PPA Self-Assessment Review[1]

Complete areas within white boxes only

Reporting Year	**2009/2010**

Part A – Basic Information[2]

PPA partner	International HIV/AIDS Alliance

Niche statement	The Alliance supports community action on HIV and AIDS in developing countries. We believe that the most successful responses to HIV are built on local leadership, commitment and responsibility. The Alliance brings together 36 nationally governed and managed civil society organisations (called Linking Organisations) as a global partnership with a shared vision of a world where communities can: bring HIV under control, enjoy better health and fully exercise their human rights. In 2009, the Alliance reached over 3 million people affected by HIV and TB with a wide range of services and programmes. We therefore have an important role to play in supporting the attainment of health Millennium Development Goals. A UK based Secretariat leverages the added value of 36 organisations working together for a common goal, while ensuring accountability, transparency and effectiveness of programme delivery. The Secretariat provides standards, monitors progress, evaluates outcomes and documents and shares evidence of best practice across the Alliance. In turn, this evidence is used to influence programming and policy more widely and to demonstrate the impact and effectiveness of our programmes to our stakeholders - as well as to raise the profile of the impact of DFID funded development work in the UK. Since 1993 the International HIV/AIDS Alliance has successfully delivered health outcomes to some of the most marginalised and vulnerable communities in the world; we have strengthened community systems as part of national heath systems; we have built the capacity of

[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.

	civil society to hold national governments to account for meeting their financial and policy commitments; and we have made measurable impact on national level HIV/AIDS targets, as well supported linkages to SRH, maternal mortality, and TB.

	2004/5	**2005/6**	**2006/7**	**2007/8**	**2008/9**	**2009/10**	**2010/11**
PPA funding (£)	1,200,000	2,750,000	3,750,000	3,750,000	4,260,000	4,480,000	4,600,000
As % of total organisational income ***figures given are for Alliance International Secretariat**	6.18%	10.88%	12.05%	8%	8%	15%	16% (estimated)

Other DFID funding (£)	**2004/5-2006/7**	**2007/8**	**2008/9**	**2009/10**	**2010/11**
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 £2,195,570	£217,592	£367,992	£546,755	£913,039	£118,905
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		£105,715	£89,134	£144,832	£43,909

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 priorities.

In 2009, DFID continued to be the largest contributor of strategic funding to the Alliance. Strategic funding from DFID enables the Alliance to meet its 4 strategic directions to; scale up quality responses; strengthen civil society; improve HIV policies; and build an effective alliance. Our partnership with DFID means we are able to:

- Invest in Linking Organisations – by providing strategic grants to expand programming and expertise within the national civil society organisations and to ensure continuity in programme delivery by providing bridge funding to organisations often dependent on time bound restricted funds
- Demonstrate organisational effectiveness and deliver quality programmes – by investing in an accreditation system, monitoring and evaluation, knowledge sharing and the synthesis of evidence of 'best practice'
- Ensure voices of vulnerable communities are heard and can effect change – by supporting communication and advocacy work at the national and global levels that reinforces the human rights of those living with and most affected by HIV
- Communicate what we do – by investing in media to build support for health and international

[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'.

DFID support for the Latin America region through our LAPPA has been invaluable in enabling us to support vulnerable communities such as men who have sex with men, sex workers and transgenders to tackle HIV/AIDS related stigma and social exclusion and influence policy change to create an environment in which they can access vital health services. Details of the achievements and the impact of the LAPPA are provided in the annex to this report.

In India and Madagascar, DFID support has led to innovation within the sector and more concrete action on HIV/SRH linkages. The ground breaking work that DFID has supported in the Caribbean between the private sector and community has been captured in a Responsible Tourism model and accompanying compendium of best practice for use across the region. Through the *Evidence for Action* research programme, important lessons have been learned about the most effective approach to implementing home based care programmes and the need to involve local communities in programming and planning for effective delivery.

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

100% Health. We take a Human Rights based approach to our work. Our vision is a world where people do not die of AIDS. For us, this means a world in which communities: have brought HIV under control by preventing its transmission; enjoy better health; and can fully exercise their human rights.

[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.

