PPA Self-Assessment Review[1]

Complete areas within white boxes only

Reporting Year	***2008/2009***

Part A – Basic Information[2]

PPA partner	International HIV/AIDS Alliance
Niche statement	The Alliance is a global partnership of 32 Linking Organisations supporting community action on AIDS in developing countries. We are currently working in over 40 countries, and in 2008 we reached over 2 million people affected by HIV/AIDS and TB. We believe we are unique amongst DFID partners in delivering health outcomes to some of those most marginalised and vulnerable in the world, whilst at the same time focussing on building robust and sustainable civil society delivery mechanisms -- an important and integral part of health systems. We believe that strong national organisations, coupled with empowered communities, mean effective responses, and the Alliance has developed a track record in building the capacity of organisations in developing countries to both operate effectively and sustainably, and to lead civil society in national advocacy efforts to hold Governments to account. The UK-based Alliance secretariat plays an important support role within this partnership. Over the last 5 years we have particularly focused on developing an accreditation system to ensure accountability and quality, ensuring transparent monitoring and evaluation of programmes, and leveraging cross Alliance learning. We believe that the Alliance network of linking organisations, rooted in strong civil society, are a vital part of a successful and sustainable response to the continuing health needs in developing countries.

	2004/5	**2005/6**	**2006/7**	**2007/8**	**2008/9**
PPA funding (including Latin America PPA) (£)	1,200,000	2,750,000	3,750,000	3,750,000	4,260,000
As % of total organisational income (using the calendar year)	6.18%	10.88%	12.05%	8%	8%

[1] This self assessment review is only part of the reporting story. Organisations will be able to supply evidence, case studies and other material they feel will show impact on the ground

[2] Part A is a useful snapshot of the full relationship between DFID and each PPA holder.

There is an opportunity to expand on some of the non-financial aspects in Part D 'Partnership with DFID' but we wanted to expand Part A to reflect the fact that our partnership with DFID is not purely financial.

Other DFID funding (£)	**2004/5-2006/7**	**2007/8**	**2008/9**	**2009/10**
Improving the Sexual and Reproductive Health of vulnerable populations: Madagascar: Total Contract amount £250,000	£250,000			
Accelerating the involvement of the private sector in the HIV/AIDS response in the Caribbean (Jamaica and Barbados) Total Contract amount £2,035,523		£217,592	£91,953	£393,216
India Challenge Fund: increasing feminisation of HIV. The project gave women better access to health, social and legal support services by creating an increased demand for information and services and enhancing knowledge of HIV and sexual and reproductive health 2006-2007: Total Contract amount £478,986			£478,986	
Building African NGO Capacity: Meeting in Johannesburg: Total Contract amount £20,000			£20,000	
Evidence for Action research programme; an International Research Consortium led by the London School of Hygiene and Tropical Medicine to maximise benefits & equity of HIV treatment & care systems 2006-2011: Total Contract amount £383,590			£114,617	

Summary of partnership with DFID and other DFID funding[3]
The Alliance partnership with DFID began in 1993 when DFID (then ODA) was a member of the consortium which provided the impetus to set up the Alliance. Since PPA funding began in 2004 the relationship has strengthened into a partnership of mutual respect with both parties engaging the other in strategy development and on-going discourse on HIV and other health sector issues. While currently the DFID funding portfolio represents less than 10% of the overall Alliance income, the Alliance partnership is seen as invaluable to the organisation. DFID's ability to provide funding to the Alliance in a strategic (eg. unrestricted) way makes it possible for the Alliance is fully meet its 4 strategic

[3] This is intended to be a cumulative list of DFID contracts etc. from when your PPA began. If there is a large amount of information, please summarise by e.g. department and add any additional information to an appendix. We wanted to leave this section quite open to interpretation by each organisation. Note the wording has changed from 'relationship' to 'partnership'.

objectives: to reach more people in more areas of the world; to build civil society capacity; to influence national programming and policy; and to strengthen the partnership of strong national organisations. Our partnership with DFID means we are able to:

- expand into new geographic and technical areas of work where gaps in HIV, SRH, TB and other services persist
- provide bridge funding for Alliance national partners (linking organisations) to prevent gaps in service delivery in a very restricted funding environment
- ensure greater sustainability of linking organisations by funding areas of work not easily covered through restricted sources (e.g. advocacy, leadership development and resource mobilisation)
- to work within an organisation able to grow and respond to its environment
- engage forcefully in policy dialogue through UK, European and global partnerships (e.g. Action for Global Health, the Stop AIDS Campaign, involvement in the board of the Global Fund, UNITAID (International Drug Purchasing Facility), the Programme Co-ordinating Board (PCB) of UNAIDS and the Brussels-based Stop AIDS Alliance)
- build a UK constituency and a more 'public' voice

Through the Latin America PPA top up mechanism DFID support has also been particularly invaluable for the Latin American region – where limited resources are leaving high-risk populations (particularly men who have sex with men, sex worker and transgender population) vulnerable to spreading the HIV infection and maintaining poor health status. The strength, flexibility and approach to partnership for the region, has meant that the Alliance has been able to not only develop a fruitful partnership with DFID but also the 12 other Latin America PPA recipients working in the region.

Elsewhere DFID support in India, the Caribbean and through the *Evidence for Action* research programme has led to innovation within the sector and more concrete action on HIV and health, particularly in the areas of HIV/SRH linkages.

Approximate % of total organisational expenditure allocated by sector or theme[4]

100% Health

The Alliance is an HIV programming organisation, supporting indigenous civil society organisations to build effective national and local responses to HIV and other related health issues. The Alliance provides financial and technical support for community based programmes across the spectrum of HIV prevention, treatment, care and support with anti stigma and discrimination interventions as a cross cutting objective. It also supports programming that integrates HIV programmes and services into broader health sector priorities with

[4] This should provide an indication of your overall organisational allocations by sector or theme (i.e. not limited to your PPA).

The % breakdown may change from year to year and is intended to reflect key organisational priorities for the Reporting Year under assessment.

specific emphasis on integrating HIV and sexual and reproductive health services, HIV and TB co-infection and linkages and referrals to essential health care (and other) services.

Part B - Progress against PPA Strategic Objectives[5]

Progress to date against PPA purpose statement
To support communities to reduce the spread of HIV and meet the challenges of AIDS

The strategic investment DFID makes in the Alliance each year is instrumental in ***reaching more and more people*** with essential services and support. In 2008 the Alliance reached 2.3 million people with services compared to 1.3 million in 2007. Through its network of 31 national-level linking organisations the Alliance currently work in 40 countries.

A particular focus of this expansion has been in the region hardest hit by the HIV epidemic -- ***Africa***, with new Alliance programmes starting in Kenya, Malawi, South Africa, Ethiopia and Swaziland – in 2008 the number of people the Alliance reached across Africa increased by 158% to 1.3 million. At the same time, Alliance Linking Organisations across Africa showed signs of greater stability with country programmes in Mozambique, Senegal, South Sudan and Zambia all securing new in-country funding, including the notable transfer of £1.4 million to in-country funding to the Alliance's linking organisation in Cote d'Ivoire (ANS-CI). Focus has also been placed on building up work in post-conflicts state building on earlier experience in Cambodia as well as in Cote d'Ivoire and South Sudan.

The Alliance drive to place those most affected by and living with HIV has maintained a top priority. During 2008 the Alliance supported an increased number of ***orphans and vulnerable children*** (115,592 in 2008 as compared to 55,862 in 2007) through comprehensive programming, including for example health care, school assistance, financial support or psychosocial support. At the same time effort to expand our work to new geographic and technical areas and has not meant our well established niche of working with ***key populations groups*** -- including men who have sex with men, sex workers, and injecting drug users – has been de-prioritized. In 2008, the number of people reached with HIV prevention services still made-up nearly 40% of all people reached by Alliance services. At the same time over three-fourths (3/4th) of our national partners continue to support the needs of key populations groups.

