FAITH ADVOCACY TOOLKIT

ADVOCACY FOR UNIVERSAL ACCESS: A TOOLKIT FOR FAITH-BASED ORGANISATIONS

Acknowledgements

It is a daunting task to write about AIDS for a multi-faith audience. But when I thought about the goals of the project, I found that the themes I wanted to convey were universal: inspiration, leadership, compassion, focus and perseverance. To achieve universal access we must hold onto these values tightly. They are the key to building inspired and informed communities that can hold our leaders accountable to their promises.

This toolkit draws upon a substantial body of literature about HIV, religion and advocacy. In particular, it builds upon resources from the following organisations: Ecumenical Advocacy Alliance, Global Youth Coalition on AIDS, Religions for Peace, Tearfund, UNAIDS and the World AIDS Campaign. It also draws on material from the other toolkits produced by the World AIDS Campaign for organised labour, youth and people living with HIV.

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In solidarity,

Emily Davila

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Introduction

People of faith, called to action for universal access

Why this kit?

This toolkit was written to equip and inspire people of faith to use the strength of their communities to advocate for the achievement of universal access to HIV prevention, treatment, care and support for all.

The need for this resource was identified by faith-based organisations (FBOs) who requested more information about universal access in order to hold their governments accountable to their commitments.

This resource includes a background on faith-based responses to the pandemic, tools for planning advocacy campaigns, and overviews the existing commitments by governments to universal access.

Achieving universal access will take everyone working together – across religion, nationality, ethnicity, gender, regardless of age, income or HIV status. It will take a movement, and people of faith are called to be leaders in this movement, working in partnership with the communities most affected by HIV, as well as governments and donors.

How will we achieve universal access?

1. Reducing sexual transmission of HIV

2. Preventing mothers from dying and babies from becoming infected with HIV

3. Ensuring that people living with HIV receive treatment

4. Preventing people living with HIV from dying of tuberculosis

5. Protecting drug users from becoming infected with HIV

6. Removing punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS.

7. Empowering young people to protect themselves from HIV

8. Stopping violence against women and girls

9. Enhancing social protection for people affected by HIV

(UNAIDS 2009)

Who is this toolkit for?

This toolkit is intended for faith communities that would like to begin or increase their advocacy around HIV and AIDS. A definition of 'faith communities' might include (but is not limited to):

-Individuals

-Religious communities (churches, monasteries, mosques, temples etc.)

-Prayer and study groups

-Women's, men's and youth groups

-FBOs and service providers

-Religious institutions

What is Universal Access?

Universal access is the global commitment to make HIV prevention, treatment, care and support available to all. It was first agreed upon during the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, but has been reaffirmed in many forums. This commitment is based on measurable, time-bound and realistic national targets specific to each country.

What is included in this toolkit?

There are five sections in this toolkit:

1. A background on faith-based advocacy and HIV

2 A step-by-step guide to planning advocacy campaigns

3. An overview of universal access and human rights

4. Worksheets that can be photocopied and used by groups to deepen knowl edge about advocacy and universal access.

5. Additional resources

How to use this toolkit:

For background and analysis on the response of faith communities to HIV, read Step 1.

The heart of this toolkit is Step 2 – planning advocacy campaigns. Advocacy is defined as a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions[1]. This section suggests that faith groups begin by organising a community plenary to identify advocacy priorities. After the advocacy goal has been identified, the following sections help you build your campaign by:

-setting specific goals and objectives

-creating your message

-building coalitions

-strategic timing

-integrated campaign tactics

-in-person advocacy with decision-makers

-working with the media.

In order to focus your campaign on universal access, the political commitments are outlined in Step 3. In Step 4, a series of worksheets are included to complement concepts in the document, and can be used by individuals or by groups as teaching tools for campaign planning. For more resources on faith-based advocacy, read Step 5.

There are several acronyms used throughout this document:

FBOs: Faith-based Organisations

GIPA: Greater Involvement of People living with HIV

NGO: Non-governmental Organisation

UNAIDS: Joint United Nations Programme on HIV/AIDS

UNGASS : United Nations General Assembly Special Session on HIV and AIDS

1 NAM, "Introducing Advocacy": www.aidsmap.com/inthival/adv2section1.pdf

Step 1: Faith-Based Organisations, Unique Advocates for Universal Access

No matter what religion we are a part of; people of faith are united by our belief in the sacredness of human life and compassion for our neighbour. Many faith-based organisations (FBOs) have a rich experience of providing spiritual care, support and services for people living with HIV and AIDS. This knowledge, combined with our moral calling, mean that faith communities have a unique voice that can make a difference in achieving universal access. We just need to raise it!

1. Rooted in our beliefs

At times, HIV has challenged faith communities because it exposes complex issues, such as life, death and sexuality. Whilst most religions proclaim solidarity and justice as fundamental principles, many people living with or affected by HIV have felt rejected, condemned, and isolated by religious communities and individuals. As people of faith, we are called to advocate for universal access, promote human rights, prevent HIV transmission and support people living with HIV.

Why should people of faith advocate for universal access?

- The sacredness of human life is a principal shared by all major faith traditions in the world today. When commitments to universal access are not kept, the value of human life is undermined.

- The reach of faith communities is greater than any other institution in the world. More people are members of religious communities than any other institution in the world. Many religious leaders are widely respected and influential. If they all raised their voices for universal access there could be a huge potential for impact.

- The world's major faith traditions are about addressing the whole person. Meeting the spiritual needs of a person also means ensuring their physical, emotional, and psychological needs. By advocating for universal access we are advocating for services that meet these needs.

Every religion has teachings that promote compassion, justice and celebrate life, for example[2]:

...

2 Religious text excerpts originally quoted in "Faith in Action: Working towards the Millennium Development Goals", World Conference on Religions for Peace. http://www.wcrp.org/resources/toolkits/faith-in-action

Treat not others in ways that you yourself would find hurtful.
Buddhism– The Buddha, Udana-Varga 5.18

In everything, do to others as you would have them do to you; for this is the law and the prophets.
Christianity– Jesus, Matthew 7:12 (NRSV)

This is the sum of duty: do not do to others what would cause pain if done to you.
Hinduism– Mahabharata 5:1517

Not one of you truly believes until you wish for others what you wish for yourself.
Islam– The Prophet Muhammad, Hadith

What is hateful to you, do not do to your neighbour. This is the whole Torah; all the rest is commentary. Go and learn it.
Judaism– Hillel, Talmud, Shabbath 31a

I am a stranger to no one; and no one is a stranger to me. Indeed, I am a friend to all.
Sikhism– Guru Granth Sahib, p.1299

Regard your neighbor's gain as your own gain and your neighbor's loss as your own loss.
Taoism– Lao Tzu, T'ai Shang Kan Ying P'ien, 213

2. Current responses of faith communities to HIV and AIDS

Background: FBOs

UNAIDS estimates that 70 percent of the world's population identifies with a religion.[4] In many places, religious leaders are some of the most trusted public leaders, and have more credibility than political leaders, the media or non-governmental organisations. Religion shapes culture and influences how people living with HIV are treated by their communities. In many of the world's poorest communities, FBOs are some of the only ones providing health services.

"Faith-based organisations are rooted in local structures and are therefore in an excellent position to mobilise communities to respond to the HIV/AIDS crisis. In many cases, religious organisations and people of faith have been among the first to respond to the basic needs of people affected by the disease."

Statement by Faith-Based Organisations attending UNGASS in 2001[3]

Faith communities generally operate at three levels:

1. Informal social groups or local faith communities;
2. Formal worshipping communities with organised hierarchy and leadership;
3. Independent faith-influenced non-government organisations (FBOs). [5]

3 "FBOs: A matter of Faith", Moments in Time, Policy Project, 2003.
4 "Developing Strategies to work with FBOs"
UNAIDS: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080410_Developing_strategies_to_work_FBO.asp
5 Definitions from UNAIDS Framework for working with FBOs. Draft 4, 2009.

Whilst all three levels influence society, FBOs provide the most HIV-related services.[6] All three types of organisations can participate in advocacy, and each has different strengths. For instance, a leader of a large place of worship can team up with a local service provider -- one has moral authority and influence, whilst the other knows the needs on the ground.

Many faith communities were some of the first to respond to the AIDS pandemic, brought in largely by necessity to provide spiritual support and counselling to the sick and grieving. In some cases HIV has changed the very nature of outreach of faith communities.[7] For example, Veena O'Sullivan, Tearfund's HIV and AIDS Advisor said:

> *"The burden of care on churches is immense. I met recently with a pastor who was conducting three funerals the next day. Another said to me: 'I trained in theological college to do evangelism but I spend most of my time conducting funerals and counselling bereaved families. Theological college did not prepare me for this.' "* [8]

Whilst many faith communities have productively responded to HIV, many others have not. Particularly in the beginning of the pandemic, many religious leaders blamed one's HIV status on immoral behaviour, perpetuating stigma and discrimination.

To this day, stigma and discrimination remain some of the largest hurdles to achieving universal access and effectively dealing with the epidemic. Stigma and fear prevent people from knowing their HIV status and seeking treatment and care for themselves. Many people living with HIV have suffered human rights abuses as a result of stigma; some have lost their jobs, been rejected by their families and community and even been killed. Experience has shown that stigma has been reduced in places where people living with HIV have come together for mutual support and advocacy. Access to treatment also makes a big difference; where there is hope people are less afraid to get tested, disclose their status and seek care when necessary. [9]

A Multi-level Approach

Around the world, communities of faith have responded to HIV in various ways, both internally, changing policies and practices within their institutions, as well as externally providing social services and advocating internationally.

Christianity, which counts over 2.1 billion members of Catholic, Anglican, Lutherans, Baptists, Orthodox and Protestant churches, has a wide-ranging response to HIV.[10] Many churches in North America and Europe have national development agencies, which support international projects as well as promote advocacy and education about issues of poverty and HIV. Additionally, many churches have a "desk" or focal point for HIV at the denominational level that provides trainers and counsellors to support local churches in developing their own HIV and AIDS response[11].

6 UNAIDS Framework for working with FBOs. Draft 4, 2009.
7 Faith Untapped,Tearfund 2006.
8 Excerpt from Faith Untapped,Tearfund 2006.
9 UNAIDS 2009, http://www.unaids.org/en/PolicyAndPractice/StigmaDiscrim/default.asp
10 "Scaling up Effective Partnerships," Ecumenical Advocacy Alliance, 2006.
11 Faith Untapped, Tearfund 2006.

HIV has affected every level of the religious institution, even changing how religious leaders are trained. In Africa, many theological institutions are mainstreaming HIV and AIDS into their curriculum.[12] Globally, the World Council of Churches, a worldwide fellowship of 349 Christian churches, has developed guidelines for "The HIV Competent Church" which calls for theological and technical competence (these guidelines are included in Appendix 1).