Part B - Progress against PPA Strategic Objectives

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 made by DFID each year, has been critical in enabling us to reach more people with HIV prevention, treatment, care and support services. In 2009, the Alliance reached 3.2 million people - over double the number of people reached in 2007. In 2009, 11 country programmes were of scale/coverage to contribute to national Universal Access targets; Burkina Faso, Cote d'Ivoire, Kenya, Senegal, Uganda, Bangladesh, Cambodia, India (Andhra Pradesh), Ukraine, Caribbean and Peru, and therefore contribute in a measurable way to the achievement of MDG 6 "*to combat HIV/AIDS, malaria and other diseases"*. Eight of these programmes reached over 20% of most-at-risk populations with prevention programmes and the Cambodia programmes reached over half of the country's orphans and vulnerable children. These countries significant results achieved demonstrate how civil society organisations can make a meaningful impact in achieving better health outcomes at scale. The Alliance's strength in building local capacity continues to be borne out by the number of local NGOs and CBOs provided with technical assistance (2,474) and grants (1,671) in 2009 to implement evidence-based programmes within their own communities. This combination of financial and technical assistance at the country level continues to be a cost effective way to support community action on HIV/AIDS. At the regional level, we continued to invest in the development of Regional Technical Support Hubs – which collectively provided almost 3,000 days of technical support - to Linking Organisations and other national civil society organisations. Alliance technical support is guided by our experience and knowledge of 'best practice' for quality programming across a range of technical areas including HIV prevention, Sexual and Reproductive Health and Rights, TB, Children and Drug Use. The Alliance, with its many members, secured a range of national advocacy and policy triumphs in 2009 which will strengthen community responses to HIV. In **Zambia**, the Alliance supported the first National HIV Prevention Convention in Zambia, In **India**, we supported the campaign to legalise gay sex in Delhi which resulted in the Delhi High Court changing a law originating from the Indian Penal code. In **Ecuador**, we secured transgender representation on the Country Coordinating Mechanism, and launched a high profile campaign to increase support for Universal Access in **Kenya**. At the international level, we lobbied successfully for a patent pool that will make drugs more affordable, lobbied for more and better financing for health and built a strategic partnership with the Commonwealth Secretariat to launch an initiative to address barriers to effective HIV programming in commonwealth countries. The Alliance has built a solid reputation for its work with vulnerable communities and this continues

to attract new organisations into joining the partnership. In 2009, Kenya AIDS NGO Consortium (KANCO) and HIV/AIDS and Malaysia AIDS Council (MAC), both mature, stable organisations with high national profiles joined the Alliance partnership.

Through our media work, we have contributed to building a constituency of support for HIV and international development in the UK and globally. By increasing the pieces of coverage received in broadcast, print and online media, and through public events, we have not only been able to demonstrate the impact of the AIDS epidemic on the lives of communities but raise awareness of the value and impact of DFID support.

The significant achievements of the Latin America programme which is supported through the DFID LAPPA top up mechanism are discussed in the LAPPA Annex to this report.

Progress against PPA Performance Framework by each Strategic Objective

Strategic Objective 1:

Scaled up quality community programmes delivered and access to health and HIV 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

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 2009, but where possible information is provided for the DFID financial year April 09 – March 10. 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.

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 11. This includes 3 country programmes in Latin America.

Progress achieved and challenges faced (2009)

In 2009, the Alliance had impact on the national epidemic in 11 countries (set out in the 3 tables below), thereby meeting the target. The 9 countries which achieved category 1 status in 2008 were joined this year by Bangladesh and Kenya. Impact is defined as a significant contribution to at least one of the 12 core UNAIDS nationally set targets for Universal Access to treatment, care and support and/ or prevention. In each of the 11 countries, the Alliance contributed to at least 20% or more of the national coverage toward the universal access target. The largest contribution made by Alliance programmes is in reaching most at risk populations with prevention programmes, with 10 of the 11 countries impacting on this target. This means that the Alliance is playing a key role at national scale in meeting MDG 6 in 11 out of the 36 of the countries in which it operates.

Table 1: Percentage of populations most at risk reached by prevention programmes:

Country	Alliance Coverage 2009	National UNGASS Target	Alliance Contribution
Burkina Faso	12,843	66,000	19%
Cote d'Ivoire	63,894	281,500	23%
Kenya	417,408	1,200,000	35%
Senegal	118,853	268,500	44%
Uganda	352,304	1,045,000	34%
Bangladesh	178,991	857,140	21%
India [Andhra Pradesh]	114,235	320,840	36%
Ukraine	216,348	360,000	60%
Caribbean	13,752	33,000	42%
Peru	40,790	56,720	72%

Table 2: Percentage of orphans and vulnerable children living in households who received a basic external package:

Country	Alliance Coverage 2009	National UNGASS Target	Alliance Contribution
Burkina Faso	12,843	66,000	19%
Cambodia	22,370	41,010	55%

Table 3: Percentage of populations most at risk who received an HIV test in the past 12 months and were informed of the results:

Country	Alliance Coverage 2009	National UNGASS Target	Alliance Contribution
Cote d'Ivoire	63,894	281,500	23%

Although there has been an overall increase in the total number of people reached, there is an apparent decline in the delivery of care and support services and services for orphans and vulnerable children (OVC). These declines are due to the close out of the Networks Project in

Uganda which came to an end in August and a scale down of OVC programming in Cote d'Ivoire and Burkina Faso as a result of reduced donor funding.

Peru remained the only category 1 country in the Latin America region. However, in 2009 Alliance Linking Organisation Kimirina became a Global Fund Principal Recipient of the Round 9 HIV grant (Kimirina is also Principle Recipient for Global Fund Round 8 Malaria grant) and will therefore reach category 1 status in 2010. El Salvador is also positioned to reach category 1. This will mean we have achieved our target of 3 countries reaching category 1 in Latin America.

List any documentary evidence of achievements[5]

- Country level M&R systems and UNAIDS reports
- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. A summary of progress made against the Alliance's strategic framework
- UNAIDS comprehensive external evaluation of the National Response in Ukraine
- Alliance You tube Video from Uganda. http://www.youtube.com/user/Aidsalliance#p/u/1/oIMTr0mQcys
- Case study from Kenya on DFID website http://www.dfid.gov.uk/Media-Room/Case-Studies/2010/Discreet-HIV-treatment-changes-lives/

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[6]

By March 2010, 13 Alliance country programmes (Morocco, Mozambique, Nigeria, South Africa, South Sudan, Zambia, Bolivia, Haiti, Ecuador, Mexico, China, Mongolia, Myanmar) were 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). We are on track to meet this target by 2011 and have already met the Latin America target with Bolivia, Ecuador and

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

[6] 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

Mexico as category 2 countries. The work of these programmes is highlighted in the LAPPA Annex to this report.

Zambia provides an example of a category 2 programme. In Zambia, a generalised epidemic where an estimated 1.1 million people are living with HIV, the Alliance ARV Community Education and Referral project (ACER) has strengthened links with local clinics and hospitals resulting in increased use of services. It has trained and deployed 565 people living with HIV as Community Adherence Supporters (CAS). CAS are based in health facilities that provide VCT and ARV services in 13 districts in Central, Western and Southern provinces in Zambia. They provide counselling and education on ARV adherence and facilitate referrals from the community to the health facilities.

In Africa, Alliance national programmes are strengthened through the Africa Regional Programme (ARP) which supports partners to increase the quality of HIV programmes. An important focus of the programme in 2009 has been to increase coverage of comprehensive prevention programmes for vulnerable populations. The ARP facilitated a best practice meeting on prevention programming for MSM and provided small grants for national level prevention activities with MSM. Given the levels of stigma and discrimination faced by people living with HIV and vulnerable communities such as MSM in Africa, a key objective of the ARP is to support national level anti stigma initiatives with PLHIV networks, national AIDS councils and key AIDS service organisations through a training of trainers model.

While category 2 programmes often represent some of the greatest innovation among all Alliance programmes, the specificity of the approach (e.g. a focus on one population group) is greatly dependent on national priorities and donor commitments remaining focused on the issue addressed. As such, some of these programmes are vulnerable to funding cuts. Where possible 'bridge funding' is used as a means to continue the invaluable work, but when long term sustainability does not seem possible programme closure has at time become the only option. In Mozambique, the need for a change in country strategy led us to a decision to start phasing out the work of the Country Office to focus on developing an existing partnership with the Mozambique Network of AIDS Service Organisations (MONASO) into one of a potential Linking Organisation.

List any documentary evidence of achievements[7]

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. A summary of progress made against the Alliance's strategic framework
- Alliance You tube Video on selling safer sex in South Sudan

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

http://www.youtube.com/user/Aidsalliance#p/u/3/4KzNMyTLtrQ

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[8]

By March 2010, 12 Alliance country programmes (Burundi, Democratic Republic of Congo (DRC), Ethiopia, Malawi, Swaziland, Colombia, El Salvador, Indonesia, Central Asia (Kazakhstan, Tajikistan, Uzbekistan), Kyrgyzstan, Malaysia and the Philippines) were in start up phase. This number exceeds the target number of 6 and includes 2 start-ups in Latin America (Colombia and El Salvador).

