The HIV Pandemic in Latin America and the Caribbean
Global Alliance on HIV in the Americas
2008–2012
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List of acronyms

AIDS: Acquired Immunodeficiency Syndrome
ART: Anti-Retroviral Treatment or Therapy
ARV: Anti-Retroviral (drug)
GAHIV: Global Alliance on HIV
HBC: Home-based Care
HIV: Human Immunodeficiency Virus
IDU: Injecting Drug User
IEC: Information, Education and Communication.
IFRC: International Federation of Red Cross and Red Crescent Societies
LGBT: Lesbian, Gay, Bisexual and Transgender.
MSM: Men who have Sex with Men
MTCT: Mother-to-child Transmission
NGO: Non-governmental Organization
OVC: Orphans and other Vulnerable Children
PLHIV: People Living with HIV
PMER: Planning, Monitoring, Evaluation and Reporting.
PNS: Partner National Society (of the Red Cross Red Crescent)
PMTCT: Prevention of Mother-to-child Transmission
SGBV: Sexual and Gender-based Violence
STI: Sexually Transmitted Infection
TB: Tuberculosis
UN: United Nations
UNAIDS: Joint United Nations Programme on HIV/AIDS
VCT: Voluntary Counselling and Testing
The HIV pandemic in Latin America and the Caribbean

The Joint United Nations Programme on HIV/AIDS (UNAIDS) classifies the HIV pandemic in Latin America as ‘stable’ with an estimated 1.4 million people living with HIV in Latin America in 2011, compared to 1.2 million in 2001. Approximately 83,000 people were newly infected with HIV in Latin America in 2011, compared to 93,000 in 2001.

The number of people dying from AIDS-related causes declined by 10% between 2005 and 2011, from 60,000 to 54,000.

The Caribbean is one of the most heavily affected regions in the world. Adult HIV prevalence in 2011 was about 1% – higher than in any other world region outside sub-Saharan Africa.

The HIV pandemic in Latin America and the Caribbean is fuelled by a range of social and economic inequalities and is sustained by high levels of stigma, discrimination against the most at-risk and marginalized populations and persistent gender inequality, violence and homophobia. The HIV epidemic in the region is mostly concentrated in and around networks of men who have sex with men. Social stigma, however, has kept the epidemic among men who have sex with men hidden and unacknowledged. There is also a notable burden of infection among injecting drug users, sex workers and the clients of sex workers. The main mode of transmission in the Caribbean is unprotected heterosexual intercourse – paid or otherwise. Sex between men is also thought to be a significant factor in several countries, although due to social stigma, this is mainly denied.

The level of stigma and discrimination suffered by those infected and affected by the virus in Latin America and the Caribbean helps drive the epidemic underground. This makes it difficult to reach many groups and makes them understandably suspicious of outsiders.

The Red Cross has for the past ten years scaled up its activities with regard to HIV with a particular focus on prevention and addressing the stigma and discrimination that marginalizes those most at risk.

Since 2008 Red Cross Societies have committed to dramatically increase the reach and quality of their interventions through membership of an operational framework called the Global Alliance on HIV.

This publication gives an overview of these efforts and the progress that has been made over the past four years since the launch of the Global Alliance on HIV in 2008.
The Red Cross Global Alliance on HIV

Since 2000, Red Cross / Red Crescent National Societies globally have scaled up their activities to prevent and mitigate the impact of HIV. Much of the effort, however, was viewed as being uncoordinated and lacking a clear institutional focus. In 2006, International Federation of Red Cross and Red Crescent Societies (IFRC) launched the Global Alliance on HIV with the intention of providing a cohesive enabling framework to improve focus and mobilize resources to provide harmonized, effective support to Red Cross and Red Crescent National Societies to tackle HIV/AIDS.

Membership of the alliance was voluntary but National Societies subscribing to the Global Alliance agreed to work smarter through what became known as ‘the seven ones’ which included:

- One set of working principles
- One plan
- One set of objectives
- One division of labour understanding
- One funding framework
- One performance tracking system
- One accountability and reporting mechanism.

In addition, members agreed on common strategies, outputs and indicators. These indicators derived directly from the Global Indicators for HIV/AIDS that have been agreed by UNAIDS, major international organisations and National AIDS Programmes.
<table>
<thead>
<tr>
<th>KEY STRATEGIES</th>
<th>KEY INDICATORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE: To scale up the International Federation's effort in reducing vulnerability to HIV and its impact</td>
<td>Number of people that benefit from Red Cross Red Crescent programming as a % of all people needing HIV/AIDS-related interventions in targeted countries.</td>
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<table>
<thead>
<tr>
<th>OUTPUT 1: Preventing further HIV infection</th>
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<tbody>
<tr>
<td>• Peer education and community mobilization</td>
<td>Numbers (%) of people reached by peer and by IEC programmes</td>
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<tr>
<td>• Information, education and communication (IEC) for targeted vulnerable groups</td>
<td>Numbers (%) of targeted groups who correctly identify HIV prevention methods and reject misconceptions on transmission and protection</td>
</tr>
<tr>
<td>• Promoting Voluntary Counselling and Testing (VCT)</td>
<td>Numbers (%) of participants who can show another person how to use a condom</td>
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<tr>
<td>• Promoting the Prevention of Mother-to-child Transmission (PMTCT)</td>
<td>Numbers (%) of pregnant women who attend VCT and PMTCT services</td>
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<tr>
<td>• Promoting skills for personal protection, including condom use</td>
<td></td>
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<tr>
<th>OUTPUT 2: Expanding care treatment, and support</th>
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<tr>
<td>• Assisting children and orphans (OVC) made vulnerable by HIV/AIDS</td>
<td>Numbers (%) of OVC and HBC clients receiving standard packages of services</td>
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<tr>
<td>• Providing home-based treatment, support and care (HBC) for people living with HIV/AIDS</td>
<td>Numbers (%) of OVC attending school on a regular basis</td>
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<tr>
<td>• Promoting community support groups and networks</td>
<td>Numbers (%) of HBC clients achieving scores of at least 75% on Quality of Life Index (parameters include: mobility, personal hygiene, food availability, emotional status)</td>
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<td>• Promoting livelihood and food support for the most vulnerable</td>
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<th>OUTPUT 3: Reducing stigma and discrimination</th>
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<tr>
<td>• Promoting community support groups and networks of people living with HIV, and partnerships with PLHIV organisations</td>
<td>Numbers of stigma and discrimination reports received from among served population groups and % of reports followed up with appropriate action</td>
</tr>
<tr>
<td>• Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent National Societies</td>
<td>Number (%) of openly HIV-positive Red Cross Red Crescent staff and volunteers who: (a) have access to treatment, if needed; (b) report stigma and discrimination from within the Red Cross Red Crescent including whether or not remedial action has been taken</td>
</tr>
<tr>
<td>• Tackling gender inequalities and sexual and gender-based violence</td>
<td>Numbers of Sexual and Gender-based Violence reports received from among served population groups and % of reports followed up with appropriate action</td>
</tr>
<tr>
<td>• Peer education, community mobilisation, and population-based information, education and communication</td>
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The Alliance was initially rolled out in priority National Societies in Africa and Asia but soon National Societies from a number of other regions, including the Americas, expressed interest in becoming members as they viewed it as a useful means to frame their own national HIV efforts.