Improving mechanisms to ensure quality standards and accountability across the Alliance has meant communities continue to be supported effectively even as the Alliance serves more and more people. The ***decentralisation of international technical support*** in 2008 to regional technical support hubs transferred the responsibility for technical support to host Linking Organisations in Burkina Faso, Cambodia, India, Peru, Uganda and Ukraine with a regional function across the Alliance. Even with the change, the Alliance was still able to serve more local NGOs with technical support than ever before with a 50% increase in the number of NGOs supported in 2008 (2,630 NGOs) as compared to 2007 (1,757 NGOs). The Alliance ***accreditation system*** also supported the rigorous assessment of Alliance members against a set of high institutional and programmatic standards. The Alliance in China was the first member of the global partnership to be

[5] The phrasing in this section is intended not to preclude referencing back to previous work in a different reporting period.

This is also an opportunity to generate a rich picture of PPA funding and demonstrate its value.

successfully accredited in 2008, followed shortly by the Secretariat and KHANA in Cambodia. The accreditation system has also been used to assess three new organisations wishing to join the Alliance as a Linking Organisation: Kenyan AIDS NGO Consortium (KANCO, Kenya), Civil Society on HIV/AIDS in Nigeria (CiSHAN Nigeria) and the Anti-AIDS Association (AAA, Kyrgyzstan).

In 2008, the Alliance completed the start-up phase of an innovative approach to ***working with the private sector and academic institutions*** to develop management and leadership skills across the partnership. Pepal, an Alliance initiative runs international development programmes that combine corporate social responsibility with talent development and staff retention. We currently have nine partnerships with placements from Tibotec, Jansen & Cilag, Eden McCallum Consulting, Pferdewetten de AG, Stuttgart India, an ex Kodak employee, an ex- Lehman Brothers employee supporting linking organisations in Cambodia, India, Kenya, Morocco, Myanmar, Ukraine, Uganda and Zambia.

Our policy work more broadly has successful focused on key areas of debate, including: Increased access and expanded coverage through strengthened health systems, prioritizing the integration of SRH and HIV, keeping key populations on the agenda, and sustaining a focus on HIV by engaging beyond the health sector. Our involvement as civil society IHP representative has provided an invaluable forum to address these issues. A merger with Health and Development Networks (HDN), a leading health communication and knowledge management organisation based in Thailand also took priority in 2008. While a sudden withdrawal of core funding from HDN in early 2009 meant the merger has been unable to proceed exactly as planned, work progressed to build HDN's National Partnership Platform initiatives (NPPs) to more effectively service the Alliance's ***national-level policy objective***. HDN learning and legacy around knowledge management and community level documentation (through trained key correspondents) has also been integrated.

Faced with uncertainty and change in the funding environment for HIV, specifically, and international development more broadly that Alliance has been able to manoeuvre and respond. Successful ***change management processes*** carried in 2007 and 2008 have prepared the Alliance to face the challenges of today – with a focus on streamlining its secretariat (UK based) staff, decentralizing technical support, and strengthening the Alliance partnership – our strength now more firmly lies within the national linking organisation who make up the Alliance. We have also shifted our charitable objectives to including HIV and SRH, and are steadfastly moving ahead our work in TB and Health Systems Strengthening. Among other things this is being achieved through an expanded ***focused on partnerships*** with organisation that complement the Alliance 'niche'.

We understand the importance of the UK public knowing our good work, and the essential support DFID provides to the Alliance. While still much more progress is needed we have invested in profiling our work in the UK through media and other communication channels and are proud of the successes we have made in a very short time.

Progress against PPA Performance Framework by each Strategic Objective

Please explain choice of indicators reported on below [6]

The remaining Part B of this assessment report details the progress made to date on the following 12 indicators agreed in the Alliance's PPA Partnership Framework. All indicators included in the Framework are reported against except for indicators 4 and 5 under objective 2 -- as both reporting on these will depend on evaluation activities that we plan to undertake at the end of the period.

Strategic Objective 1: Scaled up quality community programmes delivered and access to health and aids services improved.

1. Number of Alliance programmes that are having a proven impact on the national epidemic (called Alliance category 1 country programmes)
2. Number of Alliance programmes that are having a proven impact at either a regional level and/or with a specific population groups, eg. anti-stigma and discrimination work for sex workers (called Alliance category 2 country programmes)
3. Number of countries where the Alliance has began start-up activities (called Alliance category 3 country programmes)
4. Total number of people reached through prevention, care and treatment activities

Strategic Objective 2: Increase civil society capacity to implement effective community responses

1. Number of linking organizations that make-up the Alliance
2. Number of implementing organizations (NGOs/CBOs/networks) served
3. Total amount of small and medium sized grants channeled to implementing organizations

Strategic Objective 3: Strengthen communities influence in national programming and in national and international policy

1. Number of documented examples of key national policy change that have been achieved through Alliance policy interventions
2. Increased participation of key population groups (reaching agreed standards for Civil Society Participation) in key national level fora

Strategic Objective 4: Strengthen the Alliance as a partnership of strong national linking organizations

1. Percentage of Alliance members (including the secretariat) that have achieved full endorsement as an Alliance partner
2. Number media pieces covered (print, online, radio and broadcast coverage) and UK public events held to build awareness of HIV and AIDS and development issues in the UK

For each indicator a baseline is provided and a Global and Latin America target. Most quantifiable results shown refer to the Alliance's financial year January - December 2008, but where possible information is provided for the DFID financial year April 08 – March 09. This arrangement was agreed with our Stakeholder Manager as an appropriate methodology as the Alliance reporting systems conclude with comprehensive review and reporting at the end of each calendar year.

[6] Agencies may choose to select just some of the indicators for each year of reporting. Please indicate and explain which indicators have been chosen.

Strategic Objective 1:
Scaled up quality community programmes delivered and access to health and HIV services improved.

Indicator 1: Number of Alliance programmes that are having a proven impact on the national epidemic (called Alliance 'category 1' country programmes)
By 2011 the number of Alliance country programmes that are having a proven impact on the national epidemic will increase from 4 countries (Ukraine, Cambodia, Burkina Faso, Andhra Pradesh: India) to 19. This includes 3 country programmes in Latin America.
Progress achieved and challenges faced[7]
Over the past two years the Alliance has made significant progress scaling up programmes to reach more people with essential health and HIV services. By March 2009, nine (9) Alliance country programmes: Burkina Faso, Cambodia, Caribbean Region, Cote d'Ivoire, India, Peru, Senegal, Uganda, and Ukraine were significantly contributing to at least one of the 12 core UNAIDS nationally set targets for Universal Access to treatment, care and support and/or prevention (defined by the Alliance as 'category 1' country programmes). For example, in Cote d'Ivoire, the Alliance's programme implemented through partner ANCS-CI, significantly scaled-up in 2008 with an increase of over 144% in the number of people reached directly HIV services. The programme provides prevention services, HIV counselling and testing, care and support to people living with HIV and AIDS, and provision of PMTCT services to pregnant women. The programme is making a significant contribution to national Universal Access targets in the area of care and support for orphans and vulnerable children. ANCS-CI contributed 15% to the national OVC target for Universal Access. In real terms, the number of OVC provided with care and support more than tripled in 2008 to 27,000 from 8,500 in 2007. Similarly impressive scale up occurred in the other 'category 1' country programmes: Burkina Faso (contributing to 23% to the national OVC target for Universal Access), Cambodia (contributing to 53% to the national OVC target), India: Andhra Pradesh and Manipur (contributing 25% to the combined focused prevention target in the 2 stages), Senegal (contributing 21% to the national focused prevention target), Uganda (contribution to 38% of the national care and support target), and Ukraine (contributing 28% to the national target for prevention). Coverage also increased in the Latin America and Caribbean region with the Caribbean region (contributing 12% to a pooled regional prevention target) and Peru programmes achieving Category 1 status and making an impact on national level Universal Access targets. Through the Alliance's partner Via Libre, 57,337 people were reached with HIV and other health services in Peru. While the success of these programmes is fuelled by restricted funds (for example the US government in the

[7] Indicate the period referred to: in some cases it may be artificial to focus just on the prior year, and a focus on overall progress may be more helpful

Caribbean, Cambodia, Cote d'Ivore, and Uganda and the Global Fund in Senegal, Peru and Ukraine) strategic funding from DFID helps to bring more comprehensive programming and innovation to these programmes. In fact it is the restricted funding on which scale up to this level depends that present the greatest challenge. While this year we are on track to meeting our 2011 target of 19 country programmes, the reality going forward is much starker. This is particularly due to challenges seeking new Global Fund monies under round 8. A majority of the Alliance country programmes new applications during this round were included as Category 3 (i.e. not recommended for funding in Round 8). While we are working with them to re-submit in Round 9 limited resources may mean further failure. As this funding is one of the two major sources (the US government being the second) available to help the Alliance reach 'category 1' we have now revised our target downward to 11 country programmes having a proven impact on the national epidemic by 2010/2011 and have extended the date by which we can reach the original 19 planned to 2012/2013.

