Theory of Change AFEW
January 2020

Chapter 1. Introduction

AFEW is a well-known international partnership in the Eastern Europe and Central Asia (EECA) region with a good track record of activities with and for, and strong connection to key populations at risk for HIV, TB and viral hepatitis, and has gained extensive knowledge of the local context in all the countries in the region. Together, AFEW partners and key populations groups contribute to a healthy society with healthy individuals. AFEW started as an international organization AIDS Foundation East-West in 2001 in Russia, registered in the Netherlands. After the reorganization into a partnership in 2013, the country branches became independent organisations registered in their own countries, with AFEW International still registered in the Netherlands and based in Amsterdam.

Currently, there are independent AFEWs in Ukraine, Kazakhstan, Kyrgyzstan, Russia and in the Netherlands.[1] Over the years, the working relationship has developed and has transitioned into an equal and mutual partnership. The AFEW partners in the countries of the EECA region have become independent NGOs with their own strong track records and positions in the local networks of civil society organisations. "Eastern leadership" has been reached in the AFEW partnership within 5 years.

In the AFEW partnership, we strengthen our capacities by the exchange of experiences and mutual technical support. That creates more coherence in principles, vision and expertise, as well as an increase in knowledge and capacity. AFEW improves access to (health) services, and also improves the quality of such services for key populations through introducing innovative ways of addressing specific needs, and advocating for harm reduction through advocacy in the EECA region. Also due to this model, bridges are built between East and West: between governments and NGOs, between communities and health professionals, academic partners and NGOs. By being a part of a wider AFEW partnership, each AFEW has a safety net, access to expertise and innovations, a vision on different models of capacity development, and a wider reach when it comes to advocacy on every scale (national, regional and global).

This Theory of Change narrative and accompanying visual have been developed in close consultation between the independent AFEW's. The process was guided and facilitated by independent Theory of Change practitioner Karen Kraan[2].

Our Theory of Change has been developed with reference to our values, policies and priorities, as well as context analysis and strategic reviews and evaluations.

It represents our big-picture thinking about the change that AFEW wants to see and what our contribution is to that change. In mapping our TOC, we began with identifying the vision and

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[1] 1) AFEW International / AFEW Интернешнл
2) AFEW-Kyrgyzstan / AFEW-Кыргызстан
3) AFEW Kazakhstan / AFEW Kazakhstan
4) International Charitable Foundation "AIDS Foundation East-West" (AFEW-Ukraine) / Международный благотворительный фонд «СПИД Фонд Восток-Запад» (AIDS Foundation East-West – AFEW-Украина)
5) AFEW Russia / Фонд Содействия профилактике, лечению и здоровому образу жизни населения "СПИД Фонд Восток-Запад"
[2] www.flowz.nl

Dimensions of Change and worked backwards to determine what role that AFEW and other stakeholders play in driving the incremental steps that will ultimately lead to those end goals. One of the advantages to the TOC approach is that it can project a strategy and vision beyond the timeline of our present strategic period, as is most useful for the AFEW partnership. It speaks to how our work drives and influences longer-term change. We intend to use the TOC for ongoing monitoring and adaptation and plan to fit a strategic framework within the TOC, with more detailed, shorter-term, country specific work plans.

Our Theory of Change encompasses the following:
- Barriers, consequences and Vision for Success;
- Four Dimensions of Change;
- Drivers for Change and their intermediate steps;
- AFEW's role and strategies in driving the change in each Dimension of Change;
- Assumptions.

Our Theory of Change is bound by the following limitations:
- We have not developed pathways for change. As this is an AFEW-wide Theory of Change, the detailed pathway and the drivers for change differ from context to context, and are not described here. We have, however, identified four universal pathway steps, which are briefly described in this narrative.
- The Theory of Change is broad in its vision and precise in its definition, again for the reason that the whole AFEW partnership is using this TOC as an umbrella.

