority countries, with reference to the priorities agreed between AusAID, other donors and national governments. Key liaison points for developing initial workplan priorities will include:
- AusAID's HIV/AIDS Adviser;
- For Indonesia, the AusAID HIV Program Coordinator working in the Health Unit at AusAID's Jakarta post;
- For the Pacific region, the SPC's HIV/AIDS and STI Team, the First Secretary at AusAID's Suva post and the AusAID Pacific HIV Program Adviser based in Canberra;
- For HAARP countries, the HAARP Program Director based in HAARP's Bangkok regional Unit office and the AusAID development counsellor based at the Bangkok post; and
- For East Timor, the AusAID development counsellor at Dili post.

(ii) Development of the four year outline workplan identifying the Consortium members responsible for developing more detailed annual plans. A monitoring and evaluation framework should accompany the workplan.

(iii) Submission of the outline workplan to the PCC. The PCC will consider in assessing the indicative workplan the extent to which activities:
- align with national priorities*;*

- complement existing AusAID programs in priority countries; and
- respond to needs identified by AusAID desks and posts in priority countries, as well as key partners (e.g. Secretariat of the Pacific Community, National AIDS Councils/Commissions).

Annual Plans

For each year of operations, a detailed annual plan will be developed. This will require liaison and consultation between Consortium members and regional partners, AusAID posts and other entities in-country such as National AIDS Commissions and other donor projects. The annual plans should:

(i) directly support the overall Program goal and objectives;

(ii) respond to needs identified by country counterparts and AusAID as priorities for capacity building;

(iii) have well defined and measurable objectives, outputs and outcomes including a statement of what the activity will deliver and the expected change at the end of the activity and indicators of performance and progress;

(iii) present an analysis of risks to successful implementation and identify strategies to mitigate and manage risks as appropriate to the context; and

(iv) be informed by gender analysis so that the program promotes gender equality.

Annual plans should include a detailed workplan, M&E plan and budget (including, in year one, any costs associated with extension of AHAPI contracts if necessary).

Draft Annual Plans must be submitted to the TAG for consideration prior to submission to the PCC (as described above).

The Secretariat will be required to provide consolidated annual plans to the PCC for approval no later than 31 December each year. The PCC may request adjustments to the Plan if necessary.

It is expected that the four year outline workplan, and detailed plans and budget for year one, will be approved by the PCC in a timely manner so as to allow implementation of activities to commence in the first half of the 2008 calendar year.

When each year's annual plan is approved by the PCC, the Funding Agreement between AusAID and the organisation engaging the Secretariat will be augmented so as to fund implementation of the year's planned activities.

If in development of an annual plan the Consortium decides that it is appropriate for other organisations to either be (i) contracted as implementers or (ii) in the case of Australian HIV organisations, to be invited to join the Consortium, then a case should be presented

to the PCC as to how the organisation's inclusion will enhance the workplan and/or the Consortium's overall capacity to deliver the Program. The PCC will then determine the issue when approving the workplan, having regard to the Program goal and objectives.

Performance Reports

The Secretariat will provide to the PCC six monthly performance reports and an annual report. The draft reports will be submitted to the Consortium members for comment and to ensure accuracy before submission to the PCC. These reports will include:

- An assessment of key achievements of the Consortium against the four year work plan, with reference to the Program principles including partnerships established and sustainability;
- Details of activities being implemented including evidence that demonstrates how capacity is being built;
- Risks identified that may impede achievement of Program objectives and a risk mitigation strategy;
- Recommendations for the next Annual Plan period;
- Details of expenditure for all activities and the implications for ensuing years;
- Any other information that the Consortium considers will assist the PCC in its strategic oversight role.

In the annual report, the Secretariat (through the Financial Manager) will be expected to provide an audited annual financial statement on Program activities (which includes Secretariat expenditures) for the relevant financial year. This should be submitted with a financial plan outlining (a) the budget for proposed activities; and (b) expected costs of managing the Consortium. The Financial Manager will be responsible for timely preparation of program financial reports.

The PCC may provide comment on progress, annual and financial reports and request further information, and the PCC may require such information as a pre-condition of approving the annual plan.

Conflict Resolution

In the event of any conflict within the Consortium, in the first instance the Consortium should attempt to resolve the matter internally. The Secretariat should assist to resolve such conflicts.

In the event of a conflict that cannot be resolved internally, then the PCC may intervene and may act as mediator to help determine a resolution. If appropriate, the Secretariat can assist or act on behalf of the PCC in mediating any internal conflict between Consortium members.

In the event of a conflict within the PCC that cannot be resolved internally, then the matter will be referred to AusAID for resolution.

3.4 Monitoring and evaluation

The Consortium members, Secretariat, TAG, Financial Manager and PCC all have roles in Program monitoring and evaluation.

M&E Framework and Plans
Appendix 1 provides a draft M&E Framework. This draft should be used as a basis for developing the Program's M&E Framework, which is required to be provided to the PCC with the four year workplan prior to commencement of the Program.

The approved M&E Framework will provide the basis for more detailed annual M&E plans which should accompany each annual plan submitted to the PCC. Annual M&E plans should enable the Secretariat to provide periodic reports to the PCC that focus on key outcomes achieved (rather than only descriptions of inputs or activities).

The M& E plans should include:

(i) a clear articulation of desired outcomes at the end of each activity, and the quality and quantity of outputs to be delivered;
(ii) indicators of achievement that are unambiguous and reflect quality, quantity and time elements;
(iii) a pragmatic method to collect outcome and output information (means of verification).

M&E plans must report on any gender equality outcomes, such as outcomes achieved through promotion of participation of women and men in activities, promoting capacity to address specific gender aspects of the epidemic and addressing gender equity in access to workplaces and services.

