International HIV/AIDS Alliance

Together to end AIDS

Our strategy

HIV, HEALTH & RIGHTS

SUSTAINING COMMUNITY ACTION

UPDATED 2016-2020

Who we are

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.

Our strategy update

This strategy update reflects the priorities of the wide range of community leaders, human rights defenders, programme managers and civil society advocates who make up the Alliance global partnership. It 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 and new goals up until 2020.

International HIV/AIDS Alliance (International secretariat)
Tel: +44 (0)1273 718900
Fax: +44 (0)1273 718901
mail@aidsalliance.org
www.aidsalliance.org

Registered charity number: 1038860

Published: March 2016
Copyright 2016 International HIV/AIDS Alliance

Design by Progression

Cover image:
The BEZA Anti-AIDS youth group use their talents for music and dance to get messages about HIV prevention across to the wider public, and in particular to their peers. Ethiopia.
© Benjamin Chesterton\duckrabbit\ International HIV/AIDS Alliance

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

Foreword

I am delighted to provide some introductory remarks to this strategy, which has been updated at a time when we are at a turning point in the global response to HIV and a strong Alliance is critical to respond to these challenges.

I am proud to be part of a unique and powerful partnership that has improved the lives of millions of people and seen HIV become part of a wider approach to health, development and human rights. However, our job is far from over.

Every day we are confronted with a stark reality: thousands of adolescents and young people are getting infected; gay men and men who have sex with men, transgender people, people who use drugs and sex workers often have no safe spaces and no support, and many people living with HIV are dying because they have little or no access to treatment. It is our belief that HIV is still a global crisis but, with diminishing financial support and deteriorating political will, it is vital we focus on creating an Alliance that is fit for the future.

This strategy sets out what we can and should do over the next five years. Our programming will continue to focus on the most marginalised communities that bear the greatest burden of the epidemic. We will ensure we are working in the countries where the epidemic is most severe and the response inadequate. We will focus on ensuring that all those who need it are offered lifesaving antiretroviral treatment, and are then sustained and supported to live long, healthy and independent lives.

We will make adjustments in how we work. We will deepen our strong global partnership. It is a partnership based on solidarity and mutual respect, one that pays tribute to the principles of shared leadership. We will strengthen existing partnerships and open up new ways of partnering that are transparent and add value. If we do this, I am certain we can create an Alliance that can deliver what communities need.

This strategy is resolute and ambitious, but with your continued support we believe it is achievable.

Christine Stegling
Executive Director

Contents

Every day we are confronted with a stark reality. Our job is far from over.

Christine Stegling
Executive Director

Executive Summary

This strategy update responds to a number of critical external factors, in particular the evolution of the HIV epidemic and the momentum behind treatment scale-up, new global targets for HIV treatment, prevention and non-discrimination, the continued withdrawal of development financing from middle-income countries, uneven - and in many countries shrinking - policy and fiscal space for civil society, human rights challenges, increased efforts focusing on sexual and reproductive health and rights (SRHR), the new Sustainable Development Goals (SDGs), and the ambition to achieve inclusive development and equity. This update focuses on where we need to evolve to address these developments. It is not an entirely new strategy, so our four result areas and four responses are retained. Within our updated strategic results framework we present a new, unifying measure for monitoring and reporting public health impact.

We are at a significant stage in the fight against HIV and AIDS, where the implications of inaction could be truly catastrophic. With collective commitment in word and deed, we stand to gain a world by 2030 where AIDS is no longer a public health threat. To this end, we have sought to unite under a set of global targets. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast-Track targets provide bold goals and inspiration at a global level. However, it is evident that many of the building blocks to achieve these targets are not yet in place. These gaps need to be acknowledged and urgently addressed.

There is a significant gulf between political declarations at the global level and country realities. While, at the global level, the rallying cry is to end AIDS by 2030 by implementing a very ambitious fast track strategy[1], at country level what we see is insufficient and dwindling AIDS funding, a lack of evidence-based programming, uneven treatment coverage, poor treatment and prevention coverage for key populations, discrimination, stigma, and increasing human rights violations. Our role in this context is to present these realities, clearly outline the barriers that need to be removed, promote the approaches to be adopted and scaled, and boost our own contribution to the HIV continuum of care framework. We also continue to work to make progress on the policy changes needed to create a better chance of achieving ambitious global targets on prevention, treatment and achieving zero discrimination. For instance, the 90:90:90 treatment targets for 2020 are based on the assumption that, if 73% of all people living with HIV achieve viral suppression, we could reverse the AIDS epidemic once and for all, but in Brazil[2] only 48% of people living with HIV are receiving antiretroviral (ARV) treatment, and only 39.9% have achieved viral suppression. Similarly, in South Africa[3] the percentage of people living with HIV who are virally suppressed is estimated at 25% and in Ukraine[4] it is 17%.

HIV, Health And Rights: Sustaining Community Action

The Alliance is a unique and powerful partnership. Our model is in tune with future development directions for sustainable development, multisectoral partnerships and Southern leadership. We make a significant difference in reducing the impact of the AIDS epidemic, reducing poverty, inequality and discrimination, and protecting the human rights of the most marginalised people. We intend to continue to deliver lasting impact.

Peer educator, James, walking the streets spreading the news of a local health camp in the community in Kinawataka, Kampala, Uganda.
© Peter Caton for the Alliance

1. UNAIDS (December 2014), Fast-track: ending the AIDS epidemics by 2030.

2. WHO + UNAIDS (June 2015), Global Response Progress Report (GARPR): The Brazilian Response to HIV and AIDS.

3. Takuva S., et al (February 2015 (2012 data)), 'Disparities in Engagement Within HIV Care in South Africa', presented at the Conference on Retroviruses and Opportunistic Infections in Boston.

4. Kazatchkine, M. (November 2014 (2012 data)), ''Drug use, HIV, HCV and TB: major interlinked challenges in Eastern Europe and Central Asia' in HIV Drug Therapy, oral presentation: [slide 12], Glasgow.

Result 1: Healthy people

Response 1: Increase access to quality HIV and health programmes

The Alliance will increase the coverage, scope and quality of HIV, harm reduction and SRHR programmes. We will do this by focusing on those people most in need and using an HIV continuum of care framework. We remain resolutely focused on having an impact on HIV. Using a person-centred approach, it is essential we increase our capacity to manage co-infections and co-morbidities, with increased focus on SRHR. In all that we do we will take a human rights-based approach. Our focus will be on key populations, adolescents affected by and at risk of HIV, women and girls in all their diversity, and people whose HIV vulnerability and health is impacted by gender-based violence.

Result 2: Stronger health and community systems

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

We will continue our focus on strengthening community responses to end AIDS. The Alliance will work with others to build national 'systems for health' that integrate community systems, public health and private sectors, recognising that all actors are supporting a national response that is broader than the government response alone. In order to achieve resilient and sustainable systems for health we will place even greater emphasis on linking to the formal health system, task shifting where communities are properly remunerated, new business models and product lines, and collaborating with the private sector where goals are shared. It is our intention that, wherever we work, strong community-based organisations will address the HIV and health needs of their communities, while both working with governments and holding them to account. The Alliance will continue to support organisations to strengthen their impact on HIV, whether through direct service delivery, providing technical assistance or monitoring both human rights violations and service delivery as a watchdog.

Result 3: Inclusive and engaged societies

Response 3: Advocate for HIV, health, gender and human rights

We will continue to address harmful social norms, including stigma, discrimination and social attitudes. We will advocate for structural and policy changes that will improve access to – and availability, affordability and quality of – health services without discrimination, and also promote gender equity, sexual and reproductive rights (SRH) and human rights. We will focus on driving change at all levels and building broader coalitions. Within this strategy period, we will expand our services in countries with some of the most hostile and challenging legal and policy environments.

Result 4: Foundations for impact

Response 4: A stronger Alliance partnership that is evidence-based and accountable to communities

The Alliance has set ambitious goals to sustain the HIV response and to end AIDS. To deliver these, during this strategy period we will further develop Southern leadership through our Technical Support Hubs and Centres of Practice. These centres have been established to increase and speed up the deployment of technical expertise rooted in practice. Overall, to achieve an impact on the epidemic, we will ensure quality in our programmes, deliver capacity strengthening and organisational resilience in our partner organisations, and work to ensure a united and collaborative Alliance. We will also develop new models of partnership with existing key-population-led networks and groups to ensure that civil society is given the political space to further development in all societies.

Context

This strategy update responds to a number of critical external factors.

