

HIV, HEALTH & RIGHTS

SUSTAINING COMMUNITY ACTION

STRATEGY 2013-2020





About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

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Design by Progression

Cover from L-R:
The Banda family received support
via a four-country maternal health
programme in Africa. © Alliance

The Alliance works with the most
vulnerable populations across the
Caribbean. © Alliance

MAC engages the religious department
to raise HIV awareness and tackle
relate stigma. © Gavin Gough for the
Malaysian AIDS Council (MAC)

Beneficiaries of an antiretroviral
treatment programme.
© Gideon Mendel for the Alliance

Unless otherwise stated, the
appearance of individuals in this
publication gives no indication of
either sexuality or HIV status.



Foreword

From the very beginning of the Alliance, in 1993, we decided to take a long-term view. We chose to tackle the HIV epidemic by championing community-led programming and South-to-South cooperation. Our approach remains highly relevant as we embark on this next chapter in our own history, and in the history of the AIDS response.

After 20 years of collective action, we have accumulated a wealth of experience and expertise across four continents. Guided by a new vision, this new strategy articulates the determination of the wide range of community leaders, activists, programme managers and civil society advocates who make up the Alliance global partnership.

The good news is that we find ourselves on the threshold of one of the greatest opportunities of our times – the potential to end AIDS. With scientific advances and robust evidence of what works, that goal is no longer a distant dream but a realistic objective. The Alliance is committed to harnessing these opportunities and leveraging the political and financial support required to support the implementation of this strategy.

But we do not underestimate the challenges ahead of us. Millions of people are still not getting the life-saving treatment they need. Key populations remain stigmatised, discriminated against and criminalised. Civil society support is ever more fragmented. All of this must be addressed if we are to achieve a sustainable response.

HIV, health and rights: sustaining community action has been developed through wide consultation with Alliance Linking Organisations and partners, and has been approved by our international board of trustees. It provides high-level direction and sets ambitious but measurable goals for the whole Alliance. Linking Organisations will use it – together with their own national plans – to shape their future strategies, and the international secretariat will use it to develop an operational plan. In 2015 we will review our operating environments and our progress, and revise the goals up until 2020 accordingly.

This strategy unites our efforts to bring about a world without AIDS.

Alvaro Bermejo
Executive Director

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“We are going to need the Alliance and this strategy to really believe in us as Linking Organisations. We will work to ensure the reciprocity of the Alliance relationship is not just embedded into the strategy but enacted.”

Casper Erichsen,
Executive Director,
Positive Vibes (Namibia)

Executive summary

HIV, health and rights: sustaining community action aims to ensure that governments and civil society remain committed to a sustained response to HIV.

The epidemic is continuing to result in millions of deaths every year. Millions of people are denied their human rights, and are experiencing ill health, isolation, abuse and financial insecurity as a consequence. This strategy responds to a number of critical external factors: the unfinished Millennium Development Goals; the rapid withdrawal of development financing from middle-income countries; a more inclusive model of country ownership; and scientific breakthroughs that present new opportunities to end AIDS. We have set out three results and three responses to drive forward our strategy. A fourth response addresses the common factors that underpin our strategy and will make it happen.

Result 1: Healthy people

Response 1: Increase access to HIV and health programmes

To achieve an impact on the epidemics, evidence-based HIV and health programmes must target those most in need. In concentrated epidemics our focus will be on the key populations that are vulnerable to or affected by HIV and AIDS. That includes people living with HIV, their partners and families, men who have sex with men, transgender people, people who use drugs, people who sell or buy sex, children affected by HIV and AIDS, migrants, displaced people and prisoners. In generalised epidemics where women and girls are disproportionately affected, this will be where we will direct our attention, along with other key populations.

In order to successfully prevent HIV infection, provide care and treatment, and improve people's health, we need to intervene at different levels: individual, community, service and structural. Our programmes use a combination prevention approach that promotes actions at each of these levels. Our programmes for people living with HIV are informed by the principles within the *Positive health, dignity and prevention framework*.

To achieve our result we will:

- increase the coverage, scope and quality of HIV and health programmes
- deliver programmes that prevent HIV infection; increase access to HIV testing and counselling; provide care and support and improve access and adherence to antiretroviral treatment
- respond to new HIV prevention technologies as part of a combination approach to HIV prevention
- integrate our HIV programmes into national and state health systems and programmes, with a particular focus on integrating HIV prevention and care into sexual and reproductive health and tuberculosis services
- advocate for HIV prevention, care and treatment programmes provided by other sectors to be friendly and accessible for key populations. We will also advocate for them to work closely with community organisations and networks to ensure strong coordination, case management and a continuum of care
- work to create an enabling social and legal environment, concentrating our efforts in countries where we can have the greatest impact.

Result 2: Stronger health and community systems

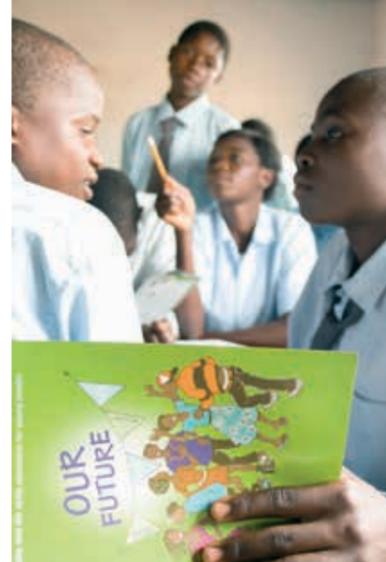
Response 2: Support community-based organisations to be connected and effective elements of health systems

Health systems need to be strengthened to address HIV and health for those people most affected, and marginalised by and vulnerable to HIV. Mobilised, connected, and effective community-based organisations are a vital part of health systems. They create demand for services, they deliver services, and they provide a bridge to government services, especially for key populations.