The Secretariat will be primarily responsible for monitoring progress against plans. The Financial Manager will be responsible for monitoring contract arrangements, including compliance of Consortium members and sub-contractors with contractual M&E requirements. The TAG will contribute to monitoring of the quality, technical feasibility and coherence of the annual plans.

Records
For the purposes of quality assurance, accountability and reporting, the Secretariat will maintain the following records:

- Number, type and location of activities funded;
- Outputs and outcomes for each activity;
- Problems faced and how they have been resolved;
- Gender disaggregated data where relevant; and
- Financial expenditure by activity, type and location.

Activity completion reports
For all completed activities, the Consortium member or other sub-contractor responsible for implementation will be expected to submit an evaluation report, outlining the activity's outputs and outcomes and how they have contributed to achievement of the

overall Program objectives. Assessment of each activity will utilise a mix of qualitative and quantitative methods.

PCC meetings
PCC meetings will provide an opportunity for a regular review of the overall performance of the Consortium, effectiveness of partnerships and relationships with other stakeholders, achievements and challenges, and emerging priorities. The PCC will have regard to performance reports from the Secretariat, as well as any formal or informal feedback provided from Consortium members, Program partners in the region, AusAID programs and other domestic and international stakeholders. The AusAID representative will monitor the effectiveness of the PCC in its strategic oversight role and in the consistency of its decision making with Program goals and objectives.

Mid Term Review
An independent review of the Program will be conducted by AusAID before the end of the Program's second year of operation, to assess:

- The adequacy of progress towards Strategy objectives;
- The efficiency and effectiveness of the Consortium model in delivering the Program, in particular whether the consortium has enabled a more strategic and coherent approach;
- The continuing validity of the Program design, given any changes in the policy and operational environment.

The Review will be wide-ranging and may make recommendations for changes to any governance and implementation arrangements including the roles of the PCC, Secretariat, Financial Manager, Technical Advisory Group and Consortium group. AusAID will take into consideration the findings of the review when determining whether the Funding Agreement with the organisation engaging the Secretariat will be extended to the end of the fourth year of the Program.

End Term Impact Evaluation
An evaluation of the Program will be conducted in the final year of the Program with a focus on the Program's overall impact in contributing to the Program Goal. Terms of Reference for the evaluation will be developed by the Health and HIV Thematic Group.

State of the Sector Reports and Country-level Annual Program Performance Updates
AusAID conducts annual reviews of progress in health and HIV across all of its programs, which are summarised in State of the Sector Reports. The AusAID Health and HIV Advisers will be responsible for monitoring the Program in the context of its contribution to sectoral objectives as reported in the State of the Sector Reports. At a country level, AusAID posts are required to report annually to AusAID's Office of Development Effectiveness through Annual Program Performance Updates, which report on progress in achieving each country program's HIV and health objectives. The Capacity Building Program's activities at country level may be assessed as part of this annual update process.

Ongoing AusAID Monitoring of Consortium Performance
AusAID will use its regular systems to assess the overall performance of the Program, including the effectiveness of the Consortium, PCC, TAG, Secretariat and Financial Manager in providing a framework for delivery of the Program. This will be assessed through AusAID's Quality at Implementation process, which rates the quality of activities according to standard indicators. AusAID's Quality Reporting Systems will monitor implementation progress, achievement of outcomes, quality of monitoring information, risk management, sustainability and gender equality measures.

1.5 Resource requirements

The indicative allocation for the Program over the four year period 1 July 2007 to 30 June 2011 is $13 million. When a funding agreement is agreed with the organisation hosting the Secretariat, AusAID will define the budget allocation for year one and also provide an indication of the amount expected to be available for the second year, to allow planning of multi-year activities.

Costs of the Program will include the following:

- Funding for implementation of capacity building activities including in-country activities, regional events and production of resources;
- Management and administration of the Consortium, including:
    - Recruitment and salaries for Secretariat staff;
    - Financial management and other management fees;
    - Technical assistance for monitoring and evaluation;
    - Office supplies; and
    - Travel.
- Monitoring and evaluation
- PCC meeting expenses; and
- TAG and Mid Term Review expenses (contracted by AusAID).

4 Feasibility, Sustainability and Risk Management

4.1 Overall Feasibility

This analysis of feasibility is based on AusAID's prior experiences in capacity building, consultation with Australian HIV and development sectors, and knowledge of lessons learned by other donors and multilateral organisations. Together, this input suggests the capacity building program will support an increase in the quality of HIV policies and programs. This is because:

- The model of "organisational twinning" which will be a feature of the Program has been demonstrated through the AusAID HIV/AIDS Partnership Initiative as an effective approach to long term capacity building;
- Australia's expertise in HIV is internationally recognised and has benefited from over two decades of Australian Government investment in developing organisations

committed to supporting national approaches to technical excellence in research, health and community responses to HIV;
- Australian HIV organisations must already have strong linkages with partners at the national, regional and international levels if they are to participate in the program.

4.2 Manageability

Consultations with the Australian HIV sector highlighted several concerns with the consortium approach, mainly from the perspective of smaller peer based organisations. These included:
- A consortium may add another layer of bureaucracy through which peer based organisations will need to advocate for the needs of affected communities, as opposed to being able to just do the work. This could have the effect of further marginalising the voices of these communities; and
- The process of negotiating principles and preferred ways of working would be unduly time and resource intensive, and divert resources from implementation.

To address these concerns, AusAID will require the PCC to closely monitor allocation of funds for peer based activities and if necessary to earmark a proportion of funds to these activities. The Technical Advisory Group will also be required to provide advice on quality of peer based activities including adequacy of participation of people living with HIV/AIDS and affected communities in the Program. It is expected that the meetings of the Consortium group, supported by the Secretariat and informed by the strategic guidance of the PCC, will provide a mechanism for planning, coordination, problem solving and dispute resolution as well as information sharing between Consortium members.