Chapter 2. The context, the problem and our vision for change

2.1 The context in which we operate and the problems we seek to address

What kind of trends in the EECA region can we make into opportunities?
We note relevant societal trends related to migration, stigma, health and health service delivery, decentralization, donors, and the NGO environment:

Migration is both a reality and an opportunity. The specifics of migration differ from country to country; what binds is that it is happening everywhere, and globally, people are in motion. People facing extreme stigma and discrimination are more likely to migrate to countries that have more inclusive and prosperous societies. As people move, so do their needs, and their ideas. We have the opportunity to present migrants as resilient, and as heroes, and in this way shape a positive narrative about migrating populations. In the EECA region, seasonal labourers migrate from their home countries and across various host countries, following the earning opportunities.[3] Central Asia and the Russian Federation have the biggest inter-regional migration flow becoming one of the largest migration corridor in the world with hundreds of thousands of migrants workers moving from Central Asia to the Russian Federation and Kazakhstan each year.[4] A lack of finances, social vulnerability and increased HIV and TB risks represent key problems faced by migrants when planning and going on their labour migration.

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[3] HIV and Migration in Central Asian countries and Russian Federation. Technical Workshop report, 19-20 February, 2018 Astana, Kazakhstan
[4] HIV and Migration in Central Asian countries and Russian Federation. Technical Workshop report, 19-20 February, 2018 Astana, Kazakhstan

Our analysis points to a set of problems related to information, as well as social, legal and education issues.[5]

In Ukraine, internal and external migration is significantly influenced by the conflict in Eastern Ukraine and the annexation of Crimea. At least 1.5 million people,[6] including key populations, are reported as internally displaced persons (IDPs) who, due to various factors of vulnerability, face barriers in access to healthcare, and social and legal justice.[7]

There are some financial opportunities available to work specifically on the topic of migration/with migrating communities.

The WHO agenda for universal health coverage[8], as well as AFEW's previous work in HIV and TB, and with harm reduction is an entry point for working on **stigma and with groups that are left behind[9]**; it also presents a broader opportunity for donor engagement and connection. Groups that are left behind in the region are becoming more empowered and active in demanding a seat at the decision table. The groups get better organised and gain skills to advocate and negotiate for, among others, better health services. They form a group that we engage with, and whom we can strengthen and support in their progress. We believe that it is more efficient and effective to build people's confidence towards advocating for themselves, than it is to influence world politics; in doing so we enable groups to increase their profile instead of talking on their behalf. As people become more visible, they can articulate the issues themselves.

The concept of **health and health service delivery** is currently fairly narrow in the EECA region. Within a post-Soviet context, the emphasis has been largely on cementing the basics of the public health system, rather than on the need for a complete mental and physical health and well-being system that services the needs of a diverse population. Many countries in the EECA region are currently undergoing a reform of public health, with more focus on decentralisation and Primary Health Care. The public health service should undergo a fundamental review and reorganization. It is necessary to move away from only the oversight and control functions of this service to the provision of preventative services to the population, coordination of the activities of health organizations, regardless of ownership of all levels of medical care, as well as coordination with other ministries and departments, NGOs, experts, development partners on health protection issues.[10] The fact that this review and reorganization need has been recognised and is included in plans gives an opening to emphasize that the needs of specific populations should also be taken into account, as well as to lobby for a broadening of the concept of health and health systems.

As an example, in accordance with the "Densaulyk" document adopted by the National Health Development Program 2016-2019 of the Republic of Kazakhstan, the state started to support the development of the private sector in providing primary health care in[11], and will continue the privatization of PHC organizations. Equal conditions for participation of private and public entities in delivering health care services (under the framework of State Guarantees Package) have been created, which has intensified the competitive environment. This trend will continue to expand in the region. AFEW was involved in the creation of an enabling environment for participation of private clinics and

[5] http://www.afew.org/publications-eng/bridging-the-gaps-report-eng/

[6] https://www.unhcr.org/ua/en/internally-displaced-persons

[7] http://www.ua.undp.org/content/ukraine/en/home/library/democratic_governance/IDPs-human-rights-observance.html

[8] https://www.who.int/features/qa/universal_health_coverage/en/

[9] People whose human rights are violated, and people facing barriers in various ways, including key populations and youth.

[10] The Program of the Government of the Kyrgyz Republic for the Protection of Public Health and the Development of the Health System for 2019-2030

[11] https://www.enbek.gov.kz/ru/node/332663

NGOs in the provision of TB and HIV care by developing referral system and improving knowledge and skills of specialists from private clinics.