The Global Alliance on HIV was officially launched on World AIDS Day 2006 with a commitment made to double by 2010 the number of people globally benefiting from Red Cross Red Crescent programming in targeted communities.

The IFRC assisted a number of National Societies in the Americas in preparing the detailed planning documents and in having them approved by the IFRC Secretariat. By the beginning of 2008, a total of ten National Societies in the Americas had committed to becoming members.

The Global Alliance on HIV in the Americas was launched at the World AIDS Conference in Mexico City in 2008 with the following initial member National Societies:
- Argentina Red Cross
- Belize Red Cross
- Colombian Red Cross
- Ecuadorian Red Cross
- Guatemalan Red Cross
- Guyana Red Cross
- Haitian Red Cross
- Honduran Red Cross
- Jamaican Red Cross
- Salvadoran Red Cross.

This group was later joined by Costa Rica Red Cross and Trinidad and Tobago Red Cross Society.

This paper documents some of the work carried out by Red Cross Red Crescent National Societies in the Americas who are using the Global Alliance on HIV (GAHIV) as the framework for their national HIV response, assesses the lessons learned over the reporting period and, looking to the future, analyses how National Societies plan to improve their programming using the GAHIV.

### Definition

The **Global Alliance on HIV** is an enabling framework to mobilize capacities and resources to provide harmonised, effective support to Red Cross Red Crescent National Societies to tackle HIV/AIDS.

It is Red Cross Red Crescent centred, Red Cross Red Crescent led, but not Red Cross Red Crescent exclusive.
Factors fuelling the HIV pandemic in Latin America and the Caribbean

The most pressing issue fuelling the HIV pandemic in Latin America and the Caribbean is that of inequality within Latin America and the Caribbean; this area continues to show the world’s greatest inequality in income distribution. Throughout the Americas, poverty continues to be one of the region’s main challenges. In Latin America and the Caribbean, the average per-capita income of households in the wealthiest 10% represents 17 times that of the poorest 40%. Despite progress, there are still 170 million people suffering from poverty in the region, 70 million of whom are homeless. Furthermore, poverty in the Americas has deep historical roots and has proven difficult to eradicate resulting in the creation of a cycle of trans-generational poverty. The countries with the highest inequalities in the region as measured by the Gini Index in 2011 were Haiti, Colombia, Honduras and Bolivia.

Poverty and HIV are linked in two respects. Firstly, a lack of resources or facilities to prevent or treat HIV is a major factor in its spread. Poorer countries have challenges providing these resources and poor individuals have little or no access to education, prevention messages and treatment services. Lack of resources also results in poorer health status such as poor nutritional status, stress and chronic diseases which weaken the immune system and reduce the individual’s ability to fight infection. Secondly, poverty may lead to the need to generate income via activities, such as sex work, that increase the individual’s risk of contracting the disease. HIV invariably leads to stigmatization, loss of income, and increasing expenditure on medical services which are all contributors to poverty.

Another major factor in the spread of HIV in Latin America and the Caribbean is the issue of gender inequality and violation of women’s rights which make women and girls particularly susceptible, leaving them with less control than men have over their bodies and their lives. Women and girls often have less information about HIV and fewer resources to use preventive measures. They face barriers to the negotiation of safer sex, including economic dependency and unequal power relations. Sexual violence, a widespread and brutal violation of women’s rights, exacerbates the risk of transmission. In many cases, HIV-positive women face stigma and exclusion, and these are aggravated by their lack of rights. And regardless of whether they themselves are HIV-positive, women generally assume the burden of home-based care for others who are sick or dying, along with the orphans left behind.
**HIV-related stigma and discrimination** continues to hamper HIV-prevention efforts in Latin America and the Caribbean by making people afraid to seek out information about how to reduce their risk of exposure to HIV, and to adopt safer behaviour in case this raises suspicion about their HIV status. It also makes individuals reluctant to find out whether or not they are infected. The fear of stigma and discrimination also discourages people living with HIV from disclosing their status, even to family members and sexual partners, and undermines their ability to adhere to treatment. Given that the populations most at risk to HIV in the region include some of the most discriminated against (men who have sex with men, sex workers, prisoners, drug users and the lesbian, gay, bisexual and transgender population), it is more challenging to gain the confidence of and tailor strategies around these key populations.

**Migration** between countries is becoming a major social and health problem because the Americas are home to 27% of the world’s migrants. Migration causes social upheaval, stress and stigmatization. It also affects continuity of health care and management of communicable diseases, vaccination and treatment continuity, and health education. **Internally displaced populations** (IDPs) are also at increased risk of violence, exploitation and disease – including HIV. It is estimated that there are two to three million displaced due people as a result of the continuing conflict in Colombia whilst, in Haiti, over 400,000 IDPs were living in makeshift camps after the January 2010 earthquake.

The Americas have experienced the most **rapid urbanization** in the world in recent decades. It is expected that, by 2030, about 84.6% of the population will be living in cities. This process will worsen existing vulnerabilities such as urban violence, traffic accidents, concentration and proliferation of slum areas, and a variety of environmental and public health problems. Violence in all its forms is dramatically increasing in the region and has been called “the social pandemic of the 21st century” by the Pan American Health Organization (PAHO).

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*Note: For further information on the factors influencing the HIV pandemic in the Americas, refer to the IFRC Advocacy Report *Inequalities fuelling HIV pandemic. Focus on Red Cross Societies’ response in Latin America and the Caribbean. *November 2009.*
Red Cross HIV activities in the Americas prior to the Global Alliance on HIV

Between 2000 and 2008, Red Cross National Societies in the Americas Zone began to scale up activities in HIV/AIDS with a particular emphasis on prevention. Youth peer education projects using the ‘Together We Can (TWC)’ youth peer education methodology were initiated in National Societies across the Zone starting in the Caribbean where the Jamaica Red Cross was instrumental in its development and roll-out. TWC was translated into Spanish, French, Haitian Creole, Dutch and Papiamento from the original English and provided National Societies with a standardized and effective tool to reach youth with clear information on HIV prevention. Tens of thousands of youth were reached and, whilst the targeted population (in-school youth) was rather limited, evidence from a number of evaluations shows that the methodology was a successful means of reaching youth with HIV-prevention and anti-stigma messages and that it encouraged many National Societies to become more involved in HIV programming.