We began new programming during the year in DRC, Ethiopia and Malawi as part of USAID funded consortiums, but in these cases we were only supporting part of the programme implementation and therefore do not capture data from the projects in our reporting system. In Malawi, the Alliance is a key technical partner in the BRIDGE II project 'The next Generation in Prevention Programming' led by the Centre for Communication Programs (CCP) Johns Hopkins Bloomberg School of Public Health. BRIDGE II promotes normative change and increases HIV prevention behaviours among adults in the general population. The Alliance is developing a referral system that builds the capacity of communities to act as referral agents. Through interaction with peers, community agents increase uptake of services and improve health seeking behaviour.

We also established partnerships with new Linking Organisations in Burundi, Indonesia and Malaysia.

The Alliance's country programmes in the Central Asia region (Kyrgyzstan, Kazakhstan, Uzbekistan and Tajikistan) and the Philippines are not considered as 'start-ups' – as work here began before 2007 – but resources or challenges in the operating environment has meant that they remain defined as 'Category 3' country programmes.

A major challenge in our 'category 3' programming has been the investment and cost involved. This category usually represents a 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

[8] 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

partners or to directly provide support to partnering CBOs. Moving forward the Alliance is looking how to re-focus by investing more in programmes that are already operational, and less in 'start-up' programming.

List any documentary evidence of achievements[9]

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. A summary of progress made against the Alliance's strategic framework
- Alliance You tube Video, on our work in Asia http://www.youtube.com/user/Aidsalliance#p/u/4/zI8_50Lccqc

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 3.5 million.

Progress achieved and challenges faced[10]

In 2009, 3.2 million people across 36 countries benefited directly from Alliance programmes – more than doubling the number of people reached in 2007. We are therefore very close to meeting our target of 3.5 million by 2011.

The increase in the number of people reached is attributed to a combination of factors. Firstly, the steady expansion of existing Alliance programmes - over half of the country programmes expanded their reach, and in 17 countries there was an increase of 10% or more. Secondly, we were able to reach more people through new Linking Organisations Kenya AIDS NGO Consortium (KANCO) and HIV/AIDS and STD Alliance Bangladesh (HASAB).

The Alliance intensified efforts in prevention programming, more than doubling the number of people reached from almost 930,000 in 2008 to over 1,919,000 in 2009. KANCO's large scale prevention programme reached over 417,000 people in Kenya. In Morocco the number of people reached increased by 245%, in the Caribbean by 239%, in Senegal by 114%, in Ukraine by 55%, in India by 42% and in China by 14%. Country programmes in the Caribbean, Kenya, Bangladesh, Senegal, India and Ukraine all contributed to national Universal Access targets for reaching most at risk populations with prevention services.

In 2009, Alliance country programmes continued to provide care and support for adults and children living with and affected by HIV. We reached over 400,000 adults and children with care

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

[10] 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

and support programmes in 2009. For example, we provided substance maintenance therapy (SMT) and adherence support for people living with HIV in China. Ten countries were implementing children's programmes: Burkina Faso, Cote d'Ivoire, Mozambique, Senegal, South Africa, Uganda, Zambia, Cambodia, India and Myanmar.

Developing and securing funding for truly 'comprehensive' programmes has been harder to realise than anticipated. However, integrating TB, SRHR and livelihoods will be components to programmes will be critical going forward. This area of our work will need further investment in 2010.

List any documentary evidence of achievements[11]

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. 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[12]	**1**

Strategic Objective 2:

Increase civil society capacity to implement effective community responses

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

[12] 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

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
4. Percentage of Alliance evaluations per year report above average satisfaction levels (on scale) regarding programme quality and effectiveness of HIV response

All indicators in the performance framework are reported against under objective 2 except for indicator 4. *An independent evaluation - focused on a representative sample of Alliance countries - reports a) increased satisfaction with Alliance capacity building support and b) increased civil society capacity to deliver effective community responses amongst target Country Offices, Linking Organisations and Community Based Organisations.* This will be reported against following an evaluation underway now with results due in November 2010.

Indicator 1: Number of Linking Organisations 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.

Progress achieved and challenges faced

Between January 1, 2008 and March 31, 2010 four new linking organisations joined the Alliance family bringing the total number to 36.