The HIV epidemic in EECA remains the fastest growing in the world[12], particularly in the Russian Federation[13], Ukraine, Uzbekistan, Kazakhstan and Belarus.[14] Access to treatment for people most at risk of or living with HIV is a crucial need. Less than 30% of people living with HIV in the EECA region are accessing treatment[15]. Within the European region (WHO definition), most new TB cases and deaths are found in the Eastern European and Central Asian (EECA) countries. We face an increasing number of drug-resistant TB cases which becomes a real concern for patients and public health. The 16 countries of Eastern Europe and Central Asia (EECA) are home to approximately 11.3 million people who are antibody-positive for the hepatitis C virus (HCV).[16]

The trend of **decentralization** continues throughout the region, and there is more regional (districts) and local (cities) financial power to invest and fund work and service delivery.[17][18][19] As an example, it is easier to cooperate on the local level than the federal level (in the case of Russia), and several Russian cities are making decisions independently of Moscow. The funding made available for HIV related work is slowly increasing throughout the region. For instance, the amount of money allocated from the state budget in Kyrgyzstan increased from 330 000 USD in 2016 to 870 000 USD in 2019.
Social contracting[20] happens at the local level. We also note disparities in wealth across regions.

Donor trends are increasingly towards promoting leadership from the South and East, rather than from the global North. Organisations that have the ability and track record to meet the criteria required by donors, in combination with the leadership from the South and East, are prime contenders for donor support. The transition to domestic funding and decentralization and Southern leadership leaves less space for East-West collaboration and for funding of multi country proposals.

There is a high level of competition in the **NGO environment** in the region, and this encourages the formation of alliances and coalitions.[21] Competition is also pushing effectiveness, as organisations realise that they need to distinguish themselves from others in order to stand out. Alliance forming has a positive effect on the possibility to influence donor trends, and to encourage donors towards following the needs of clients and local groups, as donors are more likely to respond positively to the advice of a collective of organisations speaking a common language. NGOs also experience shrinking space for civil society, eg the foreign agent law in the Russian Federation, for which NGOs need to register when they receive money from abroad, is under discussion in parliament or partially copied in other countries in the EECA region.

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[12] https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)32421-7.pdf
[13] https://www.avert.org/professionals/hiv-around-world/eastern-europe-central-asia/russia
[14] http://aidsinfo.unaids.org/
[15] https://www.unaids.org/en/resources/documents/2019/2019-UNAIDS-data
[16] According to a 2014 (updated in 2015, 2016 and 2017) systematic review, L. Maistat, N. Kravchenko, A. Reddy, Hepatitis C in Eastern Europe and Central Asia: a survey of epidemiology, treatment access and civil society activity in eleven countries; *Hepatology, Medicine and Policy 2017, 2:9).*
[17] https://www.ebrd.com/shareholders-and-board-of-governors.html
[18] https://decentralization.gov.ua/en
[19] http://www.euro.who.int/__data/assets/pdf_file/0004/98275/E89891.pdf
[20] By social contracting we mean a specific type of partnership between (municipal) authorities and NGOs, where authorities outsource service delivery to NGOs through direct contracts or tenders.
[21] We know this from experience. So far there are several networks, operating in EECA, mainly doing the advocacy work. These Eurasian Harm reduction Association, Eurasian Coalition of Men's Health, Eurasian Women AIDS network, South Caucasus Network on HIV/AIDS (SCN), Eurasian and Central Asian Union of PLHIV, Central Asian Network of PLHIV, Teenergizer, and so on. And there are also national networks, some are members of these regional networks. To be able to source funds, they unite into consortia.

2.2 The groups we seek to achieve change for

We work for people in EECA who are left behind[22] and therefore lack access to health services and social justice.
Key populations[23] are disproportionately affected by public health concerns as HIV, tuberculosis and viral hepatitis when compared with the general population, and they are key to the response. AFEW works for and with people who are using drugs, prisoners, sex workers, men who have sex with men, youth and women. Key populations are part of stigmatized groups, but that's a broader term, e.g. youth are stigmatised in certain contexts, and so are women.