In Islam, many Islamic medical associations all over the world have educated Imams and Muslim communities about HIV. For example, to create culturally relevant messages about HIV, the Islamic Medical Association of Uganda used teachings about mutual fidelity and the individual moral responsibility not to endanger others. They also held a conference, which included leaders from every district in the country to spread messages of HIV education. [13] In South Africa, a group called Positive Muslims provides education and support to people living with HIV from a Muslim perspective. They also lobby their own religious leadership "to increase our compassion, mercy and non-judgementalism for people of all walks of life." [14]

In Thailand, Buddhist monks were some of the first to respond to people dying of AIDS by opening the doors of their temples to provide hospice care, which was uniquely based on their philosophy to be compassionate to all living beings. The most well-known example is the Wat Phra Baht Nam Phu, also referred to as the "AIDS Temple". What began as a hospice with eight beds, it is now a 400-bed complex.[15] Across Asia, UNICEF has identified monks and nuns as strategic partners, creating the Regional Buddhist Leadership Initiative. The initiative outlines the Buddhist approach, which can be read at www.hivpolicy.org/Library/HPP001156.pdf.[16] Buddhist monks and nuns have come to recognise the need to provide not only care for the suffering, but also prevention and education and are taking steps to scale-up these types of programmes.[17]

The Jewish response to HIV comes from a sense of responsibility that obligates Jews to reach out to all people – Jews and non-Jews – that are suffering.[18] Perhaps the most prominent response comes from American Jewish World Service, which currently funds grassroots responses to HIV all over the world, and also promotes educational resources for Jewish communities about HIV[19]. In North America, some Jewish community centers and family service centres have resources and programmes on HIV. Community responses are led by members of the synagogue with support from an ordained rabbi. [20]

12 For more information, see: Chitando,Ezra. Mainstreaming HIV and AIDS in Theological Education, EHAIA Series, World Council of Churches, 2008.

13 "Moments in Time" HIV/AIDS Advocacy Stories, The Policy Project p 79. see also: http://imauganda.org
14 More information: http://www.positivemuslims.org.za/
15"Scaling up Effective Partnerships", Ecumenical Advocacy Alliance 2006.
16 See "HIV/AIDS From a Buddhist Perspective, The Four Noble Truths of AIDS", www.hivpolicy.org/Library/HPP001156.pdf
17 "Scaling up Effective Partnerships", Ecumenical Advocacy Alliance 2006.
18"Scaling up Effective Partnerships", Ecumenical Advocacy Alliance 2006.
19 See also "The Global HIV/AIDS Pandemic" a comprehensive resource on HIV and Jewish response including learning module: http://ajws.org/what_we_do/education/hiv_aids.html
20 "Scaling up Effective Partnerships", Ecumenical Advocacy Alliance 2006.

Hinduism, counting one billion members around the world, has yet to have a co-ordinated response to HIV for a variety of reasons. Ninety percent of Hindus live in India, and while it was not affected at the early stages of the epidemic, there are now more than five million cases of HIV in India. Hindus are less centrally organised than other religions, without national umbrella institutions. There are currently no studies on the response and the capacity of Hindu leaders and related organisations to respond to HIV. However, there are positive indications; Hindus have a strong tradition of working interfaith, which means that at the community level there are many relationships with other community and FBOs, potentially around HIV. Historically Hindus have responded to disease and suffering around the world; the two predominant unifying principles are compassion and selflessness.[21]

Some of the responses of FBOs to HIV:

-Spiritual encouragement

-Education & information

-Values & moral information

-Compassionate care

-Respectful relationships

-Curative interventions

-Material support

-Setting up income-generating schemes for affected families

-Providing prevention information and assistance

-Training volunteers

-Lobbying and advocacy [22]

21 "Scaling up Effective Partnerships", p 22. Ecumenical Advocacy Alliance 2006.
22 Some adapted from UNAIDS Framework on working with FBOs. Draft 4 2009

Faith-based Advocacy

Whilst providing services and support to people living with HIV is absolutely vital, it is different than advocacy. Advocacy is a process to bring about change in the policies, laws and practices of influential individuals, groups and institutions. [23] The focus of this toolkit is to prepare you for advocacy, particularly with government decision-makers. The goal of this advocacy is to achieve universal access for prevention, treatment, care and support for people living with and affected by HIV and AIDS.

Advocacy can be done at many levels: in inter-personal or family relations, with the community or local authorities, or at the national, regional or international level. For many faith communities, advocacy is often first internal, changing the policies and environment to be welcoming for people living with HIV. Internal advocacy is often an important first step. Many FBOs are already involved in advocacy.

In Uganda in 1992, Canon Gideon Byamugisha was the first Anglican priest in Africa to go public with his HIV status, breaking the silence within the Christian community. In 2003 Byamugisha founded the organisation ANERELA+, the African Network of Religious Leaders Living with or Personally Affected by HIV or AIDS, to provide support for religious leaders facing stigma and discrimination. The network has inspired many leaders to go public with their status and start HIV programmes in their communities. It now counts more than 2,000 members in 39 countries.[24]

Recently ANERLA+ has turned to advocacy, promoting comprehensive approaches to prevention through a method called SAVE, which refers to: Safer practices, Available medications, Voluntary confidential counselling and testing and Empowerment through education. SAVE is in part a response to abstinence only education and the ABC model (Abstain, Be Faithful, use a Condom), which many feel is not comprehensive. Byamugisha has also campaigned against the donations from the United States of non-generic HIV drugs, which cost five times as much as the generic brands. ANERELA+ recently expanded to include non-African members, changing its name to INERELA+ in 2008. [25] It continues to support religious leaders and their families today, and also partners with organisations like the Global Network of People living with HIV (GNP+) for global advocacy.

How can advocacy make a difference?[26]

-Encourage the increase of resources for AIDS response
-Campaign to make antiretroviral drugs widely and cheaply available
-Change policies to be more effective
-Reduce the stigma of people living with HIV
-Uphold the rights of HIV-positive people
-Strengthen solidarity between people living with HIV and the community
-Involve people living with HIV in all aspects of programming

23 "NAM, "Introducing Advocacy": www.aidsmap.com/inthival/adv2section1.pdf
24 "HIV-positive religious leaders break their silence", Mail & Guardian. March 17, 2008.
25 More information: http://inerela.org
26 Adapted from What Religious Leaders Can Do About AIDS, Religions for Peace, page 24

Since 2000, the Ecumenical Advocacy Alliance (EAA) has been the lead inter-church network for advocacy initiatives in response to HIV. Through its offices in Geneva, it coordinates the efforts of a worldwide network of Christian-based agencies, churches, and organisations to address issues such as fair and equal access to antiretroviral medication and the elimination of stigma of those living with HIV. [27] The EAA has led a campaign to end travel restrictions for people living with HIV, including direct lobbying of restrictive countries, and created an educational game "Around the World with HIV" . [28] The EAA has also launched a campaign to make medicines available to children through post-card writing and engagement with four leading pharmaceutical companies. [29]

Besides advocacy with governments, FBOs can also monitor and dialogue with multi-lateral organisations. Grassroots engagement with multi-lateral organisations is important in order to ensure that their programmes and interventions are rooted in and the local culture and context. For instance, representatives from faith communities around the world participate in the national country coordinating mechanisms (CCM) of the Global Fund to Fight AIDS, TB and Malaria.

Some FBOs directly engage with the private sector on access to antiretroviral medication. In the United States, the Interfaith Center for Corporate Social Responsibility (ICCR) files shareholder resolutions with pharmaceutical companies like Abbott and Bristol-Meyers-Squibb, focusing on issues like antiretroviral medications for children. [30]

There are many examples of multi-faith collaboration around the world. In India, both religious and secular organisations joined together to hold vigils as part of a "Night of Solidarity". The goal of the vigil, which was reinforced by direct lobbying and letter writing, was to get Novartis to withdraw its patent case for antiretroviral medication from Indian courts, which would have limited access to a cancer drug frequently used by people living with HIV. [31] After months of litigation and huge outcry from civil society all over the world, Novartis withdrew the case in 2007.

Learn More: If you would like to deepen your understanding of types of advocacy, see Worksheets 1 & 2 on Advocacy Approaches & Concepts at the end of this guide.

3. Challenges Facing FBOs

Whilst many religious communities are already engaged in support and services for people living with HIV, increasing advocacy for universal access may bring up some challenges that faith communities should not be afraid to address:

-Fear of perception of being political

Many religious leaders and institutions are hesitant to be seen as engaging in day-to-day politics, but religious leaders should not be afraid to hold decision-makers accountable to their promises.

27 EAA HIV and AIDS Campaign Framework: http://www.e-alliance.ch/en/s/hivaids/
28 More information: http://www.e-alliance.ch/en/s/hivaids/stigma/travel-game/
29 More information: http://www.e-alliance.ch/en/s/hivaids/accessmeds/children/what-are-we-asking-for-from-pharmaceutical-companies/
30 For more information see: http://iccr.org
31 "Church leaders call on Novartis to drop the case in India," Ecumenical Advocacy Alliance, 14 Feb. 2007.

Faith communities need to build their capacity to ask questions about public policy. To inform their advocacy, some religious institutions have created social policies developed over long periods of study based on their sacred texts.

-Engaging with most affected populations

The demographics of HIV vary by country, but communities most affected by HIV tend to include people living with HIV, young people, women, men who have sex with men, people who use drugs, and sex workers. An effective approach to HIV requires working in partnership with these communities, moving past approaches that perpetuate stigma and discrimination. To do this effectively, safe spaces for dialogue and mutual trust building must be created, and FBOs can play a key role in doing this.

-Embracing change and investing in the future

FBOs need to be open to new ways of expanding their response to HIV and AIDS, and review their existing strategies. This includes how to share appropriate and culturally relevant information on prevention and sexual health, encouraging testing and advocating for access to treatment and support for all. FBOs must also invest in human resources and in developing capacity to try new approaches. This will also require time and resources spent within organisations for internal dialogue, evaluation and analysis. [32]

-Addressing the root causes of gender inequality

In some parts of the world, particularly Southern Africa, women are becoming infected with HIV and AIDS at rates of three to five times faster than men. There are many reasons for this, including poverty, women's lack of economic power and biological susceptibility. Violence against women is linked to the rise of HIV infections of women. This includes rape, sexual assault, domestic violence, trafficking and early marriage. [33] Women often fear HIV testing because the consequence may result in domestic violence or being thrown out of their homes. To address this, faith communities must do the work of re-examining their own attitudes to women, girls, gender and sex. Men are important partners in this work.