The evolution of the HIV epidemic is uneven[5]. We have made great strides in the HIV response, largely due to the participation of most-affected communities in decision-making. Yet an estimated 35 million people worldwide were living with HIV at the end of 2013. Globally, the number of people living with HIV and receiving treatment is at a high of 15.8 million, yet treatment coverage remains staggeringly low in many regions. AIDS-related deaths are at a global low of 1.2 million a year but have been rising in the Middle East, North Africa, Eastern Europe and Central Asia. UNAIDS reports that, between 2008 and 2013, new HIV infections fell by just 13% to 2.1 million, far off the global target to reduce new infections to 1 million by 2015. New infections are rising in some regions and among certain populations.

According to UNAIDS, sex workers, men who have sex with men (MSM) and people who use drugs are estimated to be, respectively, 13, 19 and 22 times more likely to be living with HIV than the general population. The rate of new infections among some key populations such as MSM and people who use drugs is rising in some regions, and service coverage can be very low. Transgender people show high prevalence rates of between 25% and 40%. The statistics on HIV and AIDS for young people and adolescents are alarming. In 2010, young people aged 15 to 24 accounted for 42% of new HIV infections among people aged 15 and older. Between 2001 and 2012, 10 to 19-year-olds were the only age group to experience a rise in AIDS-related deaths. Globally, there is a greater HIV burden on woman and girls, especially unmarried women and women from key population groups. Multiple factors increase vulnerability for women including gender-based violence, poverty and economic inequality, harmful gender norms, a lack of access to education, and poor and unequal participation in public life.

There is global progress in the AIDS response. However, to achieve an impact on the epidemic, evidence-based HIV and health programmes must target those most in need, structural barriers such as discriminatory policy and legislation must be removed, and community responses must be strengthened.

Since 2012 there have been biomedical advances in the HIV response. Evidence from randomised control trials and pre-exposure prophylaxis (PrEP) studies[6] shows the efficacy of early antiretroviral therapy (ART) initiation for both treatment and prevention. Results from trials in which people who are HIV negative and taking ARVs have unprotected sex with people who are HIV-positive demonstrate that PrEP significantly lowers the risk of becoming HIV positive (86 to 90% efficacy) and does so without major side effects. For people living with HIV, evidence demonstrates that, through a sustained adherence to ARVs, it is possible to reach a point of viral suppression; that is, a point at which an HIV-positive person becomes clinically non-infectious. As a result, achieving viral suppression is now widely regarded as a key indicator of success in HIV programming, both

"Prevention vs treatment: If you use condoms to protect yourself you can avoid a lifetime of treatment." Image and caption from a PhotoVoice project with young people in Myanmar. © MND 2014 / International HIV/AIDS Alliance / PhotoVoice

5. UNAIDS, Fact sheet 2015, Global Reports 2013, 2014 and 2015, The Gap Report, 2014.

6. e.g. HPTN 052 ("A Randomized Trial to Evaluate the Effectiveness of Antiretroviral Therapy Plus HIV Primary Care versus HIV Primary Care Alone to Prevent the Sexual Transmission of HIV-1 in Serodiscordant Couples", The HIV Prevention Trials Network, (20 July 2015); PROUD (McCormack, S., et al, "Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial" in The Lancet, Volume 387, Issue 10013 , 53 – 60, September 2015); IPERGAY ('Pre-exposure prophylaxis also stops 86% of HIV infections in Ipergay study', NAM-AIDS map, 24 February, 2015).

as a treatment outcome and preventive benefit. The HIV continuum of care framework outlines the pathway by which a person is tested, linked to, and retained in HIV care, and initiates and adheres to ARVs.

Wide acceptance of the benefit of ART for prevention has changed the focus of the HIV response, resulting in an increasing number of people eligible for ART. This shift requires the introduction of cheaper diagnostic and drug regimens, together with a focus on key populations. New guidelines from the World Health Organisation (WHO) find the number of people eligible for treatment to have increased from 28.6 million in 2013 to 35 million in December 2015. Market shaping is now needed to rapidly scale-up demand and supply for HIV counselling and testing, effective oral and home-based self-test methods, and cheaper viral load monitoring devices. The poor ratio of physicians-to-population in many countries, coupled with access issues such as distance to facilities and discrimination faced by key populations in healthcare settings[7], requires communities to play a key role here[8]. Task shifting where communities are properly remunerated is essential but we have yet to see real acknowledgment of its value.

Many factors will determine how these developments translate. The country you live in will continue to be chief among these. The economic status of many countries most affected by the HIV pandemic has changed. Today, 58% of people living with HIV reside in middle-income countries, and by 2020 that proportion is expected to rise to 70%. Among the six countries with the highest HIV burdens, South Africa, Nigeria, India and Kenya are middle income. Nigeria, South Africa and India experience the highest numbers of AIDS-related deaths at 14%, 13% and 8% of the global total[9].

The factors influencing HIV vulnerability and causing AIDS-related deaths are complex and pernicious. Poor SRH and HIV infection share many root causes. Issues particularly relevant to our mission include poverty, poor social protection, discriminatory employment practices, and human rights violations. Gender inequity, gender-based violence and gender identity laws are key concerns for us, particularly in relation to transgender people who are subject to multiple vulnerabilities that make them most at risk of HIV. Transgender people's social and legal status results in their social exclusion and prevents them from accessing basic health and HIV services. Many face challenges in changing their registered gender identity at birth to their identified gender and engage in sex work to survive. In many countries, criminal and violent acts are perpetrated against transgender people with impunity.

Whilst there is huge progress in the drive to end AIDS, we still have a lot of work ahead of us.

Robinson Cabello,
Via Libre, Peru

7. *UNAIDS (2014), The Gap Report.*

8. WHO (September 2015), Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV.

9. UNIADS (2014), The Gap Report.

Despite this context, transgender organisations and international networks have increased in recent years, making important political gains. Several countries have approved legal frameworks that recognise transgender rights, such as the 2012 Argentinean gender identity law. Transgender voices are starting to be heard in international debates on HIV and lesbian, gay, bisexual and transgender (LGBT) rights. The Alliance will continue to expand HIV and comprehensive health services to transgender people and build on successful work in Latin America, India and South East Asia. We will promote transgender political voices in HIV, health and human rights debates and continue to support transgender organisations and networks in order to dramatically decrease HIV incidence and contribute to the full realisation of transgender rights and the integration of transgender people into society.

Addressing the criminal status of key populations lies at the heart of a human rights-based approach to HIV programming. In at least 77 countries same-sex relationships are illegal, sometimes involving life imprisonment, and in nine countries the death sentence may be invoked. Sex work is illegal and criminalised in 116 countries. A total of 42 countries have laws that criminalise HIV non-disclosure, exposure or transmission. Universally, drug use and possession for personal use is criminalised.

When laws and law enforcement practices protecting key populations are in place they are better able to access HIV and other health services, and participate in prevention, treatment, care and support programmes without fear of arrest or prosecution. But decriminalisation is not an end in itself. Rather, it is the first step in building capacity on human rights in civil society and parliament, and with health professionals and other relevant actors. Harmful social norms, including stigma and discrimination, must also be addressed. Indicators such as the Stigma Index, academic research, and the documented experiences of the people we work with demonstrate how prevalent and harmful discrimination is to the individual and the HIV response. Historically, civil society actors with a focus on marginalisation and human rights have found financial, technical and moral support from a global solidarity movement and external donors and organisations. The SDGs should become the next global unifying framework for development.

The Sustainable Development Goals[10] (SDGs) aim to "free the human race from the tyranny of poverty and … heal and secure our planet for present and future generations." In a progressive break from the Millennium Development Goals (MDGs), the SDGs address structural barriers, inequality and human rights.

We welcome the SDGs and will have a significant role to play in meeting goals 1, 3, 5, 10 and 16. Goal 1 is to "end poverty in all its forms everywhere", and our contribution stems from the fact that HIV is both a consequence and cause of poverty and inequality. Goal 3 – to "ensure healthy lives and promote well-being for all at all ages" – specifically addresses HIV and AIDS ("By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.")

It is important for us to accept that there is a crisis but also see it as an opportunity to understand how we can be more innovative.

Edgar Valdez, IDH, Bolivia

10. UNGA Resolution (21 October 2015), Transforming our world: the 2030 Agenda for Sustainable Development.

and is therefore key for us. The need to achieve “gender equality and empower all women and girls” is a focus of Goal 5. Goal 10 refers to the reduction of “inequality within and among countries” and includes two specific targets on inclusion and the elimination of discriminatory laws. Goal 16 sets out to “promote just, peaceful and inclusive societies”, and includes two specific targets on the reduction of all forms of violence, and the promotion and enforcement of non-discriminatory laws and policies. The Alliance and the broader HIV movement have many lessons to share in building inclusive societies, holding governments to account and ensuring full participation of most-affected communities in decision-making to enable the world to achieve these goals.