During the period immediately preceding the launch of the Global Alliance on HIV, National Societies initiated a number of campaigns that raised awareness on HIV and gave the Red Cross Red Crescent more visibility, relevance and respect. A very productive, strategic alliance with the advertising agency McCann Erickson resulted in what popularly became known as ‘The Faces Campaign’ focusing exclusively on promoting the correct and consistent use of condoms. The campaign was a huge success and is still used by many National Societies as part of their ongoing prevention activities.

Another successful initiative was a strategic alliance with taxi cooperatives in Guatemala, Honduras, El Salvador and Costa Rica (‘The Taxis Campaign’) where taxi drivers across the region are trained by National Societies in HIV prevention and anti-stigma/anti-discrimination messages which they pass on to their passengers.
Whilst National Societies in the Americas during the early to mid-2000s were, for the most part, interested and enthusiastic in being more involved in HIV programming, targeted populations were chosen mainly on account of ease of access rather than on their risk characterisation.

As a result, the main populations reached by TWC in many countries were in-school youth as distinct from youth living in vulnerable circumstances such as homeless youth or those within gangs. Some National Societies did modify the methodology to work with more-vulnerable populations but, for the most part, HIV programming was based in the classroom and not on the street.

By 2005, more National Societies became open to working with vulnerable populations but, in many, a resistance still remained towards engaging with the men who have sex with men (MSM), sex workers and drug-using communities which limited the scope and relevance of HIV programming.

By the time the Global Alliance on HIV in the Americas was launched at the AIDS Conference in Mexico City in 2008, most Red Cross Red Crescent National Societies had recognized the need to work with the key populations. The Global Alliance is seen by many as the catalyst that encouraged Red Cross in the Americas to open up much more and work with a range of strategic partners and at-risk populations.
Belize Red Cross Youth Peer Educators working with the ‘Together We Can’ methodology with out-of-school youth in Belize City.
Output 1: Prevention of new HIV infections

National Societies in the Americas have a strong track record of working on prevention activities mainly with in-school youth using the ‘Together We Can (TWC)’ methodology but also through social mobilization and mass media campaigns. Since the launch of the Global Alliance on HIV, National Societies are focusing much more energy and attention on reaching key populations.

The total number of people reached with prevention messages is still impressively high with the 12 National Societies reporting on reaching 1,476,449 people with prevention messages in 2012 alone. Most were reached through social mobilization and media activities such as campaigns, radio, text messages, through television ‘spots’ and, increasingly, through the use of social media. Many individuals were reached through targeted interventions such as peer education and specific training geared towards key populations. While in 2008 only four National Societies reported on reaching the key populations, in 2012 all National Societies were working closely with these groups. See see page 28 for more information.

- **Argentina Red Cross** reported on reaching almost 60,000 individuals, including sex workers, MSM, prison populations, PLHIV, substance users, transgender, youth, uniformed services personnel and health professionals, with prevention messaging in 2012. Their work with substance users is well respected and a model for other National Societies; see Case Study 5 for more information. The Argentina Red Cross also distributed tens of thousands of condoms through its branches.

- **Belize Red Cross** is targeting mainly youth with the modified TWC methodology, reaching 187,200 individuals in 2012 through TWC and social mobilization activities.

- **Colombian Red Cross** reached 1,455 sex workers, 1,882 MSM and 1,643 prisoners in 2012 as well as reaching over 244,000 individuals with social mobilization and mass media activities. Their work with transgender populations is well recognized and has encouraged other National Societies to work with this key population. Colombian Red Cross also targeted displaced populations and indigenous populations with prevention messages.
Today, young people account for 40% of all new adult HIV infections. Each day, more than 2,400 young people become infected with HIV—and some five million young people are living with HIV. Young people are a fulcrum. They remain at the centre of the epidemic and they have the power, through their leadership, to definitely change the course of the AIDS epidemic. Today, they are already doing so.

UNAIDS World AIDS Report 2012

- **Costa Rica Red Cross** reached 21,970 with prevention messages and targeted activities to 295 prisoners. They trained 200 taxi drivers as part of their Taxis Initiative with each driver reaching approximately 10 passengers per day with HIV prevention messages.
- **Ecuador Red Cross** targeted 2,536 youth and 560 prisoners in 2012 as well as giving prevention advice to 3,588 clients in their voluntary counselling and testing programme.
- **Salvadorian Red Cross** reached 16,127 with prevention activities including 40 MSM, 110 sex workers and 211 taxi drivers. Their prevention activities with sex workers has been very successful since, through their advocacy work on behalf of this heavily stigmatized group, they have gained the confidence of this key population.
- **Guatemalan Red Cross** reported reaching 111,671 persons with prevention activities including 2,812 sex workers, 1,393 MSM plus migrants and members of the uniformed services. Guatemalan Red Cross staff and volunteers have formed strong alliances with networks representing these highly affected groups. The Guatemalan Red Cross has engaged in a number of high-visibility campaigns reaching hundreds of thousands of people with prevention messages through their headquarters and branch structures.
- **Guyana Red Cross** had reached 3,381 persons with targeted prevention messages in 2012 including 233 sex workers and 846 miners in some of the most remote areas of the country. See Case Study 1.
- **Haitian Red Cross** has worked on prevention with drug and substance users, youth, MSM and in the internally displaced (IDP) camps. Given the extent of the problems in the camps, Haitian Red Cross has utilised all the tools available to them to reach over 365,000 people with prevention messages. They have used mobile phone technology, their radio programme, an interactive voice response system as well as door-to-door visits. Also, they have mainstreamed HIV prevention within other activities such as community health, psychosocial support and emergency health programmes.
- **Honduran Red Cross** reached 12,861 persons with HIV-prevention messages in 2012 including 3,288 prisoners, almost 2,000 taxi drivers and 170 sex workers.
- **Jamaica Red Cross** reached 182,104 people with prevention campaigns through social mobilization and the media and used social media to reach 1,418 MSM – mainly through their Real Flexx Initiative: see Case Study 2. The Jamaica Red Cross has an excellent track record in prevention and excellent links with all key populations.
- **Trinidad and Tobago Red Cross** has reached 270,000 with prevention messages and used large events such as the huge carnival celebration to reach tens of thousands with targeted prevention campaigns. The Trinidad and Tobago Red Cross also targeted activities within the MSM community and with sex workers and has reached over 700 prisoners with information on HIV prevention.
International Federation of Red Cross and Red Crescent Societies
Global Alliance on HIV in the Americas
2008 - 2012

Haitian Red Cross
The Guyana Red Cross has targeted mine workers and sex workers in remote mining areas in an effort to limit the spread of HIV within these two highly vulnerable groups. Its activities are focused on isolated commercial mining camps in the Barima-Waini and Cuyuni-Mazaruni regions.