We realise that stigmatized communities is a moving target. Vulnerability, or lack of access, is context specific, and changes over time. Therefore, we refrain from creating a list to define this group, but rather recognise that the facts (on who lacks access to health services and social justice) need to be reviewed periodically. Instead of a list, we choose to define as follows:

AFEW is there for *all people in EECA that face barriers regarding access to health, justice and/or voice and prioritizing those who are more at risk, more stigmatized, and are facing more severe barriers.*

We recognize that access is multi-layered and is a multi-factor term. The barriers most commonly presenting are related to gender, age, sexual orientation, and perceived (health) behaviour and health status. Further, barriers and stigma don't always go hand in hand; they can be experienced independently of each other - limited access is not only experienced by those who experience stigma.

When we mention key populations, we are referring to a particular group in a specific context, and are referring to **defined** groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context.

2.3 Barriers for change

Here we describe barriers for change that need to be addressed by our Theory of Change.

People (facing barriers) experience:
- A lack of coverage of their basic socio-economic needs, and as a consequence the focus remains on the basics of the many and not on the particulars of the individual.
- Lack of (and deliberate limitation of) access to information, and in particular about their health and their rights, and as a consequence low awareness.
- Predestined to be born into disadvantage, resulting in an arrears that has to be caught up before progress can be made.
- A strong normativity in society, which designates difference as being bad or undesirable, and as a consequence self-stigma, as well as stigma from society.

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[22] People whose human rights are violated, and people facing barriers in various ways, including key populations and youth.
[23] Key populations are groups who, due to specific higher-risk behaviours, are at increased risk of HIV, irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. These groups include the following populations: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people. People in prisons and other closed settings are also referred as key population because of high levels of incarceration of the other groups and the increased risk behaviours and lack of HIV services in these settings. The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic. (WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update).

- A legal situation that criminalises certain conditions, situations, and activities that are often beyond the control of the individual, resulting in people hiding certain information, and being exposed to harm without (legal) recourse.
- Legal barriers for obtaining health services such as parental consent required for minors under 16-18 years old (differences per country) for certain medical procedures including HIV test
- Lack of political commitment to remove legal and social barriers that hold certain people back, resulting in the reinforcement of normative beliefs and behaviours.

In the context of AFEW we often deal with *young key populations*, which UNAIDS defines as young people aged 15 to 24 years who are members of key populations, such as young people living with HIV, young gay men and other men who have sex with men, young transgender people, young people using drugs, and young people involved in transactional sex or sexual exploitation. Young key populations often have needs that are unique, and their meaningful participation is critical to a successful HIV response.[24]

Specific barriers that young people (at risk) face are:
- Particular vulnerability to HIV due to widespread discrimination, stigma and violence
- Lack of information and low risk awareness of the risks
- Turbulence of puberty and sexual debuts, associated with higher risk behaviours
- Immaturity in terms of social skills
- Economic vulnerability
- Power imbalances in relationships and, sometimes, alienation from family and friends
- Higher vulnerability due to policies and laws that demean or criminalize them or their behaviours, and by education and health systems that ignore or reject them and that fail to provide the information, services and treatment they need to protect their health and provide safety in the broad sense.

These factors increase the risk that they may engage – willingly or not – in behaviours that put them at risk of HIV, such as frequent unprotected sex, alcohol and drug use, including sharing needles and syringes to inject drugs.

Society markers:
- Religion has regained importance after suppression during the Soviet Union. Religion is generally conservative and, in some cases, oppressive to particular people. Religion reinforces normativity and othering, and gives "permission" to discriminate and exclude. This has a particular impact on girls and young women who has substantially less decision power and access to information.[25]
- Conservative values and skewed concepts of equality equated to sameness at a marker of post-Soviet socialism still reinforce the notion of "special rights" being demanded for a select few.
- A widespread feature of the post-soviet generation is the way they deal with hierarchy and bureaucracy, which is based on the common and widespread fear to openly oppose the state power and its commands, which translated into a specific way of dealing with it - people adjust their lives and activities to be in line with regulations, are very creative in how they actually deliver services in a restrictive environment, don't tell what they really think, and display lots of respect to governmental officials.
- Crisis of the education systems in the region in general; high competition to enter universities, only affordable for well-off families, and poor vocational education, with low prestige and bad reputation. The educational system does not prepare well for the labour market; outdated

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[24] UNAIDS, Terminology Guidelines, 2015
[25] AFEW fact finding missions

curricula, poorly paid teachers, top-down paradigm of teaching, and discouraged free thought and exploration. As a consequence, the need to reshape the way that people believe that they can think and learn.

