



A joint initiative by STOP AIDS NOW!  
and the International HIV/AIDS Alliance

# *Intensify linkages between HIV and sexual and reproductive health and rights for maximum impact: Stop AIDS Alliance policy position*

## **Introduction**

Linking HIV and sexual and reproductive health (SRH)<sup>1</sup> refers to joined work in these two sectors at various levels, including policy, advocacy, programming and operations. Linking HIV and SRH is not a new concept. In 1994 the International Conference on Population and Development Programme of Action stated that SRH programmes should address HIV and AIDS.<sup>2</sup> Then in 2004 the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children called for intensified linkages between family planning and prevention of mother-to-child HIV transmission programmes.<sup>3</sup> A follow-up high-level consultation held later in 2004 resulted in the New York Call to Commitment on Linking HIV/AIDS and Sexual and Reproductive Health.<sup>4</sup> Additionally, the 2001 Declaration of Commitment on HIV/AIDS and both Political Declarations on HIV/AIDS (2006 and 2011) recognised the need to link SRH and HIV.

Despite high-level political commitment to intensify linkages, challenges remain for ensuring that people receive comprehensive, high-quality services because policies are not being translated into practice. Linking HIV and SRH must go beyond integrating services and programmes to include explicit attention to rights and the structural issues that make people vulnerable to HIV and threaten their sexual and

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<sup>1</sup>. SRH programmes and policies include, but are not restricted to, services for family planning; infertility services; maternal and newborn health; prevention of unsafe abortion and post-abortion care; prevention of mother-to-child transmission of HIV; sexually transmitted infections, including infection from HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; promotion of sexual health, including sexuality counselling, and prevention and management of gender-based violence. See [www.srhivlinkages.org/uploads/docs/articles/linkagesdefinitions\\_2010\\_en.pdf](http://www.srhivlinkages.org/uploads/docs/articles/linkagesdefinitions_2010_en.pdf)

<sup>2</sup>. United Nations (1994), 'Report of the International Conference on Population and Development'. Accessed 23 November 2011. Available at: [www.un.org/popin/icpd/conference/offeng/poa.html](http://www.un.org/popin/icpd/conference/offeng/poa.html)

<sup>3</sup>. United Nations Population Fund (2004), 'The Glion Call to Action on Family Planning and HIV/AIDS in Women and Children'. Accessed 23 November 2011. Available at: [www.unfpa.org/webdav/site/global/shared/documents/publications/2004/glion\\_callaction.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/glion_callaction.pdf)

<sup>4</sup>. UNFPA and UNAIDS (June 2004), 'The New York Call to Commitment on Linking HIV/AIDS and Sexual and Reproductive Health'. Accessed 24 November 2011. Available at: [www.unfpa.org/upload/lib\\_pub\\_file/321\\_filename\\_New%20York%20Call%20to%20Commitment.pdf](http://www.unfpa.org/upload/lib_pub_file/321_filename_New%20York%20Call%20to%20Commitment.pdf)

reproductive wellbeing. Linking HIV and SRH and rights (SRHR) can deliver a more robust and cost-effective response, and increase progress on achieving Millennium Development Goals 4, 5 and 6<sup>5</sup> by 2015 and beyond.

## The rationale for linking

Linking simply makes sense. Most HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding. Sexually transmitted infections increase the risk of acquiring or transmitting HIV, and lack of sexual and reproductive wellbeing and HIV share root causes. Among women of childbearing age,<sup>6</sup> HIV is the leading cause of death. In sub-Saharan Africa, HIV is responsible for 46% of all deaths among women in that group. Furthermore, 13% of maternal deaths during pregnancy are estimated to be HIV related.<sup>7</sup>

When done correctly, linking allows for best use of limited health resources and can improve health service delivery. Linking services and interventions can prevent duplication and competition for resources. These outcomes can increase effectiveness and efficiency, improving the use of human and material resources, and the financial sustainability of programmes. Linking can also broaden the skills of health providers, and reduce stigma and discrimination towards people seeking SRH and/or HIV services. Reducing discrimination and stigma towards underserved and vulnerable communities leads to enhanced community involvement and participation in the development, uptake and follow-up of services. Once a person is comfortable asking for the services they need, knowing they will not be judged, they are more likely to encourage others to use them. This can lead to increased community buy-in and ownership over the quality and accessibility of needed services.