The North- to-South development assistance model has shifted significantly towards greater South-to-South cooperation. The emergence of new multilateral development banks established by BRICS and MINTS[11] countries are evidence of this. In this more multipolar environment, civil society is experiencing an increasingly fragmented support base. At its worst, this new world is resulting in civil society and human rights defenders being targeted and constrained by governments that will not tolerate dissent or being held to account. Each year, so-called NGO bills and foreign agent bills choke access to external funding and prevent civil society organisations from legal registration and access to banking. These bills have already been drafted or enacted in South Sudan, China, Ethiopia, Russia, Ukraine and Kyrgyzstan. Unchecked, people’s rights to health, privacy and freedom of association are violated every day. The continuity of effective HIV programmes and the sustainability of effective civil society itself are at risk.

Addressing these challenges and harnessing opportunities is how we will make a significant contribution to ending AIDS. Opportunities for the Alliance include a consensus that our model, at the heart of which is Southern leadership or locally led development and strengthening of local civil society actors, should be the path to ending AIDS and achieving sustainable development. The question of how to make operational the treatment, prevention and zero discrimination targets in communities and with key populations presents us with an opportunity to contribute. Together, we must stem a prevention emergency. The case for task shifting where communities are properly remunerated is clear. The Alliance and the network of community-based organisations we support can mobilise thousands of community healthcare workers. Innovation is needed at all stages of the continuum of care. ARVs must be incorporated into the combination prevention tools already available, not replace tools that are proven to be effective in preventing transmission. In order to achieve social inclusion and equity, it is vital that local communities are strengthened to address effectively the structural, policy and human rights issues they face. For the Alliance, this means continuing to provide, and intensify, technical and financial support to strengthen civil society and enable key populations to participate in securing their human rights.

Shumi conducting a group SRHR session with at Chittagong old railway station, Bangladesh. She was a sex worker before becoming a peer educator. © Syed Latif Hossain for the Alliance

11. These countries refer to the faster growing, larger emerging economies. The MINTs have smaller economies than the BRICs—Brazil, Russia, India and China and are Mexico, Indonesia, Nigeria and Turkey.

Response 1

Increase access to HIV and health programmes

To achieve an impact on the epidemic, evidence-based HIV and health programmes must provide for those most in need. The Alliance remains resolutely focused on making an impact on HIV. Using a person-centred approach we will increase the coverage, scope and quality of HIV and SRHR programmes for those who need it most. Our focus will be on key populations, adolescents affected by and at risk of HIV, women and girls in all their diversity, and where a person's HIV vulnerability and health are impacted by gender inequity and gender-based violence. In all that we do we will take a human rights-based approach, seeking to create enabling, non-discriminatory and protective legal and policy environments, where the right to a higher and attainable level of health is respected without discrimination, and all of the human rights of people affected by HIV are promoted.

Our response will become more centred on the HIV continuum of care, a coherent approach that extends from mapping and outreach, so that people know their status, through to service delivery. We will do this to ensure that many more of the right people are tested and know their status, to help those who test negative remain negative and those who test positive receive support and adhere to ARVs. As well as addressing people's SRH needs, we will do more to provide services and referrals for people living with HIV who are living for longer and are increasingly vulnerable to co-infections and health conditions associated with ageing such as tuberculosis (TB), hepatitis C, cancer, hypertension and diabetes. We will continue to collaborate with, and link to, health systems to help to support people-centred healthcare. This will be our contribution to the global HIV targets.

HIV is a permanent friend and I have learnt how to love and care for him. We have to live together, but I am still able to do anything.

Pacifique, youth advocate, Burundi

Nadia has initiated a female condom project in Burundi, to give more choices to women, in particular women living with HIV and sex workers.
© Gemma Taylor for the Alliance

Objectives

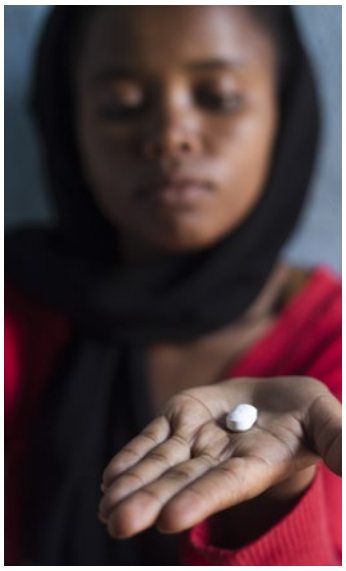
The Alliance will increase the coverage, scope and quality of HIV and SRHR programmes. We will do this by focusing on the people most in need using an HIV continuum of care framework, increasing capacity to manage co-infections and co-morbidities, and taking a rights-based approach.

Mapping and outreach. We will work with, and support, community-based organisations, community health workers and health systems to ensure we both educate and create greater awareness among people of their health needs, their rights, and the duties of the public sector to provide for them. We will work to remove barriers so that more people are willing and able to be tested and know their status, and ensure that those who test negative remain negative and those who test positive receive the care and support they need to sustain adherence to ARVs and lead healthy lives.

Combination prevention. We will continue to use a combination prevention approach that promotes actions at individual, community, service and structural levels. Our aim is to assist people who are not living with HIV to stay HIV negative and healthy. To do this, we will deliver programmes that prevent HIV infection, offering male and female condoms, HIV counselling and testing, harm reduction interventions including needle and syringe programmes (NSP), opiate substitution therapy (OST), treatment of sexually transmitted infections (STIs), PrEP, post-exposure prophylaxis (PeP), medical male circumcision and behavioural interventions. The health and prevention benefits of ART adherence for people living with HIV, together with PrEP for at-risk groups, will shape new approaches. We will continue our work to increase acceptance for, and use of, HIV home or self-test kits. These have the potential to increase exponentially the number of people who know their HIV status, and the regularity with which at-risk groups take an HIV test and can be linked to care if HIV positive. They can also increase access to HIV testing for key populations and others who face discrimination and other barriers when trying to access services in healthcare facilities such as HIV counselling and testing. In addition, we will advocate for a robust prevention framework.

Treatment. Our aim is to assist people who are living with HIV to achieve and maintain good health and viral suppression. The Alliance will do this by supporting and running programmes that increase access to HIV counselling and testing, early ART initiation and adherence support. We will continue to make the case that all interventions and regimens must make sense to people in their daily lives. We will work to ensure that HIV-affected communities are engaged and well prepared to benefit from new developments in medicines and other technologies. Our programmes for people living with HIV are informed by the principles within the Positive Health, Dignity and Prevention Framework[12]. We will contribute to seeking fair access to affordable healthcare for those in low- and middle-income countries who face price barriers to low-cost, effective medication.

Momina has been helped with access to antiretroviral therapy (ART) and support from a volunteer care giver by the Organization of Social Services for Health and Development (OSSAD), Ethiopia. © Sheikh Rajibul Islam\duckrabbit\ International HIV/AIDS Alliance



12. GNP+, UNAIDS (2011), Positive Health, Dignity and Prevention: A Policy Framework.

Key populations, women and girls, and adolescents.
The Alliance will continue to provide tailored and integrated health services for key populations. We will plan and deliver harm reduction programmes that offer opium substitution therapy (OST), clean syringes and other prevention tools, and increase ART coverage among people who use drugs. We will increase the scale and coverage of combination prevention. We will also increase access to treatment for people who use drugs, MSM, sex workers and transgender people, providing condoms, lubricant, HIV counselling and testing, ART, PrEP, PeP and other proven effective methods. While women and girls are most at risk and affected by gender-based violence, boys and men can experience it too, as can sexual and gender minorities. Regardless of the target, gender-based violence is rooted in structural inequalities and is characterised by the use and abuse of physical, emotional or financial power and control. It is clear that both female and male members of key populations face heightened and additional risk factors related to GBV [gender-based violence][13]. We will develop new partnerships and approaches to enable those most affected by gender-based violence to realise their right to access quality services.

The Alliance will also share evidence and advocate for HIV prevention, care and treatment, and health programmes provided by other sectors, to be tailored and accessible for key populations, adolescents affected by and at risk of HIV, women and girls in all their diversity, and where a person's HIV vulnerability and health is impacted by gender-based violence. We will increase capacity across the Alliance, and with external partners, to support tailored and effective services and policies for adolescents, including those who use drugs, young women in intergenerational relationships, and young MSM. We will also foster youth participation and leadership.