Government:
- Quality of Public Health system is generally below standard, and needs improvement in all areas (surveillance, prevention, treatment and care, patient-centred approach).
- Lack of or poor laws that criminalise, or do not protect, results in prosecution and/or ignoring the need for protection.
- Soviet legacy/thinking and post dictatorship means that government structures, policies and services are still built on the Soviet way of organising; centralised, bureaucratic, not people centred.
- Centralised systems and power structures that are closed to public scrutiny, and as a consequence difficult to engage and influence.

Barriers for change are at all levels, from the individual, to their social/societal environment, to the government and other power holders. Consequences, and the interplay of these, are felt at all levels, and interventions are needed at all levels in order to make a real and lasting change.

2.4 Our vision for success

If all the barriers and their root causes would be solved and disappear, we would reach the following vision for success:

All people in EECA participate fully and confidently concerning their health and rights, in an inclusive and just society.

The universal declaration of human rights underpins our vision, and includes articles that refer specifically to the right to health and the right to justice.[26]

Chapter 3. Dimensions of change

3.1 Introduction

In order to counter the barriers and consequences, and make strides towards enabling people in the EECA to participate fully and confidently, we have to ensure that people have access to the services that meet their needs, have the ability to voice their needs and be heard, are not held back by inequitable laws and policies, and that their contributions are appreciated and utilized to influence.

3.2 Four dimensions of change

1. Access to good quality health services

As defined by the World Health Organization (WHO), health is a "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." Good quality health services need to include prevention, medical treatment, (consultations /social) care and support, early detection, rehabilitation and psychological support. Access implies not only that it is available within

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[26] https://www.un.org/en/universal-declaration-human-rights/

suitable parameters, but also that it is experienced as being accessible - inclusive and non-judgemental, and affordable.

Good quality health services need to be responsive to the needs of specific communities, including needs related to SRHR, and within a context of high levels of HIV, TB and viral Hepatitis.

2. Legal and Social justice

Legal and social justice includes equality before the law, and protections against human rights violations, for all. Social justice also includes access to a certain range of services that help people to maintain at least a minimum standard of living, for example welfare services, shelter, and education. Heavily interconnected, the basic right to health has a huge impact upon and is affected by many other rights, including the right to food, housing, work, education, non-discrimination, access to information, health, and participation.[27] Justice can also imply a concern for justice, peace, and a genuine respect for people. Legal justice and social justice together mean that the legal framework has been changed in order to ensure that there is no possibility to discriminate on the basis of law, as well as that society at large has embraced this change, ultimately reinforcing the right to self-determination.

3. Power to voice, participate and decide

To ensure full participation in society, people need information, skills, and the ability to organize themselves autonomously.[28] People need platforms where they can voice their experience and their needs and experience dialogue, including (but not restricted to) in political spaces. Their power in the dialogue needs to be recognised and actively sought in decision-making processes. This requires a strong civil society, a support network, and political commitment: a reciprocal relationship between communities and decision-makers that is sustainable and resilient, and able to cope with shrinking space for dialogue.

4. Appreciation of diversity[29]

Appreciation of difference is a global challenge; people tend to be comfortable with what looks and feels familiar and suspicious or fearful of what seems different. Soviet legacy reinforces this trait, as it strived for uniformity, and a real shift is needed in this region to move from the current situation, to a celebration of difference as something that has value and adds richness to society. That said, any shifts at personal, societal, and/or governmental level, however small, will have an effect.