List any documentary evidence of achievements[8]

- Country level M&R systems and UNAIDS reports
- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- UNAIDS comprehensive external evaluation of the National Response in Ukraine

Indicator 2: Number of Alliance programmes that are having a proven impact at either a regional level and/or with a specific population groups, eg. anti-stigma and discrimination work for sex workers (called Alliance 'category 2' country programmes)

By 2011 there will be an increase from 4 to 15 Alliance country programmes that are having a proven impact at either a regional level and/or with a specific population group. This includes 2 country programmes in Latin America.

Progress achieved and challenges faced

Please draw on evidence in line with the performance framework. (Word guidance: up to 300 words.)

By March 2009, fourteen (14) Alliance country programmes: Bangladesh, Bolivia, China, Ecuador, Haiti, Kenya, Mexico, Mongolia, Morocco, Mozambique, Myanmar, Nigeria, South Sudan, and Zambia Alliance country programmes that are having a proven impact at either a regional level and/or with a specific population group (e.g. anti-stigma discrimination work with and for Sex Workers, or Men who have Sex with Men).

Building on experience working in post-conflict environments in Cambodia and Cote d'Ivoire, the Alliance's work in South Sudan expanded to reach 40,354 during 2008. While the programme continues to prosper a slow to start funding environment has meant that strategic funding to support this programme has been essential. Bridge funding was provided to the South Sudan country programme at the end of 2008 during a

[8] This can also be used as an opportunity to provide DFID with case studies, YouTube clips etc for 'building support for development'.

3 month gap in restricted funding under a project with USAID. While this restricted funding has now been secured uninterrupted services during the period has made it possible for the programme to continue to thrive.

A large number of 'country 2' programmes are providing essential prevention activities and services within concentrated epidemics. In Bangladesh for example the Alliance continued to develop its relationship with the HIV/AIDS and STD Alliance Bangladesh (HASAB) during the year. HASAB works in 44 districts of six greater divisions of Bangladesh focusing on prevention and control of HIV/AIDS and STI amongst the general population and high-risk groups. The Alliance provided a small strategic grant and technical support to strengthen organisational management processes and in particular, their financial systems. This support has proved crucial in building HASAB's capacity to manage a £3.5 million budget.

In generalized epidemic work increased around linking HIV interventions with those of sexual and reproductive health. In 2008 the Alliance began a new programme of work with young people working with partners in Zambia and Swaziland. The programme strengthens comprehensive SRH interventions to young people between 10 and 20 years old, through joint country sharing of models and skills, and documentation of best practice and lessons learned. The results are influencing programming throughout the Alliance and IPPF regional networks.

Work also scaled up in Haiti with a new three-year project with Promoteurs Objectif Zérosida (POZ). The project works with local leaders, health providers and community members to increase their involvement in anti-stigma activities, increase the uptake of HIV-related health and support services, and decrease stigma and discrimination against people living with HIV.

Despite the success of scale achieved in Category 2 programmes, the Alliance was also faced with the difficult decision of scaling down the programme in Madagascar (from category 1 to category 3) due to funding constraints.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- www.redribbonaward.org

Indicator 3: Number of countries where the Alliance has began start-up activities (called Alliance 'category 3' country programmes)

By 2011 the Alliance will have start-up activities in 6 new countries. This includes 2 new start-ups in Latin America region (NB: the Alliance was working in 28 countries at end 2007 which serves a baseline for this indicator).

Progress achieved and challenges faced

Since the end of 2007 the Alliance has started new activities in 6 new countries: Colombia, El Salvador, Indonesia, Malawi, South Africa, and Swaziland. This means we have already met are 2011 target in this area. These are identified as 'category 3' countries programmes by the Alliance; usually represented as

young programme with recent and small Alliance in-country presence. At the start-up stage energy is devoted to building national-level partner(s) capacity to provide technical support and receive and manage small grants to implementing community-based partners or to directly provide support to partnering CBOs.

Part of the Africa strategy focused particularly on the need to expand Alliance in presence in Southern Africa – linking strong existing programmes in Zambia and Mozambique to other regional partners. Both strategic funding and restricted funding have been secure to start-up and now scale-up programmes in Malawi, South Africa, and Swaziland. In South Africa, for example the Alliance is partnering with the US-based iNGO PATH and the South African-based Health and Development Associates (HAD) to implement a five-year, £7 million project called 'Thogomelo; in collaboration with South Africa's Department for Social Development. The supports caregivers to provide better psychosocial support and child protection.

In Latin America the Alliance began new partnerships with, Liga Colombiana contra el SIDA, one of the largest AIDS service organisations in Columbia, and with Asociación Atlacatl Vivo Positivo (Atlacatl) in El Salvador. Atlacatl has an influential policy voice in El Salvador and is represented on key national decision-making forums such as the Central America Human Rights Network and the national commission to reform AIDS law. A capacity assessment was carried out with Atlacatl and a sub-grant agreement was signed in November 2008 to initiate anti-stigma work with key populations.

The new start-ups in Colombia and El Salvador, the advocacy and focused prevention programming in the Andean Region and much of the Alliance regional programming in Latin America is made possible through DFID Latin America PPA support. Reacting to new evidence around the toll HIV is taking on transgender communities in Latin America, the Alliance signed a three-year sub-grant agreement with the nascent Latin American Network of Transgender People (REDLACTRANS) to build their organisational capacity, strengthen prevention programmes tailored specifically to the transgender community and build advocacy capacity.

Note that the Alliance is also working in Central Asia regional (Kyrgyzstan, Kazakhstan, Uzbekistan, and Tajikistan), Madagascar, Philippines, Thailand, and Zimbabwe. While these country programmes are not considered as 'start-ups' -- as work here began before 2007 -- resources or challenges in the operating environment has meant that they remain defined as 'Category 3' country programmes.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- DFID/PPA Agency report: working in partnership in Latin America http://www.dfid.gov.uk/Documents/publications/english-latin-america-civil-society-launch.pdf

Indicator 4: Total number of people reached through prevention, care and treatment activities

By 2011 the number of people reached through prevention, care and treatment will increase from 1.3 million in 2006 to 5 million.

Progress achieved and challenges faced

The Alliance has made significant progress towards scaling up the number of countries in which it operates and the numbers of people reached. By March 2009; The total number of people receiving Alliance HIV services rose to 2.3 million people – a 75% increase from the 1.3 million people reached by December 2007.

Again, these excellent figures meant that the Alliance was on track to meet the target of 5 million people by 2011. However, as a result of the disappointing Global Fund Round 8 proposals, the target of reaching 5 million people through prevention, treatment, care and support has had to be pushed back to the end of 2012. Our revised target for March 2011 is to reach 3.5 million people.

The number of people reached across Africa increased by 158% to 1.3 million (representing 57% of total Alliance reach last year). Disaggregated data shows that 56% of people reached by Alliance programmes in Africa are female, reflecting the disproportionate burden of disease on women and girls. Five of the 12 Alliance country programmes increased the number of people reached by 100% or more. Of significant value has been the successful programme expansion in Uganda with 709,425 people currently reached. Prevention interventions accounted for one-fifth of overall coverage in the region, with a modest increase in coverage from 281,379 people reached in 2008, as compared with 257,949 in 2007.