–Partnering with and empowering young people

Young people make up nearly half of new HIV infections. They also make up the majority of populations in many countries with the highest HIV prevalence. FBOs and religious communities should empower young people with accurate information and resources to protect themselves from HIV infection. Faith communities would also benefit from unleashing the power and energy of young people as advocates and peer educators through investing resources in youth leadership, skill building and creating opportunities for youth participation in decision-making in HIV-related programming.

32 This challenge taken from "Faith Untapped", Tearfund. 2006.
33 See also http://www.worldaidscampaign.org/en/Constituencies/Women

-Professionalism of their AIDS response

To scale-up their response and attract more funding partners, many faith groups will need more training and to address concerns about their professionalism. Many faith groups have tended to employ 'trusted religious persons' to lead their HIV and AIDS response, instead of people with specific relevant expertise. Any effective response will require a basis in strong counselling skills and sound medical knowledge [34]. At times, governments, international organisations and NGOs do not know how to work with FBOs. One resource created to address this gap is "Scaling up effective partnerships: A guide to working with faith-based organisations in the response to HIV and AIDS." [35]

-Partnerships

For faith groups to build capacity for effective advocacy and service delivery, they will need to strengthen partnerships with the communities most affected by HIV, as well as with other stakeholders in the field, including civil society organisations, governments and donors. There is growing recognition of the GIPA principle, or the Greater Involvement of people living with HIV. People living with HIV understand each other's situation better than anyone and are often best placed to counsel one another and to represent their needs in decision-making forums. [36] Networks of people living with HIV exist in many forms at the local and national level, and have international networks such as INERELA, GNP+ and the Global Coalition on Women and AIDS.

34 "Faith Untapped", Tearfund. 2007

35 See: http://www.e-alliance.ch/en/s/hivaids/mobilizing-resources/faith-literacy/

36 For more about GIPA: http://www.unaids.org/en/PolicyAndPractice/GIPA/default.asp

Step 2

Planning Advocacy Campaigns

As religious leaders, we have a very important role to play in lobbying governments and international institutions so that we can strengthen and add to the voices of organisations and the people of our churches that have been working of a day-to-day response to HIV.
-- Msgr. Gustavo Rodriguez, President, National Social Commission in Mexico of the Catholic Church.

If not us, then who? If not now, then when?"
--Winston Churchill, former Prime Minister of the United Kingdom

Advocacy can take many forms. The most successful campaigns integrate many tactics, for instance public events for World AIDS Day is followed up with meetings with members of parliament and pitches are made to journalists for media coverage. This section has tools for you to build your campaign for universal access including: 1) identifying your issue 2) setting goals and objectives 3) messaging 4) timing 5) coalition building 6) advocacy tactics 7) political lobbying and 8) working with the media.

1. Identify your issue

It is important to work with the people who will be affected by your campaign, ideally right from the beginning. Without this initial consultation, you may end up launching a campaign that is not relevant or inclusive of people you are trying to reach. Through research you will identify a topic that needs to be highlighted and you will have built up a bank of evidence including facts, figures, and comments to use in your campaign.

Research Tips: Know Your Epidemic

-Call local experts and ask them about their priorities
-Find out who key HIV and AIDS service providers are in your area and what they do
-Check statistics about your country and region from, for example, UNAIDS or other online sources
-Find out how behaviour and cultural norms relate to HIV transmission
-Ask people you know how HIV affects their lives

-Check local newspapers, television and radio for programmes on HIV and AIDS

Ask yourself: how can your faith community add value to the current AIDS response?

---→ *Action: Community identification of advocacy issues*

A great way to begin your campaign is to start learning how HIV affects your community. One way to do this is by holding a community plenary on HIV. Bringing people together generates energy and inspiration, which is a key ingredient to any campaign! For your plenary, invite speakers who can give you an overview of how HIV is affecting your community, as well as speakers from affected groups. Use this meeting to identify community priorities and set a goal for your advocacy. You can form a leadership group during this meeting that can use the resources in this guide to plan an advocacy campaign. Think about who to invite from different parts of civil society, especially networks of people living with HIV and people from other faiths-- this may turn out to be the beginning of your advocacy coalition.

Learn More: Use worksheet 3 and 4 to help plan your programme for holding a community plenary and identify advocacy priorities.

Tips for a successful community meeting:

-Be prepared
-Welcome people to your space
-Delegate tasks, the facilitator should not also have to worry about tea or lunch breaks
-Consider opening with words from a high-level faith or government leader to demonstrate the event's importance
-Establish the meeting as a safe space and discuss what it means to be non-judgemental
-Be flexible and listen
-Make sure everyone has a chance to speak
-Be aware that for marginalised or even criminalised groups, such as sex workers, there may be risks that you must be prepared to pre-empt with the provision of safe spaces
-Be careful to honour personal stories and testimonies, it is often emotional for people to talk about HIV & AIDS
-Send an invitation in advance so people have time to prepare
-Select a rapporteur to take minutes, while also noting that certain issues may require confidentiality

2. Goals and objectives

Now that you have identified your advocacy issue, it is time to build your strategy. The first thing to do is to take the issue you identified and write it in simple terms as a goal with one or several objectives.

Goal or Aim: the long-term result that you are seeking[37]
Objective: a short-term target that contributes towards achieving the long-term aim [38]

For example, your community may have identified that increased access to medicines for people living with HIV in your district is your priority issue. But because of corruption and inefficiency, medications often do not reach clinics on time and sometimes are not distributed to the people who need them.

Therefore your goal would be:

- Ending corruption and increasing efficiency of antiretroviral distribution in your district through monitoring three clinics over nine months.

Your objective breaks down this goal into pieces that can be addressed by your coalition. They could include:

- Meeting with staff of clinics to learn more about the problem ofantiretroviral distribution and tell them about your monitoring project.
- Creating a standard reporting form based on your conversations with clinic staff to use at regular visits to clinics.
- Write a report on results of your monitoring.
- Launch the report at an event that includes NGOs, journalists, the government health ministry, and the National AIDS Authority.
- Use your report to help draft an NGO shadow report for your country and submit it to the 2011 review of the UN Declaration of Commitment on HIV/AIDS, which includes universal access targets. (See Part III for more information on this.)

Now that you have identified your goal and objective are they SMART?

A SMART objective is[39]:

Specific: the objective is clear in terms of what, how, when, or where the situation will be changed
Measurable: the change is measurable (e.g. percentage increase or number of people reached)
Appropriate/Achievable: the objective delineates a particular area or population (e.g. sex, age, village)
Realistic: the objective is not beyond your group's capacity, resources, experience
Time-bound: the objective indicates a time period within which it must be realised or accomplished

37-38 This content was adapted from International AIDS Alliance's Advocacy in Action toolkit.
39 The content of this section on SMART goals is adapted from the Tearfund ROOTS 2: Advocacy in Action, http://tilz.tearfund.org/Publications/ROOTS/Advocacy+toolkit.htm

For example, a SMART Objective:
Advocacy Aim: To ensure antiretrovirals are delivered to clinics without corruption.

SMART Objective: To monitor the distribution of drugs at three clinics over nine months.

-It is Specific because you have a clear goal for access to medication.
-It is Measurable because your coalition will collect information at intervals on a standard form.
-It is Appropriate/Achievable because you are targeting three clinics and have the necessary staff capacity.
-It is Realistic because the focus is on writing one monitoring report, not direct enforcement.
-It is Time-bound because you will monitor three clinics for nine-months.

-and-

-It is Strategic because you can use your report for advocacy for the UN meeting that will occur in 2011 to reviewtargets for universal access.

3. Developing your Advocacy Strategy: Messaging

Now that you have goals and objectives, you need a unifying message to let everyone know about your campaign. This message should communicate your goal and be easy to understand. Your message should specifically address the policy change you are advocating for. One way to determine your message is to find out about commitments that have already been made by your government or the international community (See Part III of this guide, Political Commitments to Universal Access). It can be as simple as "Universal access to treatment by 2010".

Some examples of slogans people have used for issues around HIV and/or universal access include:

"Stop AIDS. Keep the Promise." – Used by the World AIDS Campaign

"15% Now!" – Used by the African Public Health Alliance on the seventh anniversary of the African Union 15 percent Health Commitment made in 2001 in Abuja, Nigeria.

"Live the Promise" – The 2009-2012 theme of the HIV and AIDS campaign of the Ecumenical Advocacy Alliance.

You should be able to integrate your message throughout your campaign. Ask yourself, will you use this message for just a few months or over several years? Is it easy to remember? Could you put it on a letterhead, a banner, a T-shirt, use it in a song or in a worship service?

4. Timing

Once you have decided on your objectives, you should structure them within a timeframe. Your timeframe should allow for all the preparation you need to do (for example printing materials or collecting letters), and it should also be strategic.

Strategic timing could be before and after an election, or to raise national awareness before an international meeting such as the UN General Assembly High Level Review on AIDS. It could also be around a date that will capture attention, such as a national or religious holiday. Decide if your campaign will last just a few months, or if you will work on it for years.

EXAMPLES

Political Timeframes:
-Lobbying your government 6 months before the UNGASS Review in June 2011
-Meetings with all presidential candidates prior to and after an election
-Marking an anniversary of a political agreement, such as the Abuja Health Declaration
For more information on Political Commitments to Universal Access and when they were made see Part III of this toolkit.

International Observances:
-International Women's Day – March 8
-International Day for Eradication of Poverty – October 17
-Universal Children's Day – November 20
-World AIDS Day – December 1
-Human Rights Day – December 10
-National HIV Testing Day – Varies by country

Case study: A voice for people living with HIV and AIDS in Malawi on World Poverty Day

The Access to Medicines campaign in Malawi was officially launched on 17th October 2008, World Poverty Day. The campaign is being supported by Oxfam International and being led by the Malawi Health Equity Network and other local NGOS, including the National Association of People Living with HIV and REACH Trust.

This campaign aims to help people like Ruth, a single mother who spoke at the launch and told how every month she has to fight to travel, wait long hours and sometimes is turned away, in order to access drugs. Sometimes people like Ruth are at the mercy of individual health staff to get the drugs they need.

Many people living with HIV and AIDS attended the launch, and shared their experiences, which were incredibly moving. For them the event was seen as a platform to speak to the government about their issues and the challenges they faced everyday when trying to access basic medicines.

If you just look at medicines as a campaign issue, the connection to poverty is not apparent. But when you listen to this woman and Ruth, and others like them, and hear how much of her time is spent on chasing basic drugs, and how she is sometimes made to choose as to which of her two sick children should get medicines, then the picture becomes clear.

Hearing stories like this renews my strength to speak out and keep working to get the message out there that this is preventable poverty, that my government can do much more, and that donors can contribute more.

People at a local level are willing to mobilise themselves. They just need our support to channel through their issues, and the confidence to demand their rights. The launch has opened an interaction, which if sustained, will bring about change.