3.3 Pathway Steps in each Dimension of Change

The dimensions of change share four high level pathway steps, namely: Awareness, Acknowledgement, Action, Anchoring:
- Awareness of people facing barriers, of a lack of appropriate response or service provision
- Acknowledgement that they need something, that there is a need and opportunity to change
- Action taken to address these needs
- Anchoring successful action for sustainability

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[27] www.healthpovertyaction.org

[28] https://www.socialcapitalresearch.com/designing-social-capital-sensitive-participation-methodologies/definition-participation/

[29] The concept of diversity encompasses acceptance and respect. It means understanding that each individual is unique, and recognizing our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies. It is the exploration of these differences in a safe, positive, and nurturing environment. It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

3.4 Drivers for change for each Dimension of Change

For each dimension of change, we have identified particular drivers for change. Drivers for change are actors, also referred to as stakeholders, that need to be activated in order to contribute to the for success. They sometimes need to act themselves, sometimes support or at least not block change. Together, these drivers for change form an ecosystem of 'changemakers', each with their own specific role. They may or may not be aware of their role as 'changemaker', but all need to play their part. Below we describe, for key drivers for change, what they should be doing, per dimension of change.[30] This 'behaviour' is what is now often lacking and is addressed by our Theory of Change. Not all of these outcomes are within the sphere of control or sphere of influence of the AFEW partnership. The outcomes for drivers for change are aspirational, and may take a long time to achieve. By formulating them aspirational, each time bound, smaller, step can be related and linked to bigger change, enabling to see each small outcome as contributing to big change. Having this overview, also facilitates longer term strategic planning for the AFEW partnership.

Dimension 1. Access to good quality health services

Health professionals:
- Respect patients' privacy
- Have a patient-centred approach, and a friendly attitude
- Form multidisciplinary teams that include psychological and mental care
- Can deliver appropriate services
- Are equipped with the latest knowledge and information about new scientific developments, and opportunities to access and share knowledge and information

Educational institutions:
- Include curricula focused on evidence-based, patient centred approaches
- Contribute to and facilitate curricula development

Researchers:
- Gather evidence to create a factual basis for the development of policies and practices
- Contribute to developing evidence-based practices
- Ensure surveillance and monitoring of health
- Liaise with patients to identify new research ideas

Patients:
- Are aware that they have health needs
- Want to act on their health needs
- Know their rights and demand quality care
- Respect health care professionals and can trust their expertise
- Adhere to treatment requirements and regimes

CSOs and social workers:
- Check and ensure social support systems are in place for patients
- Advocate for improved quality of care
- Establish good referral and collaboration systems with medical professionals and NGOs, social services, law enforcement and employment agencies

Ministries and administrations:

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[30] The change steps are not exhaustive, but exemplary key desired outcomes

- Provide adequate budget allocations to cover the costs of appropriate systems, staff, and service delivery
- Remove criminalizing laws that block equal access to healthcare
- Develop and implement enabling strategies, standards and policies, based on evidence
- Negotiate/ensure affordable prices of medicines and services

International organizations[31]:
- Increase their focus on EECA region
- Coordinate their (health) programs to ensure better coverage and impact
- Allocate funds to the full range of needs
- Educate donors in a coordinated way about the region and the specific health concerns that require attention and financial support
- Coordinate advocacy efforts aimed at mobilizing governments and international bodies focused on health

Dimension 2. Legal and Social justice

People:
- Are able to make informed choices about directions in their life
- Are aware of and claim their rights
- Can rely on a non-judgemental and non-discriminatory approach by law enforcement officers and law system
- Experience fair and just relationships with the state, other institutions and society
- Experience a socially equal society

CSO's, NGO's and service providers:
- Create and sustain social safety nets such as drop-in centres, shelters etc.
- Act together to better accommodate the needs of people
- Respect human rights, ethical codes of conduct, and the integrity of fellow citizens
- Have a non-discriminatory attitude in service delivery

Law and policy makers:
- Apply a human rights framework
- Ensure adequate policies regarding drug use, sex work, HIV etc.
- Ensure equality before the law
- Allocate budget to start/sustain specific legal services
- Ensure the basic conditions as food, shelter, education and work, are met for all citizens
- Ensure mechanisms to guarantee implementation of laws and policies

International organizations:
- Put pressure on the national governments in order to help support accountability for implementing international frameworks that governments have ratified

Dimension 3 Power to voice, participate and decide

People:
- Have the space to create a network or start an own organization
- Don't fear to be different
- Can fulfil their participation in society by being part of civil society
- Can rely on the network of CSO's as their support platform, making sure their voices are heard

