Mobilizing communities to achieve 3 by 5

World Health Organization

Background

The World Health Organization (WHO) and UNAIDS have identified the global HIV treatment gap as a public health emergency. To address this challenge, they have established the 3 by 5 target, whereby 3 million people in developing countries will be on antiretroviral treatment by the end of 2005. Their aim is to mobilize the many stakeholders globally, regionally and locally who need to play a part in rapidly expanding access to antiretroviral therapy (ART) in resource-constrained countries.

Affected communities, vunerable groups living with HIV/AIDS, and faith-based organizations have been a driving force in the response to the HIV/AIDS epidemic in many countries. They have performed a critical role in advocating for access to antiretroviral therapy as a human right, as well as in strengthening health-sector capacity through the direct provision of services. Despite limited resources, these responses have been highly successful in many countries, contributing to reductions in stigma and discrimination, empowering individuals and their communities and ensuring that health services reach, and are responsive to those who need them, including the poorest and most vulnerable.

There is strong international consensus that the 3 by 5 target can only be reached if the capacity of community and faith-based organizations — including vunerable groups living with HIV/AIDS — is greatly strengthened, so as to enable their full participation in the delivery of ART[1]. Above all, the involvement of communities is a necessary prerequisite to the full realization of the human rights of people living with HIV/AIDS, including their rights to the highest attainable standard of health and to freedom from stigma and discrimination.

Objective

In accordance with the overall 3 by 5 strategic framework, the objective of the 3 by 5 Community Mobilization Plan is to strengthen the capacity of community and faith-based organizations to be fully involved at all levels of the planning and implementation of ART programmes. This involvement is potentially very broad, and could range from participating in the design of national ART scale-up plans and acting as treatment supporters for family members and friends living with HIV/AIDS to conducting programme evaluation, including quality assurance and operational research.

The plan was developed in consultation with community-based treatment advocates, practitioners and other experts in the community sector, as well as individuals within and outside the United Nations system. Many partner groups also contributed.

The key elements of the 3 by 5 Community Mobilization Plan are:

- providing capacity-building grants for community-based organizations to strengthen their role in national HIV/AIDS treatment advocacy and education;
- supporting community-driven approaches to HIV/AIDS treatment and care;
- facilitating stronger linkages and partnerships between the public health sector and civil society groups;
- offering standardized training for community HIV/AIDS treatment supporters and educators;
- providing operational recommendations and policy guidance for ART implementers on involving communities in ART scale up at the service delivery/health facility level;
- identifying and elaborating on the key ethical principles and mechanisms for fair and equitable distribution of ART;
- promoting community-based operational research and quality assurance, including partnerships with academic and other institutions;

[1] For the purposes of this document, "community" refers broadly to all of the individuals and groups of individuals affected by HIV/AIDS. They include people living with HIV/AIDS who are and who are not taking ART, their families and friends, community health workers including treatment supporters, and community leaders (including religious leaders and traditional healers). 'Community organizations' include community-based AIDS organizations, community-based organizations representing marginalized populations (e.g. sex workers, injection drug users, men who have sex with men), faith-based organizations, associations of people living with HIV/AIDS and their advocates, and other nongovernmental organizations, including trades unions and other employee or employer associations.

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- strengthening the performance, legitimacy and accountability of the community sector through support for the establishment of guiding principles and minimum standards of good practice;
- increasing the capacity of WHO offices in regions and countries, and at headquarters, to provide effective technical support to and liaison with people living with HIV/AIDS, affected communities and their organizations; and
- ensuring access to the necessary treatment, care and support for WHO staff living with HIV/AIDS, including adequate insurance coverage and reimbursement mechanisms for ART and other medical expenses.

Activities

In January 2004, WHO will call for nominations to an international 3 by 5 Community Advisory Committee (CAC), encompassing ART expertise from people living with HIV/AIDS, community-based HIV/AIDS organizations and those representing marginalized communities, faith-based organizations and international development nongovernmental organizations (NGOs). The CAC will provide ongoing guidance to WHO on the implementation of the 3 by 5 strategy.

For 3 by 5 to be achieved, the bulk of activities described in this plan must be undertaken within regions and countries. Accordingly, a series of regional workshops for people living with HIV/AIDS and community-based organizations will take place in 2004, beginning with Eastern Europe and Central Asia (the EURO region) in January. These workshops will focus on detailed preparation for implementing the plan and its deliverables.

Timetable until mid-2004

1 December 2003	Launch of community mobilization plan
31 December 2003	Tides Foundation contracted to develop regional workshops and capacity-building fund review process
January 2004	• 3 by 5 Community Advisory Committee established • Regional workshops in EURO and Asia Pacific
February 2004	Guidance document on key ethical principles for fair and equitable distribution of ART
March 2004	• Capacity-building fund established and call for proposals distributed • Appointment of HIV/AIDS policy and education officer in human resources department at HQ
April 2004	• Complete analysis of existing models of community-based ART, care and support • Civil society technical officers appointed in all regional offices
May 2004	• Regional workshops completed • Standardized training model for ARV treatment supporters
June 2004	• Civil society technical officers appointed in 10 WHO offices in high-burden countries • First capacity-building grants distributed • First 10 CBO/academic research, evaluation and quality assurance partnerships established with support of WHO regional offices; 20 further partnerships established by mid-2005 • Revised personnel policy on HIV/AIDS in the WHO Workplace and mechanisms in place to ensure access to ART and care for all WHO staff living with HIV/AIDS
July 2004	Assess progress and complete work planning to end of December 2005

The 3 by 5 initiative will necessarily involve increasing the number, capacity and competence of WHO staff. This will specifically include increasing the number of staff responsible for liaison with and technical support for civil society, including, where possible, increasing the number of WHO staff who are themselves living with HIV/AIDS. The focus of this expanded WHO capacity will be on building strong, civil society participation in scaling up ART at regional level and in high-burden countries and on strengthening the role of WHO as a facilitator of linkages between the public sector and civil society.

Milestones: **The following milestones have been targeted for the years 2004–2005:**

- **By mid-2004, 10 000 health providers and community-treatment supporters are trained to deliver ART services; increasing to 100 000 by the end of 2005.[2]**
- **By mid-2004, 1500 partnerships are formed between formal ART service outlets and community-based groups; increasing to 30 000 by the end of 2005.**

[2] The ratio between health providers and community-treatment supporters trained to deliver ART will vary by country and region. It is likely to fall between 40-60%.