--Shenard Mazengera, Oxfam International Advocacy Manager, Joint Oxfam Programme, Malawi[40]

40 Originally posted December 12, 2008: http://blogs.oxfam.org/fr/node/841

6. Coalition Building

When civil society is organised, it is harder for governments to ignore because of the number of people involved. It is also generally easier for government to address one organised coalition instead of fragmented civil society groups.

There are many benefits to working in coalitions, such as meeting new people, learning from others and the general strengthening of civil society. Often these benefits pay off in the long-term as relationships grow stronger.

The members of your coalition are a major choice for your campaign. If your issue directly impacts a group like youth or women, it would be smart to partner with a women's group or youth organisation to increase your chances of success. The greater involvement of people living with or affected by HIV will also likely play a role in your campaign. Every coalition is different, but you should be united by your common goal.

Each partner may bring a different benefit to the table, but when inviting people to your coalition you might look for partners that have:

-direct experience working on the issue
-large membership base to mobilise
-access to information or the media
-the willingness to act [41]

Working in coalitions can be very time consuming if each member has to agree on every decision. Set some parameters from the beginning on what must be agreed upon by all partners, or perhaps share the leadership of the campaign by having co-chairs or a steering group from each constituency. Some members of the coalition may only participate in certain activities. For instance, you may want to draft a letter to the government directly from your faith community, but join a large coalition for a rally or demonstration.

To begin building your coalition, think about how HIV cuts across multiple sectors. For instance, teachers educate students about the disease, health workers treat people living with HIV, international NGOs provide social services and youth organisations do peer-to-peer education. Think about the ties your religious community has to different actors involved in your issue. Are they strong or weak ties? Which stakeholders are vital to your campaign?

Learn More: Draw a map of all the stakeholders in your campaign including if your organisation has strong or weak links to them. Use Worksheet 5 as an example.

40 This section is adapted from Tearfund's Practical Action in Advocacy toolkit and the Global Youth Coalition's Political Advocacy Toolkit.

6. Advocacy Tactics

Now that you know your goal, objectives, message, timing and coalition, you can decide which tactics to use. Most advocacy campaigns combine several tactics. For example, wearing a red ribbon does not have much significance on its own, but if thousands of people are doing it, accompanied by media exposure and direct lobbying of politicians, the campaign can affect policy.

Here are some ideas to help you design your campaign:

Letter writing
Produce a fact sheet including your talking points and where the letter should be sent. The letter should be directed to a single person e.g. the Minister of Health. You should instruct people to write directly to the person and ask them to send a copy of the letter to you for your records. A conference or event with a lot of people is a great place to start a letter writing campaign because you can get many letters written during a single day.

Postcards
Simpler than letter writing, a postcard campaign can target one or several decision-makers ranging from the pharmaceutical industry to government leaders.
You will need to produce postcards with a short specific message, clearly outlining what you want the person receiving the postcard to do. You can either ask people to mail the postcard directly, or you can ask that the postcards be returned to you. If they are returned to you, you can stage an event and turn them in personally to the person you are targeting.

Be realistic about your resources, which tactic(s) will help you best achieve your goal?

Sign-on letters
A sign-on letter is another way of showing the number of supporters to your campaign. Instead of everyone writing their own letter, one letter is written and circulated and people sign their names. You may need to decide if sign-on names will come from individuals or organisations.

Hold a religious service
Worship services can be powerful way to pull the community together and potentially invite decision-makers. Consider having a service on universal access with readings, songs, and/or prayers that tie-in to that theme. Involve people living with HIV in the planning of the service and ensure that their status is only shared by them if they choose. (See note at end of this section relating to language).

Sermons / Teaching / Practice
Ask the leader of your faith community to preach a sermon or deliver a teaching on universal access. Encourage your leaders to call for accountability from the government and international institutions. If possible record their message or obtain a written copy so that it can be shared with others or posted online.

Demonstration
A demonstration is a public way of bringing attention to your message and advo-

cacy. In some cases you may need to apply to the local authorities for permission. To ensure your event is a success, make sure you have time to spread the word and that the timing makes sense within your campaign. Consider asking people to send SMS messages to invite their friends. You could also use social networking websites like Facebook or Twitter. If your faith community belongs to a larger institutional structure, you could appeal for support from other members. You might want to fund transportation to ensure that people can get to the location. Make sure your message comes across clearly; you might want to prepare banners with your slogan and campaign message. Consider assigning a photographer to take pictures, producing t-shirts for people to wear and prepare a short hand-out. Prepare a press statement to ensure any media reporting on the demonstration is accurate.

Make a day of it

Consider dedicating a day in your community for universal access. The day can be an opportunity for your whole community to learn about the issues, the political commitments, and have fun at the same time. You could use drama and dance as well as make speeches to get your message across. You could incorporate a letter-writing workshop or make a video message to the leader you are targeting. HIV testing could also be included if you have access to trained peer counselors and medical staff. The community can begin and end the day together with prayer, meditation, or worship.

Drama, dance, music

Dance, drama and music are creative ways of conveying the message of your campaign. They allow the element of personal stories to come through and can connect with people on an emotional level. They also represent your culture and are also wonderful when you have an audience of different ages.

Wear an emblem

A simple form of advocacy can be to get supporters to all wear a symbol, which represents your campaign. Most people are familiar now with the use of a ribbon to support different causes, such as a red ribbon for AIDS which was created by the artists and activists of Visual AIDS to symbolise blood, passion and love in 1991. Why not come up with something people can wear to raise awareness that is specific to your campaign? Ask artists to help you.

Using the Media / Logos

Now that you have a strong message, consider professionalising it by asking an artist or graphic designer to design a logo for your message. There is a chapter about engaging with the media later in this toolkit but here are a few ideas: put an advertisement in printed media like newspapers, magazines, newsletters, bulletins, (sometimes advertisement space is donated to NGOs). You can also reach out to radio and TV stations (make sure your news has a visual component). Don't forget the internet – launch your own website (see Wordpress.com to start your own simple site for free) and cross post your information on blogs and social networking sites.

Language

In all of the actions listed above language is very important. As people of faith we are often accustomed to language that helps us identify those that share our faith and those that do not. To outsiders this language can sometimes appear divisive and offensive. Examples include words like redeemed, chosen ones, saved, lost, sinner, ignorant, infidel etc. When you are preparing a campaign that will reach further than your immediate faith community the language needs to consider that audience. Be aware that you are likely to have people living with HIV in your faith community, whether you are aware of it or not. Avoid using terms like 'them' and 'us' and avoid referring to HIV in the context of wrongdoing or punishment.

7. In-Person Advocacy / Direct Lobbying

Whilst a lot of effort can go to raising awareness with the public about your issue, a strategic meeting with decision-makers can go a long way to accomplishing your goals and objectives. An in-person meeting can give a human face to your issue and also builds a relationship with a decision-maker. You may consider organising "lobby days" or a week of advocacy where members of your coalition meet with elected officials on behalf of your campaign. This is an effective strategy if you need to meet with multiple officials, for instance every member of parliament. You also might ask for meetings before, during and after international conferences such as the UNGASS review or the International AIDS Conference. These global events often offer unique opportunities to meet with high-level decision-makers.

Here are a few tips for in-person advocacy:

Before the meeting:

• Find out who you should meet with. This sounds simple, but it is an important strategic choice. Your approach may be different if you are targeting elected decision-makers like members of parliament, versus officials from the ministry of health.
• Ask for a meeting. If you have a certain timeframe (like before a global meeting), make sure to ask with enough time in advance. If you do not receive an answer, follow-up by phone. Many officials prefer to be asked in writing, via fax, letter or in some cases email.
• To gain access to decision-makers, it helps to have high-level religious leaders attend the meeting. But it is also important to include stakeholders who are directly affected and can speak for themselves, such as young people or people living with HIV.
• Assign roles before the meeting, such as who will speak first, chair and take notes.
• Know what questions you want to ask in advance and prepare materials to leave with the official.
• Practice your argument and use stories, facts and figures.

During the meeting:

• Make sure to tell the official who you are and what constituencies you represent. Leave your contact information and any information you have prepared.
• Keep an open mind. The official might have never heard about your issue; they could also be from your faith community.
• You might start with an easy opening question, but don't let the official steer the agenda away from the tough questions you have prepared in advance.
• Don't be afraid to be passionate and persuasive about the issue. That's your role!
• Stay friendly and polite, you do not want to burn any bridges. You may have to build up a relationship over time and have several meetings in order to reach your goal.

After:

• Follow-up with a thank you letter and any additional materials that were requested.
• Debrief with your group about next steps.

Case study: 15% Now! Campaign[42]

Issue: The annual death of eight million people in Africa due to preventable, treatable or manageable health conditions.

Goal: Educate public and government institutions on their political commitments to the health-related Millennium Development Goals and universal access targets for prevention, treatment and care.

Objective: Ask the finance ministers of the members of the African Union to reaffirm their 15 percent commitment at the next AU Summit in Egypt.

Message: 15% Now!

Coalition: 140 African and global organisations, led by the African Public Health Alliance, with Archbishop Desmond Tutu.

Timeline: Before, after and during the seventh anniversary of the African Union 15% Health Commitment, made in April 26, 2001 in Abuja, Nigeria's capital city.

Strategies:

-Mass mobilisation on political commitment anniversary in Abuja

-Targeted follow-up meetings with decision makers and other global stakeholders and donors such as the UN, European Union, World Bank, International Monetary Fund, and international NGOs.

What makes this campaign media friendly:

-High-level speaker Desmond Tutu

-Sound bites:

-The 8 million annual death toll is equal to 43 transatlantic jets with 500 passengers each crashing every single day.

-The cost of not treating TB to Africa between 2006 and 2015 would be $519 billion while TB can be controlled with $20 billion in the same period.

42 For more information see "Allocate 15 Percent of Budget to Health, African Govts Told", Abimbola Akosile, 29 April 2008 http://allafrica.com/stories/200804300307.htm.

8. Working with the Media

Media coverage can enhance almost every advocacy campaign. Media coverage can add credibility, serve as good results to show partners, and demonstrates to decision-makers that you are serious. Media also of course spreads awareness about your message to the broader public. Oftentimes, campaigners do not designate enough resources towards media outreach or leave it until the very last minute. Working with the media can be a lot of work, so if you have limited resources make sure you know what your objective is for gaining media attention. However, getting the media to cover your campaign is not rocket science, it just takes some preparation and common sense. [43]

Media Hooks: Ask yourself 'Why is this interesting? What will catch people's attention? What is the likely reaction?' News with elements of local impact, personal stories, conflict or controversy, injustice, special events, and celebrity involvement tends to get more attention.

Be Prepared: Appoint one person or a small team to work on press releases and media outreach. Establish who your media spokesperson is before the event. Know who you represent and what you're trying to accomplish. Be aware of local impacts as a result of media coverage. Be clear about your proposed solutions and goals when you talk to journalists.