In line with our commitment to scale up in Africa, 2 new African Linking Organisations joined the Alliance. KANCO joined the Alliance during the first quarter of 2009, followed by L'Alliance Burundaise contre le VIH/SIDA (ABS) in Burundi in March 2010. We also expanded the Allance partnership in Asia and admitted organisations in Indonesia (Rumah Cemara) and Malaysia, the Malaysia AIDS Council (MAC).

All four organisations successfully passed the accreditation assessment and are now signatories to the Alliance Charter and Linking Agreement.

KANCO and ABS expand the Alliance partnership in Africa to 11 organisations. Rumah Cemara and MAC are organisations with 'specialist programmes' – making 2009 the first time that such organisations have made approaches to join the Alliance. Both organisations bring with them significant expertise and experience working with people who use drugs. Such additions will make an important contribution to Alliance's global learning in the future.

The Alliance is on track to exceed its target of 40 by 2011 with 6 existing partnership expected to become new linking organizations over the next 12 months. These include Promoteurs d'Objectif Zerosida (POZ) in Haiti; Asociacion Atlacatl Vivo Positivo (ATLACATL) in El Salvador; Liga SIDA in Colombia; Humsafar in India; Vietnam Civil Society Partnership Platform on AIDS (VCSPA) in

Vietnam; and AMO-CONGO in DRC.

With the addition of ATLACATL and Liga SIDA, the Alliance will have 6 Linking Organisations in Latin America by 2011. We will not meet the target of 7, as we have no plans to scale up further in this region under our new strategy.

A focus also remains to transition country offices to linking organizations. During 2010 the Uganda and Zambia country offices will transition to become independent national Linking Organisations. This means that by 2011 all Alliance's programmes in Africa, Latin America and the Caribbean will be implemented through nationally governed and managed linking organizations.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. A summary of progress made against the Alliance's strategic framework
- Accreditation reports

Indicator 2: Number of implementing organisations (NGOs/CBOs/networks) served with technical and/or financial support

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

In 2009 2,474 implementing organisations received technical assistance from Alliance Linking Organisations. In addition 1,671 implementing organisations received financial support in the form of grants. This represents a 32% increase in the number of grants from 2008. We have therefore exceeded this target. The strength of the Linking Organisation approach to providing technical assistance lies in the fact that they are able to provide technical assistance to a wide range of NGOs, CBOs and FBOs with varying capacity needs. For example, some may be non HIV focused groups such as womens groups who require capacity building in HIV and AIDS programming areas, whilst others may have HIV experience but require organisaitonal development support. Alliance Linking Organistion technical assistance includes; setting up financial systems, financial management and monitoring and evaluation systems, establishment of governance structures, human resource management and capacity building community mobilsiations and different aspects of HIV/AIDS technical programming.

With Alliance support, the regional networks RETRASEX and REDLACTRANS have developed significant organisational capacity, strengthening their links to country level groups and achieving external recognition. In 2009 REDLACTRANS was awarded the prestigious Clarence H Moore Award for Voluntary Service at the Awards for Excellence in an Inter-American Public Health event

and RETRASEX was able to present a Global Fund Round 9 proposal endorsed by the CCM from 13 countries.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. 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

1,671 civil society organisations were also provided with small grants by Alliance member organisations. This represents a 32% increase in the number of organisations that received grants in 2008.

The total of 1,671 represents all grants provided, including those funded in country. However, although we collect data on the total *number* of grants, we do not collect data on the *value* of grants where they are provided through sources other than Secretariat funds. We do not therefore have a total value for the grants received by the 1,671 organisations.

In 2009, 476 civil society organisations received grants through Secretariat funding, and the total value of these grants was $8,893,000 (£5,700,000); the average grant size being £12,000. The total value of grants funded through the Secretariat has fallen compared to 2008, mainly because Alliance Ukraine's major Global Fund Round 1 programme closed out in 2009 and the funding for the successor Round 6 programme is going directly in country. Hence the value of grants made in Ukraine under that programme is not captured within our total of £5,700,000. However, if it was, we would expect to be on track to meet the indicator target above.

Next year, we expect to be able to report on the value of all Alliance grants – both Secretariat funded and those funded from other sources.

The Alliance Linking Organisation model, which builds capacity nationally and locally, has demonstrated efficiency over time. As mature Linking Organisations develop sufficient capacity to secure in-country funding, they have been able to increase the amount of grants going directly to communities and reduce the proportion of administration and support costs. Such cost saving ensures that the Alliance becomes an ever more cost efficient means to support community responses to HIV. This trend is demonstrated in Cambodia by KHANA where onward granting has increased by 444% from just over $1m in 2006 to $4.5m in 2009. Running costs in this period as a

proportion of onward grants have decreased from 42% to 5%, highlighting efficiency increases over time.