Strong communities are essential to stopping HIV transmission, providing HIV treatment and care, safeguarding health, and protecting the rights of people with HIV. We aim to complement the work of national governments that are ultimately responsible for meeting universal access goals and upholding the human rights of their citizens. Sustained responses will require, in most countries, significant changes in the civil society landscape and in the way government and civil society organisations work together.

To achieve our result we will:

- support community-based organisations with technical and financial resources to build their leadership and programmatic capacity. This will enable them to work effectively with government, the private sector and other organisations active in health and human rights
- go beyond an emphasis on strengthening individual organisations to a focus on community and health systems strengthening
- develop and test new models in different contexts so wherever we work, strong community-based organisations will address the HIV and health needs of their communities by working as part of a wider system.



A sexuality and life skills class, in Chipata, Zambia, where young people were involved in the development of the 'Our Future' textbook. © Alliance

Result 3: Inclusive and engaged societies

Response 3: Advocate for HIV, health and human rights

Much HIV funding continues to be misdirected to generalised HIV programming and HIV prevention activities for low-risk populations. Where countries are increasing domestic expenditure, funds are largely covering the costs of HIV treatment. Yet many people in need are still not getting life-saving treatment. There is limited evidence to demonstrate that countries are substantially increasing domestic investments to target key populations. These groups remain stigmatised, discriminated against and criminalised. We are gravely concerned by the increase in government actions to enforce existing or draft new punitive laws, such as those criminalising sexual minorities. This needs to change.

To achieve our result we will:

- advocate for structural and political changes that will improve access to and availability, affordability and quality of health services, and that promote human rights
- focus our advocacy against the criminalisation of HIV transmission, and of sex between men, sex work and drug use because these laws undermine effective HIV programming and violate the human rights of the people we support
- provide technical support to strengthen civil society and key population participation in decision-making
- advocate for greater government transparency and accountability on HIV, health and human rights, policymaking and health spending
- work in partnership with national civil society coalitions and platforms.

Making it happen

Response 4: Build a stronger Alliance

The shifts this strategy requires are significant. Scaling up responses to have a greater impact on HIV requires our programmes to be more cost-effective and integrated. Sustainability is essential, and we will seek the financial and political support needed to deliver our goals.

Through the South-to-South learning and cooperation championed by our Linking Organisations and regional Technical Support Hubs, the entire global Alliance will play a role.

To deliver this strategy we will:

- work in new ways and nurture new skills so we can be better at connecting health and community systems, and at understanding government budgeting and contracting processes
- build partnerships with public and private sectors, and learn to mobilise resources from new and diverse non-governmental income sources
- intensify existing Alliance approaches to capacity-building, knowledge-sharing, quality programming and evidence-based policy and advocacy
- differentiate our approach in low- and middle-income countries.

In line with the Millennium Development Goals timeframe, *HIV, health and rights: sustaining community action* sets a long-term vision for the Alliance up until 2020, with clear targets from 2013 to 2015. In 2015 we will review our progress in order to assess what needs to be done from 2016 to 2020.

The HIV epidemic, health, development and human rights

In 2000 United Nations Member States committed to the Millennium Development Goals. The world was galvanised by these development priorities that included a goal to combat HIV/AIDS, malaria and other diseases. Yet despite much progress, it is clear that the Millennium Development Goal targets will not all be met by the end date of 2015, and that progress varies greatly by country and region.

There are 34 million people living with HIV globally.¹ More than half do not know they are HIV positive. In 2011 1.7 million people died of AIDS-related causes and there were 2.5 million new HIV infections. Tuberculosis and conditions associated with hepatitis B are common causes of death for people with HIV. Yet most AIDS deaths can be prevented with access to antiretroviral therapy. In 2011 only 54% of the estimated 14.8 million people eligible for HIV treatment in low- and middle-income² countries were receiving antiretroviral therapy. Poor sexual and reproductive health and HIV infection share many root causes: poverty, gender inequity, stigma, discrimination, violence and harmful cultural norms.

The external context is turbulent. Since 2000, and in a silent march, many countries with large HIV epidemics have graduated from low-income to middle-income status. Now, two-thirds of people living with HIV are living in middle-income countries.³ Infection rates are rising in Eastern Europe, Central Asia and the Middle East. A significant withdrawal of donor aid from most middle-income countries in Asia, Eastern Europe and Latin America and the Caribbean



Sex workers expressing their solidarity in Anantapur, Andhra Pradesh.
© Peter Caton for India HIV / AIDS Alliance

1. UNAIDS (November 2012), Report on the global AIDS epidemic 2011.

2. World Bank (2011), Country and lending groups. In order to clarify the context in which the Alliance will be working during the period of this strategy, we use low-income countries to refer to official development assistance (ODA) prioritised states and middle-income countries to refer to non-ODA prioritised states. ODA-prioritised countries are those where external donors are in active partnership with local actors (most of sub-Saharan Africa) and non-prioritised states those where domestic governments and the local agenda define the response (typically countries in Latin America, Asia and Eastern Europe).