Stick to your message: Reduce complex issues into simple talking points for a wide audience. Frame the problem as a social justice issue that everyone can relate to.

Never lie or say something you're unsure of: If a reporter asks you a question you don't know, say that you don't know and will call back with an answer. Lying or providing false information may cause complications for your advocacy campaign or organisation.

Remember that no news is unbiased: Most media have values behind them, whether they are political, religious, poverty focused etc. Make sure you find out what this is before you approach them.

Build your press list: Before your event or campaign launch, take the time to research which press you would like to reach and compile their contact information in one place. You can get this by calling general phone numbers or looking on the internet for fax numbers and email addresses. Form a small team to call everyone on your list. Give the press at least one days notice before your event so they have time to pitch the story to their editor. If you think your issue necessitates a longer in-depth article, take time to build a relationship with the reporter.

Utilise Faith-based media: Does your faith have a press officer or news service? Make sure to contact them and ask them to cover your event. They might also be able to help you write your press release and pitch your story to other media houses. There are multiple religious newswires that can help spread your news around the world.

43 Some content has been adapted from GYCA Political Advocacy Community Training Toolkit, the San Francisco AIDS Foundation's grassroots advocacy manual and Tearfund's Practical Advocacy in Action Toolkit.

Case study: Media Advocacy

Church Leader Calls S.African AIDS Policy a 'Sin'
Reuetrs NewMedia - Monday January 28, 2002

JOHANNESBURG (Reuters) - South Africa's Anglican archbishop said it was a "sin" that the government was denying HIV-positive pregnant women a drug that reduces a newborn's risk of contracting the virus, a newspaper reported on Saturday.

"If the life of a child rests on drugs, but she does not receive them, it's a sin, it's immoral," Archbishop Njongonkulu Ndungane was quoted by the Johannesburg-based Saturday Star as saying.
President Thabo Mbeki's government is appealing against a ruling by the country's high court that the government has a constitutional duty to increase access to the antiretroviral drug nevirapine, which has been shown to cut mother-to-child infection rates by up to 50%.

Why was this story picked up by the media?
-high-level religious leader
-specific
-affects many people (100,000 babies and their families)
-controversial to call the government's action a sin
-facts & figures are easy to understand
-has global implications
-the willingness to act

The government argues against the use of nevirapine, saying it is costly and that there are concerns about its safety. There are side effects from the drug, but medical experts say they are limited and the drug is a life-saver.

Up to 100,000 babies are born HIV-positive every year in South Africa, which has more people living with HIV-AIDS than any other country. One in nine South Africans is estimated to be HIV-positive.

Going against the national government's policy, two provincial governments have said they will distribute nevirapine to pregnant women after securing a deal with a German pharmaceutical company to supply the drug free for five years. Ndungane said HIV-AIDS had to be declared a national emergency. "When the government stands in the way of our right to live then the government has overstepped its boundaries," he said.

Step 3

Universal Access

"Universal access can only happen because of you... You, the faith based leaders supporting communities around the world... who will hold us all to account for reaching our universal access goals. We know what it takes— now we need your inspiration and action."

UNAIDS Executive Director, Michel Sidibe [44]

In the last ten years, governments have made numerous and comprehensive commitments in responding to the AIDS pandemic. This section will examine those commitments and take stock of global progress towards meeting them, as well as outline ways in which faith-based organisations can help ensure these commitments are kept.

1. Background

In 2007, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimated that there were over 33 million people living with HIV around the world. In 2008, for every two persons on antiretroviral treatment another five persons were newly infected with HIV. Almost 7,500 people are still being infected with HIV every day. AIDS is one of the top ten causes of mortality worldwide, and the leading cause of death in Africa.

Universal access is the global commitment to make HIV prevention, treatment, care and support services available to all those in need. This commitment is based on measurable, time-bound and realistic national targets specific to each country [45]. During the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in 2001, Member States adopted a series of time-bound targets, which were reaffirmed at the 2006 United Nations High Level Meeting on AIDS.

44 "Letter to Partners" from UNAIDS Executive Director. Feb 10, 2009. Accessed Sept. 20, 2009. http://www.unaids.org/en/AboutUNAIDS/Leadership/EXD/Partnerletter/20090210_page1.asp

45 See also: World AIDS Campaign Youth & Universal Access Factsheet: http://www.worldaidscampaign.org/en/Constituencies/Youth/Resources/Towards-the-Finish-Line

Snapshot: Universal Access Commitments in the Declaration of Commitment

Specifically, universal access is access for "all people all over the world to education and counselling, multi-sectoral care and support services, and health services, including medicines, that will:

-prevent the transmission of HIV;
-support persons living with HIV, their families and those who care for them, in living longer with HIV and slowing the onset of AIDS-related illness;
-help HIV and AIDS affected families in mitigating the effects of the illness and death on their own households and communities" [46]

These commitments included time-bound targets by the year 2010, such as:

-25% reduction in HIV infection among young men and women (15-24 years)
-50% reduction in percentage of infants born to HIV infected mothers who are infected;
-Increased percent of adults and children living with HIV still alive 12 months after initiating antiretroviral treatment;
-Scale-up prevention approaches for vulnerable groups;
-Assist countries to employ the TRIPS flexibilities, including local production of antiretroviral drugs;
-Recognise that around $20 billion is needed per annum by 2010;
-Set ambitious national targets for 2010 and pledge to fund all credible national AIDS plans.

Universal access to prevention means ensuring that all people have access to comprehensive information and services to prevent new HIV infections. Comprehensive and evidence-informed HIV prevention requires a combination of programmatic and policy actions that promote safer behaviours, reduce vulnerability to transmission, encourage appropriate approaches and technologies, promote social norms that favour risk reduction and address drivers of the epidemic.

Prevention also includes access to information about HIV and sexual health, including the benefits of waiting longer to become sexually active, reducing number of partners and concurrent relationships, encouraging sexual abstinence and mutual fidelity between partners who know that they are not HIV positive. Ensuring human rights and reducing HIV-related relation stigma, and addressing homophobia, and gender inequality are also key elements to preventing HIV. People living with HIV must also be involved in prevention efforts to ensure relevant and effective interventions. [47]

Universal access to HIV treatment means ensuring that people living with HIV have access to life-saving antiretroviral therapies, including second-line therapy (used after first-line treatments fail as the virus mutates). Access to drugs depends not only on financial and human resources. It depends also on people who need them being aware of their HIV status, knowledgeable about treatment, and empowered to seek it. [48]

46 Commitments in the 2001 UN Declaration of Commitment on AIDS.
47 For more on prevention: http://www.unaids.org/en/PolicyAndPractice/Prevention/default.asp
48 For more on HIV treatment: http://www.unaids.org/en/PolicyAndPractice/HIVTreatment/default.asp

Universal access to care and support means ensuring that people living with HIV have access to a wide range of continuum care and support interventions including nutrition, education and food security, home-based care, palliative care, psychological support, and care giver support. These include treatment for 'opportunistic infections' (the illnesses to which they become vulnerable as the immune system is destroyed by the virus). However, the vast majority of people around the world do not yet have access to such services.

AIDS-related care and support are key elements in the response to the epidemic; not only do they directly benefit people living with HIV, but they also reduce the social and economic impact of the epidemic and boost HIV prevention [49].

Important Milestones

Universal access commitments evolved over time, and were built upon at key milestones.

2015: Target date for achieving the Millennium Development Goals
2011: Comprehensive review of the United Nations General Assembly on the progress in realising the UNGASS Declaration of Commitment
2007: Halfway point to reach all of the Millennium Development Goals
2006: New universal access targets in the 2006 Political Declaration from UN Review of UNGASS
2005: Universal access committed to at Group of 8 Summit in Gleneagles and reaffirmed at the UN World Summit.
2001: Millennium Development Goals announced. Goal 6: To halt and begin to reverse the spread of HIV and the incidence of malaria and other major diseases.
2000: United Nations Millennium Development Summit; 189 Heads of State from 189 countries met to discuss major problems affecting the developing world. Summit culminates in the Millennium Declaration and a year later the eight MDGs

2. Towards Achieving Universal Access

Countries are still far from reaching their universal access goals: global coverage of antiretroviral therapy is still low, reaching only 42 percent (around 4 million) of the estimated 9.5 million people who need it. [50] For every two people who get on treatment, another three need it. Lack of funding and a critical shortage in health care personnel contribute to the obstacles in reaching universal access by 2010. [51]

Severe gaps in access to services and medicine remain. For instance, only one in four (28%) of pregnant women in Africa is offered and accepts HIV testing, due to stigma and fear and lack of available facilities. [52] Gender inequality reduces the ability of young women (especially those who are married) to negotiate condom use and access services. Currently in sub-Saharan Africa this is reflected by the fact that women make up three out of every four people infected. [53]

49 For more on care and support: http://www.unaids.org/en/PolicyAndPractice/CareAndSupport/default.asp
50 World Health Organization, 2009. http://who.int/hiv/en
51 Adopted: http://www.worldaidscampaign.org/en/Constituencies/Youth/Resources/Towards-the-Finish-Line
52 UNAIDS 2009. http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090930_who_pmtct.asp

Faith communities are especially concerned about the lack of resources and programmes for orphans and vulnerable children. Vertical transmission from the mother to the child is the main cause of HIV infection in children under 15. About 45 percent of the 1.4 million women living with HIV who give birth every year received antiretrovirals to prevent HIV transmission to their child. Nearly half of babies born with HIV die by their second year. [55] Vertical transmission can largely be prevented with proper education and treatment, which costs about $11.40 per mother and child. [56]

HIV is particularly devastating for children and young people when HIV impacts the important adults in their lives. There are currently 12 million children and adolescents who have lost one or both parents to HIV. This is expected to grow to 25 million by 2010. [57]

Funding Universal Access

UNAIDS estimates that $23 billion annually is needed for Universal Access. While current funding levels have risen to nearly $14 billion annually, they still don't reflect the urgency of the situation. More than half (52%) of AIDS funding comes from domestic sources. Annually out-of-pocket expenses, by individuals living with HIV and AIDS and their families, are estimated to be nearly $1 billion. Bilateral and multi-lateral funding make up 32% of global AIDS funding [54], the majority of which comes from:

-The Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund)
-The World Bank's Multi-Country HIV and AIDS Programme (MAP) for Africa
-The US President's Emergency Plan for AIDS Relief (PEPFAR)

Ultimately, HIV and its impacts affect everyone. HIV tends to deepen existing social inequities that already exist within societies across the world, inequalities such as poverty, gender inequality, and other social and economic exclusion. The result is that groups of people are more likely to be exposed to HIV and its impacts than others. Sub-Saharan Africa, for example, continues to be home to two-thirds of people living with HIV and 72 percent of the over 2 million AIDS deaths. [58] Women in Sub-Saharan Africa bare an unequal burden of HIV infections, while in other parts of the world HIV is more common in groups who face discrimination and criminalisation, namely people who use injection drugs, sex workers, gay men and other men who have sex with men.