As new Linking Organisations join the Alliance, including network organisations such as KANCO, we expect to continue seeing considerable increases in the number of implementing organisations receiving grants over the coming years.

List any documentary evidence of achievements

- Alliance Monitoring and reporting system (MRS)
- Annual Results Report 2009. 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.	**1**

Strategic Objective 3:

Strengthen communities influence in national programming and in national and international policy

Please explain choice of indicators reported on below

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

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 2010 seven Alliance programmes had documented successful initiatives that led to policy change, in addition to seven during 2008, compared to two at the end of December 2007.

In 2009, the Alliance strengthened the capacity of seven organisations to host National Partnership Platforms (NPPs). The NPPs are an approach that creates a space for effective dialogue between civil society and governments to strengthen accountability and ownership of national health programmes. For example, the Vietnam Civil Society Partnership Platform on AIDS (VCSPA) was selected by UNAIDS and the Vietnam Administration of AIDS Control to help assess progress towards the 2001 UNGASS Declaration of Commitment on HIV. This included raising awareness of UNGASS and organising a series of conferences. Nominated representatives commented on the UNGASS report and attended the Consensus Workshop held with UN representatives, donors and the National AIDS Committee to agree on UNGASS progress.

Alliance Zambia was a key player in Zambia's first national HIV prevention convention, a high profile event attended by many national and international agencies including the NAC, various UN agencies, USAID and others. Over 250 delegates came for the three day event. The convention identified six key drivers of Zambia's epidemic. A series of resolutions was taken to the Vice President, increasing pressure for policy change to address them.

Other policy successes were in the Caribbean (improved police handling of violence against sex workers in Antigua and **c**ommunity HIV testing for most-at-risk-populations in Barbados); Colombia (public policy on transgender issues shaped by the community in Cali); Ecuador (transgender representation on the CCM); and India (increased coverage of co-trimoxazole prophylaxis for children under five born to HIV+ mothers).

Not all of the Alliance policy work has been documented however; we can still report further examples of national policy change that has been achieved with Alliance input. For example, in India the Alliance supported campaigns to legalise gay sex in Delhi which resulted in a historic judgement being made in the Delhi High Court in July 2009 to legalise gay sex between consenting adults, overturning a law from the 1860 Indian Penal Code. In Senegal, the Alliance Linking Organisation Alliance Nationale Contre le SIDA (ANCS), supported by the Secretariat, worked with other civil society organisations and the National AIDS Council to call for the overturn of the conviction of 9 AIDS activists who were imprisoned and sentenced to 8 years in prison for "indecent acts against nature". The Court of Appeal overturned the conviction.

The Alliance model provides unique value to national level policy work in that it enables us to 'speak' at national level whilst leveraging an 'international' voice and influence to affect change. It also allows us to raise issues of national importance, for example speaking out against the bill tabled in the Ugandan Parliament that would criminalise the non-reporting of MSM behaviour and sentence to death those found guilty of aggravated homosexuality, without compromising programming on the ground.

List any documentary evidence of achievements
• Annual Results Report 2009. 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 • Alliance You tube Video on the Robin Hood Tax **http://www.youtube.com/user/Aidsalliance#p/u/0/L1sgoKfmSoM**

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

The Alliance supported key population networks to help them represent themselves better.

At the regional level, the Alliance worked closely with partners REDTRASEX and REDLACTRANS to ensure key populations were represented on national CCMs. Alliance partner, REDTRASEX, ensured the active participation of sex workers in 10 CCMs in the region (Argentina, Bolivia, Brazil, Ecuador, Guatemala, Honduras, Mexico, Paraguay, Dominican Republic and Uruguay). Transgender people were also supported by REDLACTRANS to participate in 9 CCMs in the region (Nicaragua, Honduras, Mexico, Argentina, Uruguay, Peru, Bolivia, Ecuador and the Andean Regional coordinating mechanism). These initiatives should lead to a greater focus on access to services by these communities, which is critical for the AIDS response in Latin America. Further detail can be found in the LAPPA Annex.

Through our work on key population representation on the CCMs, we have exceeded the target for participation of key populations in Latin America – reaching a total of 12 countries.