Meeting the needs of orphans and vulnerable children affected by the HIV epidemic is central to the Alliance Africa strategy. In 2008 significant expansion meant an increase in scale of 151% across the region with 78,602 OVC reached with services as compared with 31,312 in 2007. In total, 8 of the 12 existing African country programmes have a strong focus on orphans and vulnerable children including 3 southern African countries (Mozambique, South Africa and Zambia) with among the highest incidence of orphans and vulnerable children worldwide.

The three Category 1 country programmes in the Asia and Eastern Europe Region (Cambodia, India and Ukraine) continued their steady growth, reaching 22% more people with direct services.

The Ukraine country programme supported by the Global Fund Round 1 (nearly £69 million over five years) concluded in December 2008. It did so having exceeded the great majority of its targets, most notably having provided life-saving antiretroviral (ARV) drugs for over 6,000 people living with HIV. The programme worked with the government to ensure funding continued at the end of the period, having scaled-up harm reduction services to reach 94,583 injecting drug users (IDUs) in 2008 (up from 67,476 in 2007).

Focused prevention programmes account for almost 70% of people reached with services in Asia and Eastern Europe with the largest of these being the AVAHAN project in India. The Alliance Linking Organisation Alliance for AIDS Action (AAA) has been implementing a four-year £7.5 million prevention programme for high-risk groups of female sex workers, men who have sex with men and transgender in 14 interior districts of the Rayalaseema and Telangana regions of Andhra Pradesh – one of India's six highest prevalence states.

By the end of 2008, the project had significantly scaled-up from an initial 27 sites to 139 sites, increasing the number of people reached to 68,000. Clear progress has been made in the health-seeking behaviour of high-risk groups, with 26% now attending regular monthly medical check-ups at static, outreach and public

private partnership clinics.

Alliance programmes in Mongolia and Myanmar also scaled-up their coverage by over 75% each in 2008. In China there was a small decrease (15%) in the number of people reached due to funding constraints. The Alliance continues to explore and find ways to strengthen key population groups in these countries.

There has been a 51% increase in the number of children reached through programmes in India, Cambodia and Myanmar. In 2008, there has also been a trend towards the lowering of the age of children reached to below 15 years. In 2007, OVC programmes accounted for just 8% of the total coverage in AEE; in 2008 that contribution has increased to 15%. The Global Fund supported CHAHA programme in India has contributed significantly to this scale-up with an increase in coverage of 150%

The Caribbean HIV/AIDS Alliance's focused prevention programmes reached 4,060 people – a 12.3% contribution to national targets of 33,000. Also with support from DFID, CHAA is working on a project to engage private sector stakeholders from the informal and formal sectors of the hotel and tourism industry in Jamaica and Barbados, to work with groups of people living with HIV and other vulnerable groups in order to reduce the impact of HIV in the region.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework

What is the likelihood that Strategic Objective 1 will be achieved? Rate 1 to 5[9] *See footnote 10.*	**2**

Strategic Objective 2:

Increase civil society capacity to implement effective community responses

Indicator 1: Number of linking organizations that make-up the Alliance

By 2011 there will be an increase in the number of Alliance national Linking Organisations from 29 to 40. This includes an increase from 4 to 7 in the Latin America Region.

[9] Having the ratings at the end of each section puts more emphasis on the earlier narrative and qualitative information, rather than on the quantitative rating.

Ratings to be applied:

1. = Likely to be **completely** achieved, i.e. well on the way to completion (or completed)
2. = Likely to be **largely** achieved, i.e. good progress made
3. = Likely to be **partly** achieved, i.e. partial progress made
4. = Only likely to be achieved **to a very limited extent**
5. = **Unlikely** to be achieved

Progress achieved and challenges faced

Since the end of 2007 three new linking organisations in Kenya, Kyrgyzstan and Nigeria have joined the Alliance. The Alliance's new accreditation system was used to assess the Civil Society on HIV/AIDS in Nigeria (CiSHAN Nigeria), the Anti-AIDS Association (AAA, Kyrgyzstan) and Kenyan AIDS NGO Consortium (KANCO, Kenya). All three organisations successfully passed the assessment and are now signatories to the Alliance Charter and Linking Agreement.

2008 also saw the successful evolution of the Alliance Caribbean and Ukraine country offices into independent national linking organisations. These organisations can now develop stronger local ownership and more empowered local leadership.

Plans have been made for a further two new LOs in Indonesia and Malaysia to join the Alliance by the end of 2009.

During the period one LO (AIDSNet, Thailand) was dropped from the roster of Alliance linking organisations due to differences in organisational and programmatic priorities; however, the organisation continues to be a participant in the Thai national response, with a focus on northern Thailand.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- Accreditation reports

Indicator 2: Number of implementing organisations (NGOs/CBOs/networks) served

By 2011 the number of implementing organisations NGOs/CBOs/networks supported by Alliance Linking Organisations increase from 1200 to 2000.

Progress achieved and challenges faced

During 2008 2,630 implementing organistions were supported[1] by the Alliance, a 50% increase from the 1,757 NGOs provided with supported at the end 2007. We expect to exceed this target as the number of NGOs supported by the Alliance will increase as new Linking Organisations join the Alliance family. For example CiSHAN in Nigeria has over 3,000 member organizations and KANCO in Kenya has a membership of 960 NGOs and CBOs.

[1] Support comes in the form of both financial and technical support. Of the 2,630 organisation receiving support nearly one-half (1,270) also received financial support. See next indicator for more details.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework

Indicator 3: Total amount of small and medium sized grants channeled to implementing organizations
By 2011 there will be an increase in the total amount of small and medium size grants obligated from £9.6 million to £15 million (or the equivalent adjusted amount for 2011 prices)
Progress achieved and challenges faced
Due scale up in 'category 1' country programmes and the addition of new members to the Alliance we have already reached this 2011 target. In 2008, the Alliance allocated a total of £19 million[1] in small and medium-sized grants to 1,270 implementing partners. This increase represents an increase of organisation receiving financial support by over 50% from the 823 supported in 2007. Grants range in size from £3,500 to over £135,000 per year and are disbursed based on assessed capacity and programme performance. The mean size of grants increased to £12,324 compared with £5,600 in 2006. As shown above with the introduction of new linking organistions to the Alliance partnership, it expected that these figures will increase considerably over the next two years. For example in the first quarter of 2009 KANCO in Kenya joined the Alliance as an LO, however, the statistics from KANCO are not yet included. As LOs come on board with all the Alliance systems, including the MRS, we will be able to present a more comprehensive picture of funding for Alliance partners. [1] This figure refers to the Alliance audited accounts for the calendar year January to December 2008.
List any documentary evidence of achievements
• Alliance Monitoring and reporting system (MRS) • 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework • Financial reports

What is the likelihood that Strategic Objective 2 will be achieved? Rate 1 to 5. ***See footnote 10.***	**1**

Strategic Objective 3:
Strengthen communities influence in national programming and in national and international policy

Indicator 1: Number of documented examples of key national policy change that have been achieved through Alliance policy interventions
By 2011 seven documented examples of key national policy changes that have been achieved in Alliance countries through input from Alliance policy interventions. This includes 1 documented example of a key national policy change that has been achieved in Latin America through input from Alliance policy interventions. (NB: The baseline set at the end of 2007 for this was 2 --Ukraine and Burkina Faso)

Progress achieved and challenges faced

By March 2009 the Alliance seven Alliance programmes had documented successful initiatives that led to policy change compared to two at the end of December 2007. Ukraine (2), India, Bolivia, Senegal, Cambodia, Burkina Faso and Madagascar.

At the national level the Alliance is particularly proud of policy achievements in Ukraine: securing agreement with the Ministry of Health to transfer patients that were on an antiretroviral treatment from the Global Fund-supported programme to state-funded programmes. As a result of the large scale-up over four years led by Alliance Ukraine, by October 2008 over 6,000 people were supported on treatment (i.e. 63% of all PLHIV on treatment).