Linking can also increase service outreach. While HIV clinics serve those with HIV-specific demands, SRH centres see a greater number of people and a larger cross-section of the population. Linking can therefore increase opportunities for broadening key HIV interventions, including increasing voluntary HIV counselling and testing to identify people living with HIV and help them access treatment, care and support. According to the UNAIDS 2011 World AIDS Report, it is estimated that over half of people living with HIV do not know their status.

Linked programming can help ensure that populations traditionally underserved by SRH services, such as people living with HIV and marginalised groups, receive the care they need. For example, integrating<sup>8</sup> family planning services into HIV prevention, care, support and treatment programmes is critically important for sex workers and people who use drugs, as well as for their sexual partners. Studies show they face substantial unmet needs for family planning.<sup>9</sup>

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5. Millennium Development Goal 4: Reduce child mortality; Millennium Development Goal 5: Improve maternal health; and Millennium Development Goal 6: Combat HIV/AIDS, malaria and other diseases. See [www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/)

6. Defined as aged between 15 and 44.

7. Global Fund to fight AIDS, Tuberculosis and Malaria (2010), 'Investments in the health of women and children: Global Fund support of Millennium Development Goals 4 and 5'.

8. Definitions and various linkages components can be found at: [www.srhhivlinkages.org/uploads/docs/articles/linkagesdefinitions\\_2010\\_en.pdf](http://www.srhhivlinkages.org/uploads/docs/articles/linkagesdefinitions_2010_en.pdf)

9. International HIV/AIDS Alliance (2010), 'Integration of HIV and sexual and reproductive health and rights: good practice guide'. Available at: [www.aidsalliance.org/Publicationsdetails.aspx?Id=507](http://www.aidsalliance.org/Publicationsdetails.aspx?Id=507)

## Core criteria for successful linking

There is no single blueprint for linking, nor is linking a panacea for weak health systems. Indeed, integrating services can increase the burden of already overstretched health workers, and a weak health infrastructure can drag down newly integrated services. So it is essential that linking be undertaken on the basis of evidence and be adapted to the context of application (for example, analysing needs in relation to capacity) using a case-by-case approach. Nevertheless, all linking must meet certain specific minimum conditions.



## Zero stigma and rights violations

HIV-related stigma<sup>10</sup> and rights violations are pervasive. Research shows that stigma and rights violations are impediments to the uptake of HIV testing, treatment and care, and to adherence to treatment.<sup>11</sup> The consequences for HIV responses are dramatic. For example, modelling shows that up to 55% of cases of transmission in settings where services for the prevention of mother-to-child transmission of HIV are readily available may be caused by stigma and discrimination. The most effective stigma and discrimination programmes could potentially reduce mother-to-child transmission by as much as one-third in settings where stigma is prevalent.<sup>12</sup>

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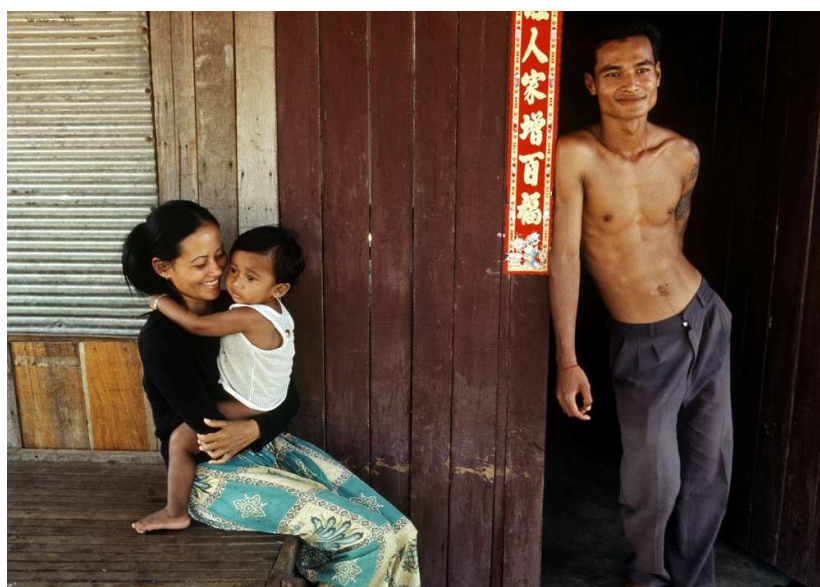
10. Whether measured by stigmatising attitudes, fear of or perceived stigma, or enacted stigma.