AusAID's Health and HIV Thematic Group will maintain oversight of program implementation and provide a first point of contact for the Secretariat and PCC should manageability issues arise that require an AusAID response.

4.3 Technical Feasibility

This Program is focused on developing skills in the health, community and research workforce to deliver HIV related programs and services. A strong emphasis therefore is on technical expertise in aspects of the HIV response. However the way in which the HIV epidemic manifests itself is highly influenced by social, political, economic, gender and legal factors. Activity implementation must take these complexities into account if the Program is to be effective.

Activities funded through AusAID's existing HIV programs including AHAPI have demonstrated that it is possible to transfer technical expertise from Australia to partners in resource poor settings. On this basis, this Program is expected to be technically feasible provided that:

- Consortium members and sub-contractors have sufficient technical *and* cultural competence to implement activities, and are well respected by partners in country;
- The Secretariat and Financial Manager have the skills and experience to manage the program and resolve issues as they arise;
- The TAG and PCC possess sufficient expertise in HIV *and* knowledge of social, political, economic and legal contexts to provide advice and strategic guidance to the Secretariat, Financial Manager and Consortium members in the implementation of activities.

4.4 Financial and Economic Feasibility

There is clear evidence of the serious financial and economic impact of HIV at the individual, community and national level.[14] A program specific cost/benefit analysis has not been completed, as this Program constitutes a relatively small but significant input to the HIV response. If successful in developing local, national and regional capacities, the program will contribute to scaling-up prevention services to the level required so as to have an impact on reducing HIV incidence. The Program will also mobilise civil society responses through targeting key community and professional groups, and enable increased access to prevention, treatment, care and support. Increased community mobilisation and access to essential services can be expected to reduce the social and personal impacts of HIV in the Asia Pacific region, including the financial and economic costs.

Increased local capacity also equips countries to better utilise the funds of other donors (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria) more effectively. Beyond the four year implementation period, it is likely there will be changes in HIV transmission trends and that leadership at national levels will have strengthened in addressing HIV. It is therefore not possible to say if a further commitment will be needed at the end of this four year Program.

4.5 Gender

HIV has a differential impact on men and women, reflecting gender inequalities and different roles and responsibilities in society. For example, women living with HIV may find it more difficult to access appropriate health care services because of financial or cultural reasons. Similarly, women may face significantly more discrimination from health services, their families and communities, and require different forms of peer based support to men living with HIV/AIDS.[15] Women are often blamed for HIV entering families and communities, which may lead to violence directed at women. Women and

[14] See for example AusAID (2006) *Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia and East Timor: Final Report of HIV Epidemiological Modelling and Impact Study* Commonwealth of Australia

[15] Asia Pacific Network of People Living with HIV/AIDS and the Global Network of People Living with HIV/AIDS (2004) *AIDS Discrimination in Asia* http://www.gnpplus.net/regions/files/AIDS-asia.pdf accessed 5 March 2007

girls also generally carry the community burden of caring for sick family members and orphans.

Prevention responses must be gender informed to be effective and address socio-cultural factors that shape behaviour. Gender based violence is known to increase the vulnerability of women and girls to HIV/AIDS, and economic factors often determine women's involvement in sex work. Men may also be at enhanced risk of HIV due to gender specific factors such as illicit drug use cultures. Gender is also a major consideration in understanding and addressing the health needs of men who have sex with men and transgender populations, who may be marginalised by dominant cultural concepts of gender norms.

Capacity building activities funded through this Program must take proactive steps to address gender equity, encourage women's participation and ensure services will be of benefit to both women and men. Ongoing gender analysis of the Program and its activities will be ensured through the following mechanisms:

- Gender expertise on the PCC, to ensure a perspective about the impact of activities on women and men is incorporated into the design, implementation and review of the workplan, as well as guidance on priorities given to the consortium;
- Use of specialist gender expertise in conducting the mid term review and Program evaluation.
- Inclusion of gender equality indicators in M&E Plans and collection of sex disaggregated data.

A positive outcome for women is expected from the Program. The benefits from the Program of reducing HIV related harm will flow to both men and women, including vulnerable groups such as sex workers. Where appropriate the Program will support development of HIV related skills within sexual, reproductive and maternal health services, of which women and their children are the primary beneficiaries.

4.6 Factors to promote sustainability

The primary purpose of this Program is ensuring sustainability of the HIV response in the region, through the transfer of skills and structures to local counterparts. Mechanisms for achieving sustainability include:

- A four year implementation period allowing long term capacity development partnerships (as opposed to short term training), building on the 3 year AHAPI program;
- The Program's capacity to fund policy and advocacy activities that mobilise and support leaders in community, health and research sectors to strengthen political will and address policy and resource gaps;
- Promotion of partnerships and networks within the region to build capacity and regional cooperation;

- The use of "twinning" arrangements, and a focus on follow up and mentoring, which allow Australian organisations to work intensively with counterparts on a day to day basis to ensure the latter have the knowledge and systems to independently provide high quality HIV prevention, treatment, care and support services; and
- Integration into AusAID bilateral and regional programs, allowing capacity building activities to be linked to other HIV resources and developments.

Australian HIV organisations have pre-existing relationships with partners in the region, including those which developed through the three year *Australian HIV/AIDS Partnership Initiative* (Appendix 3). This new Program is expected to build on these existing relationships, thus increasing the likelihood of sustainability.

Developments in the operating environment, such as the commitments of donors and partner governments to support scale up for universal access to HIV services, increased donor cooperation and harmonisation of programs, and stronger leadership on HIV in many countries in the region bode well for the ongoing sustainability of the skills, structures and services this program will help put in place.