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[31] UN Agencies with the primary mandate to support governments to adhere to international guidelines (WHO, UNFPA, UNAIDS, UNICEF, Global Fund etc.) and thus support key populations through creating an enabling environment

- Are ready to go and get the services that they need
- Feel the urge to support other people and join initiative groups and (in)formal organisations
- Are confident to become activists

NGOs:
- Focus on their key strengths in their individual approaches
- Cooperate with each other, build alliances and partnerships, towards creating ideal coverage of the needs

Researchers:
- Provide an evidence base for other drivers for change

Government at national and regional level:
- Allocate budgets for programs for community and movement organising
- Are open to partnerships with NGOs and CBOs in providing services, acknowledge strengths of NGOs and CBOs and outsource to them activities for which they are best positioned
- Create an enabling environment for communities, NGOs and CBOs to effectively deliver services for target groups through enabling legal frameworks and social contracting

Dimension 4. Appreciating diversity

People:
- Have the awareness and knowledge to understand the value of diversity
- Have the space to be diverse and different without fear of repercussions
- Experience an appreciation of diversity
- Experience no stigma or discrimination in all spheres of life

Society:
- Has access to information and education about diversity
- Recognizes and appreciates that all people are unique and add value to society
- Experiences a reduction in stigma amongst the general public

Other Stakeholders:
- Policy makers are concerned about equality of citizens and ensure non-discriminatory policies are in place, and existing good laws are working
- Religious leaders are allies who appreciate difference and make space for diversity within the faith
- Young generation are spokespeople for a diverse and inclusive society
- Community leaders set an example on community level
- Educational institutes ensure that curricula address diversity
- Medical doctors and professionals ensure health services are inclusive

3.5 Key assumptions

We have grouped our key assumptions about what we believe to be true under the four pathway steps in each dimension of change. These are potential 'weak spots' in the model, which require further research and learning.

Awareness
- We assume that there is space in society to become aware of barriers and opportunities
- We assume that we can reach people to make them aware
- We assume that awareness of a situation makes you acknowledge a specific need
- We assume that people facing barriers know that they face barriers
- We assume that people will grasp the opportunity for change

Acknowledgement
- We assume that acknowledging a need makes you act
- We assume that people care about their health and rights

Action
- We assume that people have the resources and capacity to act
- We assume that there is an enabling environment that makes action possible
- We assume that action leads to change for the better
- We assume that providing information and skills will make people change their behaviour

Anchoring
- We assume that there is an enabling (political) environment
- We assume that resources for anchoring are and continue to be available
- We assume that interactions with policy makers through advocacy makes for an enabling political environment

Chapter 4. Our role and our strategies for change

4.1 Who we are

All AFEW partners have their own independent roles and responsibilities within the partnership. By working together, we create a unique synergy that can be seen as the collaboration model of the future of Southern/Eastern leadership. In this partnership model, the work that we do is driven by the country realities and the needs of the country populations.

Core strengths of AFEW include the local presence in EECA and linking East and West, as well as the clearly articulated definitions of roles that the AFEW partnership has developed. AFEW has a unique position, as no other partnership has such strong connections and collaborations between NGOs from the West and the EECA region, with the commitment to equal partnership and clear roles that make full use of local presence. AFEW is known for particular roles:
- *Bridge builder and connector:* As a unique partnership in the region, we are well positioned to support a wider scope of needs with regards to health and access to justice;
- *Content expert*: AFEW has broadened scope from that for which we are best known - expert in HIV, TB, and viral Hepatitis, and for the target audience of key populations - to embrace an expanded role and definition of health and rights that is inclusive and better able to respond in an agile way to the needs that arise in the region;
- *Innovator*: AFEW is recognized for the introduction of interventions and approaches that are new for the EECA region. AFEW introduced harm reduction interventions and the client centred approach;
- *Knowledge broker*: AFEW collects and creates space for exchange of international and regional knowledge and best practices through conferences, workshops, the educational system, and by linking researchers, clinicians, practitioners, community leaders and activists, and governmental officials;
- *Resource mobilizer,* both financial by mobilising funding, and substantive, for example by adding skills through capacity building.