11. ICRW (2009), 'HIV-related stigma and discrimination: a summary of recent literature'.

12. Ibid

Health care providers frequently fail to respect a variety of human rights when dealing with HIV-positive clients. These include the right to information, freedom of choice, self-determination and bodily integrity. They fail to provide people living with HIV with information for access to safe conception – that is, if they discuss their clients' fertility intentions at all. The assumption is that people living with HIV do not want to have children; and if they do, they shouldn't. Health care providers often fail to inform people living with HIV of the full range of contraceptives available, and sometimes insist that antiretroviral treatment is conditional on use of contraception. They may even coerce pregnant women living with HIV to terminate their pregnancies. At other times they perform involuntary or coerced sterilisations on women living with HIV.<sup>13</sup>

Furthermore, health care providers routinely operate under a bias that emphasises prevention of vertical transmission<sup>14</sup> over the rights and wellbeing of the mother. There is substantial evidence that they often fail to give pregnant women the possibility of opting out of provider-initiated testing,<sup>15</sup> or simply test women without their knowledge. Research shows that violations of consent discourage pregnant women, regardless of their HIV status, from obtaining health care services.<sup>16</sup>



Linking HIV and SRH services shows immense promise for making progress on universal access to prevention, treatment, care and support. For example integrating HIV testing into family planning has been shown to increase HIV testing levels, condom distribution and uptake, and access to and use of family planning services. Integrating family planning into HIV services increases HIV testing and follow-up visits by women living with HIV. And integrating HIV into antenatal care is correlated with higher antiretroviral treatment and HIV testing coverage in pregnant women.<sup>17</sup>

But for linking to be as effective as possible, it must expressly combat stigma and promote human rights, including SRHR. However, it is not possible to do so successfully without addressing structural barriers to claiming those rights, since health care settings exist within a broader social and institutional context.

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13. Anand, N. et al. (2010), 'Bridging the gap: developing a human rights framework to address coerced sterilization and abortion'.

14. Also referred to as prevention of mother to child transmission.

15. Ujiji et al. (2011), 'Is 'opt-out HIV testing' a real option among pregnant women in rural districts in Kenya?' *BMC Public Health* 11:151.

16. PEPFAR (2010), 'PMTCT: expert panel report and recommendations to the U.S. Congress and U.S. Global AIDS Coordinator'.

17. WHO, UNFPA, IPPF, UNAIDS, and UCSF, (2008), 'Linkages: evidence review and recommendations'.

## Responding to gender-based inequality

Gender-based inequality is one of the key societal barriers to claiming human rights. It deprives women and girls of the knowledge and tools they need to make informed health decisions, and results in their health being devalued, especially in the family. It also puts them at higher risk of violence, which in turn threatens their health and increases their risk of HIV infection.<sup>18</sup> Indeed, research suggests a close association between intimate partner violence and HIV-positive status in women partners.<sup>19</sup> All these and other consequences of gender-based inequality negatively affect the ability of women and girls to seek and access services.<sup>20</sup>

Gender-based inequality also creates barriers to accessing SRH services for men and boys. Social attitudes bias SRH programmes in favour of women of reproductive age, and all too often focus exclusively on the mother–infant dyad. This means that men and boys are typically excluded from SRH services. To be effective, programmes must include women and girls and men and boys. Not only is this essential for the health of men and boys, but it also helps create a favourable environment for the health of women and girls. Indeed, it is important to bear in mind that attitudes and role expectations around masculinity increase the vulnerability of men to HIV, and this in turn increases women’s HIV risk.