4.7 Risk management

The risk management matrix at Appendix 2 outlines the risks for the Program as a whole. Risk analysis of individual activities will be an essential part of the appraisal and approval of annual plans. The matrix will need to be reviewed at Program commencement to ensure continued validity. The Secretariat is required to report annually on changes to the risk environment and the Consortium's responses to identified risks as part of the annual planning process.

Appendix 1: DRAFT MONITORING & EVALUATION FRAMEWORK

	Indicators	Means of verification
Goal / Impact Strengthened capacity of organisations and individuals in the Asia – Pacific region to respond effectively to HIV/AIDS	Progress towards universal access to HIV prevention, treatment, care and support services in priority countries (eg. in Indonesia, Pacific, and Mekong)	Country reports from National AIDS Councils/Committees and SPC on progress towards universal access targets Reports from regional civil society, research and health sector bodies on improved availability and access to HIV services UNAIDS, UNODC and WHO data on coverage of programs and service gaps
Purpose / Outcome To foster strategic partnerships and linkages between Australia and the Asia Pacific region that will enable sustained performance improvement for individuals and organisations working in HIV/AIDS health care, research and community responses. .	Number of regional partners (individuals and organisations) in the health, research and community sectors who are enabled to sustain ongoing performance improvement in developing and implementing HIV policies and programs Capacity building partnerships established within the region that are: o Durable o Focussed on areas where skills gaps have been identified o Of high technical standard	Reports from the Consortium's regional partners Reports from national and regional clinical, research and community sector agencies Consortium six monthly reports Reports from National AIDS Committees/Councils and SPC

Objective 1: To develop the capacity of health care workers and their organisations (eg, health services, professional associations) to scale up and manage HIV services	Increased number of health care workers and health service organisations able to provide quality HIV services and to sustain their own performance improvement New or improved systems established for supporting health care workers to improve skills in delivering treatment, care and support services Systems established to monitor and improve quality of testing, treatment and care services, including introduction or improvement of standards for HIV testing and treatment Functioning HIV medical associations networked to each other throughout the region Mentoring relationships established	Consortium reports and partner data Feedback from: National medical/health care worker associations AusAID country and regional programs and national and regional partners eg, APCASO and APN+ National HIV/AIDS Councils or Committees National HIV/AIDS Plans Ministries of Health
Objective 2: Develop capacity of researchers and research institutions to develop and maintain a local evidence base on HIV and effective responses, including through social, behavioural, economic, epidemiological and clinical research	Increased number of individuals with technical skills to carry out and disseminate HIV research in the region. Research organisations have systems established to support staff to improve skills in conducting research and to share expertise with other research organisations in the region	Consortium reports and partner data Reports from research capacity building partnerships Reports from National HIV/AIDS Councils Research Committees Research studies, reports, peer

	Partnerships and regional networks of researchers established Knowledge management and research dissemination systems established so that locally relevant evidence base can be maintained Increased availability of sound research on which to base HIV policy and programming decisions	reviewed articles and presentations Presentations to Conferences or peers
Objective 3: To develop the capacity of community organisations and community sector workers to scale up and manage community and peer based HIV services	Number of community sector workers that improve their service delivery, planning and management skills, enabling improved quality and availability of community and peer based prevention, care, support and advocacy services Organisational systems strengthened in community and peer based organisations that focus on the needs of people living with HIV/AIDS and marginalised communities Number and scope of partnerships established between community based organisations addressing similar needs that support exchange of learning and skills	Consortium reports and partner data Reports from peer based capacity building Reports from national and regional NGO/CBO organisations Feedback from AusAID country and regional programs and national and regional partners eg, APCASO and APN+, National HIV/AIDS Councils

Objective 4: To establish and maintain sustainable capacity building partnerships across the region to support improved HIV responses of health care, research and community sectors.	Number and scope of partnerships established between organisations and professionals in Australia and counterparts the region Number and scope of partnerships established between organisations and professionals in low and middle income countries within the region Duration and continuity of partnership arrangements Number and technical focus of professional mentoring and organisational twinning relationships Number and scope of training opportunities and resources produced through partnerships	Reports from Consortium members and regional partners Reports from conferences, training or other partnership events Resources produced through partnerships

Appendix 2 HIV/AIDS Capacity Building Program Risk Management Matrix[16]

Risk Event	Source of Risk	Impact on Program	L	C	R	Risk Treatment	Responsible
Consortium members unable to agree on priorities and approaches	Consortium comprised of organisations with differing views, expertise and interests	Delays in negotiation of workplan and commencement of activities Some members may "opt out" of involvement in the Program if participation proves too time consuming or difficult	3	4	3	Regular and open consultation facilitated by Secretariat between Consortium members, and between Consortium and PCC Use of TAG and meetings of the PCC to raise and resolve issues TAG and PCC monitor appropriate application of funds including sufficiency of focus on peer based work with PLWHA and affected communities AusAID earmarks funds for the Consortium to receive advice on consortium structure and related legal issues	PCC members, Consortium members

[16] L = Likelihood (5=almost certain, 4= likely, 3= possible, 2=unlikely, 1=rare)
C = Consequences (5=severe, 4=major, 3=moderate, 2=minor, 1=negligible)
R = Risk Level (4=extreme, 3=high, 2=medium, 1=low)