The initial activities were based around the development of material specifically for working with miners and sex workers focusing on STIs including HIV, with an emphasis on increasing knowledge on the importance of safe sex and condom use and promoting the importance of voluntary counselling and testing.

The Guyana Red Cross designed, field-tested and produced a number of call-to-action posters for miners and sex workers in the mining communities.

Volunteer educators along with staff conducted targeted, systematic and tailored interventions with sex workers and miners. Sex workers received kits each containing condoms, lube, personal hygiene products and an information booklet.

The Guyana Red Cross forged collaboration with other organizations to provide VCT in these remote areas.

The project has been very well received by the two target groups and has gone a long way towards increasing education around STIs and in improving knowledge, attitudes, practices and behaviours.

Unprotected sex between men and women – especially paid sex – is thought to be the main mode of HIV transmission in the Caribbean. According to recent surveys, HIV prevalence among sex workers is considerably higher than it is in the general population.

UNAIDS Regional Fact Sheet 2012
Using social media to reach most at-risk populations
Jamaica Red Cross

The use of social media by Men who have Sex with Men (MSM) in Jamaica is steadily trending upwards, as MSM seek to establish safe and confidential spaces in which to interact with like-minded individuals. This increase is attributed to the pervasive use of smartphones and other high-tech devices (i.e. laptops, tablets etc.), and a reduction in the overall cost of purchasing data. In addition to using social media to interact with like-minded individuals, MSM often use these tools to share/access information, to solicit sex and to ‘hook-up’ with other gay and/or bisexual men. These are factors that could contribute to increasing their susceptibility to contracting HIV and other STIs.

In order to reach out to this key population, Jamaica Red Cross (JRC) initiated a project called ‘Real Flexx’ using social media to connect with the MSM community, providing them with easily accessible and confidential information about safer sex, violence prevention and stigma and discrimination. JRC is achieving this by using some of the most popular social media platforms in Jamaica (Facebook, Twitter and Wordpress, etc.), posting frequent and easily understandable messages and creating safe online spaces where MSM are free to express themselves in whatever capacity they desire.

The term ‘Real Flexx’ is the Jamaican vernacular for relaxation, having fun and hanging out with friends, and was strategically selected so that MSM would understand that the space was created for them to feel comfortable and to discuss any issues affecting them, with the confidence that they will not be stigmatized or discriminated against. Real Flexx spans the use of (four) different social media platforms, collectively pushing safer-sex content to approximately 1,300 MSM in Jamaica and the rest of the Caribbean.

"According to 2012 country progress reports, HIV prevalence among men who have sex with men (MSM) in Jamaica, Chile and Panama was 38%, 20% and 23% respectively – far higher than it is among the general population in these countries."

UNAIDS Regional Fact Sheet 2012
Red Cross HIV programming in the Americas since the launch of the Global Alliance on HIV

Output 2: Expanding treatment, care and support for people living with HIV

This output is focused on assisting people living with HIV and orphans and other children made vulnerable by HIV. Activities typically include psychosocial, physical and socio-economic assistance, legal care and help with the formation and organization of support networks. Although all National Societies report on prevention work, an increasing number of National Societies have been reporting on activities under Output 2 over the past two years.

A total of 13,932 people living with HIV were supported by Red Cross programmes in Latin America and the Caribbean in 2012. In addition, 1,430 HIV clients were referred for TB testing and 6,520 individuals on anti-retroviral therapy were receiving adherence support by volunteers. This type of adherence support is critical for the sustainability of treatment programmes as it prevents the emergence of drug resistance. Additionally, Red Cross assisted 1,737 PLHIV in support groups by providing physical space in their buildings for meetings, logistical support and training, and assisting with other organizational aspects of the support groups.

National Societies in Latin America and the Caribbean assisted 2,517 orphans and other children made vulnerable by HIV in 2012 by assisting with the running of shelters, providing psychosocial support, providing food and supporting educational needs.

A number of National Societies engaged in supporting PLHIV with micro-projects, emergency economic assistance and with livelihood activities.

The IFRC training package on prevention, treatment, care and support is being rolled out in some National Societies with the Trinidad and Tobago Red Cross receiving financial support from its government to train staff in the use of the toolkit. The Trinidad and Tobago Red Cross was able to reach 800 PLHIV with the information in the kit in 2010 and 2011. The Haitian Red Cross has also presented the toolkit to its Ministry of Health and has trained a number of leaders of local MSM networks as instructors in the use of the package.
Prevention of HIV and tuberculosis co-infection in prisons
Honduran Red Cross

Prisons are characterized by overcrowding, poor access, lack of political will, discrimination, violence and the significant representation of high-risk populations among prisoners. All these factors contribute to a ‘perfect storm’ for HIV and TB infection among prison populations worldwide according to researchers at the 40th Union World Conference on Lung Health held in December 2009 in Cancun, Mexico. Statistics provided by the UN Office on Drugs and Crime and UNAIDS indicated that up to 65% of some prison populations are infected with HIV, with TB rates in prisons up to 50 times higher than they are in the general population. Prisoners are also more likely to die from TB and/or default from treatment than are non-incarcerated populations. The general public is endangered as prisoners return to their communities. Overcrowding and poor ventilation are key factors in the spread of TB in prisons but, as expressed by the World Health Organization (WHO), “Prisoners have the right to at least the same level of medical care as that of the general community. Catching TB is not part of a prisoner’s sentence.”

The Honduran Red Cross (HRC) has a long history of working successfully with prison populations – especially in the area of HIV/AIDS.

As an extension of their HIV activities, HRC started a project targeting reduction of HIV and TB co-infection in selected prisons. “The Global Alliance on HIV proved to be a good model to build our project on”, stated Dr Joel Duron, Coordinator of the HRC Health Department. “With its focus on prevention and treatment, care and support and since a prisoner suffering from TB also encounters stigma and discrimination, we were easily able to adapt existing tools to cater for this new target group.”
HIV testing and counselling (HTC) services have helped millions of people learn their HIV status and, for those testing positive, learn about options for long-term care and treatment. Early knowledge of one’s positive HIV status maximizes opportunities for people living with HIV (PLHIV) to access treatment, thereby greatly reducing HIV-related morbidity and mortality, and/or preventing mother-to-child transmission of HIV. Being on effective HIV treatment reduces, by up to 96%, the likelihood that someone living with HIV will transmit HIV to his/her sexual partner.