3. World Bank country income status, people living with HIV country estimates – UNAIDS, report on the global AIDS epidemic, 2010.

means that political and financial commitment in these regions may decline sharply. Governments in middle-income countries in particular will bear greater responsibility for achieving health outcomes for their own citizens. However, there are welcome signs that domestic financing for HIV and AIDS is increasing.⁴

The North-to-South development assistance model is shifting towards greater South-to-South cooperation. The world is increasingly multipolar. New and emerging economic and political forces bring new priorities and approaches. Civil society will find a more fragmented base of support – and in many instances, no support at all. In some countries, the continuity of effective HIV programmes and the sustainability of civil society's contribution are at risk.

Structural factors create barriers to the realisation of health and human rights. The factors influencing HIV vulnerability and causing AIDS deaths are complex and deep-rooted. Particular issues relevant to our mission include: poor social protection; laws that criminalise sex work, sex between men and drug use; gender inequity and gender-based violence; poverty; weak health systems; isolated and poorly resourced community systems; discriminatory employment practices; limited livelihood opportunities; and human rights violations, such as the criminalisation of HIV transmission.

Addressing these challenges is difficult work, and it requires sustained engagement from affected communities themselves. We recognise the battles won and the progress made so far to prevent HIV transmission, provide care and treatment to people living with HIV, and strengthen communities affected by HIV and AIDS. This is the result of the determination of activists and civil society, and those health care workers who are supportive and well trained. It is also the result of the rallying call of the Millennium Development Goals and an unprecedented global response by donors and governments. Overall, the number of people becoming infected with HIV continues to fall. For the first time people are talking about the possibility of bringing an end to AIDS – one of the most ambitious goals in the history of global health.

Opportunities for the Alliance include a consensus that our model – community-led programming and South-to-South cooperation – is a way towards lasting solutions. Scientific advances, behaviour change and structural interventions have been proven to reduce HIV transmission and improve health outcomes. Many political leaders have made commitments to halting the epidemic and protecting human rights.⁵ An emerging emphasis on the democratic ownership of development priorities⁶ presents particular opportunities. Key to the concept of 'democratic ownership' is a more inclusive model for country ownership, where the role of civil society is seen as vital. Civil society must own the development process and its goals. Participation, transparency and accountability are critical.

Addressing these challenges and harnessing these opportunities is how we will make a significant contribution to ending AIDS.

Amidst all the optimism of an AIDS-free generation, I sense danger. Danger that the effective community responses we have built up over many years of hard work, and with the significant investment by international donors, will falter. We must NOT stop now!

Tanya Deshko, Alliance Ukraine, Programme Manager of the Community Action on Harm Reduction Programme

4. Together we will end AIDS (UNAIDS, July 2012) stated that low- and middle-income countries invested US\$8.6 billion for the response in 2011, an increase of 11% over 2010. According to the report, 81 countries increased their domestic investments for AIDS by more than 50% between 2006 and 2011.

5. United Nations (June 2011), Political declaration on HIV/AIDS: intensifying our efforts to eliminate HIV/AIDS

6. Wood, B. et al. (2011), The evaluation of the Paris Declaration: final report. See also Javier Pereira (2011), Democratic ownership beyond Busan: building inclusive partnerships for development, Alliance 2015.



Response

1

Increase access to HIV and health programmes

To achieve an impact on the epidemic, evidence-based HIV and health programmes must target those most in need. That includes people living with HIV, their partners and families, men who have sex with men, transgender people, people who use drugs, people who sell or buy sex, children affected by HIV and AIDS, migrants, displaced people and prisoners. These are the key populations at higher risk of HIV with whom we work.

We recognise that in order to successfully prevent HIV infection and improve people's health, we need to intervene at different levels: individual, community, service and structural. Our programmes use a combination prevention⁷ approach that promotes actions at each of these levels. We deliver a context-specific and results-oriented response that promotes safe practices (sexual and injecting); increases the uptake of services and commodities; addresses social and structural barriers to health and builds social capital for health. Our programmes for people living with HIV are informed by the *Positive health, dignity and prevention* framework⁸ and are committed to its key principles: empowerment; gender equality; health promotion and access; human rights; preventing new infections; sexual and reproductive health and rights; social and economic support and measuring impact.

Taking antiretroviral treatment. © Alliance



"I have been HIV positive for 10-12 years. Now methadone has replaced heroin. That's the most important change in my life. Now I take this medicine I can manage my addiction. I feel optimistic, totally different from before."

Nga, who accesses harm reduction services provided by the Centre for Supporting Community Development Initiatives (SCDI) in Viet Nam

7. The combination prevention approach seeks to achieve maximum impact on HIV prevention by combining behavioural, biomedical, and structural strategies that are human rights based and evidence informed, in the context of a well-researched and understood local epidemic (UNAIDS terminology guidelines, 2011)

8. GNP+, UNAIDS (2011), *Positive health, dignity and prevention: a policy framework*

OBJECTIVES

The Alliance will deliver evidence-based HIV and health programmes targeting those most in need. We will continue to deliver programmes that prevent HIV infection; increase access to HIV testing and counselling; provide care and support, and improve access and adherence to antiretroviral treatment. In addition to delivering programmes and services ourselves, we will continue to advocate for HIV prevention, care and treatment programmes provided by other sectors to be friendly and accessible for key populations. We will also advocate for them to work closely with community organisations and networks to ensure strong coordination, case management and a continuum of care. Our HIV programmes will be integrated into national and state health systems and programmes, with particular focus on integrating HIV prevention and care into sexual and reproductive health and tuberculosis services.