As a result of concerted advocacy efforts by the Alliance with the All-Ukrainian Network of People with HIV, the government officially acknowledged the transfer of full responsibility for continuation of treatment on 1 December 2008. By January 2009, the number of people being treated and funded by the government had risen to 10,000.

In India, the Alliance's CHAHA programme, one of the largest (in India) helping children and families affected by HIV (described under Strategic Direction 1), was able to influence the National AIDS Control Organisation to launch a pilot phase of a new children and HIV/AIDS policy. This document outlines the roles and responsibilities of state and non-state actors involved in care and support for children. Alliance India has initiated state-level consultations to encourage wider use of this document, particularly advocating for supplementary nutrition for children and for cotrimaxazole prophylasis for children below five years old. These two issues have become the focus of the first coordinated advocacy campaigns between Alliance India and its five linking organisations.

The Alliance has been – through Action for Global Health – a key actor in ensuring civil society engagement with the **International Health Partnership** and Related Initiatives – a partnership between the 'Health 8' agencies, bilateral donors and 14 African and Asian countries that aims to improve the effectiveness of aid and to increase investment in health systems strengthening. Participation in the II IHP+ Ministerial Review highlighted the urgent need for civil society to ensure that a renewed emphasis on MDGs 4 (reducing child mortality) and MDG 5 (improving maternal health) and health systems strengthening does not undermine hard fought for gains in tackling MDG 6 (combating AIDS, malaria and other infectious diseases).

At the country level Alliance Zambia has played a key role in supporting civil society engagement with the IHP+ in Zambia. This has included hosting the IHP+ civil society forum and working closely with other civil society actors, such as Oxfam, TALC and others to influence the content of the Zambia IHP+ country compact.

List any documentary evidence of achievements

- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- Documented examples can be found on www.aidsalliance.org

- Policy briefing notes
- Case studies

Indicator 2: Increased participation of key population groups (reaching agreed standards for Civil Society Participation) in key national level fora

By 2011 participation of key population groups (reaching agreed standards for Civil Society Participation) in key national level fora will have increased from 7 (Mexico, Ecuador, Bolivia, Peru, Cambodia, Burkina Faso, Senegal) to 19 Alliance countries. Participation of key population groups in key national level fora will have increased from 4 to 7 countries in Latin America.

Progress achieved and challenges faced

While we are yet to measure this indicator systematically there are some successes in the past year that we would like to share in this report.

In Cambodia, policy-makers, activists, people living with HIV, sex workers and MSM gathered in Phnom Penh for Cambodia's third National AIDS Conference, co-organised by KHANA, the Alliance's Linking Organisation. Through the conference KHANA advocated strongly to government partners the importance of sustaining focused prevention efforts. Despite a decline in HIV prevalence from 2% in 1998 to 0.9% in 2006, experts warned that unless prevention is treated as a priority issue, Cambodia could see a second wave of infection.

In Bolivia, Alliance Linking Organisation, Instituto para el Desarrollo Humano (IDH) worked to strengthen the participation of people living with HIV, sex workers, MSM and transgenders in decision-making spaces and the national health system. Last year finally saw real change: the Ministry of Health and Sports passed a resolution to make it mandatory for health programmes and services to provide comprehensive healthcare and respect for the dignity and rights of key populations; also a provision was made for discrimination on the grounds of sexual orientation or gender identity to be included in the new constitution as a criminal offence.

An Alliance joint delegation formed by representatives from India, Ukraine, Mexico and the Secretariat attended a high-level UN meeting on HIV in New York in June 2008, to push for the delivery of Universal Access to HIV prevention, treatment, care and support for key populations. An event on marginalised communities was co-chaired by Jacqueline Rocha Cortes, from Brazil's national AIDS and sexual health programme and an Alliance trustee, and Malcolm McNeil from DFID.

Big changes in the political and economic landscape generated a whole new set of threats and opportunities that will have major impact on the ability of communities – particularly of marginalised groups – to respond effectively to the epidemic. With this in mind, the Alliance engaged forcefully in policy debates, building on work that our member organisations are carrying out across the globe, their experiences and views proving invaluable to policymakers. Through high-level UN meetings, the Communities Delegation on the Board of the Global Fund, UNITAID and participation in numerous conferences, the Alliance used this knowledge and experience to link country-level community views to the international policy debate and supported civil society to engage at country level.

The impact of current policy and donor changes on key population programmes is complex and difficult to

adjust to. On the one hand we have seen positive changes coming from the US on policies affecting the vulnerability of key populations. On the other hand the risk of many of the activist networks collapsing in the current environment is pretty obvious. If we look at Alliance work and challenges in each area:

- **Sex workers**. As part of our commitment to working with networks of sex workers, we have re-established our relationship with the Network of Sex Work Projects, and with other key global sex worker rights advocates. In September 2008 the Alliance supported a meeting at IDS of researchers and advocates interested in working to improve the quality of research on sex work and the participation of sex workers themselves in this research. This led to the establishment of the Paolo Longo Research Initiative, a space for collaboration between researchers, advocates and programming partners. We have also held an international workshop on Sex Work, HIV and Violence in Hyderabad with 25 participants from the Brighton and Delhi Secretariats and 17 LO/COs and Implementing Partners;

- **MSM**. The MSM Global Forum (MSMGF) was established in 2006 to advocate for equitable access to effective HIV prevention, care, and treatment services tailored to the needs of gay men and other MSM, while promoting their health and human rights worldwide. The Alliance has been a strategic partner since its inception. The MSMGF has built its profile and credibility significantly over 2008. The Alliance attended the MSMGF's Strategic Planning meeting in Amsterdam in January and has subsequently pursued a number of potential collaborations, working with the MSMGF's executive committee members to secure core funding for the forum

- **Injecting drug users**. UN drug control policy was a dominant feature in our international advocacy in early 2009. The UN High Level Meeting on Drugs was held in Vienna in March, and resulted in a very poor outcome for a progressive, public health-led policy on drugs and drug control. The Political Declaration makes no mention of harm reduction, scant reference to HIV/AIDS and no mention of the human rights violations drug users experience in the name of drug control. This is despite some considerable efforts from progressive government delegations, and sizable civil society delegation. The UK Government, along with other Europeans, some Latin American governments and Australia/New Zealand worked hard to 'modernise' the declaration so that it was consistent with UNAIDS HIV prevention policy. However the US, Russian and Japanese delegations acted as leaders of the status quo, blocking references to harm reduction and limiting access for civil society.

  Prior to the meeting Alliance secretariat staff were pushing for a positive outcome. This included briefing Secretary of State Douglas Alexander's staff and Downing Street staff; briefing advisors to Michel Kazatchkine from the Global Fund and Michel Sidibe from UNAIDS and encouraging their involvement in the debate; and working with US-based AIDS advocates to try to organise for US representation at Vienna that reflected changing US policy on harm reduction. The effort was a good reminder of how little is being invested in drug users networks and building their capacity.

At the international level, the Alliance worked diligently through Action for Global Health to engage in health policy debates on health system strengthening and develop synergy with DFIDs response. Through advocacy and sharing of lessons from the HIV/AIDS response, the Alliance facilitated civil society engagement with the International Health Partnership+ related initiatives (IHP+) – a partnership between the 'Health 8' agencies, bilateral donors and 14 African and Asian countries. In recognition of the Alliance's contribution, a Secretariat staff member was elected to represent northern NGOs on the IHP+ steering

committee. Resources have now been set aside in the partnership to enable greater civil society participation at global and country level. The experience of Alliance Zambia and partner organisations in the country compact was critical to demonstrating the added value that civil society participation can bring to country health policy dialogue.

Work began in 2008 to develop national-level advocacy partnerships, working with Health and Development Networks and building on their National Partnership Platform initiatives (NPPs). NPPs aim to create a national space for effective dialogue between civil society, government and other stakeholders – with a particular focus on transparency and accountability. Activities of the NPPs in each country differ, but examples include social networking tools and e-forums, citizen journalists, community consultations, online dissemination of information, capacity building and advocacy.