A couple supported by MAAYGO in Kisumu, Kenya. © Corrie Wingate for the Alliance

MSM want to be who they are. Our drop-in centre gave them a place where they can be themselves.

Kennedy, programme coordinator of MAAYGO, a youth group organisation that we partner with in Kenya

13. Management Science for Health/ USAID, AIDSTAR 2 (September 2013), Technical Paper; Review of training and programming resources on gender-based violence against key populations.

Fragile, conflict-affected states and emergencies.
The Alliance has been working in fragile settings for years to meet the needs of people affected by HIV and AIDS, in particular those of key populations which are exacerbated in countries experiencing fragility, conflict and emergencies. Globally, there is increasing awareness that addressing HIV in these countries is key to ending the AIDS epidemic, yet millions of people affected by fragility, conflict and emergencies worldwide are being left behind. Rape and gender-based violence continues to be a widespread tactic of war, which increases risk of HIV transmission and violates individuals' human rights. The Alliance is committed in this strategy period to increasing access to HIV services to people we are currently not reaching in these contexts. We will improve our ability to deliver support safely in these settings by supporting the development of LOs' emergency preparedness and contingency plans. We will also seek greater collaboration with the humanitarian sector, both globally and locally.

Rights based and participatory. We will continue to employ, and advocate for, a rights-based approach. This will mean working to promote and create non-discriminatory and protective legal and policy environments where human rights are respected. We will also work to create an enabling social and legal environment for HIV prevention, care and treatment. This will mean addressing gender-based violence, and defending the rights of people living with HIV, sexual minorities, people who use drugs, sex workers, refugees, migrants and displaced people. It will also entail fostering greater youth participation and leadership, and greater involvement of people living with HIV (GIPA)[14].

Peer educator Fabiana in Ecuador: "The first time I was made up as a woman, I looked in the mirror and thought - yes, this is me!" © Gideon Mendel for the Alliance

14. International HIV/AIDS Alliance and GNP+ (June 2010), Good Practice Guide: the greater involvement of people living with HIV.

Response 2

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

The devastating Ebola outbreak of 2014 placed greater emphasis on strengthening health and community systems. There is now a greater recognition that health systems consist of all organisations, people and actors whose primary interest is to promote, restore or maintain health[15], and that conceptualising distinct approaches to health and community systems strengthening creates gaps in services, allocation, prioritisation and financing. In the coming years, many national governments will institute new health bills, increase health budgets, set up universal healthcare schemes, and invest in primary healthcare.

Ultimately, they are responsible for meeting universal access goals and upholding their citizens' human rights but there is a need to recognise that all actors support a national response that is broader than the government response alone. Access issues, including distance to facilities and discrimination in healthcare settings and a poor ratio of physicians-to-population in many countries, require communities to play a key role. To achieve resilient and sustainable national systems for health for all, without discrimination, we aim to complement the work of government, working collectively to integrate the community, public health and private sectors. Mobilised, connected, and effective community-based organisations and community health workers will be vital to this process.

Strong communities are essential to stopping HIV transmission, providing HIV treatment and care, safeguarding health, and protecting the rights of people with HIV. They create demand for and deliver services, and provide a bridge to government services, especially for key populations and marginalised groups. In most countries, sustained responses to HIV will require significant changes in civil society and the way in which government and civil society organisations work together. Evidence demonstrates the efficacy and cost-effectiveness of community delivery. Task shifting where communities are properly remunerated is essential to success. The Alliance and others can mobilise a community healthcare workforce of thousands. There is more scope for community-led delivery and innovation to bring public health closer to people and reduce the burden on health systems.

Medicine distribution room at AAS's clinic for HIV/AIDS patients. © Syed Latif Hossain for the Alliance

15. WHO, 'Health Systems Strengthening Glossary', http://www.who.int/healthsystems/hss_glossary/en/index5.html, accessed on 25 January2016.

Objectives

The Alliance will continue our focus on strengthening the community response, supporting organisations to strengthen their impact on HIV. In this strategy period it is our intention that wherever we work, strong community-based organisations will address the HIV and SRHR needs of their communities by working to build resilient and sustainable systems for health.

Strengthen community responses. The Alliance will support community-based organisations with technical and financial resources to build their leadership and programmatic capacity. Our accreditation system, which all LOs and the secretariat must meet every four years, will continue to act as the backbone of the Alliance, assessing and promoting good practice in programming, good governance and accountability. We will place greater focus on the overall impact for an individual through improved client tracking and feedback, data quality, and the sustainability, efficiency and value for money (VfM) of the LO business model. This will enable LOs and Alliance Centres of Practice to work more effectively with government, the private sector and other organisations active in health and human rights. Our robust accreditation system, which all LOs and the secretariat must meet every four years, will continue to act as the backbone of the Alliance, assessing and promoting good practice in programming, good governance and accountability.

Resilient and sustainable systems for health. We will place even greater emphasis on ensuring that community systems, which deliver HIV and SRHR work, are better co-ordinated and co-operate successfully with the formal health system (public and private). We will be working collaboratively to ensure that systems for health are responsive to people's needs, and are effective and truly inclusive. This will involve task shifting where communities are properly remunerated, new business models and product lines, and collaborating with the private sector where our goals are shared. Our particular focus will be on integrating HIV prevention, treatment and care with SRH, co-infections such as hepatitis C and TB, and co-morbidities such as cancers and diabetes. In addition to delivering programmes and services ourselves, the Alliance will continue to share evidence and advocate for non-discrimination, human rights, and HIV prevention, care and treatment programmes provided by other sectors to be tailored and accessible. We will also advocate for task shifting where communities are properly remunerated, and for the government to work closely with community organisations and networks to ensure strong coordination, case management and a continuum of care.

Accreditation gave us pause to reflect with a strong group of peers but also introduced a necessary urgency to fix gaps.

Casper Erichsen, Executive Director of Positive Vibes in Namibia

Increased Southern leadership. We are taking the next step in the Alliance's history of Southern leadership by launching new global Alliance Centres of Practice to bridge knowledge and practice. These are to be led and run by LOs with recognised expertise and VfM business models to increase the supply and utilisation of technical leadership. The centres will increase and speed up the deployment of technical expertise rooted in practice, and will provide policy leadership globally. There will be five centres initially, one on harm reduction and hepatitis C, one on adolescent health, one on HIV treatment, and two on key populations. Our regional Technical Support Hubs will continue to deliver high-quality technical support to strengthen the capacity of LOs and partners to increase the coverage, scope and quality of programmes. Technical Support Hubs and Alliance Centres of Practice are intended to become leading agencies themselves, providing technical support directly to Global Fund to Fight AIDS, Tuberculosis and Malaria recipients and Country Coordinating Mechanisms, and working in countries beyond the Alliance's own footprint. Our aim is to create a cadre of Alliance Centres of Practice and Technical Support Hubs that are viable beyond the Alliance's direct financial support.

Adaptive HIV responses. We will champion community experience, and prioritise innovation, implementation, science and evidence to support communities to secure the policies and plans that will meet their needs. This will mean developing and testing new models of delivery in different contexts, so that, wherever we work, strong community-based organisations can address the HIV and health needs of their communities.

By investing in these Centres, the Alliance is demonstrating a commitment to a model of distributed technical leadership across the global partnership.

Casper W. Erichsen, Positive Vibes, South Africa

A condom demonstration at Naguru Teenage Information and Health Centre, offering services at Kinawataka, Kampala, Uganda. © Peter Caton for the Alliance

Adaptive organisational models. Some LOs 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.

In countries where we do not deliver services ourselves, we will continue to shape and influence government health systems and delivery. We will work with other advocates and governments to ensure government services are inclusive, targeted, comprehensive, high quality, cost-effective and scaled up. We will link services to communities, and build the capacity of governments and private sector workforces to ensure that health services meet the needs of HIV-affected people and protect and promote their human rights, become accessible to all, and treat marginalised people with dignity and respect.

In some countries the Alliance will become a watchdog, monitoring 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 provide legal services and, through the national judicial system, use strategic litigation and generate evidence for the international human rights system. This will help us to address HIV, health and human rights, including rights of access to services and equality in health budget allocation.