Guatemalan Red Cross (GRC) has a long history of working with HIV – mainly in the area of prevention. In 2009, the Guatemalan Red Cross strengthened its partnership with the Guatemalan Ministry of Health (MSPAS), sharing with the Ministry information about the Global Alliance and the ‘Get Tested’ (Hazte la Prueba) campaign, which encourages people to find out their HIV statuses. As a result of this initial meeting, MSPAS agreed to train and certify volunteers of the GRC in pre and post counselling. The following year, the MSPAS and GRC carried out the ‘Get Tested’ campaign together, through the branches in Retalhuleu, Palmar and Coatepeque. The GRC volunteers who had been certified in pre and post counselling worked under the umbrella of the MoH, providing testing and counselling to the public.

In December 2010, the GRC purchased 1,000 testing kits with funds from the Global Fund for AIDS, TB and Malaria and, in close coordination with the Ministry of Health’s National HIV Programme, began expanding the geographical reach of the national VCT campaign. The MoH requested the GRC to assist them specifically with male and female sex workers and with the MSM community.

In 2011, the GRC expanded the programme to cover a broadened geographical area including Tecún Umán, El Estor, Santo Tomás, Chiquimula, Cobán, Jalapa and Guatemala City. This time the MoH donated 4,800 rapid-testing kits to GRC in order to amplify the reach into these ‘new’ areas. Gradually GRC has assumed a greater responsibility for carrying out VCT as part of the national campaign and is now seen as a very important and credible partner in the national response. The GRC has significantly raised its national profile and continues to provide high-quality voluntary counselling and testing services to urban and rural communities in partnership with MSPAS.
Red Cross HIV programming in the Americas since the launch of the Global Alliance on HIV

Output 3: Reducing stigma and discrimination

This cross-cutting activity underpins National Societies work across the entire HIV programme which reaches out to promote respect for those infected and affected by the virus.

National Societies have been increasingly vocal in advocating for the rights of vulnerable populations be they women, MSM, sex workers, prisoners, PLHIV, migrants, displaced people, substance and drug users, transgender or indigenous populations.

Every National Societies reports on activities aimed at reducing stigma and discrimination. In the past, National Societies relied on generic campaigns aimed at promoting respect but now they are much more adept at targeting messages towards specific key populations.

The Argentina Red Cross has campaigned strongly for substance users to be respected by focusing on social mobilization campaigns highlighting the plight of this marginalized group. Also, over the years, it has campaigned for the rights of women and, through their excellent relationship with the national media, has advocated for other discriminated-against groups such as PLHIV, sex workers and MSM.

The Salvadorian Red Cross played an important role as members of a broad alliance of NGOs and government agencies advocating for the rights of sex workers whilst the Colombian Red Cross has been at the forefront of advocacy activities in favour of transgender populations and the MSM community. The Guatemalan Red Cross has very strong links with networks of PLHIV and has advocated strongly on their behalf. The GRC has linked with UNAIDS on a nationwide campaign, which focuses on anti-stigma, that has been very well received and has elevated the profile of the National Societies and its work on HIV. The Jamaica Red Cross has supported the MSM community for many years by advocating against homophobia and violence directed against this group.

National Societies also placed emphasis on developing workplace HIV/AIDS policies and in implementing the IFRC HIV in the Workplace directive. A total of 2,844 staff members and volunteers were trained in HIV/AIDS in 2012 building up their capacity to implement high-quality HIV programmes and ensuring that the Red Cross Red Crescent remains a welcoming environment for those living with and affected by the virus.
Substance and drug use is a public health issue with an impact on development and security. One of the top 20 risk factors to health globally, it is closely associated with HIV, hepatitis, tuberculosis, suicide, overdose death and cardiovascular diseases. The continuing criminalization of substance and drug use results in the fostering of stigma and the generating of multiple forms of discrimination and social exclusion, including access to healthcare. People who use substances and drugs are hence further pushed underground and away from services they rightfully need.

In 2002, the Argentina Red Cross (ARC) began to explore ways of incorporating work with substance users within its HIV programme. Between 2002 and 2007, the ARC began a substance component within its broader HIV programme. In 2007, the ARC signed the Rome Consensus for a Humanitarian Drugs Policy which commits the strength of the Red Cross to actively encourage the formulation and implementation of a humanitarian drug policy that saves lives and alleviates human suffering. In 2010, the ARC developed a National Programme on the Prevention and Reduction of Risk and Harm Associated with Substance Users; the project began in 2011.

The programme was established in nine geographically dispersed branches with the intention of reaching over 163,600 direct and indirect beneficiaries within the first year. The goal was to reach substance users with key messages on HIV, in order to reduce the risk of infection, prevention of harm from substance use, to improve the level of attention provided to substance users and improve their quality of life. The National Society also aimed to sensitize the general population to the issue of substance use thus reducing stigma and discrimination towards users.

In its first year, the programme produced information, communication and educative material, initiated sensitization campaigns, trained over 200 volunteers and established alliances with regional and provincial governments, prisons and community and grassroot organizations. At the national level, the programme has given the ARC visibility and a platform to advocate on behalf of substance (including drug) users promoting a climate of tolerance and respect.

In 2012, ARC reached 102 substance users with targeted messaging on prevention and harm reduction and reached tens of thousands of people with messages promoting respect for substance users.

To end the AIDS epidemic, sex workers, men who have sex with men and people who inject drugs cannot remain invisible. They have to be counted in. Getting to zero will require better mapping and effective combination prevention. That means combined behavioural, biomedical and structural strategies, both intensively in specific populations, in concentrated epidemics and across the whole population in generalized epidemics.

UNAIDS World AIDS Report 2012

Volunteers from the Santiago del Estero Branch handing out material on harm reduction as part of its Sensitization Campaign.
Sexual and gender-based violence and HIV
Haitian Red Cross

Criminality and violence, and particularly sexual and gender-based violence (SGBV), are significant concerns throughout the Americas. The number of reported cases represents only a fraction of the actual incidents. In Haiti after the earthquake, additional security was placed in the camps as one of several measures to attempt to mitigate the violence but it was apparent that more robust interventions were required.

Studies in the IDP camps in Haiti after the earthquake indicated high levels of sexual violence with 14% of respondents surveyed reporting that one or more members of their households had been victimized by rape or other forms of sexual assault, or both, since the earthquake. In addition, there were high levels of fear about sexual violence and perceived increases in ‘transactional’ or ‘survival’ sex.