In Kenya, Alliance Linking Organisation KANCO has built the capacity of ISHTAR, a nascent MSM network, to represent themselves in key national fora. Whilst they not yet represented on Kenya's CCM, they have contributed to Kenya's new National Strategic Plan to ensure that MSM are represented within it.

In India, the Alliance was elected as the coordinator of the civil society constituency on the CCM. Through this position, the Alliance is able to ensure stronger participation and representation of civil society constituents, including key population groups.

In addition, we supported the Network of Sex Work Projects, to enable full participation of Latin American delegates in the Global Sex Work Working Group that advises UNAIDS on sex worker guidance and policy; the International Network of People Who use Drugs, to attend and participate in the harm reduction deliberations of the UNAIDS Programme Coordinating Board; and the GNP+/UNAIDS consultation on Positive Health, Dignity and Prevention.

List any documentary evidence of achievements

- Annual Results Report 2009. 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.	**1**

Strategic Objective 4:

Strengthen the Alliance as a partnership of strong national linking organizations

Please explain choice of indicators reported on below

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

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

In 2008, the Alliance introduced an accreditation system to set a 'standard' for credible and sustainable civil society organisations. The system rigorously assesses Alliance members against 38 standards to improve their HIV responses and accountability to the communities they serve. The Alliance Secretariat and two existing LOs (Alliance China and Khmer HIV/AIDS NGO Alliance (KHANA) in Cambodia) were the first to be accredited. The accreditation system is also used as a tool for assessing new organisations eligibility to join the Alliance. The first 2 new Linking Organisations to go through this process were Civil Society on HIV/AIDS in Nigeria (CiSHAN) and the Anti-AIDS Association (AAA) in Kyrgyzstan.

Those accredited in 2009 included Initiative Privée et Communautaire Contre le VIH/SIDA au Burkina Faso (IPC), Alliance India Secretariat and Alliance Nationale Contre le Sida (ANCS) in Senegal. New Alliance Linking Organisations Kenya AIDS NGOs Consortium (KANCO) and Malaysia AIDS Council (MAC) were accredited and admitted.

By March 2010, more new LOs were admitted to the Alliance through accreditation (Rumah Cemara in Indonesia and L'Alliance Burundaise contre le VIH/SIDA (ABS) in Burundi). Existing LOs accredited during early 2010 include Alliance Nationale contre le SIDA en Cote d'Ivoire (ANS-CI), Lepra in India, Kimirina in Ecuador and Via Libre in Peru. Kimirina had failed to meet all of the standards when originally assessed in 2008, but with Secretariat support it developed a strengthening plan to address areas of weakness and improve systems, and has now achieved accreditation. Via Libre also did not originally pass its assessment, due to lack of independence on its governing body (although it was compliant with national law). However it responded by strengthening its governance function and changing its statutes, leading to recruitment of independent Board members.

A total of 15 linking organisations, plus the UK Secretariat, are therefore accredited bringing the

total to 44%. During the rest of 2010, accreditations of four existing Linking Organisations and three new ones are planned.

An external consultant has conducted review of the accreditation tools, leading to recommendations to improve the process of applying for and acquiring accreditation. A need was identified for more clarity about the standards. There was a request that reviewers should be armed with more information about the in-country context and the role of the organisation when making their assessments. Another recommendation suggested supporting organisations with resource mobilisation if they do not have sufficient funds in existing budgets to make improvements to meet the standards. To acknowledge accredited members, a kite mark was proposed for use in publicity materials and on websites.

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

The Alliance secured 96 items of broadcast, print and online media coverage during 2009, referencing Alliance-supported work. Features included human interest stories and in-depth comment and analysis on topical issues. Of the 96 items, 59 were in-depth features (almost double our internal target) which appeared across a range of outlets including: BBC World Service TV News, Sky News, The Guardian, The Times, The Telegraph, Financial Times, British Medical Journal, The Lancet, Reuters, AlertNet and IRIN. Improved media coverage has led to an increasing number of journalists coming to the Alliance for expert comment and the repeat commissioning of articles from a number of publications such as The Lancet.

In the UK, this coverage helped mobilise public support for HIV programming in low and middle income countries. However, despite the successes, gaining coverage on HIV related issues is never easy – media demand for 'headlines' and competing development issues frequently push out HIV.

We organised 3 events to raise our profile in the UK and mobilise public support for responses to HIV/AIDS. We ran an event to build the capacity of the Student Stop AIDS Campaign in media and advocacy. This was to support efforts in the 'Push for the Pool' campaign (for an HIV patent pool to deliver vital drugs and save millions of lives).