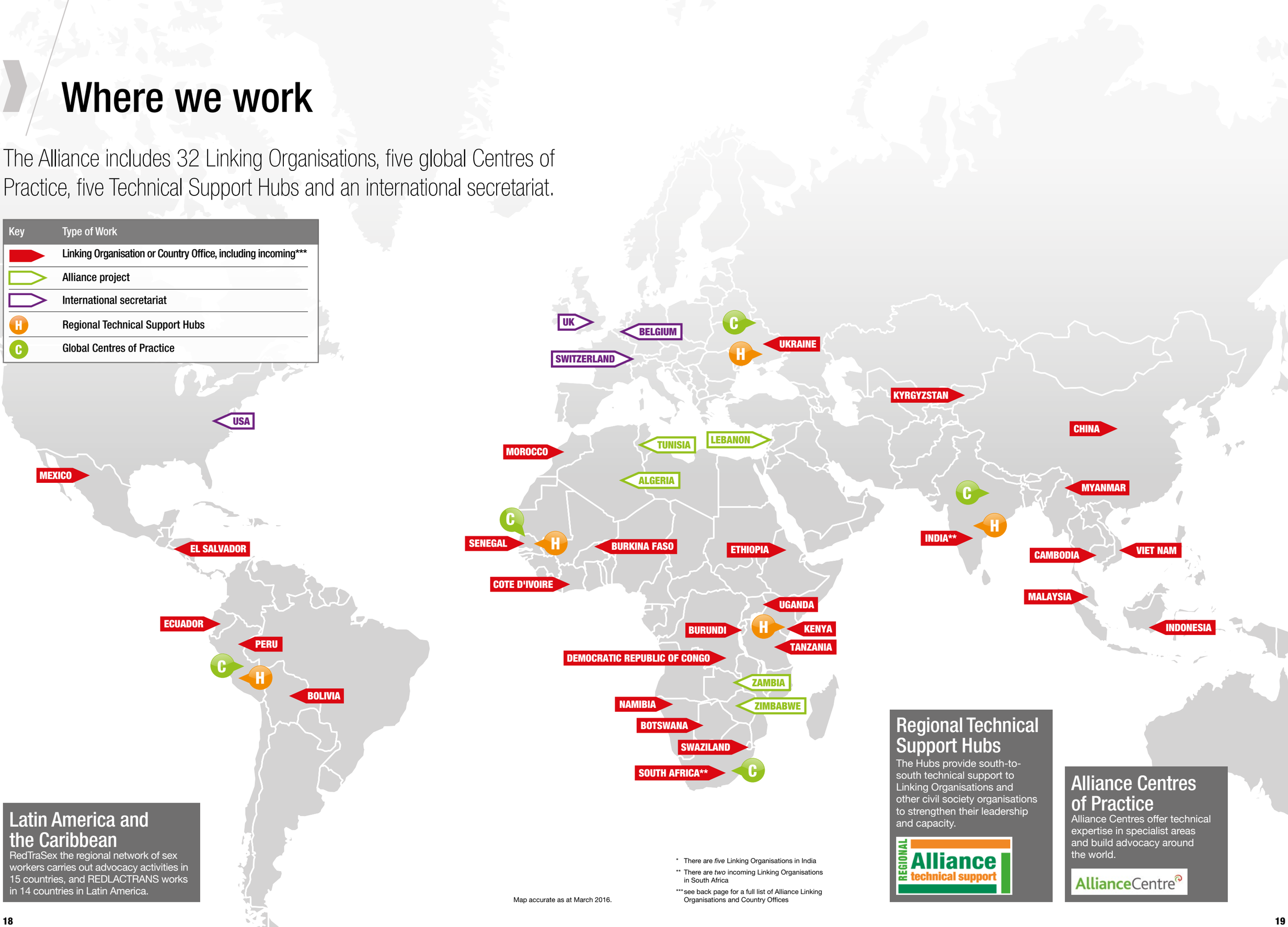
In middle-income countries where donors have withdrawn, or plan to withdraw, where appropriate we will work with donors, government and civil society to ensure responsible transitions are planned. In some cases we will adapt to create different business models, find new income sources and look for new ways of covering costs. This might be through national and local government contracting or charging fees for services to those who can afford to pay. 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 further develop social enterprise models that can subsidise accessible and free services for poor or marginalised groups. In others, we will contribute to social movements to demand public accountability and inclusion of these groups in policies and services.

Moonlight outreach clinic in Kisumu, Kenya. It's run twice a month for MSM to access services. © Corrie Wingate for the Alliance

Where we work

The Alliance includes 32 Linking Organisations, five global Centres of Practice, five Technical Support Hubs and an international secretariat.

Key	Type of Work
	Linking Organisation or Country Office, including incoming***
	Alliance project
	International secretariat
H	Regional Technical Support Hubs
C	Global Centres of Practice



Latin America and the Caribbean

RedTraSex the regional network of sex workers carries out advocacy activities in 15 countries, and REDLACTRANS works in 14 countries in Latin America.

Map accurate as at March 2016.

* There are *five* Linking Organisations in India

** There are *two* incoming Linking Organisations in South Africa

*** see back page for a full list of Alliance Linking Organisations and Country Offices

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.

REGIONAL Alliance technical support

Alliance Centres of Practice

Alliance Centres offer technical expertise in specialist areas and build advocacy around the world.

AllianceCentre

Response 3

Advocate for HIV, health, gender and human rights

Disparities in health, wellbeing and mortality between different groups remain stark. According to UNAIDS, sex workers, MSM and people who use drugs are estimated to be, respectively, 13, 19 and 22 times more likely to be living with HIV than the general population[16]. Yet much HIV funding and programming continues to be misdirected to generalised programming and low-risk groups. Where countries are increasing domestic resources, funds are largely intended to cover the costs of treatment. Focused prevention and treatment for key populations and community strengthening are essential to making an impact on the HIV epidemic, yet in many cases these areas are not prioritised or funded.

Key populations remain stigmatised, criminalised, and discriminated against in law and custom. These groups are often affected by poverty, violence and gender inequality. They frequently experience harmful cultural and religious practices, a lack of access to credit, property or inheritance rights, and other factors that contribute to their HIV risk and vulnerability, and pose major barriers to accessing HIV and other lifesaving health and support services. The Alliance is gravely concerned by the wave of anti-gay legislation spreading across many parts of the world as governments continue to draft new retrograde laws – such as those criminalising sexual minorities, with penalties as severe as death for homosexuality – or enforce existing ones. We see related, widespread violations of the rights of key populations with impunity, even in countries and regions now classified as middle income and where there is protective legislation, such as in Latin America.

We also see a rapidly shrinking space for civil society. Human rights defenders are targeted and constrained by governments that will not tolerate dissent or being held to account. Each year, so-called NGO bills and foreign agent bills choke access to external funding and prevent civil society organisations from legal registration and access to banking. In 2014 there were serious threats to civic freedoms in at least 96 countries[17]. When you factor in these countries' population sizes, the stark reality is that six out of every seven people live in countries where basic universal rights and freedoms are under threat. Unchecked, their rights to health, privacy and freedom of association are violated every day. For these and many other reasons, a commitment to equity should be at the heart of all development and health strategies. In order to deliver an impact for those who need it most, the Alliance will continue to take a human rights approach and will work to further the fundamental rights of the individuals and communities we work with and among.

We cannot deal with AIDS as a standalone issue anymore. AIDS, TB, Hep C and human rights are important issues. Whilst the Alliance is standing strong on ending AIDS, the world is changing and "end AIDS" may be too narrow.

Andriy Klepikov, Alliance for Public Health, Ukraine

16. UNAIDS (2013), 2013 UNAIDS report on the global AIDS epidemic.

17. CIVICUS (June 2015), Civil Society Watch Report.

Objectives

The Alliance will continue to address harmful social norms including stigma, discrimination and social attitudes. We will advocate for structural and policy changes that will improve access to and availability, affordability and quality of health services, and that promote gender equity and human rights. We will focus on driving change at all levels and building broader coalitions. In this strategy period, we will expand our services in countries with some of the most hostile and challenging policy environments.

Gender and human rights. We will expand our work in this area and increase capacity across the Alliance, and with external partners, to support tailored and effective programme approaches to tackling gender-based violence. The Alliance gender-based violence approach is inclusive of women and girls but also of key populations and their intimate partners. We will apply a gender analysis to understand the gendered impact of all policies and programmes, develop gender empowerment programmes, and create and advocate for an environment that encourages more equitable gender and social norms. We will also improve access for vulnerable groups by training and sensitising healthcare workers, police and others to provide services that are non-discriminatory and gender sensitive to the needs of vulnerable groups.