The Haitian Red Cross, supported by the IFRC and a number of sister National Societies, placed a strong focus on highlighting the issue of violence in the camps and in implementing programmes to address the issue. A position of Violence Prevention Coordinator was established to coordinate the Red Cross Movement’s response to violence in the camps and elsewhere and the issue of violence was given a very high profile as a cross-cutting issue involving health, shelter, water and sanitation, livelihoods and communications.

Practical steps were taken to limit violence beginning in the camps for which the Red Cross Red Crescent was responsible. Sanitation facilities including toilets and shower blocks were better situated and provided with solar-powered lighting. Transitional shelters were designed to allow for a back door to provide for escape in the event of fire or intruders entering. Negotiations were held with the police and security forces to increase their presence in and around the camps. Violence was included as a module in Red Cross Red Crescent community health methodologies with sessions regularly held with male and female members of the camps on violence prevention and on the rights of those subjected to violence, and where they could go to report incidences of violence and seek assistance. A particular emphasis was placed on most-vulnerable groups including female-headed households, unaccompanied minors and people with disabilities. The Haitian Red Cross psychosocial support programme staff and volunteers provided counselling to individuals who had suffered from violence and provided referral services linking victims of violence to other services.

Sexual and gender-based violence was given a high profile in the Haitian Red Cross communications efforts and regularly featured in panel discussions on the twice-weekly Red Cross Radio show with an emphasis on informing listeners on violence prevention and advising victims on their legal rights and where they could access assistance and support. Text messages were sent reaching hundreds of thousands of mobile phone users providing similar information thanks to an agreement with national telecommunications providers. Information on violence was included in the Haitian Red Cross interactive voice response (IVR) system where callers to an advertised number could receive information and advice on violence prevention, their legal rights and other services available.
An IDP Camp in Port-au-Prince, Haiti. 
Haitian Red Cross.
Red Cross HIV programming in the Americas since the launch of the Global Alliance on HIV

**Output 4: Strengthening the capacities of National Red Cross Red Crescent Societies to deliver and sustain scaled-up HIV programmes**

National Societies have recognized that their capacity to deliver scaled-up and sustainable HIV programmes depends on internal institutional strengthening and on building closer relationships with other stakeholders including networks representing affected populations, government agencies, the UN and civil society, and academia as well as with donors and the private sector. Much effort, as we have seen, has gone into training and raising awareness about HIV programming including stigma and discrimination with governance, management, staff and volunteers.

National Societies have integrated HIV/AIDS programming within their broader health activities – and indeed with other programmes such as disaster management and response. At the *Global Alliance on HIV Lessons Learned Workshop* in 2011, National Societies indicated that closer linkages have been established between HIV programmes and blood donor recruitment, community health programmes, first aid, health education, maternal, newborn and child health, sexual and reproductive health and family planning, and gender-based violence activities.
Closer working relationships have been established with disaster risk reduction through the training in the HIV in Emergencies and through mainstreaming HIV within disaster-response tools and guidelines training. Very productive relationships have been formed between HIV programmes and communications units. In Haiti for instance, the National Society broadcast a number of radio programmes with HIV as the main theme and hundreds of thousands of text messages (SMS) were sent on topics relating to safe sex and the promotion of tolerance and gender awareness – including a targeted campaign against gender-based violence.

Whilst there is agreement that the GAHIV is a programmatic framework and not a funding instrument, consistent and predictable funding over the past four years has been critical to the success of the GAHIV in the Americas. From 2008 to 2012, there was a significant increase in funding although a high percentage from 2010 onwards may be attributed to the donor response to the Haiti earthquake appeal and other country-specific initiatives such as the Guatemalan Red Cross and UNAIDS stigma campaign contribution.

Multi-year multilateral contributions from, for instance, the Norwegian Red Cross have provided a solid financial platform for the regional roll-out of the alliance. Country-specific or bilateral contributions from sister Red Cross Societies and other sources have also greatly assisted National Societies in scaling up activities. National Societies have also been successful in obtaining funds from government, UN and private sector sources. Long-term funding, however, remains a concern for National Societies within the Alliance and they have highlighted the need for technical support to assist them in the development of resource-mobilization strategies.
National Societies’ progress in reaching most at-risk populations

By 2012, twelve National Societies in the Americas had strengthened their capacity to respond to HIV in target communities with Federation and PNS support, increasing the total population reached and served from a reported 1.60 million people in 2009, to 2.60 million people in 2010, to 1.28 million people in 2011 and to 1.73 million people by the end of 2012. Whilst the numbers reached between 2011 and 2012 have remained relatively stable, there has been a significant improvement in targeting those most at risk.

Over the four years of the GAHIV in the Americas, a total of 7,210,000 people have been reached with HIV/AIDS services by the Red Cross Red Crescent in the Americas.

In 2012, a total of 1,773,439 persons was reached by Red Cross Red Crescent in the Americas with HIV activities focusing mainly on prevention and anti-stigma and anti-discrimination but also with an increasing number reached with treatment, care and support activities. The majority was reached through targeted social mobilization efforts using television, radio, the press, mobile phone technology and, increasingly, social media such as Facebook and Twitter.

Many innovative projects which began in 2010 and 2011 are now showing clear results in terms of numbers reached and impact. National Societies have shown a greater capacity, however, to focus on most at-risk populations (MARPS) and have, over the past 12 months, reached a significant number of individuals and groups with tailored messaging on prevention and treatment, care and support, including:

- 45,457 youth reached through peer education
- 5,348 sex workers
- 52,689 substance and drug users
- 5,244 men who have sex with men (MSM)
- 6,607 prisoners
- 111 transgender people
- 116,422 displaced people
- 997 members of the police and army
- 846 miners
- 13,932 people living with HIV
- 2,517 orphans and other children made vulnerable by HIV.

2,844 volunteers were active in HIV/AIDS programming in 2012 and gave 1,033,564 hours of voluntary service to the work of the National Societies in HIV programming.

By addressing the need of the most at-risk groups Red Cross Red Crescent has played a much more visible and relevant role in HIV and has displayed a capacity and commitment to advocate for the rights of these highly marginalized groups. All National Societies are working in prevention activities with key populations. For more data, see the case study outlining the Guyana Red Cross experience with miners and sex workers and Argentina Red Cross work with substance and drug users.
Apart from traditional work in prevention, Red Cross Red Crescent has offered a greater selection of services, including treatment options such as Voluntary Counselling and Testing (VCT) services in Ecuador, Guatemala and Honduras, and training on the use of the IFRC toolkit on prevention, treatment, care and support in Trinidad and Tobago Red Cross and other National Societies.