4.2 Our specific role in and contribution to the dimensions of change

There is a range of potential roles for AFEW in each of the dimensions of change. We unpack those in more detail, per dimension.

AFEW's role in Access to good quality health services

AFEW has a role in **connecting people and services**: accessing difficult to reach groups, and ensuring that they are linked into service provision, and with specific health service providers.

AFEW has a role in the education of **health professionals** in the region, both in terms of producing information and materials, and in facilitating workshops and presentations. AFEW can facilitate knowledge sharing and access to best practices, also from outside of the region. AFEW can access and share information about the latest scientific developments and both encourage and conduct attitude changing activities within the health sector.

In terms of the **education system**, AFEW can contribute to and facilitate curricula development. AFEW also has the access and the trust in the region that is necessary to be able to facilitate patient education and peer support.

Regarding **research**, AFEW is ideally placed to facilitate a meeting of the minds of researchers and patients, in order to identify new research ideas, as well as to promote the results of research to a wider audience. AFEW can advocate for more evidence generation through research, to support the development of policies and practices.

AFEW also has a role to play in **advocacy** related to health and health service provision in the region, for example in the provision of advocacy tools and training.

AFEW's role in Legal and social justice

AFEW can contribute to and **facilitate the cooperation** between different actors within the frame of legal services and social justice. AFEW has a history of forging collaborations between NGO's, local authorities and business, with a role in educating and linking communities to create opportunities.

In terms of **lobby and advocacy**, AFEW can contribute towards influencing regulatory frameworks, for example for a less harsh drug use policy, and linking health and human rights agendas.

In terms of paralegal support, AFEW can offer capacity building in the form of trainings on for example ethical code and appropriate response to human rights violations across various disciplines.

Advocacy is an integral part of all *AFEW* activities and takes place at international and country levels. Our role in international advocacy is focused towards international (global) players such as the UN, The Global Fund, the EU and donors outside the region of Eastern Europe and Central Asia. At a country level we advocate towards national or local authorities or organisations. AFEW can strategically advise on policy and projects aimed at policy and law reform.

AFEW's role in Power to voice, participate and decide

AFEW strengthens the capacity of community-based organisations in organisational, project and financial administrative management. AFEW **strengthens the skills** to advocate, to do research, and to mobilise resources, in order to improve the sustainability of CBOs and local NGOs. AFEW is committed to **bringing various groups together**, and ensuring that in the interaction, we humanise those who are hidden behind the label of "key populations". AFEW **secures opportunities** for representatives from within the affected communities to present their story in a safe and inclusive way. We amplify their voices through media, campaigns, and other forms of profiling, creating role models. We **support role models** with training and development to ensure that they are best equipped to take up this role in a sustainable way. AFEW ensures that people are able to monitor and evaluate health services and can **voice their needs**, in order to influence and improve the quality of services, as well as the range of services on offer. AFEW continuously **learns and expands the knowledge base** about the needs of communities and groups that are left behind, in order to better serve these communities.

AFEW's role in Appreciating diversity

Starting with a focus on ourselves and the diversity appreciation and inclusivity that we want to **mirror** for other organisations in the region, we see a role for ourselves in the improvement of our own knowledge of the meaning and application of diversity, in order to be able to play a **supportive role** to others on this front. Once we have made the investment in ourselves, we will be well positioned to **share our knowledge** with others through channels such as information and materials sharing, **creating opportunities for exchange**, curriculum influencing, and to ensure an inclusive tone in policy and law development. We see real opportunities for working with youth, as they are receptive to new approaches and are less influenced by the past, and are key drivers of creating a more inclusive future.

Chapter 5. How we will use our Theory of Change for ongoing critical reflection and adaptation of our plans

Our Theory of Change is a living document, in the sense that it will evolve along with the partnership. Just as we use the TOC to guide and plan our work through strategic planning, the results we identify and various data gathered throughout implementation will then feed back into informing how our TOC should be adjusted as we progress. In order to ensure that the TOC is kept relevant and therefore useful, we will institute an annual check-in and evaluation workshop where we convene for a half-day or full-day session to reflect on and update our TOC. This workshop can be planned in conjunction with regularly planned partnership meetings.