Stigma and discrimination. Addressing HIV-related stigma and discrimination is critical. Without this, key populations and the most marginalised people risk being abandoned by the post-2015 'end AIDS' agenda. While discrimination remains rampant, people will not seek out testing and will remain unable to access HIV services and care. Our role is to ensure that no one is left behind and that key populations can access the care and support they need to lead healthy lives. To achieve this, the Alliance will continue working to reduce vulnerability to stigma and criminalisation, and challenge harmful social norms. This will involve collaborating with, and training, the formal health workforce, sensitising healthcare workers, and building the capacity of key populations in monitoring, advocacy, technical assistance provision, and participation in decision-making at all levels.

Criminalisation. The Alliance's decriminalisation agenda, which includes the decriminalisation of HIV transmission, extends further than the rights of LGBT people to encompass other key population groups such as sex workers and people who use drugs. The criminalisation of these populations will remain a focus of our advocacy and campaigning because these laws undermine effective HIV programming and violate the human rights of the people we serve. The Alliance Position on Decriminalisation of Key Populations[18] will become our basis for action. This will mean a focus on human rights abuse reporting and response mechanisms, use of information, communication and technology, new work with broader human rights coalitions and the private sector to create more enabling environments for change, strategic litigation, and technical and financial support for human rights defenders.

A group session for awareness raising at Doulatdia Brothel. © Syed Latif Hossain for the Alliance

18. Adopted at the 45th meeting of International HIV/AIDS Alliance Board of Trustees, 2013.

Universality. To achieve truly universal health coverage, and ensure that key populations are not left behind, we will work to integrate HIV into universal healthcare plans. Many universal healthcare schemes have excluded HIV provision in the past. We have a great deal of learning to assimilate from our LOs in Latin America and the Caribbean: a region where many of the changes we forecast (such as universal healthcare implementation and donor withdrawal) have been in effect for some years now. The knowledge of LOs in this region will become an invaluable resource for the Alliance and the wider HIV response. In all that we do, we will go beyond strengthening individual organisations to focus on building resilient and sustainable systems for health that are truly inclusive and meet everyone's needs. This includes the needs of key populations, women and girls affected by gender-based violence and adolescents affected by, and at risk of, HIV.

Support to civil society in challenging policy environments. In challenging policy environments, the Alliance will support and work in partnership with global, regional and local key population organisations and networks, local civil society groups and human rights defenders. This work will include fostering activism, and contributing to global and local campaigns and social movements for change. We will also link these groups to, and provide, HIV and health services, together with financial and technical assistance, security training, participation in decision-making and policy spaces, and leadership development. The Alliance has a wealth of experience to share and replicate.

It is seldom emphasised in telling the story about AIDS that the first generation of AIDS activists were ordinary people taking control of their own lives and bodies.

Mark Heywood, Section27, South Africa. Taken from his essay in AIDS Today http://www.aidsalliance.org/aidstoday

Arrested for possession of marijuana Yogi is six years into a 14 year prison sentence in Bandung prison, Indonesia. Yogi took part in a training session organised by the prison when he was first diagnosed with HIV positive in order to learn more about living with the virus. He now shares his knowledge with the other inmates and teaches them how to stay healthy in prison. © Vincent Rumahloine for the Alliance

Advocacy. Our global advocacy will continue to call for effective financing for HIV. We will only end AIDS with a sustained response in middle- and low-income countries. Following the latest WHO guidelines for the adoption of a test-and-treat model, and in order to achieve the Fast-Track targets, we need a combination of approaches. We will advocate for OECD Development Assistance Committee donors to further develop nuanced health frameworks and keep a close watch on the development of initiatives such as the Equitable Access Initiative[19]. This acknowledges that 75% of the world's poor live in middle-income countries and that most of the global disease burden falls in the 105 middle-income countries. The Alliance will advocate for domestic governments to create or better utilise fiscal space and domestic budgets to increase their expenditure on HIV prevention and treatment. This might involve innovative tax schemes, such as those on tobacco, or budget reallocations. We will work with other health organisations to ensure that broader financing models, such as universal health coverage schemes and the Global Financing Facility, work for the greatest disease burdens such as HIV[20].

We will also support and contribute to the work of civil society organisations and institutions working to reform unethical intellectual property regimes and trade agreements that impede access to affordable essential medicines for people living with HIV in these countries.

Together, we can devise new modalities and more effective transition strategies. We will advocate for task shifting to communities, when these communities are properly remunerated, and close working by government with community organisations and networks to ensure strong co-ordination, case management and a continuum of care. We will advocate for a robust prevention framework and contribute to its development and implementation at global and national levels. We will intensify our advocacy for a rights-based approach and enabling policies.

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

19. Global Fund, The Equitable Access Initiative: overview and updates, http://www.theglobalfund.org/en/equitableaccessinitiative/, accessed on 25 January 2016.

20. The Global Financing Facility, http://www.globalfinancingfacility.org/, accessed on 25 January 2016.

Response 4

A stronger Alliance partnership that is evidence-based and accountable to communities

How we operate, our strategy and our core values unite us. The Alliance includes 32 Linking Organisations, five Centres of Practice, five Technical Support Hubs and an international secretariat. Together, in any given year, we provide technical and financial support to more than 2,000 community-based organisations, and work with many thousands of community health workers. In addition, we have many strategic implementing partners at national, regional and global levels.

> **My leadership role came out of anger…leadership through activism is a powerful form of leadership which is inspirational."**
>
> Juan Jacobo Hernandez, Colectivo Sol, Mexico

Objectives

To achieve an impact on the epidemic, we need to ensure quality in our programmes, capacity strengthening and organisational resilience in our partner organisations, and a united and collaborative Alliance.

Capacity strengthening. We will continue to use and improve our accreditation system to which all members of the global partnership are subject, to ensure ongoing relevance and effectiveness. Accreditation is the backbone of a strong Alliance. It is both a quality assurance system that guarantees high standards and a capacity-building tool that identifies an organisation's development needs. It promotes South-to-South learning and ensures a shared vision and values. We will support peer review teams to carry out assessments of the organisations undergoing accreditation, and support the follow-on from identification of capacity needs to provision of capacity strengthening. The Alliance will also work with the International Organization for Standardization and others to ensure the value of accreditation is understood by external stakeholders in country. We will continue to support the capacity needs of LOs and community-based organisations with technical assistance and capacity development grants.

A service beneficiary of the Link Up project, which has improved the sexual and reproductive health and rights (SRHR) of more than one million young people in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. © Syed Latif Hossain for the Alliance

Partnership models. We will endeavour to strengthen our existing partnerships at national, regional and global levels with key population-led organisations, human rights activists and others contributing to the global HIV response. Our partnership strategies will be transparent, respectful of the spaces already occupied, honour existing expertise and political engagement, and add value rather than duplicate effort. The Alliance is aware of the multitude of partners engaged in HIV and health responses at all levels, and that any partnership strategy needs to be based on mutual respect and have strong accountability to the communities we serve. In this strategic period, we will be opening up new ways of partnering with organisations working on broader social justice issues and those active in the field of alternative/diversified income generation.

Embed human rights and gender. 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. Alliance organisations will continue to integrate human rights-based principles such as non-discrimination, equality and participation – including the greater participation of people living with HIV and other key populations – in all that they do. In this strategy period, we will also focus on embedding across the Alliance a unified tool called Rights-Evidence-Action (REAct), which community groups can use for identifying human rights abuses and providing timely responses. We will give particular emphasis to partnerships that will scale-up access to justice for key populations, including, when required, strategic litigation to address HIV-related discrimination and human rights abuses.

Gender inequality has been widely recognised as a key driver of the HIV epidemic. A gender analysis brings greater understanding of the implications of HIV interventions and can allow for better strategies, implementation, impact, monitoring and assessment. The Alliance key principle is that programmes are gender responsive, and promote gender transformative approaches. While a human rights perspective is considered to be fundamental to Alliance strategies, theories of change, advocacy and programming, it is evident to us that gender should – and must – be clearly articulated in policy and programming. We will therefore not only bring gender-responsive approaches to HIV programming, but also seek to realise an overall goal of contributing to gender transformative approaches.

Recording client information during community visits, Burkina Faso. © Ollivier Girard for IPC, Burkina Faso

The Alliance combines public health approaches with a vulnerability lens that allows for the identification of those most vulnerable and underserved within different groups. At a service level, this addresses the needs of people of any gender and sexual orientation, as well as those seen to challenge or transgress gender and sexual norms, such as women who have sex with women, men who have sex with men, sex workers and transgender people. To achieve our results, we will apply a gender analysis to understand the gendered impact of all our policies and programmes, develop gender empowerment programmes, create and advocate for an environment that encourages more equitable gender and social norms, and improve access for vulnerable groups by training and sensitising healthcare workers, police and others to provide services that are non-discriminatory and gender-sensitive to the needs of vulnerable groups. In this strategy period we will expand our work in this area, increasing capacity across the Alliance, and with external partners, to support tailored and effective services and policies for tackling gender-based violence.