Innovation is being shown in a number of National Societies. The Jamaica Red Cross is pioneering the use of social media and radio to reach highly marginalized communities, such as MSM where confidentiality is vital due to the threat of violence. In 2012 the Jamaica Red Cross reached 182,104 persons through prevention campaigns including those reached through social media, radio and other information-dissemination approaches, as well as the general population reached through community-wide interventions. Guatemalan Red Cross had 46,311 people on their Facebook page (23,047 male and 23,264 female) which focused on their HIV activities. Haitian Red Cross used text messages and an innovative interactive voice response (IVR) system where the public called a number and, following a series of prompts, were led to information on a particular topic of interest to them – in health, the system listed a number of diseases and conditions focusing on prevention and treatment. A total of 151,022 persons called to receive information on HIV/AIDS.

A number of National Societies have taken very public advocacy roles in promoting the defending of the human rights of marginalized groups for example, the work of Argentina Red Cross and substance users and the Salvadorian Red Cross work advocating for sex workers. In the latter case, the Salvadorian Red Cross, working in coalition with other groups, was successful in supporting the creation of legislation against hate crime and gender-based violence and the creation of a LGBT unit within the Office of Human Rights.

The introduction and popularity of new Red Cross Red Crescent methodologies have also enhanced numbers reached in National Society HIV work. For instance, National Societies involved in rolling out Community based Health and First Aid (CBHFA) have found that the approach complements their work on HIV given that a number of the CBHFA modules focus on HIV prevention, anti-stigma and anti-discrimination and family planning. The GAHIV has assisted the Zone in rolling out these methodologies and approaches and has, in many cases, encouraged National Societies to use common tools and to use standardized planning, monitoring, evaluation and reporting tools.

Also, National Societies have, more recently, formed fruitful partnerships with civil society and other coalitions and alliances. An excellent example is the work of Salvadorian Red Cross who, as part of a broad alliance with a number of other actors including NGOs and government agencies, encountered discrimination and violence against sex workers, PLHIV and transgender people. This advocacy supported the creation of legislation against hate crime and gender-based violence and the creation of a LGBT unit within the Office of Human Rights. Guatemalan Red Cross has continued a very positive alliance with UNAIDS, promoting anti-discrimination messaging at a national scale using the campaign ‘Llegando a Cero’.

The four-year evaluation of the Global Alliance on HIV in Latin America and the Caribbean early in 2013 (see main findings on Page 33) involved visiting three National Societies (in Argentina, Guatemala and Jamaica) to interview management, staff and volunteers. The evaluation found it evident, from both the document review and field visits, that the Global Alliance approach had broken down stigma within National Societies and was “instrumental in prompting National Societies to build their capacity to work more intensively (and more effectively) with key populations such as men who have sex with men (MSM), transgender people, male and female sex workers, substance users, out-of-school and vulnerable youth, prisoners, migrants and indigenous populations”.

As the Periodic Results Report 2009–2011 states, only four National Societies were working directly with key populations at the start of the Global Alliance in 2008 but, by 2011, all 12 Global Alliance members were actively engaged with the most at-risk populations.
Linkages with other approaches, tools and methodologies

Integration within and across programmes is a priority for the Red Cross Red Crescent movement and National Societies are finding that having HIV incorporated in our community-based approaches, such as Community-based Health and First Aid (CBHFA), means we can reach significant numbers of people through mainstreaming HIV within these approaches and tools. Over the past four years, with financial support from American, British, Finnish and Norwegian Red Cross, the IFRC has promoted the use of CBHFA which has been enthusiastically welcomed by 16 National Societies in the Americas as their standard health approach. During 2012, 675 Red Cross Red Crescent staff and volunteers, and 311 community volunteers, were trained on CBHFA and CBHFA implementation in these National Societies has benefited up to 13,072 people – including many who have been reached with HIV messages.

Promoting voluntary, non-remunerated blood donations (VNRBD) is, along with first aid, a traditional Red Cross Red Crescent activity. Many National Societies in the Americas are very active in blood programmes with a number running large blood banks and, in some cases, being the lead agencies for blood donation in their countries. Given that there is a clear relationship between safe sex and safe blood, most National Societies that are active in blood programmes have encouraged close relationships between both programmes. In March 2006, a total of 46 National Red Cross or Red Crescent Societies attended the 10th International Colloquium on the Recruitment of Voluntary Non-remunerated Blood Donors (VNRBD) in Santiago, Chile. Many Latin American and Caribbean National Societies became very interested in the example of good practice, in Zimbabwe where there is a youth-based blood-donor recruitment methodology called Club 25 where young donors pledge to donate a set number of blood units up until they reach the age of 25 and commit to engaging in healthy behaviours to ensure their donations are safe. The Continental Club 25 Project was developed and rolled out throughout the Americas region, with support from the Finnish Red Cross, and a total of 18 National Societies were involved; many becoming members of the GAHIV. National Societies have been quick to explore the synergies and have trained Club 25 members as HIV Peer Educators as well as promoting prevention messages during blood-collection days and so reaching tens of thousands of youth with HIV information.

More and more National Societies are developing psychosocial support programme (PSP) capacity and establishing links between this programme and disaster and health activities. In this manner, PSP is now much more
mainstreamed in all our activities. It is seen as an important cross-cutting issue in regards to HIV/AIDS and violence. In Haiti, the PSP programme included amongst its target group orphans and other vulnerable children, PLHIV and individuals who had been victims of violence including sexual and gender-based violence.

Also, National Societies have been quick to recognize the importance of training staff and volunteers in violence prevention and a number of pilot projects and programmes have begun with the support of sister National Societies – particularly the Canadian Red Cross which has expertise in this area. HIV coordinators work closely with their communications counterparts on developing strategies around social mobilization and mass media campaigns – especially on HIV prevention and anti-stigma and anti-discrimination. Hundreds of thousands of people have received tailored messages on these topics thanks to this close working relationship. Working with colleagues in disaster preparedness and response, HIV coordinators have trained staff and volunteers in the HIV in Emergencies guidelines and have ensured that needs of high-risk populations are included in emergency planning documents and appeals.

Through these integrated approaches, thousands of additional people are being reached with HIV messages and services.
Epidemiological trends
UNAIDS World AIDS Day report
December 2012

The UNAIDS Report published on 1 December 2012 gives cause for optimism in respect of efforts to address the HIV/AIDS epidemic in Latin America and the Caribbean.

The epidemic in Latin America is classified as being stable with an estimated **1.4 million people living with HIV in Latin America in 2011**, compared with 1.2 million in 2001. Approximately 83,000 people were newly infected with HIV in Latin America in 2011, compared with 93,000 in 2011 and the number of people dying of AIDS-related causes declined by 10% between 2005 and 2011, from 60,000 to 54,000.