Gender inequality also creates barriers to accessing SRH services for key populations,<sup>21</sup> who are at higher risk of HIV infection. While they may access HIV services successfully, they often lack access to appropriate SRH services. These services routinely fail to be user-friendly and provide information about a range of sexual practices, and do not respond to the specific needs of transgender people or men who have sex with men.<sup>22</sup>

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18. Institute of Medicine and National Research Council (2011), ‘Social and economic costs of violence: workshop summary’.

19. Dunkle, K. L. et al. (2006), ‘Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa’, *Lancet* 363: 1415–21. See also Hale, F. and Vazquez, M. (2011), ‘Violence against women living with HIV/AIDS: a background paper’.

20. UNFPA, (2010), ‘Addressing violence against women and girls in sexual and reproductive health services: a review of knowledge assets’.

21. Key populations are groups that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Key populations vary according to the local context, but include vulnerable and marginalised groups such as people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, people who use drugs, orphans and other vulnerable children, migrants and displaced people, and prisoners.

22. India HIV/AIDS Alliance (2011, draft), ‘Issue brief: HIV/SRHR integration for men who have sex with men and transgender people’.

## Yayasan Harapan Permata Hati Kita

In Indonesia about 10% of injecting drug users are women, and they receive little support. Women who inject drugs are stigmatised both for injecting drugs and for violating traditional gender roles, leading to discrimination and their isolation.

Yayasan Harapan Permata Hati Kita (YAKITA) is a community-based organisation in Bogor that seeks to improve the quality of life of people addicted to illegal drugs. It initiated the Bogor Female Support group, which brought together women drug users, former users and/or partners of users. Some were living with HIV; all were affected by HIV.

The support group organised meetings twice a month to discuss sex, sexually transmitted infections and HIV, including condom negotiation, staying healthy, gender roles, and addiction and recovery issues. Support group activities included free distribution of condoms; income-generating activities, such as learning to make and sell sandals; developing skills useful for formal employment; and special support sessions for women living with HIV, and their families.

YAKITA witnessed the women move from depression and low self-esteem to greater acceptance of their reality, and finally to a stronger sense of self-worth. The women began sharing information and networking, developing a sense of solidarity with each other. And as they increased their knowledge along with their self-esteem, they began negotiating safer sex and talking about stigma and self-stigma. The economic skills they gained also gave them hope and the assurance that they need not depend financially on others. And the family support group sessions helped the families understand HIV and its treatment. They encouraged them to support each other to take care of themselves, and avoid stigma, self-stigma and discrimination.

Widespread homophobia and transphobia, and criminalisation<sup>23</sup> of same-sex sexual activity, further alienate key populations from health services. In this negative social environment, transgender people in particular face multiple causes of stigma and discrimination, criminalisation and violence. The prejudice and violence they encounter in health care settings further limits their access to appropriate care – if indeed they receive any care at all.<sup>24</sup>

If integrated HIV and SRH services are to promote the human rights of people, and therefore their sexual and reproductive health, they must address gender inequality. This means that service providers should encourage men to become engaged in HIV and SRHR, and women to become fully informed and able to make their own health-related decisions. They should also establish linkages with organisations working for women's empowerment; for example, so they can refer women for legal or economic assistance. However, it is important to remember that while one-stop-shop integrated services can increase access and uptake, they must be designed according to what works best in each context and according to the needs of different key populations.<sup>25</sup>

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23. In 86 countries consensual same-sex sexual activity is a criminal offence. In 21 countries male-male sex is punishable by prison sentences of 10 years or more; in 7 countries, it is punishable by death. See amfAR (2008), 'Special report: MSM, HIV, and the road to universal access – how far have we come?'