The commitment to universal access was won through the demands of dedicated, highly organised, informed and creative civil society movements including FBOs drawn mainly from people living with and affected by HIV. These movements worked independently and collectively to demand that local, national and global leaders respond adequately to HIV and protect of human rights.

53 Keeping the Promise: An Agenda for Action on Women and AIDS. The Global Coalition on Women and AIDS.
54 UNAIDS Fact Sheet AIDS Funding 2008-2009 is it online? Full references needed
55 UNAIDS 2009 Towards Universal Access Report, http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090930_who_pmtct.asp
56 Adopted from Tearfund, Faith Untapped 2008. Professor Andrew Tompkins, OBE. Institute of Child Health, London.
57 UNICEF 2009.
58 UNAIDS (2008). Report on the Global AIDS Epidemic.

The 2006 UNGASS High-Level Meeting Review reaffirmed the important role of NGOs, people living with HIV organisations, labour and trade unions, faith-based organisations, youth organisations, women's rights organisations and all members of civil society and the private sector in the response to assist country-driven processes to scale-up HIV prevention, treatment, care and support. This includes holding governments accountable for setting targets for universal access and ensuring that they are met.

Achieving Universal Access will take an increase of resources, but also of will. It will require engagement from the highest levels of government to the grassroots. Investments will need to be made to strengthen health systems and train and educate health workers. Medicines will have to flow across borders regardless of trade rules, and reach everyone despite how remote they live or what they can afford to pay. Reaching universal access will take breaking the silence, again and again, and working together across divisions of religion, nationality, ethnicity or income. People living with HIV need to take leadership and participate in decision-making. Stigma must disappear, and the human rights of every person must be upheld. Reaching universal access will take leadership, vision and a lot of work-- and faith communities must play a role.

3. Political Commitments to Universal Access

In advocacy for universal access, it is important to understand where the goals come from. Universal access has been referenced and reaffirmed in multiple political agreements. This section will focus on the Abuja Declaration, the Millennium Development Goals, the meeting of the G-8 and the UN General Assembly Special Session on AIDS (UNGASS). One of the most significant obstacles in responding effectively to the HIV epidemic is inadequate accountability and leadership. While political commitments, human and financial resources are all essential to support implementation efforts, they do not of themselves guarantee results.

1. Abuja Declaration, 24-27 April, 2001.

At this summit heads of state of the African Union declared that "AIDS is a state of emergency in the (African) continent." The leaders pledged to "set a target allocating at least 15 percent of their annual budgets to the improvement of the health sector". This commitment was renewed in May 2006, by the African Union at the Abuja+5 summit.

⇢ *If you are from Africa, does your country spend at least 15% of its budget on its health sector?*

Get Involved: Push for and participate in your government's completion of the Abuja Indicators Questionnaire prepared by the World Health Organization. Monitor the commitment of your country of the Targets of the Abuja Plan of Action.

More information:

http://www.worldaidscampaign.org/fr/Principaux-evenements/Abuja-5/African-Summit-on-AIDS-Malaria-and-TB-ABUJA-5

2. United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration of Commitment, 25-27 June, 2001, Review 2006, 2008 & 2011.

In June 2001, the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS adopted The Declaration of Commitment (DoC) - a long needed first step toward building a successful global response to HIV and AIDS. The DoC emphasised that with sufficient political will, leadership commitment, and resources, communities and countries could change the epidemic's course. The enormous task ahead was clearly outlined with measurable benchmarks and a defined timeframe. The DoC is not a legally binding document; it provides specific targets including milestones to be met by 2003, 2005, 2007 and 2010 that are subjected to thorough review. The monitoring and reporting mechanisms put in place to review the DoC are called CHAT and CRIS (listed below). Civil society can also use them as guides and points of participation for monitoring and engagement with governments.

➙ *The next High Level meeting on AIDS is in 2011, will your government fulfil their promise?*

Did you know?

- 123 countries have held national consultations to identify obstacles to scaling up to universal access
- 111 countries have set ambitious national targets to reach universal access
- 83 countries have integrated their national Universal access targets into their National Strategic plans [59]

What has your country done and how can you be involved?

Get Involved: The high-level review of the universal access targets will occur at the United Nations in New York in 2011. While many advocates will surely attend this meeting, some of the most important work happens in the nine months before the meeting. For instance, each country is asked to fill out a questionnaire prepared by UNAIDS. Faith-based organisations can participate in the stakeholder consultations at the national level. If there are no consultations with civil society, faith-based organisations can push the government to be included. Whilst labour intensive, civil society coalitions often also write their own "shadow reports" based on their own research and submit them to the national government and UN meetings Additionally, civil society can ask the government to be included on the national delegations to this meeting.

For more information on how to monitor your country's commitments and submit your own shadow reports:

-UNAIDS:http://www.unaids.org/en/CountryResponses/UniversalAccess/default.aspAIDS

-Country Response Information System (CRIS): http://www.unaids.org/en/KnowledgeCentre/HIVData/CRIS/

-Country Harmonisation and Alignment Tool (CHAT): http://data.unaids.org/pub/Report/2007/jc1321_chat_en.pdf

-Accountability International: http://aidsaccountability.org

59 UNAIDS. Accessed Sept. 22: http://www.unaids.org/en/CountryResponses/UniversalAccess/default.asp

3. G-8 Commitment 2005

In 2005, at the G-8 Summit in Gleneagles, Scotland, governments of the "Group of Eight" including France, United States, United Kingdom, Russia, Germany, Japan, Italy, and Canada pledged an immediate doubling of aid to Africa to $50 billion annually in order to fight poverty and disease on the continent, in addition to cancelling at least $40 billion in debt owed by the worlds poorest nations. The communique also included an agreement on providing universal access to HIV/AIDS treatment that pledged to provide 10 million HIV-positive people with treatment access by 2010. [60]

⇢ *If you are from a G-8 country, has your country increased its aid?*

Get Involved: Consider attending G-8 meetings as part of civil society coalitions. Raise awareness about G-8 commitments, and monitor the evolution of the G-20 meetings since the Group of 20 includes developing countries like Brazil, India, China and South Africa who are focused on alleviating poverty and responding to AIDS.

4. Millennium Development Goals – September 2000-2015

At the UN Summit in September 2005, 191 countries agreed unanimously to accelerate progress towards the Millennium Development Goals, which were set in on 2000 at the UN Millennium summit. Goal 6, Target 2 states: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. [61] The fifteen-year goals are well-known by world leaders and the UN has invested many resources on making sure they are achieved.

Goal 6 is not the only goal that affects Universal Access. Achieving the targets of goal 4 & 5 on infant and maternal mortality also depend on decreasing number of deaths of women and children from AIDS. The targets of Goal 8 "Global Partnership for Development" commit high-income countries to work in partnership with medium- and low-income countries to: reduce debt, develop fair, rule-based trading system, provide access to affordable essential drugs in developing countries, and make new technologies available. For example, a country with fewer debt commitments is able to spend more on its health sector, and affordable essential medicines mean that people living with HIV and AIDS can access all the treatment they need for opportunistic infections.

Whilst there has been progress towards achieving the goals, the recent financial crisis means that nearly half of the world's achievements in poverty reduction in the last 10 years have been wiped out in 2008-2009. The World Bank estimates that 130-155 million people were pushed into poverty in 2008 alone because of rising food and fuel prices. High food prices and insecurity has resulted in riots around the world. It goes with out saying that having food to eat is critical to treating HIV. In addition, the World Food Programme estimates that the number of chronically hungry people in the world has surpassed the 1 billion mark in 2009. [62]

⇢ *The next checkpoint to goals is in 2010, will your country meet its commitments?*

60 "G8 Appears To Be On 'Verge Of Backtracking' On Gleneagles HIV/AIDS Commitments, Financial Times Reports". http://www.medicalnewstoday.com/articles/73568.php Accessed: Sept. 21, 2009. See also examples of faith-based advocacy at the G8: http://www.e-alliance.ch/en/s/hivaids/accountability/g8/
61 http://www.un.org/millenniumgoals/aids.shtml Goal 6, Target 2
62 FAO's State of World Food Insecurity, October 2009

Get Involved: Whilst the mid-point for the MDGs passed in 2007, an important review of the progress happens in 2010. Start planning events and mobilisations for 2010 & 2015. As the global food and finance crisis unfolds, monitor and educate people about how it affects the poorest people in the world.

Consider joining the annual "Stand Up Against Poverty" mobilisations, which occurs ever year in October 16-18 all over the world.

More Information: MDG progress indicators http://www.undp.org/mdg/tracking_home.shtml

To get involved in campaigns for the MDGs see: http://millenniumcampaign.org
Stand up Against Poverty: http://standagainstpoverty.org/

Political agendas like universal access are often discussed for years in various forums before they become concrete agreements. Advocates should keep in mind the following forums as strategic meeting places:

International AIDS Conferences: These meetings happen every two years and are attended by thousands of participants including high profile leaders, medical community, private sector, civil society, faith-based groups, donors, governments and international organisations. The conference serves as a giant global conversation on the pressing needs and new learnings of the pandemic, and are strategic events for advocates.

Regional Forums: Every 2 years each region has an AIDS Conference. At each conference there will be a greater chance of media interest and campaigners are well placed to mobilise large numbers of delegates to keep the spotlight on universal access. These forums are great places to connect to national decision makers, and will be listed by region: http://www.worldaidscampaign.org/en/In-country-campaigns
To learn about the next one, go to: http://www.iasociety.org/

2. Universal Access & Human Rights

Universal Access will not be achieved without human rights. Human rights are expressed in and guaranteed by international laws and treaties and in national constitutions and laws. Human rights laws bind governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups. Faith-based organisations have a special responsibility to reflect on and work to promote human dignity and respect by protecting the human rights of people living with or affected by HIV, and those who are vulnerable to infection.

Across the globe many laws have been passed and codes have been written to protect people living with HIV or suspected to be, and to protect people from getting HIV. As early as 1991, the World Health Organization listed 583 laws and regulations concerning HIV infection and AIDS from different countries.[63] Still, the 2008 UNAIDS Report on the Global AIDS Epidemic, [64] cites the need for sustained progress in addressing human rights violations, gender inequality, stigma and discrimination as essential to the long-term success in the response to the epidemic.

Stigma and discrimination are among the most recognised harmful features of the epidemic, yet almost no country has prioritised activities to reduce or eliminate them in their national HIV and AIDS plans or programmes.