As we further integrate work with the NPPs in 2009, we will be better position to measure progress against this indicator.

List any documentary evidence of achievements

- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework

What is the likelihood that Strategic Objective 3 will be achieved? Rate 1 to 5. ***See footnote 10.***	**2**

Strategic Objective 4:

Strengthen the Alliance as a partnership of strong national linking organizations

Indicator 1: Percentage of Alliance members (including the secretariat) that have achieved full endorsement as an Alliance partner

By 2011 the secretariat and 80% of all Alliance Country Offices/Linking Organisations will have achieved full endorsement as an Alliance partner, through meeting requirements of a rigorous Alliance accreditation system and process, and have management systems meeting agreed standards (NB: the baseline set at the end of 2007 was 0%)

Progress achieved and challenges faced

During 2008 the Alliance began implementation of its new accreditation system. By March 2009 the Secretariat and two existing LOs were accredited. In addition the Alliance applied the accreditation system to assess and admit 3 new linking organisations.

In order to be accredited to the Alliance, each Alliance Linking Organisation, Country Office and the Secretariat must meet 38 standards: statements that serve as a reference in measuring quantities or qualities, establishing practices or procedures, or evaluating results. A number of standards fall within each

of the 10 component areas of governance, strategic planning, Alliance values, programmes, monitoring and evaluation, policy and advocacy, financial management, resource mobilisation, human resources and security, communications and knowledge sharing. A strengthening plan accompanies each accreditation to build the capacity of Alliance members.

The Alliance in China was the first member of the global partnership to be successfully accredited in 2008, followed shortly by the Secretariat and KHANA in Cambodia. For the Secretariat, the accreditation process was an important learning experience; a number of detailed observations and recommendations were made by the review team to improve working practices: for example, by developing an operational plan, programme development guidelines and updating the finance manual. Decisive action has been taken to implement these recommendations in 2009.

For the accreditation process to be respected and valued throughout the Alliance, and amongst external stakeholders, it is essential that the accreditation committee's decision-making upholds the principles of quality, accountability and transparency. Following the assessment process, Kimirina (Ecuador) failed to meet all of the standards and was not accredited in 2008. However, with Secretariat support, Kimirina has developed a strengthening plan to address areas of weakness and improve systems in order to meet all of the accreditation standards in 2009.

In 2008, the accreditation system was also used to assess two new organisations wishing to join the Alliance as a Linking Organisation: Civil Society on HIV/AIDS in Nigeria (CiSHAN Nigeria) and the Anti-AIDS Association (AAA, Kyrgyzstan). Both organisations successfully passed the assessment and are now signatories to the Alliance Charter and Linking Agreement.

List any documentary evidence of achievements

- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- Accreditation reports

Indicator 2: Number media pieces covered (print, online, radio and broadcast coverage) and UK public events held to build awareness of HIV and AIDS and development issues in the UK

Increase the number of print, online, radio and broadcast coverage aimed at UK audiences from 60 pieces of coverage in 2008 to 90 pieces in 2009 and 120 pieces in 2010, and the number of UK public events from 2 in 2008 to 3 events in 2009 and 4 events in 2010.

Progress achieved and challenges faced

From the beginning of 2008 until March 2009 the achieved 122 pieces of UK coverage and organised three UK public events.

Last year the Alliance invested in its media work as a strategic priority. As a result, 205 pieces of media coverage were posted in a full range of international media including the medical and HIV/AIDS press, national newspapers and business media, international radio and television such as the BBC, Voice of America, More 4 News (Channel 4) and the BBC World Service, as well as international, online and UK

charity press and publications.

The Alliance's media work showcased its strategic relationship with the UK government in particular and presented opportunities to collaborate further on areas of mutual interest. For example, the UK Secretary of State, Douglas Alexander's visit to the Secretariat in November 2008, provided an opportunity to film a World AIDS Day message on behalf of the government which was posted both on the Alliance website and on the YouTube site, as well as linking DFID and Alliance websites through DFID World AIDS Day online game. The Alliance was also able to produce a joint Q&A article for BBC online by Douglas Alexander and Alvaro Bermejo, the Alliance's Executive Director. The Alliance's expanding media profile is a good example of how making a relatively small, strategic investment can leverage significant results and have a far-reaching impact.

On 24th March 2009, Over 100 students came to London to meet with Ivan Lewis MP as part of the Stop AIDS Campaign's Day of Action. The campaign presented the minster with 21,696 petitions calling for an HIV patent pool, to be set up. The minister announced that he would personally set up meetings with the chief executives of big pharmaceutical companies to ask them to support a patent pool for HIV medicines, being designed by UNITAID. The Alliance was heavily involved in organising and running the event and we also achieved some great local media coverage.

The Alliance secured 25 pieces of coverage on the Alliance activities at the International AIDS conference and data we presented on HIV and transgender people was cited in UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People, drawing particular attention to the very high HIV prevalence rates among this group.

In 2008, the Alliance partnership with the UK government was referenced in a new government strategy, *Health is Global*, which set out the breadth of global health issues and its plan for tackling them:

"We also consider it important to encourage global health to remain in the forefront of the wider public's mind. This is important in galvanising and sustaining action. We will encourage NGOs and foundations that promote global health, and networks such as the International HIV/AIDS Alliance…"

List any documentary evidence of achievements

- 2008 Annual Review Supplement. A summary of progress made against the Alliance's strategic framework
- Case Study of the Alliance's work with sex workers in Latin America http://www.dfid.gov.uk/Media-Room/Case-Studies/2009/Latin-america-sex-workers-AIDS/
- World AIDS Day Coverage including Statement by Douglas Alexander http://www.youtube.com/watch?v=05cv0Zdyrfg
- BBC news online: Q&A world AIDS Day 2008 UK International Development Secretary Douglas Alexander and Dr Alvaro Bermejo Executive Director from the International HIV/Aids http://news.bbc.co.uk/1/hi/world/7758151.stm
- You tube: The work of the Alliance http://www.youtube.com/watch?v=7jLolMx1StQ
- UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People (P2)

http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2009/20090515_Action_Framework.asp

- Health is Global: A UK Government Strategy 2008-2013 (P32) http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088702
- Guardian Newspaper & guardian.co.uk – Winning feature article on HIV prevention in India with men who have sex with men. "Telling our secrets: sex between men is illegal in India, putting them at high risk of contracting HIV." December 2008. The Guardian International Development Journalism Competition.
- Positive Lives magazine. Feature on 'HIV & Me: young people's views on living with HIV'. August 2008.
- Society Guardian. Comment piece Alvaro Bermejo. "We must double our efforts of face failure" 24/09/08.
- Media tracking reports

What is the likelihood that Strategic Objective 4 will be achieved? Rate 1 to 5. ***See footnote 10.***	**1**

Part C – Lessons Learned[10]

What lessons are being learned from this PPA?
Building our ability to generate and disseminate new knowledge The Alliance relies on its core strategic funding from DFID and other Government donors to support knowledge management and organisational learning. Over the period of the last strategic plan in particular the Alliance has invested significantly in these areas, and there is no doubt that without the support from DIFD this would not have been possible. Knowledge sharing and learning are exactly the kind of core functions that we need to continue to support with strategic funding PPA funds have made a vital contribution to disseminating and sharing knowledge across the Alliance. Examples of how PPA funding has supported knowledge generation and organisational learning, as well as generating new knowledge to date include: • ***Defining and developing good practice:*** Work began on a series of good practice standards and guides, with the process for developing the first of these, *Community level HIV and harm reduction programming,* being launched with a workshop in Bangkok. • '***Communities of Practice'*** (horizontal learning; sharing best practice, research findings and helpful theoretical approaches) have been developed in thematic technical areas – prevention, SRH and rights, TB, children, human rights, drug use and HIV – and these include Linking Organisation partners, staff and technical support providers from the TS hubs, as well as

[10] We left this section fairly open to interpretation.