24. International HIV/AIDS Alliance (2010), 'Integration of HIV and sexual and reproductive health and rights: good practice guide'. Available at: [www.aidsalliance.org/Publicationsdetails.aspx?Id=507](http://www.aidsalliance.org/Publicationsdetails.aspx?Id=507)

25. India HIV/AIDS Alliance (draft), 'Policy brief. Key linkages and key populations: is HIV/SRHR integration serving the needs of vulnerable communities?'

## Strong health systems

Successful linking requires good base programmes into which additional services should be integrated. For example, if HIV prevention, treatment, care and support are being integrated into SRH services, then the family planning services and maternal, neonatal and child health programmes that should offer these HIV-related services need to function well. A recent AIDSTAR-One review found that integrating prevention of mother-to-child transmission services into reproductive, maternal, neonatal and child health programmes faces important funding weaknesses and lack of human, logistical and technical resources.<sup>26</sup>

SRH programmes cannot function in a vacuum, and they need a strong backbone. Therefore it is thus crucial to strengthen the basic building blocks of overall health systems.<sup>27</sup> This means strengthening programme policy, resource mobilisation, planning, budgeting, logistics and supply systems, human resource capacity, infrastructure, service delivery, monitoring and evaluation, and coordination mechanisms.<sup>28</sup> Having these building blocks in place allows for linking that improves health interventions and, ultimately, health systems.



Strengthening overall health systems implies consciously strengthening the capacity for integration. Integrated service delivery needs to be supported through a harmonised programme, budget, planning, and monitoring and evaluation system. It also requires a national policy that provides a comprehensive rationale and framework for integration. It is crucial that decision-makers support these policies otherwise they risk not being developed, or being developed and not implemented.

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26. USAID, AIDSTAR-One, 'Integrating PMTCT of HIV interventions with MNCH services'. Accessed 24 November 2011. Available at: [www.aidstar-one.com/focus\\_areas/pmtct/resources/technical\\_briefs/integrating\\_pmtct\\_mnch\\_services#tab\\_5](http://www.aidstar-one.com/focus_areas/pmtct/resources/technical_briefs/integrating_pmtct_mnch_services#tab_5)

27. World Health Organization (2007), 'Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action'.

28. UNAIDS (June 2010), 'Background paper. Linking sexual and reproductive health (SRH) services with HIV intervention in practice. 26th meeting of the UNAIDS Programme Coordinating Board'.

## Meaningful community engagement

The importance of community engagement and mobilisation for linking SRHR and HIV is not widely recognised or supported. Communities play a critical role in increasing access to HIV and SRH services. The HIV response has shown how important it is to have the active participation of communities in all stages of programme development and implementation. The response has increased ownership and helped to ensure that interventions are appropriate and relevant. It has also improved the delivery of HIV programmes and health outcomes, and increased the sustainability of programmes. Furthermore, community mobilisation has been effective in addressing structural barriers, such as stigma and discrimination, gender inequality and other causes of vulnerability.

Community mobilisation can do for linking what it has done for HIV responses. There is evidence that community mobilisation helps create demand and improve the uptake and quality of linked services.<sup>29</sup> It can also potentially improve uptake among hard-to-reach groups not currently served by SRH providers, such as sex workers, people who use drugs and men who have sex with men.

### Case study on community mobilization in linking: setting up a one-stop shop in Kenya

Sex workers in Kenya tend to avoid mainstream health care services because of stigma, poverty and the illegal, invisible nature of sex work. In response, the Alliance linking organisation Kenya AIDS NGOs Consortium (KANCO) set up an HIV prevention centre for sex workers especially designed to increase access to HIV and SRH services.

The centre offers information; condom education and provision; family planning; HIV testing and counselling; sexually transmitted infection screening and management; opportunistic infection management; referral for antiretroviral treatment; tuberculosis screening and referral; cervical cancer screening; breast examination; and group empowerment activities. The centre also trains sex workers to reach out to their peers at their place of work, and encourages them to socialise. There are weekly peer group meetings in different areas, and the sex workers give out pamphlets and cards, inviting other sex workers to the centre.