Risk Event	Source of Risk	Impact on Program	L	C	R	Risk Treatment	Responsible
						during the initial Consortium inception stage	
Consortium unable to tap into and utilise all the relevant HIV expertise in Australia and the region	Some individuals and organisations have relevant HIV technical expertise that would add value to Consortium activities but are not currently employed by Consortium members	Missed opportunities for effective capacity building and partnership development in priority technical areas	3	3	2	Consortium and PCC scope new partnerships and sub-contract technical expertise if not available from within the Consortium	Consortium members, Secretariat, PCC members
Inadequate coordination with AusAID and with other donors to ensure an integrated response	Tension between priorities of the Program, AusAID desks/posts and other donors	Potential to create duplication and reduce effectiveness of program if it is acting in isolation rather than complementing AusAID programs and the work of other development partners.	3	3	3	Regular and open consultation by Secretariat and Consortium members with AusAID desks and posts and with other donors Program planning and activity approval completed with the investments of AusAID and other donors in mind, as well as the priorities agreed with	Consortium members, Secretariat, TAG members, AusAID

Risk Event	Source of Risk	Impact on Program	L	C	R	Risk Treatment	Responsible
						partner country governments.	
Changes in Government policies in Burma	Policy changes could relate to travel, restrictions and constraints on Aid Project implementation	Travel could be restricted for consortium members and Technical Advisers for Burma activities. Government constraints on Program implementation and working relationships with counterpart agencies.	4	4	3	Through liaison with AusAID, Secretariat keeps informed of changes, constantly monitors the situation and reviews management responses	AusAID, Secretariat and Consortium members

Appendix 3 AHAPI Projects 2004 – 2008

National Serology Reference Laboratory, Australia (NRL)

This project funds expansion of NRL's current program of improving quality assurance and laboratory management for HIV diagnostic facilities in the Asia Pacific region.

Albion Street Centre

This project aims to establish a network of HIV/AIDS healthcare workers and institutions across the region to improve occupational safety and minimise the risk of infection from blood-borne viruses.

Australasian Society for HIV Medicine (ASHM)

The project aims to support ASHM's international program that will assist countries in the region to increase their level of clinical knowledge on HIV/AIDS and its treatment and care.

AFAO/ APCASO Leadership and Advocacy Collaboration Project

- Partners: Australian Federation of AIDS Organisations (AFAO) and Asia Pacific Council of AIDS Service Organisations (APCASO)
- Objective: To strengthen the advocacy and leadership capacity and skills of vulnerable communities through HIV community organisations in selected Asian and Pacific countries, and in the APCASO and selected members.

Strengthening the People Living With HIV/AIDS (PLWHA) Response – HIV Peer Support and Capacity Building

- Partners: National Association of People Living with HIV/AIDS (Australian) and Igat Hope Inc (Papua New Guinea); Timor Aid (East Timor); APN+: Asia-Pacific Network of People Living With HIV/AIDS (Thailand)
- Objective: To build the capacity and visibility of PLWHA organisations and groups to develop and sustain HIV positive people for delivering representation and involvement within their country's HIV/AIDS response.

Community Sex Worker Network Response to HIV/AIDS

- Partners: Scarlet Alliance (Australia) and Save the Children PNG
- Objective: To increase the capacity of Papua New Guinea sex workers to develop and implement an effective community response to HIV/AIDS.

The Australia – Thailand HIV/AIDS Nutrition Care, Treatment and Support Partnership Project

- Partners: Albion Street Centre (Australia) and Thai Red Cross AIDS Research Centre, Institute of Nutrition, Mahidol University
- Objective: To develop the capacity of project partners to promote, develop, implement and evaluate nutritional strategies to address the needs of PLWHA in Thailand. The project includes training of Nutrition Educators

Strengthening HIV-related social research capacity in Papua New Guinea

- Partners: National Centre in HIV Social Research (Australia) and Papua New Guinea Institute of Medical Research

- Objective: To strengthen HIV-related social research among PNG tertiary students and other researchers; and to increase understanding of the benefits of HIV-related social research among health workers, policy-makers, NGOs, political leaders, community leaders and members.

Appendix 4

AusAID HIV/AIDS Regional Workforce Capacity Development Strategy
HIV/AIDS Taskforce
November 2006

1 BACKGROUND AND RATIONALE

There have been major advances in HIV/AIDS interventions over the last decade. Antiretroviral medication can extend the lives of people living with HIV/AIDS dramatically and reduce mother to child transmission. Harm reduction programs can prevent transmission of HIV through injecting drug use *if* injecting drug users have access to them, and condom usage in the sex industry can reverse an HIV epidemic, as has been demonstrated in Thailand and Cambodia.

Despite clear evidence of what works, HIV continues to spread across the Asia-Pacific region. Most recent estimates indicate the majority of people living with or vulnerable to HIV/AIDS do not have access to appropriate prevention, testing, treatment, care and support services. For example, HIV prevention programs reach only 5.4% of injecting drug users in South and South East Asia, and treatment programs only 12% of people requiring antiretrovirals in the Western Pacific.[17]

One of the major impediments to scaling up HIV related services is the lack of a skilled local workforce. Countries in the region can only mount comprehensive responses to the epidemic if supported to skill up key personnel to provide prevention, treatment, care and support services, build the evidence base of what works in a particular country context, and advocate for an appropriate response to HIV.

In recognition of this, AusAID will implement an *HIV/AIDS Workforce Capacity Development Strategy 2007- 2011* targeting segments of the workforce critical to a strengthened response to HIV/AIDS. The Strategy incorporates lessons from the substantial capacity building work done through AusAID's HIV/AIDS programs in Papua New Guinea, the Pacific, Indonesia, China, Burma and Vietnam, as well as the *Australian HIV/AIDS Partnership Initiative* (AHAPI).

The Strategy delivers on the commitment made in *Australian Aid: Promoting Growth and Stability* (the White Paper) to build HIV/AIDS capacity in the region, and is in line with the overall goals and objectives of *Meeting the Challenge: Australia's International HIV/AIDS Strategy*. AusAID, through this Strategy, will also assist states in the region to meet the UN commitment to universal access to HIV prevention, treatment, care and support by 2010.