We will continue to work to create an enabling social and legal environment for HIV prevention, care and treatment. This means addressing gender inequity and defending the rights of people living with HIV, sexual minorities, people who use drugs and sex workers. It also means addressing HIV-related stigma and discrimination, and advocating for laws and policies that promote and support evidence-based HIV prevention, care and treatment.

Scientific developments, in particular advances in HIV prevention technologies, will become a focus of our work. New technologies based on the HIV prevention potential of antiretroviral therapy (for example, microbicides, pre-exposure prophylaxis, treatment as prevention) will become more important, widening the range of HIV prevention tools available to people.

We will continue to advocate for HIV prevention technologies that make sense to people in their daily lives and that empower women. These include, as part of a combination approach to HIV prevention, male and female condom use, harm reduction interventions, behaviour change communication, and building knowledge and skills to negotiate safer sex and safe injecting. We will work to ensure that HIV-affected communities are engaged and well prepared to benefit from new developments in medicines and other technologies. We will also aim to shorten the timeframes between proof of efficacy and implementation of programmes that deliver new HIV prevention technologies to people.

Our investment will be concentrated in the countries where we can have the greatest impact. This may require expansion into new low-income countries, predominantly but not exclusively in sub-Saharan Africa. In countries where we already have a presence, we will increase programme coverage and scope. However, in these challenging times some organisations may not survive in countries where our ability to impact on the epidemic is low, or the burden of the epidemic itself is lower.

Health promoters travel by foot, by canoe or by motorcycle to reach communities, Ecuador. © Jorge Vinueza for Kimirina



Result Healthy people

How we work will differ from country to country depending on the specific nature of the epidemic and the operating environment. In generalised epidemics where women and girls are disproportionately affected, we will direct more attention to them. We will maintain our efforts to increase the capacity of families and communities to support and care for children affected by or vulnerable to HIV and AIDS. In many countries with generalised epidemics, HIV prevalence rates among key populations are high. We will work to address this. In concentrated epidemics our focus will be on key populations. In both generalised and concentrated epidemics young people's needs will be addressed. We will especially address the HIV needs of young people most vulnerable to HIV, including those who use drugs, young women in intergenerational relationships, and young men who have sex with men.

A peer outreach service provides safer injecting equipment harbour side in a fishing community, Malaysia. © Alliance



We need to rapidly apply new science and innovation to improve the effectiveness and efficiency of our programming. We know that in some middle-income countries we will have to adapt to different income sources and find new ways of recovering costs. This may be through national and local government contracting or charging fees for services for those who can afford to pay.

Our regional Technical Support Hubs will deliver high-quality technical support to strengthen the capacity of our organisations and partners to increase the coverage, scope and quality of our HIV and health programmes.

Targets 2013-2015*

In **25%** of Alliance countries, the Alliance contributes 10% or more of the national coverage for HIV prevention, care or treatment, as reported to national HIV coordinating bodies

In **12** countries in sub-Saharan Africa, the Alliance has doubled its coverage among men who have sex with men, sex workers or women living with HIV with a tailored package of HIV services

In **15%** of Alliance countries, the Alliance contributes to a 5% increase in contraceptive prevalence rates (modern methods) among young people affected by HIV

In **50%** of countries targeted by UNAIDS as having the highest prevalence of HIV among people injecting drugs, the Alliance is the largest civil society provider of evidence-based harm reduction services

One million women and girls are reached by the Alliance's HIV and integrated sexual and reproductive health programmes

**In 2015 we will review our progress in order to set new targets for 2016-2020.*

Response 2

Support community-based organisations to be connected and effective elements of health systems

HIV starts and ends in communities. We believe that the best place to act on HIV – to prevent transmission or to provide care, support and treatment – is in communities. For these actions to be effective we need to mobilise communities and strengthen community systems.

Health systems need to be strengthened to address the needs of people most affected by and vulnerable to HIV. Community-based organisations achieve this by creating demand for services, by providing services directly, and by providing a bridge to government services, in particular for the key populations with whom we work. Connected and effective community-based organisations are vital components of health systems: linking, reaching, mobilising and advocating. When community systems are strengthened, health systems are strengthened too.

We will support more community-based organisations to better connect health and community systems for a greater impact on HIV. To do this we will go beyond strengthening individual organisations to focus on community and health systems strengthening. This evolution will ensure we complement the work of national governments that are ultimately responsible for meeting universal access goals and upholding the rights of their citizens.

Our focus will not only be on government partnerships and linkages. We will also work with the private health sector that also provides many health services to poor and marginalised people.⁹



Mildred, a community mobilisation worker receives antiretroviral treatment at her local hospital, Kenya. © Nell Freeman for the Alliance

9. Many poor people buy their healthcare from private and other non-state providers – over 50% in sub-Saharan Africa, and over 80% in South Asia (Operational plan 2011-2015: DFID private sector department, updated June 2012).

Result › Stronger health and community systems

Targets 2013-2015*

60% of more than 1,000 community-based organisations provided with technical and financial support from the Alliance achieve their planned programme and financial targets due to increased capacity and effectiveness

In **70%** of Alliance countries, community-based organisations are sensitising service providers and local officials, and acting together to increase uptake of and access to HIV and health services

In **75%** of Alliance countries, community-led interventions result in increased access for key populations and people living with HIV to government-led HIV and integrated health services and commodities

40 documented examples of capacity to reduce vulnerability to stigma and criminalisation, gender inequity, or lack of livelihood opportunities

**In 2015 we will review our progress in order to set new targets for 2016-2020.*

OBJECTIVES

We will support community-based organisations with technical and financial resources to build their leadership and programmatic capacity. This will enable them to work effectively with government, the private sector and other civil society organisations active in health and human rights. In different countries this may mean working in partnership to shape the government response, influencing the spending priorities of national and local governments, or advocating for governments to better serve the needs of key populations. We will advocate for both health and community systems strengthening¹⁰ to contribute to health outcomes.