Up to 300 sex workers now access services, and uptake of HIV testing and other health services has increased. The sex workers have established a support group for those living with HIV, and they have registered self-help groups that run income-generating activities. Sex workers have reported reducing their risks and a greater uptake of HIV testing and other health services. Recognising their role in preventing the spread of HIV, they are also referring their regular clients and partners for sexually transmitted infection and HIV services.

KANCO's one-stop shop experience shows that service delivery must be flexible and adaptable, as sex workers are particularly mobile and have unpredictable working hours. It also demonstrates that programmes must have medical, psychosocial and behavioural components, and that friendly, non-judgmental attitudes among staff are essential.

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29. KIT (2011), 'Community-based versus community-placed interventions: a qualitative study examining the involvement of communities in HIV and AIDS programmes in four African countries'.



Programmes seeking to link SRH and HIV must strengthen the capacity of communities to participate in linking efforts. International experts argue that strategic investment in the role of communities is critical (not optional, or additional).<sup>30</sup> This means that programmes must give a significant and equitable role to community-based organisations and actors, and to key affected populations and communities at all programme levels. They must also promote human rights, including the rights to equality and freedom from all forms of discrimination, to information and education, and to the benefits of scientific progress. Programmes must be informed by evidence and be responsive to community experience and knowledge. They have to be accountable to the communities they aim to serve.

## Sufficient and smart financing

The share of official development assistance for health going to sexual and reproductive health, including HIV, has declined in the past decade. United Nations member states have pledged to invest from US\$22 to 24 billion by 2015 for the global AIDS response. However, international funding for HIV and AIDS fell from US\$8.7 billion in 2009 to US\$7.6 billion in 2010. The Global Fund to Fight AIDS, Tuberculosis and Malaria has now cancelled its next call for country proposals (Round 11). This is a recent consequence of donors not fulfilling their commitments to combating HIV, tuberculosis and malaria in developing countries.<sup>31</sup>

If current funding trends continue during 2008–2015, the 68 countries that account for more than 95% of all maternal and child deaths may face a \$60 billion funding gap for implementing a full package of maternal, newborn and child health services.<sup>32</sup> But the international funding shortfall is not only to blame. Countries most affected by HIV have also failed to take adequate responsibility for their citizens' health and wellbeing. Only Tanzania has achieved the Abuja Declaration target of allocating at least 15% of total government expenditures to health.<sup>33</sup>

In keeping with current thinking on HIV investment and programming,<sup>34</sup> financing must be smart. It needs to go to programmes that are based on evidence and that target populations with the highest need. Moreover, it needs to support critical social enablers, such as community mobilisation, changing laws and stigma reduction, and programme enablers. These include community-centred design and delivery, communication, management, procurement, research and innovation. Crucially, smart financing also means supporting HIV programmes that involve synergies with development sectors. Working with other health and development sectors such as SRH is necessary to maximise impact and cost-efficiencies for both HIV and SRH outcomes. Linking and integrating SRHR and HIV across all key aspects of programming makes sense to beneficiaries, donors and governments.

Harmonised funding is also an essential component of smart financing. There must be funding for integrated programming, as opposed to vertical funding. This is part of translating harmonised HIV and SRH policies into integrated service delivery. The need for harmonised funding not only applies to the national level but also to multilateral and bilateral (donor) funding, which often dictates national policy development. Also, financial reporting mechanisms need to be harmonised to support the development and implementation of linked SRH and HIV programmes, as well as to document outcomes.