Ten Reasons why human rights should occupy the centre of the global response to HIV [65]

1. Universal access will never be achieved without human rights.
2. Gender inequality makes women more vulnerable to HIV, with women and girls now having the highest rates of infection in heavily affected countries.
3. The rights and needs of children and people living with HIV are largely ignored in the response to HIV, even though they are the hardest hit in many places.
4. The worst affected receive the least attention in national responses to HIV.
5. Effective HIV prevention, treatment and care programmes are under attack.
6. HIV and AIDS activists risk their safety by demanding that governments provide greater access to HIV and AIDS services.
7. The protection of human rights is the way to protect the public's health.
8. HIV and AIDS poses unique challenges and requires an exceptional response.
9. "Rights-based" responses to HIV are practical, and they work.
10. Despite much rhetoric, real action on HIV and AIDS and human rights remains lacking.

Learn more: For a deeper look at the links between Universal Access and Human Rights, see Worksheet 6.

63 UNAIDS, Courting Rights: Case Studies in Litigating the Human Rights of the PLHIV http://data.unaids.org/Publications/IRC-pub07/jc1189-courtingrights_en.pdf
64 UNAIDS, 2008 Report on the Global AIDS Epidemic http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008_Global_report.asp
65 Jürgens R and Cohen, J – OSI, Human Rights and HIV/AIDS: Now More Than Ever. http://www.soros.org/initiatives/health/focus/law/articles_publications/publications/human_20071017/english_now-more-than-ever.pdf

Key Human Rights issues

Stigma and Discrimination

Since the 1980's, stigma and discrimination have been cited as one of the most significant barriers to reducing HIV. [66] Because it is so persistent on so many levels—families, communities, popular culture, institutions and governments—countering stigma and discrimination demands a global, national and community response. As moral authorities, religious communities have a particular responsibility to stand up for and work with people who are being discriminated against. Unfortunately, especially during the early stages of the pandemic, some religious communities spread misinformation and exacerbated stigma, for example refusing to serve communion to HIV-positive church-goers, or calling AIDS a punishment from God for sins or disobedience.

There is still a great need for programmes that counter stigma and discrimination and religious communities can take a leadership role by encouraging greater participation of people living with HIV in all levels of decision-making.

Women and girls and human rights

The special vulnerabilities of women to HIV have long been recognised. The stories of today are the same stories told over two decades of the epidemic—such as violence against women and girls, including for example spousal abuse, rape in conflict or not, sexual abuse by "caretakers," sexual exploitation, assault for not conforming to gender norms, as well as violations such as the deprivation of property inheritance rights and other economic assets, and the inability to collect health and death benefits. Some women living with HIV have been forcibly sterilised without their consent. Women also need information and access to comprehensive sexual and reproductive health services. Again, the problem is not a lack of awareness of the violations of the rights of women and girls; it is a failure to act in ways to stop these violations.

Religious communities can also step forward with advocacy and programmes that counter the violations of women and girls human rights, particularly violence against women because of their role influencing family behaviour and gender norms. This can be through making places of worship safe spaces where women can get support and access to services if they are facing domestic violence, have been thrown out of the house because of their HIV status or are facing disinheritance of their property after their spouse's death. This also means publicly denouncing domestic violence and encouraging men to learn about gender equality. For example, the Fellowship of Christian Councils and Churches in the Great Lakes and Horn of Africa (FECCLAHA) has launched the Tamar Campaign to encourage Churches to speak out openly against abuse and violence through using contextual bible study. [67]

66 UNAIDS, 2008 Report on the Global AIDS Epidemic http://data.unaids.org/pub/GlobalReport/2008/JC1511_GR08_ExecutiveSummary_en.pdf
67 For more information: http://www.fecclaha.org/

Travel Restrictions

In the early days of the HIV and AIDS epidemic, governments often took actions that were motivated by fear and misunderstanding that proved neither beneficial to the health crisis in general, nor the people affected by it. One such example was travel restrictions to slow or all together stop people living with HIV from travelling to countries with the restrictions. In the 20 years since, a number of countries have lifted these restrictions because the public health community declared them ineffective and discriminatory. In spite of this, 74 countries still have some form of HIV specific travel restrictions, and 12 countries ban people living with HIV from entering the country for any reason or length of time. [68] After years of advocacy from civil society including faith-based organisations, the United States lifted their travel ban on persons with HIV in November 2009.

Religious leaders can use their moral authority to point out the injustice and discrimination of these laws. For example, the Ecumenical Advocacy Alliance has encouraged members to advocate with their own national governments and used a game to raise awareness (see http://www.e-alliance.ch/en/s/hivaids/stigma/travel-game/)

Criminalisation

Masquerading under the guise of preventing HIV infection, many countries have laws designating the transmission of HIV a criminal offence, and in some countries even exposing someone to HIV can be prosecutable. In Western and Southern Africa model laws are being drafted that contain aspects of criminalisation of HIV transmission. There is no evidence to support the view that criminalising HIV is an effective prevention strategy. In addition, there are potentially negative implications for marginalised groups already stigmatised as likely to be HIV positive, such as men who have sex with men and sex workers. [69]

Criminalisation is a symptom of societies more willing to look for scapegoats rather than mounting serious prevention programmes that are geared towards marginalised groups. What does it say about societies who would rather jail the person with HIV rather than trying to promote prevention in the first place?

Faith communities should be vigilant and speak out for the rights of those who are persecuted because of their HIV status. Additionally, many faith communities have outreach programmes within prisons for counselling and spiritual care. Faith communities can be sensitive to how prisoners living with HIV are treated and if they are accessing the services they need.

Right to Prevention

The ability to protect oneself from HIV depends on accurate and complete information about the modes of transmission of HIV, methods of prevention, and sexual and reproductive health, as well as access to resources for prevention. The right to know how to prevent disease is broadly included in the right to health and the right to education. While the right to education may be narrowly defined as the right to attend a formal education institution, HIV education should be taught as part of wider health education—both formal and informal. Providing information on

68 Denying Entry, Stay and Residence due to HIV Status - http://www.ua2010.org/en/UA2010/Universal-Access/Travel-Restrictions
69 For more information: http://www.worldaidscampaign.org/en/Constituencies/Youth/Resources/Criminalization

only one form of prevention (use of condoms or abstinence or partner reduction) as the only way to protect oneself from HIV, without providing broader knowledge of how the virus is contracted and the multiple ways of protecting oneself, is in one sense a denial of human rights. However, along with having the knowledge about prevention, people need to have the support and access to appropriate resources in order to use the knowledge effectively.

Faith communities must not forget that prevention is one of the most important parts of the HIV response. Accurate and comprehensive information about HIV and sexual and reproductive health is proven and simple way to prevent the spread of HIV. Promoting comprehensive HIV prevention means speaking out about the factors and myths that put people at risk of infection. Preventing the spread of HIV in the first place is much easier and cost-effective than treating it later. [70]

70 For examples of what faith-based organisations are doing about prevention, see: http://www.e-alliance.ch/en/s/hivaids/prevention/

Conclusion

There are many components to advocacy for universal access. We hope you have found tools in this guide for:

- Inspiration and leadership
- Creating a campaign strategy
- Meeting face-to-face with decision-makers
- Knowing your epidemic and building on existing responses
- Networking with global coalitions and building your own
- Knowing existing commitments to universal access and making the link to human rights.

This movement for universal access will take everyone. Thank you for being a part of it.

Worksheets

How to use these worksheets: These worksheets are intended to help you deepen your understanding of advocacy.

Campaigners are encouraged to discuss the worksheets in groups while developing their plans. Each worksheet has several discussion questions for you to consider. They could also be used as teaching tools or handouts at community workshops.

Worksheet 1: Advocacy approaches

THREE APPROACHES TO ADVOCACY

1. For the People: Issues are identified and advocated for by outsiders.

+ Quick access to decision-makers.
+ Good access to information about wider context.
- May strengthen existing power structures
- May not increase capacity of local groups to act.

2. With the People: Issues are identified by the community and outside organisers mobilise capacity for advocacy.

+Increase access of affected people to decision-makers.
+Advocacy skills and capacity developed.

-Outsiders set the agenda.
-Slower because building consensus takes time.

3. By the People: Issues are identified and advocated for by the community.

+Affected people see themselves as agents of change.
+Sustainable.
+Can correct power imbalance.
-Access to fewer resources and information.
-Policy change may take longer

LEVELS OF ADVOCACY

International
Declaration of Commitement, Trade in antiretrovirals

Regional
Trafficking and prostitution

National
HIV/AIDS policy; national commitment to international agreements; criminalisation

Local authority
Access to HIV testing, counselling services, treatment; HIV and AIDS curriculum in schools

Community care and support for infected/affected community members; Stigma and discrimination

Family negotiating safe sex with partners; Prevention of mother-to-child transmission

Inter-personal drug use; safe sex

Discussion Questions:

1. Is your campaign doing advocacy for, by and with the people?
2. Is your advocacy local, national, regional or international?
3. What would you do if you were to expand your advocacy from one level to another level?

These charts have been adapted from Tearfund's Practical Advocacy in Action.

Worksheet 2: Advocacy concepts

	Advocacy	Information, Education & Communication	Community Mobilisation	Networking & Partnerships	Fundraising & Resource Mobilisation	Overcoming Stigma and Discrimination
What can it change?	Policies, Implementation of policies, laws and practices	Awareness & behaviour	Capacity of communities to identify and address problems	Isolation & duplication	Level of resources available for HIV/AIDS work	Level of stigma and discrimination against people
Target group	Decision-makers, policymakers, leaders, people in positions of influence	Particular age group, gender, residents of an area, etc.	Members of a community	Individuals or groups who have a similar agenda	Communities, local councils, government, donors	People who stigmatise or discriminate
Does it mainly target people who have influence over others?	Yes	No	Yes	No	Yes	No
Typical indicators of success	Policies, Implementation, laws or practices which enable improved HIV and AIDS prevention and care	Percentage of youth delaying sexual debut; changes in attitude to people living with HIV and AIDS	A community problem is solved; more people attend community meetings	Members of the network or partnership achieve more than they could if they worked alone	Farmer gives use of building for meetings; members of mosque give alms; donor gives grant	Fewer workers dismissed because of HIV status; less cases of depression among people living with HIV/AIDS

Discussion Questions:

1. Which category does your campaign fall into?
2. If it fits more squarely in another category other than advocacy, can you include an advocacy component, i.e. targeting people with influence over others?

This table was is adapted from its original version in the Advocacy in Action Toolkit prepared by the International AIDS Alliance: http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=142.

Worksheet 3: Planning a community

This outline is to get you started. You should adapt it to best fit your context.