[17] UNAIDS (2005) *A Scaled Up Response to AIDS in Asia and the Pacific* UNAIDS/05.15E

2 GOAL AND OBJECTIVES

The overarching goal of this Strategy is:

To build the capacity of organisations and individuals in the Asia – Pacific region to address HIV/AIDS.

This Strategy focuses on the health care, community and research sectors, which together form the backbone of an effective national response to HIV/AIDS.

Objectives are to build capacity in these sectors to:

- scale up and manage HIV prevention, treatment, care and support services;
- develop and maintain a local evidence base on HIV through social, epidemiological and clinical research;
- advocate for comprehensive HIV policies and programs at the national and regional levels; and
- share expertise and work collaboratively across the region, including through cross-sectoral approaches and "south-south" partnerships.

3 GUIDING PRINCIPLES

This Strategy is underpinned by the following principles:

Sustainability through long term approaches rather than short term "parachuting in" of experts

Partnership including facilitating south-south collaboration and encouraging collaboration across disciplines

Strategic Focus on organisations and individuals best placed to transfer skills to others

Alignment with national priorities, in keeping with the "Three Ones" principles

Harmonisation with other donors

Leveraging of extra investments from other donors

Integration where appropriate of HIV/AIDS with sexual and reproductive health, child and maternal health, and drug use treatment and support services.

4 GEOGRAPHIC PRIORITIES

The geographic focus of the Strategy will reflect overall AusAID policy, as articulated in the White Paper and country and regional strategies, and areas of

greatest need. Initial priority will be accorded to **Indonesia** and countries in **Melanesia** and the **Greater Mekong Subregion**. Activities at the regional and sub-regional level will also be supported.

5 STRATEGY IMPLEMENTATION

This Strategy will be implemented through four components:

5.1 Integrating Capacity Building into Key Bilateral and Regional Programs

AusAID HIV/AIDS bilateral and regional programs are being implemented or in the design phase in PNG, Indonesia, China, the Pacific and Asia (encompassing Burma, Vietnam, Laos, China, the Philippines and Cambodia). All of these programs will have capacity building as a significant component of their work.

Capacity building is also supported through funding to accredited Australian development NGOs. In PNG, the Churches Partnership Program is building the capacity of Churches to address HIV as part of a broader program of support. In Burma, AusAID funds Australian NGOs to undertake community based HIV/AIDS and reproductive health activities. In Indonesia, under the AusAID NGO Cooperation Program, AusAID is funding UNICEF Australia to strengthen the capacity of educators in HIV prevention and life skills education.

It is important that HIV capacity building activities are integrated into bilateral and regional health and HIV programs, and managed at country posts if possible. Stand alone projects interfere with a coordinated AusAID response in-country and go against the "Three Ones" principles to which Australia has subscribed.[18]

The HIV/AIDS Taskforce will monitor relevant activities undertaken by AusAID programs and those of other donors and national programs, to ensure capacity building lessons are shared across countries. AusAID may fund activities that support consistent uptake of best practice approaches across the region (e.g. under component 4 below), but only if this work is not already taking place at country level.

Specific capacity building activities in the research sector may be linked to HIV research projects funded at the country level and through the proposed AusAID Health and Development Research Initiative[19].

[18] Endorsed by key donors in 2004, these are (1) One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (2) One National AIDS Coordinating Authority, with a broad based multisectoral mandate; and (3) One agreed country level Monitoring and Evaluation System. www.unaids.org/en/Coordination/Initiatives/three_ones.asp

[19] AusAID (2006) *Helping Health Systems Deliver: A Policy for Australian Development Assistance in Health* p 31 http://www.ausaid.gov.au/publications/pdf/health_policy.pdf

Ongoing liaison and consultation with relevant AusAID country programs is necessary to determine:

- The types of capacity building planned in the bilateral/regional programs, and whether they can be complemented by different approaches. Treatment and care services in Indonesia for example could be candidates for long term partnerships or twinning arrangements;
- How AusAID can harmonise its capacity building investments with those of other partners, including DFID, USAID, ADB, GFATM, governments and the SPC;
- If it is more appropriate in certain circumstances to integrate HIV into other health workforce strengthening initiatives, rather than have stand alone, specialist HIV projects. In the Pacific especially, given the low prevalence of HIV and high prevalence of other sexually transmissible infections, it may be more effective to incorporate HIV/AIDS into health workforce training on broader sexual and reproductive health issues.

5.2 Strengthening Regional Advocacy

The *2006 UN Political Declaration on HIV/AIDS* commits member states to ensuring universal access to HIV prevention, treatment, care and support by 2010[20]. Governments have further agreed to set targets in 2006 and review progress in 2008 and 2011.

Australia strongly endorsed the principles of the Greater Involvement of People Living with HIV/AIDS (GIPA) in *Meeting the Challenge: Australia's International HIV/AIDS Strategy*. Recent consultations have also highlighted the need to bolster civil society involvement in promoting universal access in the region[21]. AusAID can play a strategic role in supporting regional advocacy organisations to monitor and evaluate the progress governments in the Asia Pacific are making towards universal access and to advocate for accelerated action.

Through UNAIDS, AusAID funds the Asia Pacific Leadership Forum on HIV/AIDS (APLF) and the Seven Sisters project. The APLF is focused on garnering high level political leadership on HIV/AIDS, while Seven Sisters brings together networks dealing with affected communities such as men who have sex with men, injecting drug users, sex workers, transgender communities, mobile populations and people living with HIV.

Through AHAPI, AFAO and NAPWA are funded to develop the capacity of the Asia Pacific Council of AIDS Service Organisations (APCASO) and Asia Pacific Network of People Living with HIV/AIDS (APN+) respectively.