We will also explore new models. Some Linking Organisations may evolve towards government-contracted service delivery, supplying home- and community-based services, and working closely with clinical services. This will require us to define standard packages of services and models of service delivery that are cost-effective. We will develop a better understanding of health systems and government budgeting and contracting processes. In addition, we will link with budget monitoring groups and open government initiatives.

A voluntary home-based carer in her home village, India. © Gideon Mendel for the Alliance



“Working with [the Alliance] is a plus because most donors only provide funding, but the situation is different with Alliance Zambia. They visit us, they support us, and they build the capacity of our staff.”

Zikhalo Phiri, programme director of Young Happy Healthy and Safe, a community based organisation in Zambia

In other countries we will work to influence government health systems and delivery. We will work with other advocates and governments to ensure that government services are targeted, comprehensive, high quality, cost-effective and scaled up. We will link services to communities, and build the capacity of the government and private sector workforce to ensure that health services meet the needs of HIV-affected communities, are accessible to all, and treat marginalised people with dignity and respect.

Lipi, a radio jockey in Bangladesh, increases awareness of sexual and reproductive health and rights through her radio show. © Alliance



In some countries our role will be to monitor government progress towards the targets they have committed to, and their compliance with international human rights commitments. We will join with other civil society organisations to hold these governments to account. Where necessary we will use the judicial system and strategic litigation to address HIV, health and human rights, including rights of access to services and equity in health budget allocation.

In some middle-income countries a growing middle class means a market of clients who can afford to pay for health services. Hybrid organisations and social enterprises are growing apace. In some countries we will explore social enterprise models that provide a social return on health, in addition to a financial return that can subsidise accessible and free services for poor or marginalised groups.

It is our intention that wherever we work, strong community-based organisations will address the HIV and health needs of their communities by working as part of a wider health system. The Alliance will continue to support these organisations to strengthen their impact on HIV.

10. Global Fund to Fight AIDS, Tuberculosis and Malaria (May 2010), Community systems strengthening framework (which the Alliance helped to develop).

Where we work

The Alliance includes 40 Linking Organisations, seven Technical Support Hubs, and an international secretariat.

Key	Type of Work
	Linking Organisation or Country Office**
	Alliance project***
	International secretariat
	Regional Technical Support Hubs



Regional Technical Support Hubs

The Hubs provide south-to-south technical support to Linking Organisations and other civil society organisations to strengthen their leadership and capacity.

* There are six Linking Organisations in India.
 ** See back page for a full list of Alliance Linking Organisations and Country Offices.
 *** Where there is no Alliance Linking Organisation or Country Office

Response 3

Advocate for HIV, health and human rights

Much HIV funding continues to be misdirected to generalised HIV programming and prevention activities for low-risk populations. Where countries are increasing domestic expenditures, funds are largely being used to cover the costs of HIV treatment. Yet many people in need are still not getting life-saving treatment.

Despite high-level rhetoric, there is limited evidence that countries are substantially increasing domestic investments to target the key populations with whom we work. These groups are still unable to access appropriate health services, such as maternal and child health and sexual and reproductive health services.

Key populations remain stigmatised, discriminated against and criminalised. We are gravely concerned by the increase in government actions to enforce existing or draft new punitive laws, such as those criminalising sexual minorities, with penalties as severe as death for homosexuality. This situation must be addressed if we are to achieve a sustainable response to HIV and AIDS.

A couple who are members of a rights organisation for men who have sex with men in Mombasa, Kenya. © Nell Freeman for the Alliance



“Some may have doubted that a community once criminalised by this country could become a key partner in the government’s strategy to prevent HIV.”

Sonal Mehta, Director for programmes and policy at India HIV/AIDS Alliance who manage Pehchan, the Global Fund’s largest programme working to prevent HIV among men who have sex with men, transgender and hijra.

OBJECTIVES

We will advocate for structural and policy changes that will improve access to health services and promote human rights. The criminalisation of HIV transmission, and of sex between men, sex work and drug use, will remain a focus of our advocacy because these laws undermine effective HIV programming and violate the human rights of the people we serve. We will provide technical support to strengthen civil society and key population participation in decision-making. Nationally, this will mean ensuring communities play a part in decision-making to define national AIDS plans. At a regional or transnational level we will ensure that the policies of regional bodies are shaped by evidence, along with the experience of affected communities.

REDLACTRANS on a march through the streets of Guatemala to demand an end to transphobia in Latin America. © Aldo Fernandez / REDLACTRANS / Alliance



We will advocate for greater government transparency and accountability on HIV, health and human rights, policymaking and health spending. We will do this work in partnership with national civil society coalitions and platforms.

As a global Alliance informed by our local contexts, we will intensify our work to influence and shape the global HIV response. Our global advocacy will increasingly take a campaigning approach. It will continue to advocate for effective financing for HIV and human rights-based responses to HIV. We will also seek to influence global HIV technical debates, informed by our programming experience and our expertise as community-based HIV programmers and advocates.