1) Organise a plenary discussion on HIV-related issues specific to your country and community. Invite speakers from different sectors, such as women's organisations, health ministries, non-governmental organisations, youth organisations, networks of and people living with HIV and other faith communities.
2) Host your plenary in a place of worship and open with a word of prayer, keeping in mind being inclusive of those who do not share your faith.
3) Have each panellist share their knowledge and experiences, as well as their recommendations on which areas of advocacy are most urgent. Make sure at least one of the panellists can give an accurate and comprehensive overview of how HIV is affecting your community.
4) Have participants break into small groups.
5) Ask each group to construct an issue-ranking matrix (see Worksheet 4) for any HIV-related advocacy issues that come to mind. This entails assigning 1-5 points to each issue for each of the following criteria. The higher number of points renders the issue more desirable for advocacy:
    - o Potential for being solved through advocacy
    - o Benefits for people affected by the issue
    - o Possibilities to involve those affected by the issue

Notes:
- o Ask participants to add up the points for each issue and share with others their highest-scoring issues. Remind participants that ideally their issue-ranking matrix would be informed by research and consultations with affected parties and others.
- o Adjust this exercise and criteria as is relevant to you. Instead of using the matrix, you could simply have small groups come to consensus on their top priority issues.

6) Have the small groups share their priorities with the plenary, then facilitate consensus around one priority advocacy issue. The greater the consensus and ownership of the issue, the greater your chances of success.
7) Take a list of everyone who wants to be involved in this advocacy campaign. Designate a leadership group including men and women to plan the next steps for your campaign. You can use the tools in this guide to determine your objectives, tactics, message and timing.

This section was inspired by Global Youth Coalition's Political Advocacy Toolkit

Worksheet 4: Advocacy issues identification

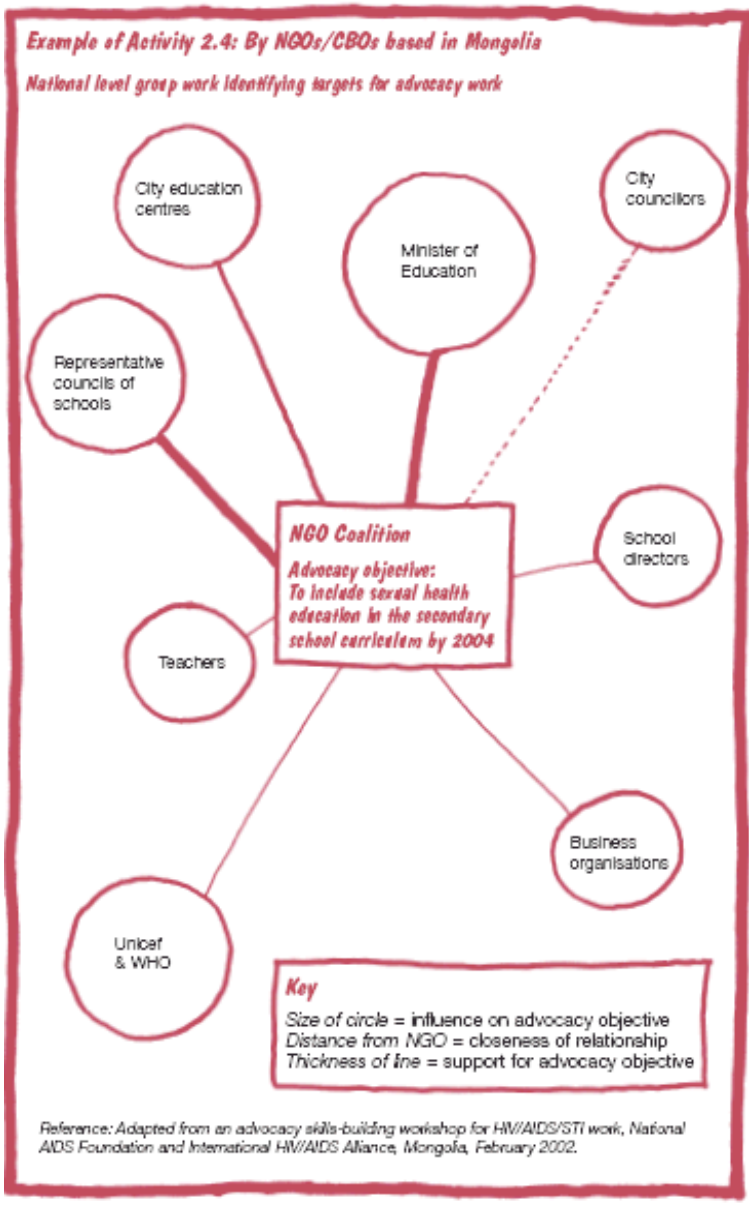
This table is a useful and easy tool to use to determine whether a campaign will be viable. You can fill it in as an individual or in a small group. You can expand the table to include other key questions and you can set the outcome level as you wish. Assign a rank of one to five for each category. The issue with the highest number of points will likely be your top priority.

ISSUES	CRITERIA				
	Can the issue be solved by advocacy?	Will many people be motivated to advocate?	Benefits for people affected	Possibilities to involve those affected	Totals

This worksheet is adapted from the International AIDS Alliance's Advocacy in Action Toolkit, available www.aidsalliance.org/.../adv0602_Advocacy_toolkit_eng.pdf

Worksheet 5: Mapping your NGO coalition

Use this example from Mongolia to help you draw your own campaign map. Notice that thin lines are weak links and thick lines are strong ones. This map was taken from the National AIDS Foundation and HIV/AIDS Alliance in Mongolia.



Worksheet 6: Know your human rights for universal access and network matrix

Important Rights for People Living with HIV and AIDS

Human Right	*What does it mean for people living with HIV*
Right to equality, right to dignity	A person cannot be discriminated against because of their HIV status.
Right to liberty and security of person	A person has the right to make their own decisions about themselves, for example, a person may not be forced to take a HIV test.
Right to privacy	People living with HIV have the right not to disclose their HIV status.
Right to freedom of movement	No person should have travel restrictions imposed on them because of their positive status.
Right to health	People living with HIV have the same rights to health care and to access treatment as all other people. People living with HIV may not be denied health care and treatment services because of their status. People living with HIV have the right to sexual and reproductive health. All people have right to knowledge and means to prevent themselves from HIV infection.
Right to work	People living with HIV have the same right to work as other people. Nobody may be denied work opportunities because of their positive status.

UNAIDS, for more info: http://www.unaids.org/en/PolicyAndPractice/HumanRights/default.asp

Additional Resources

Advancing Reproductive Health and Family Planning through Religious Leaders and Faith-Based Organizations. Pathfinder International, August 2006.
http://www.pathfind.org/site/DocServer/FBO_final_reference.pdf?docID=6901

Advocacy in action – A toolkit to support NGOs and CBOs. International Council of AIDS Service Organizations (ICASO), January 2002.
http://www.aidsalliance.org/custom_asp/publications/view.asp?publication_id=142

Developing Strategic Plans: A Tool for Community- and Faith-Based Organizations Communities Responding to the HIV/AIDS Epidemic (CORE), March 2007.
http://coreinitiative.org/Resources/publications.php

Engaging with the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Primer for Faith-Based Organizations. Friends of the Global Fight, 2007.
www.theglobalfund.org/documents/friends/TGF_APrimerForFBO.pdf

Exploring Solutions: How to Talk about HIV Prevention in the Church, Ecumenical Advocacy Alliance, 2008.
http://www.e-alliance.ch/en/s/hivaids/publications/exploring-solutions/

Faith untapped. Why churches can play a crucial role in tackling HIV and AIDS in Africa. Tearfund, August 2006.
http://www.tearfund.org/webdocs/Website/Campaigning/Policy%20and%20research/Faith%20untapped.pdf

HIV/AIDS Advocacy and Media Relations Manual + Stigma and Discrimination Handbook Religions for Peace, 2008.
http://www.wcrp.org/resources/toolkits/HIV

HIV, AIDS, & Islam: A Workshop Manual Based on Compassion, Responsibility and Justice. Positive Muslims, 2007.
http://coreinitiative.org/Resources/publications.php

HIV Prevention: A Global Theological Conversation. Ecumenical Advocacy Alliance, 2009.
http://www.e-alliance.ch/en/s/hivaids/publications/theological-conversation

Keep the promise! A teaching resource on advocacy and HIV and AIDS. Ecumenical Advocacy Alliance, 2006.
http://www.e-alliance.ch/en/s/hivaids/keep-the-promise/

Moments in Time HIV/AIDS Advocacy Stories. The Policy Project, July 2003.
http://www.policyproject.com/stories/

ROOTS 1 - Understanding Advocacy. Tearfund, 2002.
http://tilz.tearfund.org/Publications/ROOTS/Advocacy+toolkit.htm

ROOTS 2 - Practical Advocacy in Action. Tearfund., 2002.
http://tilz.tearfund.org/Publications/ROOTS/Advocacy+toolkit.htm

The Global HIV/AIDS Pandemic, an educational resource on the Jewish response to the pandemic. American Jewish World Service, 2005.
http://www.ajws.org/what_we_do/education/hiv_aids.html

Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organizations in the response to HIV and AIDS, Ecumenical Advocacy Alliance, 2006.
www.e-alliance.ch/hiv_faith_guide.jsp

What Religious Leaders can do about HIV/AIDS. Religions for Peace, 2004.
http://www.wcrp.org/resources/toolkits/HIV-AIDS

Appendix 1

AN HIV COMPETENT CHURCH…

is a church that has first developed an inner competence through internalisation of the risks, impacts and consequences and has accepted the responsibility and imperative to respond appropriately and compassionately. In order to progress to outer competence, there is need for leadership, knowledge and resources. Outer competence involves building theological and institutional capacity in a socially relevant, inclusive, sustainable and collaborative way that reduces the spread of HIV, improves the lives of the infected and affected, mitigates the impact of HIV and ultimately restores hope and dignity.

THE PROCESS TOWARDS HIV COMPETENCE
INNER COMPETENCE
Acknowledge the scope and risk of HIV: attitude change

1. Personalise / internalise the risk in an honest open way.
2. Recognise the impact and consider long term consequences.
3. Assess the risk factors that increase vulnerability.
4. Confront stigma, discrimination and denial associated with HIV. Accept the imperative to respond appropriately and with compassion.

THE BRIDGE BETWEEN INNER AND OUTER COMPETENCE

- Leadership
- Knowledge
- Resources

OUTER COMPETENCE

1. Develop theological competence on HIV.
2. Develop technical competence through building institutional capacity to plan, implement, monitor and evaluate and coordinate HIV programmes effectively.
3. Ensure social relevance, inclusivity and seek to build social cohesion.
4. Network: seek allies and collaborate for increased scale and sustainability.
5. Advocate and reclaim the prophetic role of the church.
6. Restore dignity and hope, with compassion, to all who are infected and affected.

Dr Sue Parry, HIV Competent Church, EHAIA documentation

For more information see EHIAA at: http://www.oikoumene.org/en/programmes/justice-diakonia-and-responsibility-for-creation/hivaids-initiative-in-africa-ehaia.html