[20] 2006 UN Political Declaration on HIV/AIDS A/RES/60/262 paragraphs 20, 49 and 53

[21] UNAIDS (2006*) Asia Pacific Regional Consultation on Scaling Up Towards Universal Access to HIV Prevention, Treatment, Care and Support* Pattaya, Thailand, 14-16 February 2006

The primary objective for AusAID in supporting regional advocacy organisations is to assist them, in conjunction with UNAIDS, to hold governments accountable to the universal access commitment. A secondary objective, also tied to the universal access agenda, is to enable regional bodies to help members at the local and national level to:

- develop policy and advocacy skills;
- build institutional capacity in program planning, governance and financial management; and
- develop resources and provide training on issues such as treatments education, health promotion, counselling and peer support.

Issues to be considered in implementing this component include:

- Whether to support organisations focused solely on the Pacific, as well as Asia Pacific regional bodies, given the social and epidemiological contexts of HIV transmission in the Pacific are different to Asia;
- how to establish sustainable financing arrangements; and
- The suitability of international organisations (eg International Treatment Preparedness Coalition, International HIV/AIDS Alliance or International Community of Women Living with HIV/AIDS) as partners for capacity building on specific issues.

5.3 Facilitating South-South Collaboration

AusAID will also enhance the HIV response in the region through so called "triangular cooperation", whereby a "northern" (high income country) partner facilitates exchange of expertise between "southern" (low or middle income country) partners[22]. AusAID has started to do this through the *Asia Regional HIV/AIDS Project*, which encourages discussion and information sharing on harm reduction among officials from Burma, China and Vietnam. Some Australian organisations, such as ASHM, AFAO, NRL and the Burnet Institute, also support such exchanges in their international programs.

The rationale behind south-south collaboration is that southern partners may be better placed than northern ones to build capacity in other resource poor settings. Appropriate southern partners should have experience in political, social, economic and cultural contexts similar to those of the organisations whose capacity they are developing, and may also speak the same or very similar languages.

Other donors have begun to facilitate south-south collaboration on HIV/AIDS. For example, DFID, UNAIDS and GTZ are co-funding the *Latin American HIV and AIDS Regional Programme*, which supports Brazil to share its technical expertise with other Latin American countries. Similarly the *South – South*

[22] UNDP (2004) *Forging a Global South* www.tcdc.undp.org

Initiative of the US Centers for Disease Control enables CDC Brazil to build capacity in Angola and Mozambique.

There are many local organisations in the region with substantial experience in particular aspects of the HIV response. In scoping potential collaborations, AusAID could focus on, for example:

- **Thailand** for treatment delivery programs and prevention of HIV through sexual transmission;
- **China** for harm reduction (i.e. including needle and syringe programs and methadone maintenance programs); and
- **Indonesia** for harm reduction in prisons specifically. Notably Kerobokan Prison in Bali Province is the first prison in Asia to have a methadone program.

5.4 Linking Australian Organisations with In-Country Partners

This final component aims to bring Australia's technical expertise on HIV/AIDS to the region in a systematic, strategic and cost effective way. It has evolved through consultations which took place during and since development of the White Paper, and will be characterised by the following:

- **Complementarity** with AusAID bilateral and regional programs and the investments of other donors: Additional capacity building work will only be funded under this component if not already covered in the HIV programs of AusAID or other donors. Examples of technical and thematic areas which might be considered gaps in the current response of some countries might include building research capacity (which is not a feature of any AusAID HIV program apart from PNG), long term health workforce development and interventions for specific vulnerable populations such as men who have sex with men.

- **Sustainable long term approaches**: this component will focus on "twinning" Australian organisations and their counterparts overseas. Australian staff members should ideally spend substantial time in country, working alongside counterparts to institute sustainable structures and systems, as well as provide ongoing mentoring. The intention is to move away from short term technical assistance which is neither sustainable nor effective in transferring skills to local counterparts.

- **Comparative advantage:** AusAID will support sharing of expertise in areas where Australia has a comparative advantage. This includes community based prevention, research and surveillance, HIV medicine, treatments education and support, and policy development. Australian organisations can also share experiences in cross-sectoral approaches that partner community, health care, research and government sectors in development and delivery of comprehensive, integrated HIV policy and programs.

It is proposed to fund a consortium of agencies to implement and/or subcontract activities under this component. This approach encourages cross-sectoral collaboration between Australian HIV/AIDS organisations, and the consortium will also be expected to both include partners from the Asia –Pacific region and to facilitate south-south expertise exchange as part of its program of activities.

A work plan will be developed in consultation with AusAID country programs and taking into account GFATM funded activities and the programs of other donors such as USAID, DFID and the ADB.

A consortium should be better placed than individual organisations to garner support from other sources. Consortium members will be encouraged to seek funds from partner governments, other donors and foundations to subsidise the costs of training programs, ongoing "twinning" and associated long term capacity development activities.

6 MONITORING AND EVALUATION

The majority of HIV/AIDS capacity building work will take place through bilateral and regional programs and therefore be evaluated through country based performance assessment systems. Initiatives which fall outside these programs will be evaluated using multiple approaches, including joint donor reviews, cluster evaluations and quality assurance group assessments.

Overall implementation of the Strategy will be monitored by the HIV/AIDS Taskforce. The effectiveness of the Strategy will be assessed having regard to the extent to which outcomes of activities under the four components realise the Strategy's aims and objectives. A Mid Term Review will be conducted in 2009 and an impact evaluation of each of the four components conducted in 2011.

Appendix 5

Capacity building activities: Implementation approach

The Program relates both to building the skills and capabilities of *individuals* and to strengthening *organisations* (eg, through improving internal systems and external relationships). The Program will support Australian organisations to partner with individuals and organisations in developing skills, professional and institutional relationships, and sustainable structures and systems. The Program may include a mix of short and longer term activities.