Result › Inclusive and engaged societies

Targets

2013-2015*

In **50%** of Alliance countries the Alliance is playing a leadership role, representing HIV affected communities on national HIV and/or health bodies

In **80%** of Alliance countries, the Alliance is supporting representatives of communities most affected by HIV to participate in decision-making on HIV and health

In **60%** of Alliance countries, and globally, the Alliance has documented contributions to policy processes that address the human rights of HIV affected communities

In **70%** of Alliance countries, and globally, the Alliance has documented its advocacy for increased financing for HIV

**In 2015 we will review our progress in order to set new targets for 2016-2020.*

Response 4 Build a stronger Alliance

The shifts this strategy requires are significant.

Increasing access to HIV and health programmes in this era requires our programmes to be more cost-effective and integrated.

In order to connect health and community systems more effectively, we will need to define our offer clearly and better understand government budgeting and contracting processes. Partner selection and partnership building with the public and private sector require us to bring new skills into the Alliance.

We are a strong voice in national, regional and global policy, advocacy and technical developments. We will continue to ensure that this policy and technical influence translates into real action on the ground in countries where we work.

And in the coming years we will need to differentiate our approach in low- and middle-income countries (see page 22). We will do this in part by strengthening South-to-South learning and cooperation. Our activities will continue to be evaluated and monitored for impact.

OBJECTIVES

We anticipate the need for innovation in our programme approaches and models of implementation. We will establish an Innovation Fund to pilot new interventions, and explore new partnerships with governments and the private sector.

We will also foster partnerships with research institutions to improve our understanding of our impact, particularly on the drivers of HIV. Using the concept of 'critical enablers' from the investment framework for HIV,¹¹ we will research, evaluate and analyse the critical factors that lead to, or undermine, effective HIV responses with different populations in different settings.

The Alliance has an unparalleled body of international experience in community action on HIV. We will continue to share knowledge to increase effectiveness and efficiency, and improve quality. This is fundamental to building a stronger Alliance that learns from and responds to change.

We will continue to maintain and expand our Alliance-wide accreditation system to ensure we implement good practice HIV programmes, and that our organisations have the appropriate governance and financial management capacity to do so. More Linking Organisations will become fully accredited.

The Alliance will also deploy our considerable capacity-building expertise through our investment in regional Technical Support Hubs. The Hubs will design and deliver technical support that draws on practitioners' field experience, offers value for money and is sustainable. The Alliance's collective experience as implementing organisations will feed the work of the Hubs.

"Our partnership will integrate HIV and sexual and reproductive health across the policies, programmes and services of both organisations."

Michael Holscher,
senior vice president,
Marie Stopes International

11. Schwartländer, B. et al. (2011), Towards an improved investment approach for an effective response to HIV/AIDS, *Lancet* 377(9782): 2031-41.

Result Making it happen

Targets 2013-2015*

50% of Alliance countries have Linking Organisations that receive 5% or more of their total funding from sources beyond official development assistance (ODA)

In **80%** of Alliance countries, Linking Organisations have documented organisational improvements, as identified through the Alliance accreditation process

90% of all Alliance Technical Support Hub assignments are provided by local expertise based in Alliance and neighbouring countries, and, where applicable, in accordance with Alliance good practice standards

20 or more innovative programmatic models are created, documented and evaluated

**In 2015 we will review our progress in order to set new targets for 2016-2020.*

We know it is important to build partnerships with organisations that have complementary skills and the expertise essential to delivering our strategy. We already have a global memorandum of understanding with Marie Stopes International to help both organisations integrate HIV and sexual and reproductive health programmes. New partnerships, for example with budget monitoring groups, will help us monitor and engage with national and local government contracting mechanisms. Partnerships with humanitarian agencies will help us reach key populations in emergencies.