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. Then we operationalise our values. We will continue to bring together our knowledge, experience and values in the form of good practice programme standards, which define and direct our HIV programming approach. We will 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.

Evidence and research. Knowledge management that supports South-to-South learning has been, and remains, a critical Alliance offer. We will also focus on demonstrating and evidencing the effectiveness of community testing, ART initiation and adherence support. As the Alliance, and the wider HIV sector, trial new approaches we will generate and share evidence. We will deliver and update our research strategy with a focus on the HIV continuum of care, particularly new approaches to, and models of, delivery and evidencing the case for task shifting and investment in community-based services. The research strategy will also place greater emphasis on partnerships with regional and national research institutions. We will continue to support our research think tank, which unites into one virtual unit, the research expertise of seven LOs and the secretariat with research fellows seconded from the London School of Hygiene & Tropical Medicine. The think tank aims to foster effective the generation, sharing and use of evidence throughout the Alliance. We will work in partnership with other principal investigators, pre and post trials, to share learning at the community level, and together seek opportunities to generate evidence. The Alliance Innovation Fund will continue to provide seed grants for innovative pilot studies and initiatives.

We have been given drug recording cards where we have to tick every time after taking the drugs. This helps us to see if we have missed any dose.

Female patient from Ratana Metta Organization, a CBO in Myanmar

Tuc tuc outreach in Uganda as part of the Link Up programme. © Georgie Kane for the Alliance

Value for money. Between 2010 and 2012, the Alliance emerged as a strong leader around the value for money framework. We developed important partnerships and helped inform the VfM debate within and beyond the UK. Our leadership included developing guidance documents that helped others to understand what VfM is, piloting new methods for demonstrating VfM, and testing mechanisms for compiling unit cost data for community-based programmes. In the next phase of our strategy, we will embed our VfM framework across the Alliance, starting with the secretariat. Our framework combines three different VfM methods – managing VfM, demonstrating VfM, and comparing VfM – with a fourth component: making the VfM case.

Innovation and sustainability. Globally, the Alliance will develop our work with the private sector to bring cheaper and more client-centred HIV diagnostics and drug management systems (testing, ART and methadone delivery) to market. We will provide and seek support to ensure we have adaptive organisational models. We will diversify our revenue streams to mitigate risk and ensure sustainability. We will support some LOs to adapt and remodel their approaches 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. The goal is to find new and sustainable ways to meet the needs of, and provide for, the people who need it most.

Nahimana, 22, a mother of two, works at a market and also sells sex in order to provide for her children. © Gemma Taylor for the Alliance

Annexes

1. EPIDEMIC DATA

People living with HIV Globally, an estimated 36.9 million people were living with HIV at the end of 2014[21]. The largest amount were living in sub-Saharan Africa (25.8 million in 2014), with Asia and the Pacific having the second largest population living with HIV (an estimated 5 million in 2014)[22].

AIDS-related deaths Globally, 1.2 million people die from AIDS-related diseases every year. This is the lowest figure since the peak in 2005, having declined by 35%. However, AIDS-related deaths have risen steeply in the Middle East and North Africa by 66%, and by 5% between 2005 and 2013 in Eastern Europe and Central Asia[23].

New infections UNAIDS reported 2.1 million new HIV infections in 2013. Between 2010 and 2013, new HIV infections fell by 13%. However, progress is uneven with new infections rising in some regions and among certain populations. Globally, as of June 2015, the number of people living with HIV and receiving treatment is at a high of 15.8 million. However, treatment coverage is staggeringly low in many regions. In sub-Saharan Africa coverage is 41%, and it is lowest in the Middle East and North Africa at just 14%[24].

Key populations and HIV According to UNAIDS, sex workers, MSM and people who use drugs are estimated to be, respectively, 13, 19 and 22 times more likely to be living with HIV than the general population. The rate of new infections among some key populations, such as MSM and people who use drugs, is rising in some regions, and service coverage can be very low. Transgender people are among the populations most affected by the HIV epidemic. Historically, epidemiological data has included transgender people in the MSM category, but in countries where data has been disaggregated, transgender people show high prevalence rates of 25% to 40%[25].

Adolescents and HIV The statistics on HIV and AIDS for young people and adolescents are alarming. In 2010, young people aged 15–24 accounted for 42% of new HIV infections in people aged 15 and older. The 10–19 age group is the only one in which AIDS related-deaths rose during the period 2001–2012. Adolescent girls and young women account for one in four new HIV infections in sub-Saharan Africa. Recent research from Africa also presents evidence that 15–24-year-olds are significantly more likely to dropout of HIV care. Structural barriers such as the need for parental consent, policies for provision of certain services, and the specific challenges of working with people who are at a risk-taking developmental stage, are not being adequately addressed[26].

Women, girls and HIV Globally, there is a greater HIV burden on woman and girls, especially unmarried women and women from key population groups. Multiple factors increase vulnerability for women, including gender-based violence, poverty and economic inequality, harmful gender norms, access to education, and poor and unequal participation in public life. More than one-third of all new infections in Africa are in young women, and 15% of all women living with HIV are adolescents and young women aged 15–24 years old. Of these, 80% live in sub-Saharan Africa[27].

The BEZA Anti-AIDS youth group use their talents for music and dance to get messages about HIV prevention across to the wider public, and in particular to their peers. Ethiopia.
© Benjamin Chesterton\ duckrabbit\International HIV/ AIDS Alliance

21. UNAIDS (2015), Global AIDS Response Progress Reporting.
22. UNAIDS (2015), Fact sheet.
23. UNAIDS (2015), Fact sheet
24. UNAIDS (2015), Fact sheet
25. UNAIDS (2014), The Gap Report.
26. UNAIDS (2012), Fact sheet: Adolescents, young people and HIV.
27. UNAIDS (2014), The Gap Report.

Glossary and Terminology

Accreditation The Alliance accreditation system promotes good governance, accountability, and good practice programming across our membership. It guides the admission of new LOs 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.

The **Alliance model** is based on the belief that communities are critical to an effective HIV response. The model is one of Southern leadership, where we connect the national with the regional and global. Our role is to support and promote locally driven and owned development. In countries where we are active, our LOs deliver long-term and sustained action at local and national levels. They provide this through technical assistance, organisational strengthening, and policy and financial support to over 2,000 community-based organisations and networks. Alliance LOs actively participate nationally, regionally and internationally in generating evidence, convening the sector, crafting normative guidance, creating best practice guides and toolkits, and shaping policy and planning. Guided by our Southern leadership principle, LOs take on increasing global technical and policy leadership on behalf of the whole Alliance. This principle led to the creation of Alliance Technical Support Hubs hosted by selected LOs in 2007, and Alliance Centres of Practice hosted by selected LOs in 2014.

Governance bodies and advisory committees As a global collective, the Alliance is represented on many governance bodies and advisory committees. We participate in:

Global Fund to Fight AIDS, Tuberculosis and Malaria, Board (three delegations)

Global Fund Human Rights Reference Group

Global Fund Advocates Network

WHO Civil Society Reference Group on HIV

UNAIDS Programme Coordinating Board

UNAIDS Inter-Agency Task Team on Children and AIDS (Chair)

UNAIDS Inter-Agency Working Group on Young People

UNAIDS Community Systems Strengthening Task Team

Inter-Organizational Task Team (IOTT) on Community Systems Strengthening

Strategic Advisory Group to the UN on HIV and Drug Use (Chair)

Harm Reduction Reference Group

Inter-agency Working Group on Sexual and Reproductive Health and HIV/AIDS Linkages

European Confederation of Relief and Development NGOs (CONCORD)

Global AIDS in Post-2015 Working Group (Co-convenor)

TB/HIV Working Group of the STOP TB Partnership

Open for Business, a network of multinational companies for LGBT inclusion

Alliance Centres of Practice have been established to increase and speed up the deployment of technical expertise and policy leadership rooted in practice. The Centres of Practice bridge knowledge and practice, and are led and hosted by LOs with recognised expertise. We have started with five global centres: one on harm reduction and hepatitis C, two on key populations, one on adolescent health, and one on HIV treatment.

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 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, and private sector bodies and businesses. Civil society can act as advocates and critics of government, mobilise communities and help 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 may be connected by shared experiences, challenges, interests, living situations, culture, religion, identities or values. Communities are both diverse and dynamic, and a person may be part of more than one.