Activities should generally not occur in isolation but be framed within the context of national HIV/AIDS priorities and the development of long term capacity building relationships which will support countries to meet these priorities. These relationships will facilitate follow-up and exchange of learning after training or other targeted events, and identification of emerging needs and appropriate responses. It is expected that these relationships will not only build the capacities of in-country partners but also enhance the capacity of the providers of program services in achieving sustainable outcomes.

As the Program seeks to provide broad geographic coverage with limited resources, activities are expected to be identified that have wide reach or cascading impacts such as regional training events, supporting regional hubs of expertise, production of regional resources and development of partnerships with organisations that have national or sub-regional mandates. Implementing partners should have expertise in capacity building methods including how to secure local leadership and ownership of the change agenda.

By way of example, the following types of activities may be considered appropriate:

- Formalising and maintaining relationships and exchange with like-minded organisations at a country and regional level, including facilitating collaboration and exchange of information between organisations based in the region

- Supporting attendance at Australian and regional conferences and events, with structured sessions set aside for networking and the development of initiatives

- Delivery of targeted training or ‘train the trainer’ courses relating to the areas of expertise of Australian organisations in response to requests or training gaps

- Follow-up after training, and ongoing mentoring and networking

- Collaborating on development of training and technical resources, guidelines and educational curricula

- Providing policy development and technical advice.

Workplan proposals should:

- demonstrate how capacity of partners will be developed, in areas such as:

- epidemiological, social, behavioural, economic or clinical research;
- HIV and STI medicine, laboratory technical skills and transfer of medical technologies;
- HIV prevention, treatment, care and support;
- HIV prevention, health promotion and peer education for people living with HIV/AIDS, sex workers and their clients, people who inject drugs and their sexual partners, transgender populations and men who have sex with men; and
- advocacy and policy development.

- be informed by gender analysis and address integration where appropriate of HIV services with sexual and reproductive health services, child and maternal health services, and primary health care services for people who use drugs.

The Program is one contribution to capacity development and is not intended to exclude use by AusAID of other Australian and international entities to provide capacity building support to the region's HIV responses, consistent with the overarching Workforce Capacity Development Strategy. Activities will align with national and regional priorities and complement other AusAID bilateral and regional HIV programs in PNG, Indonesia, China, East Timor, the Pacific and Asia Region (China, Burma, Laos, Philippines, Vietnam and Cambodia).

Links should also be made where relevant with AusAID's health systems strengthening and child and maternal health activities, projects funded through the Health and HIV Research Program, and Australian Scholarships including Australian Leadership Awards, which provide scholarships and fellowships for study, research and professional attachment programs delivered by Australian organisations.

Appendix 6

Secretariat – Role Description

Background: A Secretariat will be engaged to provide a central coordination point for the Program, enter contracts for implementation of activities, monitor progress and to ensure that the PCC and Consortium are supported in their work.

Purpose of the Secretariat: To play the central role in managing the program on a daily basis, and to help deliver the Program under the PCC's direction and guidance. The Secretariat will be led by a Program Director.

Responsibilities: AusAID will enter into a Funding Agreement with an organisation to engage a Secretariat that will:

- provide administrative and secretariat support to the PCC;
- provide administrative and secretariat support to meetings of the Consortium group;
- facilitate the oversight role of the PCC;
- manage the contracting of and monitoring of program activities;
- ensure consultation with AusAID (Advisers, Desks, Posts) and other stakeholders on program activities;
- contract the provision of independent financial management services for the program by a Financial Manager;
- negotiate and manage contracts with Consortium members or other providers (e.g. external technical agencies or regional partners) to deliver activities described in agreed workplans;
- prepare program progress and annual reports to be submitted to the PCC for endorsement;
- work with the Consortium members to develop joint budgeted annual plan proposals and M&E plans for submission to the TAG for review and the PCC for endorsement;
- work with the Consortium members to consider and respond to TAG recommendations in consultation with Consortium members;
- provide support where appropriate to resolve problems and maximise effective collaboration between partners.

Reporting: A Program Director will lead the Secretariat in its duties and will be the Secretariat Manager. Staff of the Secretariat will report to the Program Director in the first instance.

Appendix 7

Financial Manager - Role Description

Background: In order to ensure that the Program meets AusAID financial and project management requirements, an independent financial manager will be engaged by the Secretariat.

Purpose of the Financial Manager: To oversee the financial accountability of the Secretariat, to monitor all contracting arrangements of the Program and to provide certified financial reports of the program.

Responsibilities: The Financial Manager will:

- monitor all contracting arrangements for the Program to ensure financial accountability and transparency, and to ensure that arrangements fulfil Australian Government requirements;
- provide independent financial auditing of the Program overall and to assess and approve the financial reports received from the Consortium members on their activities. Certified audit reports will be required to be submitted with annual reports; and
- conduct independent financial investigations if directed by either the Secretariat or the PCC.

Reporting: The Financial Manager will be contracted by the organisation hosting the Secretariat and will report to the Secretariat. The position will ultimately report to the PCC on program financial matters, through the Secretariat.

Appendix 8

Organisations to be invited to be founding members of Consortium

Albion Street Centre

Australian Federation of AIDS Organisations (AFAO)

Australian Research Centre in Sex, Health and Society (ARCSHS)

Australasian Society for HIV Medicine (ASHM)

Australian Injecting and Illicit Drug Users League (AIVL)

National Association of People Living with HIV/AIDS (NAPWA)

National Reference Laboratory (NRL)

National Centre in HIV Epidemiology and Clinical Research (NCHECR)

National Centre in HIV Social Research (NCHSR)

Scarlet Alliance