After Sub-Saharan Africa, the **Caribbean** is one of the most heavily affected regions in the HIV epidemic. Adult HIV prevalence in 2011 was about 1% – higher than in any other region outside of sub-Saharan Africa – although the number of people living with HIV in the Caribbean remains relatively low (230,000 in 2011) and has varied little since the late 1990s. Positively speaking, the region has seen a **sharp decline (42%) in new HIV infections** since 2001 from 22,000 in 2001 to 13,000 in 2011 making it the **region with the sharpest decline in numbers of new HIV infections**.

In Suriname, the rate of new HIV infections fell by 86% and in the Dominican Republic by 73%. A more than 50% decline was observed in the Bahamas, Barbados, Belize and Haiti. In Jamaica and Trinidad and Tobago, the number of new HIV infections fell by more than one-third. In Latin America, the number of new HIV infections has remained stable.

In addition, the report states that the countries of the Caribbean experienced a 48% decline in AIDS-related deaths. The Dominican Republic had 61% fewer people dying from AIDS-related causes while Guyana, Haiti, Jamaica and Suriname saw a more than 40% reduction.

The number of children acquiring HIV infection has declined significantly **in the Caribbean (32%)** and Oceania (36%), with a more modest decline in Asia (12%). New infections also dropped in Latin America (24%) and Eastern Europe and Central Asia (13%); these are regions that had already significantly reduced the numbers of children newly acquiring HIV infection.

The Caribbean has reached a high percentage of anti-retroviral coverage for pregnant women (79%) whilst in Latin America coverage of anti-retroviral regimens to prevent mother-to-child transmission in 2011 was 56%. The number of children newly infected with HIV fell by 24% in Latin America and by 32% in the Caribbean. In 2011, coverage of anti-retroviral therapy was 68% in Latin America and 67% in the Caribbean compared to a global average of 54%.
In late 2011, the Federation Secretariat conducted a review of the first three years of the Global Alliance on HIV in the Americas. The review examined the extent to which the outputs have been achieved among the National Societies involved with the GAHIV in Latin America and the Caribbean and the lessons learned to date. While not a comprehensive evaluation, the analysis attempted to ascertain the extent to which the GAHIV objectives are being accomplished and how the GAHIV has contributed to change at the National Societies level.

The review showed that the GAHIV has provided an appropriate model for working with the most marginalized populations which are at higher risk of HIV in the region. The relatively flexible funding provided multilaterally through the Federation Secretariat has enabled each National Society to tailor its programmatic approaches to local needs and to complement other funding sources. The GAHIV has also contributed to institutional learning and change, including strengthening the capacity of National Societies to work in partnership with others on the National AIDS response in their countries.

In late 2012, the IFRC Americas Zone Office selected a consultant to carry out a more comprehensive evaluation of the four-year GAHIV in the Americas including visiting three National Societies (Argentina, Guatemala and Jamaica) to interview management, staff, volunteers and partners.

The evaluation found that all three National Societies considered the structure and approach provided by the GAHIV to be an effective and strategic way of working that gave coherence to their HIV programming. Staff interviewed in all three National Societies suggested that they would continue to use this framework, regardless of whether or not the GAHIV continued to be promoted by IFRC in the future. It was found that the Global Alliance approach encouraged National Societies to respond to the realities of the HIV epidemic in their countries by increasing their work with the key populations, sometimes for the first time.

National Societies have increased the involvement of PLHIV and other key populations within their HIV programmes, including increasing numbers of PLHIV volunteers and staff, all of whom report that the National Societies are much more PLHIV-friendly organizations now than they were in the past. In order to reach key populations, National Societies have developed new approaches and methodologies for working with individual populations, recognising the importance of tailoring their work to the characteristics of each group.
The three National Societies visited have been able to scale up their programming significantly through the Global Alliance approach, initiating or extending work in more branches, training more volunteers and reaching more at-risk beneficiaries with a broader range of services and activities. Including a fourth objective within the GAHIV, which focused on strengthening National Societies’ capacities to deliver and sustain scaled-up HIV programmes, was an important contribution to achieving overall results. National Societies visited during the evaluation clearly built capacity at all levels, although there were concerns about the longer-term sustainability of some activities, as well as about the extent to which capacity gains had been mainstreamed throughout the organization.

The programming of all three National Societies visited was well aligned with the National AIDS programmes and, in all three cases, the National Societies was a trusted partner with the government bodies charged with delivering HIV-related services. At both branch and headquarters levels, the National Societies coordinated their activities with the most active stakeholders, including local government, civil society and faith-based organizations, and UNAIDS. In many cases, these relationships have developed into important strategic partnerships.

All three National Societies visited during the evaluation strengthened their profiles and reputations in HIV over the period of the Global Alliance, both with the public and with other institutions such as UNAIDS. This was particularly the case for the Guatemalas Red Cross due to the shift in focus to working with key populations and expanding its work to more branches throughout the country.

The availability of multilateral funding to support National Societies in the Global Alliance was pivotal for the success exhibited by National Societies. Particularly useful was the flexibility that National Societies had to assign these funds where they were most needed: for example, to fill gaps around other HIV programme funds sources. For a number of branches (and the Guatemalan Red Cross in general), it seems that the Global Alliance has been transformative, contributing to efforts to revitalise and modernize the National Societies.

“The first major achievement of the GA was the unification of goals and the recognition that all the work implemented by the various HIV/AIDS projects in the National Society was guided by a single global agenda. Before this introduction of the seven ones and the development of a single workplan, we operated each project separately and reported accordingly.

“We also appreciated that we were united across the globe helping to attain the same targets and it was empowering to meet with and share with our Caribbean neighbours recognizing that we shared similar challenges as well as successes. Good practices were evaluated and shared so we saved resources and time and were able to be part of a team interested in supporting each other. It was at this time that the different territories were able to acknowledge our strengths and similarities and build on them. The Faces Campaign, the Taxi Initiative and Together We Can all had an important effect – reaching out and changing the lives of thousands.

“The Global Alliance further provided much needed training and we felt the unwavering support of our Movement from the highest level.”

Lois Hue, Deputy Director General, Jamaica Red Cross
Acknowledgements

The International Federation of the Red Cross and Red Crescent Societies (IFRC) has, over the past four years of the Global Alliance on HIV in Latin America and the Caribbean, received generous financial and technical support from a number of partners including the Norwegian Red Cross, British Red Cross and Swedish Red Cross.

In addition, country level support has been received from the American, Canadian, Finnish, Italian, Netherlands, Norwegian, Spanish and Swiss Red Cross Societies, the Global Fund for AIDS, TB and Malaria, the Italo-Swiss Foundation, Ely Lilly Foundation, United Way, UN agencies, national governments and a range of private sector companies, including REPSOL Petroleum, PRIME Condoms, TAME Airlines and Diners Club.
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.