Continuum of care A coherent approach to achieving viral suppression in people living with HIV is referred to as the HIV continuum of care. It outlines the pathway by which a person is tested then linked to, and retained in, HIV care, and initiates and adheres to ARVs. A state health system needs to be able to track patients from their entry into this cascade through to the end. Data-tracking systems and privacy protections need to be strong and comprehensive for this model to work. The modelling exercise supporting the 90:90:90 Fast-Track strategy predicts that, if 73% of all HIV-positive individuals achieve viral suppression, we will achieve a substantial prevention effect at the population level[28]. In the absence of a vaccine, this presents the brightest hope for the foreseeable future, although in reality a great deal will have to change in order to deliver on it. The Alliance contribution to supporting the continuum of care model will include, but not be limited to, improving coverage for key populations, increasing the availability and uptake of comprehensive testing for more of the right people, improving adherence support for people on ART through better links and retention in care, monitoring of stock-outs, and establishing and using patient systems for those who are unable to access state facilities.

A Gender transformative approach engages women and men in the process of changing harmful gender norms, both masculine and feminine, which shape and limit people's autonomy and capacity. Gender norms, roles and relations influence people's susceptibility to different health conditions and diseases, and affect their enjoyment of good mental and physical health and wellbeing. They also have a bearing on people's access to, and uptake of, health services and on the health outcomes they experience throughout their lifespan. Gender norms are key to understanding and addressing HIV risk and vulnerability, and effective HIV prevention.

Harm reduction is an approach that aims to reduce the harm 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, information about injecting safely, and OST to treat opiate dependence. Harm reduction interventions are endorsed by the WHO as highly effective in preventing HIV transmission among people who inject drugs.

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

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 sex, men who have sex with men, transgender people, people who use drugs, children affected by HIV and AIDS, refugees, migrants, displaced people and prisoners.

Linking Organisations (LOs) are national civil society organisations that form the Alliance partnership. They provide technical and financial support to community-based organisations and others, enabling them to respond effectively to HIV. They work as part of national HIV programmes, and are often key to the scale-up of national community-based HIV responses. LOs are intermediary, non-governmental support organisations. Diverse in nature, some LOs provide direct HIV services or focus on policy work, while others supervise grants to community-based organisations and manage sector co-ordination.

28. UNAIDS (September 2014), 90-90-90 Ambitious treatment targets: writing the final chapter of the AIDS epidemic.

Person-centred approach to HIV and AIDS attempts to understand the needs of a person, their capacity to make responsible decisions, and the environment and behaviour that puts them at risk. For example, sex workers can operate in unsafe places where they are forced or pressurised to buy alcoholic drinks, smoke or use drugs. This affects their health, dignity and ability to negotiate safer sex. For a sex worker, a person-centred approach would take these factors into consideration and also take into account their needs for SRHR services such as STI testing, contraception and access to safe abortion. Person-centred approaches can increase the real-life efficacy of the HIV prevention and treatment tools that randomised and pilot studies confirm are effective.

Sustainable Development Goals (SDGs)[29] The Millennium Development Goals (MDGs) expired in 2015 and were replaced by a post-2015 development framework, including new SDGs that were developed and signed off at the United Nations General Assembly (UNGA) summit in September 2015. The post-2015 development framework has three guiding principles – equality, sustainability and human rights – developed along four interdependent dimensions: social development; economic development; environmental sustainability; peace and security. In 2015, member states signed up to the SDGs, which present 17 goals and 169 targets. In a break from the rich–poor paradigm of the MDGs, these goals are universal and set targets for everyone not just poor countries.

Technical Support Hubs The Alliance has five regional Technical Support Hubs, each hosted by an LO 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 LOs, 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, support, and treatment with the goal of achieving universal access to these services for all those who need them by 2010.

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

29. UNGA Resolution (21 October 2015), Transforming our world: the 2030 Agenda for Sustainable Development.

International HIV/AIDS Alliance
Together to end AIDS

FSC
Mixed credit
certified paper

The Alliance includes 32 Linking Organisations, five global Centres of Practice, five Regional Technical Support Hubs and an international secretariat.

International secretariat

United Kingdom
International HIV/AIDS Alliance (International secretariat)
mail@aidsalliance.org
www.aidsalliance.org

USA
International HIV/AIDS Alliance (Washington DC)
kkillberg@aidsalliance.org

Belgium
Stop AIDS Alliance (Brussels)
afetai@stopaidsalliance.org
www.stopaidsalliance.org

Switzerland
Stop AIDS Alliance (Geneva)
mhart@stopaidsalliance.org
www.stopaidsalliance.org

Linking Organisations and Country Offices

Bolivia
Instituto para el Desarrollo Humano (IDH)
info@idhbolivia.org
www.idhbolivia.org

Botswana
Botswana Network on Ethics, Law and HIV/AIDS (BONELA)
bonela@bonela.org
www.bonela.org

Burkina Faso
Initiative Privée et Communautaire de Lutte Contre le VIH/SIDA au Burkina Faso (IPC)
ipcbf@ipc.bf

Burundi
Alliance Burundaise Contre le SIDA (ABS)
allianceburundi@yahoo.fr

Cambodia
KHANA
khana@khana.org.kh
www.khana.org.kh

China
AIDS Care China
aidscarecn@gmail.com
www.aidscarechina.org

Côte d'Ivoire
Alliance Nationale Contre le SIDA en Côte d'Ivoire (ANS-CI)
madiarra.offia@ansci.org
www.alliancecotedivoire.org

Ecuador
Corporación Kimirina
kimirina@kimirina.org
www.kimirina.org

El Salvador
Asociacion Atlacatl Vivo Positivo (Atlacatl)
info@atlacatl.org.sv
www.atlacatl.org.sv

Ethiopia
Organization of Social Services for Health and Development (OSSAD)
ossa@ethionet.et
www.ossa-ethiopia.org

India
India HIV/AIDS Alliance*
info@allianceindia.org
www.allianceindia.org

The HUMSAFAR Trust
info@humsafar.org
www.humsafar.org

LEPRA Society
info@leprahealthinaction.in
www.leprasociety.org

MAMTA Health Institute for Mother and Child ✓
mamta@yrshr.org
www.mamta-himc.org

Vasavya Mahila Mandali (VMM)
vasavyamm@gmail.com
www.vasavya.org

Indonesia
Rumah Cemara (RC)
rumah_cemara@rumahcemara.org
www.rumahcemara.org

Kenya*
Kenya AIDS NGO Consortium (KANCO)
kanco@kanco.org
www.kanco.org

Kyrgyzstan
Anti-AIDS Association (AAA)
volvoxinkg@yandex.ru
www.antiaids.org.kg

Malaysia
Malaysian AIDS Council (MAC)
contactus@mac.org.my
www.mac.org.my/v2

Mexico
Colectivo Sol
colsol@prodigy.net.mx
www.colectivosol.org

Morocco
Association Marocaine de Solidarité et Développement (AMSED)
a.eljout@amsed.ma

Myanmar (Country Office)
International HIV/AIDS Alliance in Myanmar
aidsalliance@myanmar.com.mm

Namibia and South Africa ✓
Positive Vibes (PV)
info@positivevibes.org
www.positivevibes.org

Peru * ✓
Via Libre
vialibre@vialibre.org.pe
www.vialibre.org.pe

Senegal * ✓
Alliance Nationale Contre le SIDA (ANCS)
ancs@ancs.sn
www.ancs.sn

Tanzania Council for Social Development (TACOSODE)
tacosode@yahoo.com
www.tacosode.or.tz

Uganda
Community Health Alliance Uganda (CHAU)
info@chau.co.ug

Ukraine * ✓
Alliance for Public Health
office@aidsalliance.org.ua
www.aph.org.ua

Viet Nam
Supporting Community Development Initiatives (SCDI)
scdi@scdi.org.vn
www.scdi.org.vn

Organisations undergoing accreditation

Democratic Republic of Congo
AMO Congo
henrimukumbimas@gmail.com
www.acs-amocongo.njno.info

South Africa
NACOSA
info@nacosa.org.za
www.nacosa.org.za

AIDS Legal Network
alncpt@aln.org.za
www.aln.org.za

Swaziland
CANGO
administration@cango.org.sz
www.cango.org.sz

We have five Regional Technical Support Hubs*, and five Global Centres of Practice ✓, each hosted by a Linking Organisation. For more information visit:

www.aidsalliance.org/hubs
www.aidsalliance.org/centres

List accurate as at March 2016.