Additionally, it's an opportunity to show the reach and value PPA money has.

programme and other Secretariat staff. As Alliance IT capacity is growing and improving, the technology needed to make Communities of Practice easily accessible to Linking Organisation partners is currently being improved.

- ***Research activities*** have expanded as part of the DIFD-funded *Evidence for Action* research programme consortium. Key initiatives include exploring adaptation to home-based care packages in the area of ART provision, examining the SRH needs of positive adolescents and a systematic review of the role of community responses to HIV treatment and care.

  In the final quarter of the year, the Secretariat began a series of **technical updates** published in *The Loop* (the Alliance e-bulletin) and on the website. In late 2008, two updates were prepared on HIV, antiretroviral treatment, and HIV sexual transmission and substitution treatment for opiate dependency.

- ***Publishing tools and resources to enable effective HIV responses:*** The Alliance continued to play a major role in developing, publishing and distributing tools and resources for local NGOs and CBOs in HIV programming and organisational development. During 2008 over 35,000 printed copies of toolkits and publications were distributed, with over two-thirds of these going to countries in Africa.

  The Alliance and the UK Consortium on AIDS and International Development also launched PortalSIDA, an online knowledge hub, in July 2008. The website provides Spanish language tools to support collaboration and knowledge sharing among new and existing networks of people responding to HIV in the region. During its first six months PortalSIDA attracted nearly 20,000 visitors who downloaded 4,000 documents.

- ***Building capacity at the national level for communication and advocacy:*** Work began in 2008 to develop national-level advocacy partnerships, working with Health and Development Networks by building on their National Partnership Platform initiatives (NPPs). NPPs aim to create a national space for effective dialogue between civil society, government and other stakeholders – with a particular focus on transparency and accountability. Activities of the NPPs in each country differ, but examples include social networking tools and e-forums, citizen journalists, community consultations, online dissemination of information, capacity building and advocacy.

- ***Supporting Horizontal Learning Exchanges*** continued with seven taking place throughout the course of the year: The exchange visit between Myanmar and India was one of a number of strategies the Myanmar Country Office used to develop its skills and understanding of working with orphans and vulnerable children. to education and vocational training and psychosocial support.

  The Alliance took a key role in the **organisation and participation in the 2008 International HIV/AIDS Conference in Mexico.** It was an important opportunity for the Alliance global partnership to come together in major debates such as HIV/AIDS financing, the transgender crisis and male circumcision, allowing members to express their diversity and bring perspectives from the field to global audiences and most importantly, raising the concerns of the most affected communities. The Alliance hosted and participated in a wide range of events – with a particular

focus on the importance of communities in the HIV response and in achieving universal access to prevention, treatment, care and support. The conference also created a lot of media opportunities with 25 pieces of coverage received as a result of the conference.

Impact

The Alliance places high priority on measuring achievement towards the goals and outcomes outlined in our strategic framework and PPA log frame and objectively verifiable indicators have been developed for each of the expected outcomes. Strategic funds from DFID have been instrumental in allowing us to build our capacity to do this.

In 2008, the Alliance began to see the value of this investment in monitoring and evaluation and knowledge sharing with a comprehensive set of data being produced for the third year running. By the end of the year, the Alliance's Global Monitoring and Reporting System (MRS) was being used by Linking Organisations in 28 countries. There are visible signs of increased M&E capacity with the eighth largest Alliance Linking Organisations now independently managing and reporting on large-scale programmes with annual budgets of approximately £2.5 million.

In addition, 2008 saw an increasing number of evaluations being individually managed by Linking Organisations reflecting increased M&E capacity at the country level. The Secretariat directly supported six evaluations that provide further evidence of the Alliance's impact and effectiveness in supporting community responses to HIV/AIDS. External evaluations of Alliance impact included INSP'S evaluation of the **Frontiers Prevention Project (FPP)** a £ 24 million Gates funded multi-country prevention-focused initiative which aimed to slow the spread of HIV and build up effective and sustainable community responses. It identified a 50% reduction in the prevalence of sexually transmitted infections (taken as a proxy indicator of HIV infection) over the life of the 4 year programme in Andra Pradesh (population of aprox 60 million people) proving that community-based focused prevention interventions work well in concentrated epidemics.

Another example of the Alliance's impact is demonstrated in the positive evaluation by UNAIDS of the Alliance Ukraine programme. The results of Alliance Ukraine's five year round 1 Global Fund programme showed that it had exceeded the majority of its targets including providing life saving treatment for over 6,000 people living with HIV and reaching over 94,500 injecting drug users in 2008, an increase of 40% from 2007. *"The impressive performance of the Alliance as a Principal Recipient demonstrates that direct financing of Global Fund grants to civil society recipients can improve the speed of grant implementation and help to mobilise additional implementation capacity" Comprehensive External Evaluation of the National Response to AIDS in Ukraine.*

Following a MRS review, the Alliance launched an initiative to upgrade the MRS to build a system that reflects best practice in management information systems (MIS) and is based on sustainable, cost-effective technology.. This project will be rolled out in 2009. Improving the integrity and reliability of data will strengthen the Alliance's ability to evaluate its impact on the HIV/AIDS epidemic at community, national and global levels.

Relationships

Over the period of the PPA the Alliance has continued to build effective partnerships within and

outside of Civil Society . We recognise that these are essential in meeting our mission of a world without HIV/AIDS. Strategic funds are essential in supporting this work -- and we continue to prioritise building relationships with organisations working more broadly in Health -- both in Europe and the US. In terms of government and multilateral relationships we are proud to currently be working in partnership with **DFID, Sida, CIDA, NORAD, Danida, IrishAid, Swiss Development Cooperation, AusAID, USAID**, the **Global Fund, UNAIDS**, **UNDP** and the **EU** to deliver on our objectives. Other key partnerships include:

- The Alliance has been – through **Action for Global Health** – a key actor in ensuring civil society engagement with the **International Health Partnership** and Related Initiatives – a partnership between the 'Health 8' agencies, bilateral donors and 14 African and Asian countries that aims to improve the effectiveness of aid and to increase investment in health systems strengthening.
- At the country level Alliance Zambia has played a key role in supporting civil society engagement with the IHP+ in Zambia. This has included hosting the IHP+ civil society forum and working closely with other civil society actors, such as Oxfam, TALC and others to influence the content of the Zambia IHP+ country compact.
- Alliance staff were active participants in the **STOP TB partnership** and worked closely with **TB Alert** who represented its work and experience at the international union against TB and lung disease annual conference in Paris in October. This partnership will continue in 2009 with joint work planned around the development of a satellite symposium on community responses to TB and HIV for the 2009 union conference in Mexico.
- We have continued to build our partnership with international bodies – particularly **UNAIDS**, through our Collaborating Centre Agreement and also with the **Global Fund**. During the last year, two members of Alliance staff worked directly with the Global Fund Board in the capacity of members of the Communities Delegation. Towards the end of 2008, the Alliance was asked to be a member of the UNAIDS HIV Global Prevention Reference Group, demonstrating in a very concrete way the reputation of the Alliance in supporting the unique role of civil society in the global response. The Alliance was also actively involved in the UNAIDS/Global Fund Task Team on HIV related travel restrictions, co-chaired the short term working group with the Government of Brazil. The task team developed recommendations for the board of the Global Fund and the UNAIDS PCB.

Finally in 2008 the Alliance has deepened its relationships with the private sector and in 2008 completed the start-up phase of an innovative approach to working with the private sector and academic institutions to develop management and leadership skills across the partnership. **Pepal** is an initiative of the Alliance which runs international development programmes that combine corporate social responsibility with talent development and staff retention.