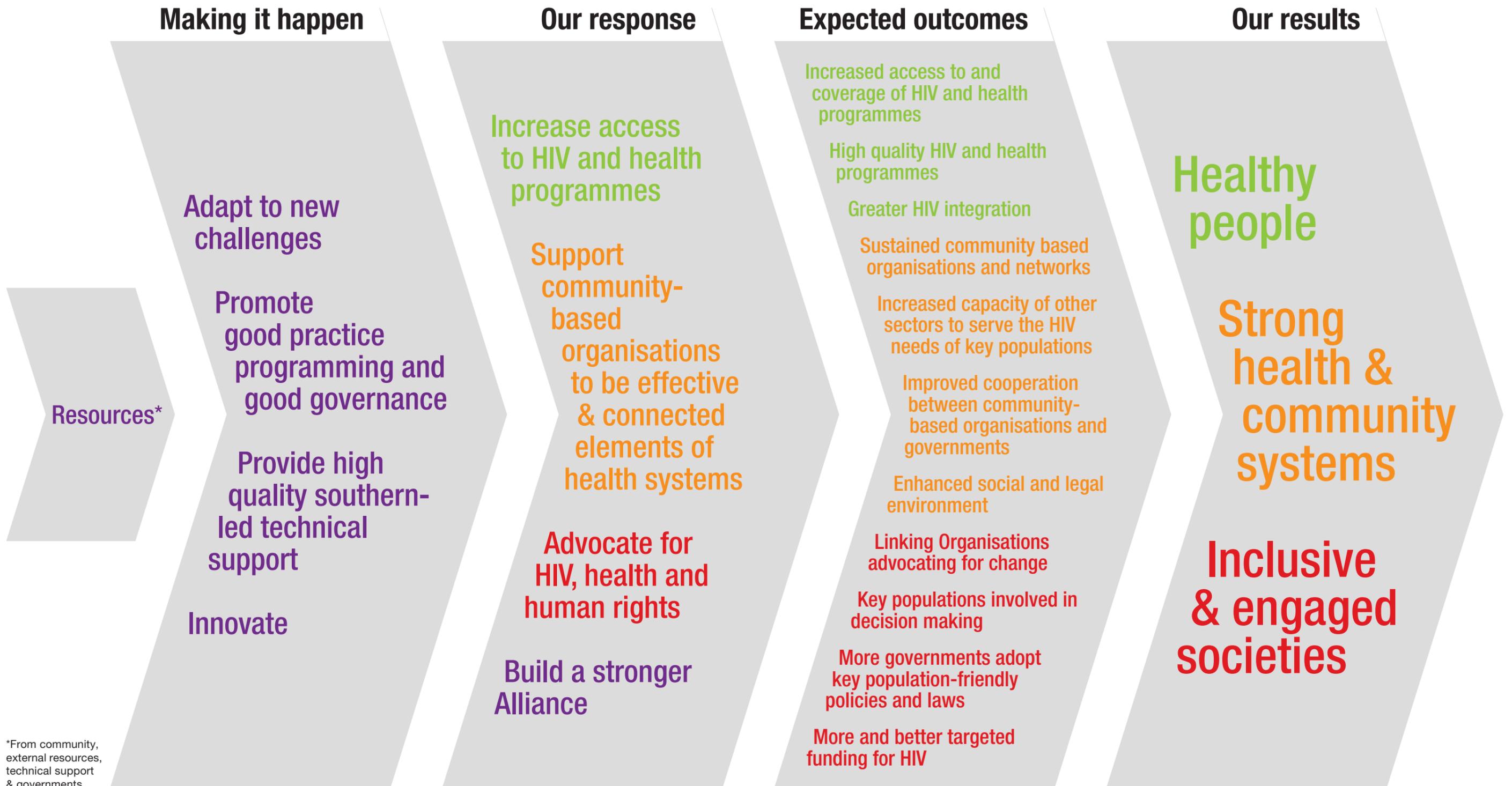
Sustainability is essential. We will seek the financial and political support needed to deliver the goals of this strategy. We will build capacity and expertise in mobilising resources from national governments. Task shifting and decentralised government provision lies ahead. As this occurs, we will need to ensure task shifting is equitable and fairly remunerated. Communities should not be a free labour source. With any devolution of responsibilities, we will advocate for appropriate resourcing and support. Task shifting is already a reality in some countries. As this increases, our Linking Organisations will need to be well positioned and ready to take on new and expanded roles. We will build organisational capacity to create programme models that are cost-effective.

Diversification is important. We will build capacity and expertise in mobilising resources from new and diverse non-governmental income sources. This might be private sector contributions and partnerships, fundraising from individuals and social enterprises.

With growth and change comes the challenge of effective communication. Our role must be clearly articulated. Using innovative and inspiring communications tools and media, we will build support for HIV, health and human rights, and position the Alliance and community-based organisations as influential leaders in the HIV response, in partnership with other stakeholders. We will use new technology and social media to boost activism and connect local communities with global campaigns and social movements.

Against the backdrop of a global financial crisis, Linking Organisations and the secretariat will work to become more effective and efficient, focusing on greater impact through this ambitious strategy. Current funding levels will not be sufficient to achieve the ambitious goals this strategy sets out. Achieving our targets will require a more diversified Alliance funding base that increases from the current US\$110 million to approximately US\$130 million by 2015.

Our strategy



*From community, external resources, technical support & governments

Our approach

The Alliance has set ambitious goals to sustain the HIV response and end AIDS. The following approaches will guide us.

Human rights:

The Alliance is committed to a human rights-based approach to HIV programming and advocacy. We recognise that respect for, and the protection and promotion of, human rights is essential to preventing the spread of HIV and mitigating its social and economic impact. We are striving towards the fulfilment of the human rights of all people affected by HIV, by addressing not just HIV but wider health and development issues. Therefore Alliance organisations integrate human rights-based principles such as non-discrimination, equity and participation, including the greater participation of people living with HIV and other key populations, in our local, national and international work.

Transforming gender norms is part of our human rights approach. This means we aim to change gender norms that legitimise unequal relationships between men, women, girls and boys; perpetuate gender-based violence; and that lead to sexual and injecting risk practice. A gender transformative approach addresses the quality of relations between men and women, and with people who have other gender identities. We also prioritise the meaningful involvement of women and girls living with HIV in global, national and local responses to HIV.

Good practice:

The Alliance promotes a culture of good practice in HIV programming. We define good practice by analysing the evidence base for the effectiveness of HIV interventions. We operationalise our values, and reflect on our significant HIV programming experience across the world. We then bring this knowledge and experience and our values together in the form of good practice programme standards that define and direct our HIV programming approach. We use these good practice standards to assess our own HIV programmes, evaluate their impact, and shape discussion and debate on HIV programming across the Alliance. Our efforts towards good practice programming and learning from each other will grow.

Differentiation:

The Alliance will achieve greater impact on the epidemic by differentiating how we work in:

- Low-income countries: official development assistance (ODA)-prioritised states, where external donors are still in partnership with local actors
- Middle-income countries: non-prioritised states, where national governments and local agendas define the HIV response.

In low-income countries our contribution will be to build capacity for high-quality, targeted HIV responses that address broader health needs. To make the greatest contribution in countries where we already have a presence, we will increase the coverage, scope and quality of our HIV and health programmes. We will also initiate work in new countries where the burden of HIV is greatest. The rate of new HIV infections is decreasing in many low- and middle- income countries, indicating that our work is having an impact. However, HIV rates among often hidden key populations are still alarmingly high. This will be a distinct focus of our work.