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

31. UNAIDS press statement, 27 November 2011.

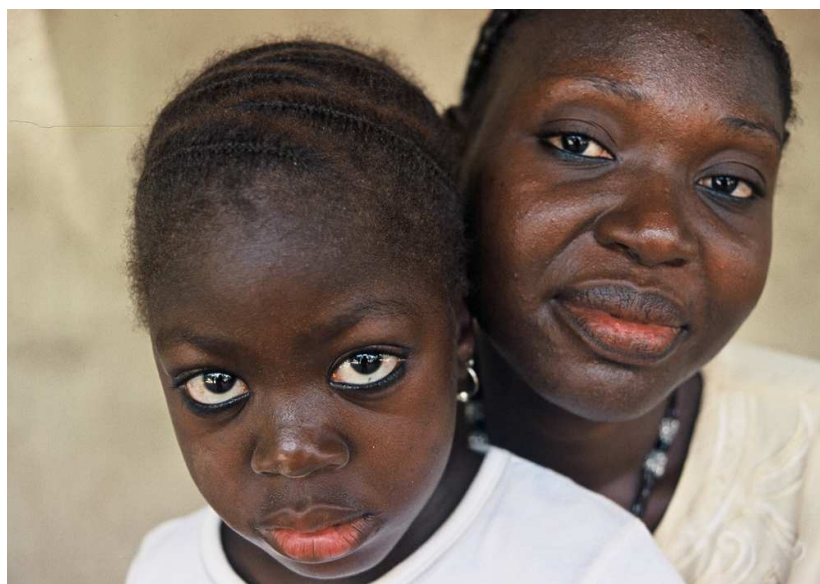
32. Countdown to 2015 (2010), 'Countdown to 2015 decade report with country profiles: taking stock of maternal, newborn & child survival'.

33. World Health Organization (2011), 'The Abuja Declaration: ten years on'.

34. In June 2011 the *Lancet* published the work of the Investment Framework study group. In its basic form the Investment Framework is a model for HIV investment and HIV programming for the next decade. See Schwartländer, B. et al. (2011), 'Towards an improved investment approach for an effective response to HIV/AIDS', *Lancet* 377(9782): 2031–41.

## Key recommendations for successful linking

- Ministries of health must ensure that health care workers are well trained on legislation, policies and professional standards on human rights and patient care. Health workers should receive specific training to improve their technical skills in sexual and reproductive health care for people living with HIV, as well as their capacity to promote confidentiality, informed consent, gender equality, and a non-discriminatory and stigma-free environment.<sup>35</sup>
- National governments and donors need to keep their promises and fund health systems strengthening in line with the Abuja target of 15% and international commitments in the area of HIV and SRH. Cutbacks jeopardise the gains made. They are counterproductive, and present major barriers to achieving universal access to HIV prevention, treatment, care and support and reproductive health, as well as the Millennium Development Goals.
- Ministries of health need to develop, adopt, modify and strengthen relevant policies, HIV and SRH strategic plans, and coordination mechanisms to foster effective linkages. Accordingly, funding needs to allow linking and not inhibit it by creating vertical funding channels.
- Funding for health systems strengthening needs to include support for strengthening the capacity of communities to challenge underlying structural barriers to access, like gender inequality, and create a facilitative social and legal environment for women and girls and sexual minorities.
- International, national and local linking efforts need to build the capacity of communities to engage, mobilise and ensure that linked SRH and HIV programmes are appropriate to the needs of people living with HIV and key populations affected by reproductive ill health and HIV.



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35. GNP+ et al. (2009), 'Advancing the sexual and reproductive health and human rights of people living with HIV: a guidance package'.

## About the Stop AIDS Alliance

Stop AIDS Alliance (SAA) is a partnership between STOP AIDS NOW!, based in the Netherlands and the International HIV/AIDS Alliance, based in the United Kingdom, with policy and advocacy offices based in Brussels, Geneva and Washington D.C.

Through engaging with EU and US policy makers, EU Institutions, United Nations agencies and other relevant stakeholders, we aim to ensure that the HIV response remains a high priority on the global policy agenda to achieve universal access to HIV prevention, treatment, care and support.

Our presence in the three main global policy centres as well as in the Netherlands and the UK aims to contribute to harmonized HIV policy messages, building linkages between advocacy groups active in the different locations and voicing the concerns and needs of the International HIV/AIDS Alliance's and STOP AIDS NOW! partners working in the field. Please see our website at: [www.stopaidsalliance.org](http://www.stopaidsalliance.org).

### Colophon

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