Part D – Partnership with DFID[11]

Partnership with DFID
At the Alliance we feel that our expectations of our partnership have been met. We appreciate the opportunities to engage with the civil society team, and throughout DFID and particularly in this very economic challenging time we feel our voice is being heard by DIFD colleagues. During the past 12 months we feel there has been many examples of mutual engagement between the Alliance and DIFD. A few more recent examples include: • The Alliance welcomed UK government minister Douglas Alexander, Secretary of State for International Development, to the secretariat's new offices in Brighton on 23 October 2008. As well as officially opening the offices, Douglas Alexander spent an hour with Alliance staff and representatives from key Brighton-based tuberculosis (TB) organisations discussing how joint HIV and TB work is improving health services in some of the world's poorest countries. • In February Alvaro Bermejo: Executive Director, Susie McLean: Senior Advisor, Best Practise Unit and Anton Kerr: Senior Policy Advisor joined Katy Athersuch, of the Stop AIDS Campaign, to meet Gordon Brown's Special Advisor at 10 Downing Street. They called on the Prime Minister to do more to support Universal Access, especially as the financial crisis deepens. This is the first time the Alliance has had such a high level meeting with the UK Government – a great milestone for us. • The Alliance hosted its annual meeting for donors at the end of January 2009. Eighteen donor representatives, including Sandra MacDonough from the AIDS and Reproductive Health team at DFID attended the event, held over two days in Brighton. Over the two days, participants heard presentations that illustrated areas of innovation and challenges at the community level the Alliance is responding to such as work with the transgender community and harm reduction services to street based injecting drug users. There was also an opportunity to hear about how the Alliance is contributing to health systems strengthening through community HIV responses and also about its active engagement and civil society leadership with the International Health Partnership and related initiatives (IHP+) at global and country levels. • The media gave us an exciting opportunity to work with DFID in new ways during the year, with the UK's Guardian newspaper and fellow NGOs coming together in a competition to find aspiring UK-based journalists who care about the developing world. In November 2008, Sylvia Rowley, journalist, won the competition. Her winning article was published in a Guardian supplement and described her visits to outreach programmes for MSM coordinated by the Linking Organiations, Alliance for AIDS

[11] Again, we wanted to focus on partnership over relationship here and have left this section open to interpretation by each organisation.

This is where the mutual accountability framework will slot in, once it has been developed by DFID.

This is an opportunity to expand on some of the information in Part A on the partnership between DFID and PPA holders and a chance to flag up issues.

Again, there is a shift in emphasis from a purely financial relationship to a partnership that is also about learning, accountability and communication with other parts of DFID beyond the Civil Society team.

Action in Andhra Pradesh, India.

We feel that DFID's engagement to consult with partners on how the relationship and work towards a mutual accountability framework has been a very good exercise. At DFID's request, the Alliance went through a process of strategic mapping of key DFID and Alliance relationships which culminated in a meeting with our Stakeholder Manager and a report which outlines requests from the Alliance for key meetings with DFID personnel and our commitments to DFID as a PPA agency. While the work has yet to be finalized and thereby the mutual accountability framework complete, we have been able to use the results of this exercise to improve even more our own strategy for engaging with DFID. We see this as a success.

Despite these high level successes, we have had less interaction with the AIDS and Reproductive Health team in 2008 – frequent staff changes have made it difficult to forge relationships. However, we are committed to re-building these relationships over the coming period as this team has proved critical for our close partnership with DFID. Equally over an 18 month period, there have been five different ministers responsible for HIV making long lasting policy engagement a real challenge.

Part E – Corporate Governance and Organisational Change[12]

Provide evidence of how your organisation demonstrates good corporate governance, whether this has changed as a result of the PPA, and if so how.

You must include in your response assurance that your organisation complies with UK equalities legislation on disability, gender and child protection, and shows due regard for environmental impact.

The economic crisis that has emerged during the second part of the year has left most people uncertain – least of which are those people that depend on the important support of oversees development and aid to live. This uncertainty has meant that the Alliance must, more than ever, focus on not only what we are doing but how we are performing to ensure maximum use of resources doing these difficult times. Good corporate governance and change management has been key to ensuring a more acute focus on not only doing things right, but all doing things well.

During the 2007-8 period the Alliance underwent a dynamic change process in its secretariat operations with a focus on streamlining processes to ensure international resources were being used for the best possible purpose and decentralizing technical support to regional technical support hubs

[12] This section is about both ticking the basic legal compliance boxes and showing that PPA holders are pioneering dynamic new approaches to e.g. environmental standards.

This also provides an opportunity for PPA holders and other organisations in the sector to learn from each other and presents PPA holders as at the forefront of new approaches to good corporate governance, accountability, transparency, organisational change etc.

This is an opportunity to list which standards and codes you are signed up to (e.g. HAP, Sphere etc).

Emphasising how PPA funding has contributed to improving governance and change in your organisation and how this learning has been shared in order to strengthen the sector will also provide more material to demonstrate the reach and value that PPA funding has.

in 6 Alliance sub-regions. The results of this have meant a 'down and out' transfer of responsibility and accountability across the organisation – making the Alliance (in the opinion of its members) a much more horizontal operation – with innovations and leadership coming from national organisations working at the forefront of the response. This is well articulated in the new Charter and Linking agreement which is signed by all partners, and replaces the former Framework agreement previously signed between one linking organisation and the UK-based secretariat. It has also meant a regionalization of technical support which focuses on south-to-south support and the increased recognition of the Alliance's role to provide technical support to civil society organisation beyond its membership.

During this same period the Alliance also introduced an accreditation system to assess Alliance members (including the secretariat) against agreed institutional and programmatic standards. The system ensures that the Alliance's programmes are supported by well performing, sustainable and credible civil society organisations. It is also used to assess organisations wishing to join the Alliance as Linking Organisations.

This 2-year commitment to change management not only prepared the Alliance for the expansion and growth illustrated in the results summarized in section B of this report (Progress against PPA Strategic Objectives) but also positioned the organisation to be stronger at the national level and able to manoeuvre and adjust in its current environment. It is without doubt that these change management processes would not have been possible without DFID's support.

Also key to our ability to change has been the foundation of good governance practices enjoyed by the Alliance for some time. The Alliance secretariat is governed by a very established and represented Board of Trustees, which meets two times each year. During annual meetings trustees authorise annual work plans, funding requests and programme priorities, decide annual budgets, approve accounts and review organisational risk. Meetings also provide very fruitful opportunities for trustees and secretariat operational directors (and staff more broadly) to discuss, exchange and often reflect.

With a focus on the financial health of the organistion, the Finance and Audit Committee reports to the Board of Trustees and comprises up to six members, including four trustees and two external members. The Committee reviews the Secretariat's annual budget and statutory accounts of the Secretariat and its Country Offices, while also approving changes in accounting policies, the assessment of risks facing the Secretariat and the systems put in place to mitigate them, the approval of internal audit plans, and the consideration of findings and recommendations of both the internal and external auditors.

A second board committee -- Policy and Advocacy Committee (PAC) – helps the organization to prioritize the international policy agenda and adopt advocacy positions that represent the Alliance across the partnership.

All UK equalities legislation is complied by The Alliance. In terms of gender and disability the Alliance follows the UK's governing statute law; an example can be seen in our equal opportunities forms for recruitment. Our child protection policy has been written in line with UK laws.

The Alliance is committed to complying with accepted environmental practices, including the commitment to meet or exceed applicable legal and other requirements, to strive for continual improvement in our environmental management system, and to minimise the creation of wastes and pollution. We therefore, manage our processes, our materials and our people in order to reduce the environmental impacts associated with our work. The Environmental Sustainability Policy is guided by the policy principles to Reduce, Reuse, Repair and Recycle to minimise our environmental impact, which apply to all activities undertaken by The Alliance.

In particular we are reducing the amount of air travel as a part of our business model as we decentralize more of our technical support provision to the South though regional hubs and continually invest in innovative ways to hold meetings with distant partners by using cutting-edge technology such as web conferencing.

The Alliance approach ensures that participatory site assessments are conducted before it begins implementing programmes. The assessment provides opportunity for communities to include environmental concerns in defining programme interventions. The Alliance always works though and with existing community based organizations, rather than setting up any new infrastructures that may have an impact on the environment.