Our concern for key populations leads us to extend our reach to working in emergencies in some low- and middle-income countries. Our aim is to ensure key populations and people living with HIV are better served in emergencies. In emergency settings, humanitarian agencies will focus on immediate needs, including providing water and shelter, and preventing disease outbreaks such as cholera. We will work in partnership with these agencies to build HIV sensitivity and capacity to the needs of key populations into their response. We will support Linking Organisations and key population networks as part of an emergency response to HIV and AIDS.

In middle-income countries where domestic governments define the response, success or failure rests not only on the availability of financing, but also the political will of national governments to better target resources and work with civil society in their national HIV responses. We will develop and test different approaches to sustaining the HIV response. In some countries, for example in Asia, a much closer working relationship with domestic governments is needed. Here we will build the capacity of Linking Organisations so that they are well positioned and ready to take on decentralised service provision and task shifting.

In other middle-income countries, for example in Latin America and parts of South Asia, a different approach with governments is needed. Here we will work through policy and advocacy initiatives to ensure existing HIV programmes are targeted, comprehensive and high quality. Many of these countries will have implemented universal health coverage programmes. In these contexts our role will be to ensure the health needs of those most affected, marginalised and vulnerable to HIV are addressed.

Glossary

Accreditation: The Alliance accreditation system promotes good governance, accountability and good practice programming across our membership. It guides the admission of new Linking Organisations and maintains standards for existing Alliance partners. An accredited Alliance member must meet our standards for good governance and good practice programming, as assessed through a peer review process.

Capacity-building: Capacity-building is the process of enabling people, groups or organisations to build their knowledge, skills and resources in order to undertake activities effectively.

Civil society: Civil society encompasses the wide range of organisations and bodies that are not under direct government control and have a range of useful functions in support of a country's citizens. Civil society includes community-based organisations, non-governmental organisations, private sector bodies and businesses. Civil society can act as advocates and critics of government, mobilising communities and helping to shape policy. Civil society organisations provide health, social or economic support and services that complement, provide alternatives to, or fill gaps in government provision.

Community: The term 'community' has no single or fixed definition. Rather, communities consist of people who are connected to each other in distinct and varied ways. Community members may live in the same area or they may be connected by shared experiences, challenges, interests, living situations, culture, religion, identity or values. Communities are both diverse and dynamic, and a person may be part of more than one community.

Gender transformative approach: A gender transformative approach engages women and men in the process of changing harmful gender norms, both masculine and feminine, which shape and limit peoples' autonomy and capacity. Gender norms are key to understanding and addressing HIV risk, vulnerability and effective HIV prevention. A gender transformative approach engages men and women separately and together, according to local circumstances, to address violence towards, and coercion and abuse of, all those who are perceived to challenge or transgress gender norms. It addresses gender inequity along with the specific vulnerabilities of women and girls, men and boys and transgender people.

Harm reduction: Harm reduction is an approach that aims to reduce the harms associated with drug use, such as HIV and hepatitis C transmission, overdose and unsafe injecting. A harm reduction approach does not necessarily set out to stop people from taking drugs. Rather, it aims to prevent the harm associated with drug use, acknowledging that people who are currently unwilling or unable to abstain from drug use remain at risk of HIV and other preventable harms. Key harm reduction interventions

include providing clean injecting equipment and information about injecting safely, together with opiate substitution therapy to treat opiate dependence. Harm reduction interventions are endorsed by the World Health Organization as highly effective in preventing HIV transmission among people who inject drugs.

Implementing partners: Alliance implementing partners are supported by Linking Organisations to implement community-based HIV programmes. They include various kinds of organisations that mobilise and provide services to communities affected by HIV and AIDS, such as non-governmental and community- and faith-based organisations.

Key populations: Key populations are groups that are vulnerable to or affected by HIV and AIDS. Their involvement is vital to an effective response. Key populations vary according to the local context, but are usually marginalised or stigmatised because of their HIV status or social identities. They include people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, transgender people, people who use drugs, children affected by HIV and AIDS, migrants, displaced people, and prisoners.

Linking Organisations: These are national civil society organisations providing technical and financial support to community-based organisations, enabling them to respond to HIV. They work as part of national HIV programmes, and are often key to the scale-up of national community-based HIV responses. Linking Organisations are intermediary non-governmental support organisations. Some provide direct HIV services.

Millennium Development Goals: The eight Millennium Development Goals form a blueprint to address the needs of the world's poorest, agreed to by all governments and leading development institutions. They include halving extreme poverty, reducing child mortality, improving maternal health and halting the spread of HIV (Goal 6) – all by the target date of 2015. They were developed at the Millennium Summit in September 2000.

Technical Support Hubs: The Alliance has seven regional Technical Support Hubs, each hosted by a Linking Organisation, whose role is to build capacity for strong and effective civil society organisations. The Hubs consist of small teams of technical support providers and regional experts, who work with Linking Organisations, community-based organisations, governments and other sectors to strengthen their leadership and technical capacity.

Universal access: The United Nations and governments agreed to scale up HIV prevention, care and support and treatment with the goal of achieving universal access to these services for all those who need them by 2010.



The Alliance includes 40 Linking Organisations and Country Offices, seven Technical Support Hubs and an international secretariat.

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* We have seven Regional Technical Support Hubs, each hosted by a Linking Organisation.

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List accurate as at June 2013