We supported the opening of the Brighton AIDS Memorial. Opened by Sir Elton John's partner, David Furnish, it brought together local organisations and community activists to commemorate the lives of people who have died of AIDS related illnesses.

On World AIDS Day, we raised awareness amongst crowds in London that HIV is still an important issue for young people globally. Nearly half the world's population is under 25, and the Government's Minister for International Development Mike Foster encouraged young people to take a lead on HIV.

List any documentary evidence of achievements

- Annual Results Report 2009. A summary of progress made against the Alliance's strategic framework
- A list of selected media items is in the Annex attached.

What is the likelihood that Strategic Objective 4 will be achieved? Rate 1 to 5.	**2**

Part C – Lessons Learned[13]

What lessons are being learned from this PPA?

Knowledge Generation and Disseminiation

The PPA is allowing the Alliance to continue to invest in valuable knowledge generation and dissemination initiatives throughout the partnership. Horizontal learning exchanges for example provide the opportunity for LO staff to learn from each other. In 2009 four horizontal learning exchanges between Alliance Linking Organisations took place. For example, staff from *Instituto de Desarrollo Humano* (IDH) in Bolivia visited *Via Libre* in Peru to learn about

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

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

comprehensive care and treatment programmes to enable them to strengthen the quality of the services they provide. Learning outcomes from the visit included best practice in the delivery of patient care, particularly the role of well trained and sensitive support staff, how to approach mental health issues and building awareness of different approaches to treatment adherence.

Another key area has been the ability to further develop the Key Correspondents team (previously supported by the Health and Development Network), comprising more than 250 'citizen journalists' based in more than 50 countries. Key Correspondents document the local situation and ensure that people not normally heard are empowered to tell their stories. They have developed links with the Alliance media and communication programme and published a series of articles in the ICAAP conference newsletter.

The development of Standards and Good Practice Guides to define and promote good practice in seven technical areas of community based HIV programming was also initiated in 2009. Based on evidence and programme learning, the Guides are also shaped by the Alliance values. The 'HIV & Drug Use' guide was used to share good practice with technical assistance providers at the South East Asia Pacific Hub, who provided positive feedback in response to the training they received.

Last year saw the re-launch of an interactive, global knowledge hub on children and HIV programming. OVCSupport.net is a platform for sharing resources, exchanging news and finding latest policy, research and technical programming information. Supported by USAID, the website has been developed to encourage programming based on best practice.

At the same time the Alliance's own website was re-launched to make it more user-friendly and present a stronger, more consistent, brand identity to its key audiences.

Measuring Impact

The Alliance aims to become more effective in its programming work by promoting stronger reporting and accountability and more effective use of its resources. In 2009, we continued to invest in strengthening our M&E systems to measure impact and worked with external groups in their effort to improve global monitoring and evaluation of AIDS programming. The Alliance Monitoring and Reporting System (MRS) is used across the Alliance partnership as a global monitoring tool which collects data from community (CBO, local NGO, FBO) level to national level. The cornerstone of the MRS is the harmonised set of Alliance programme and quality indicators. These 130 output and outcome indicators cover the majority of HIV/AIDS and health related interventions and are set to international standards for the major international HIV/AIDS Monitoring and Evaluation (M & E) frameworks such as UNGASS, PEPFAR, the Global Fund, UNAIDS and the WHO. The MRS allows Linking Organisations to contextualise programme performance within national, regional and global contexts.

In 2009, the Alliance launched a ground breaking enhancement to the MRS - the Interactive Application ('App'). The MRS Interactive App generates simple and accessible charts and maps of programme interventions based on selected process and outcome indicators from the MRS.

Unlike other free mapping and charting services available online, the MRS Interactive App does not require an internet connection or a high powered computer making it a cost efficient and effective tool. The MRS Interactive the Alliance has placed the power of advanced visualisation and analysis tools at the hands of implementers at the community level, empowering them to make robust decisions about the most effective programming responses. Our work with external agencies included:

- The Alliance Secretariat, Alliance Ukraine and KANCO participated in Technical Working Groups of the UNAIDS Monitoring and Evaluation Reference Group (MERG). This included e.g. a review of UNGASS indicators and process.
- We participated in the technical oversight group for an 'Evaluation of the Community Response to HIV/AIDS', a joint partnership between the World Bank, DFID and the UK Consortium on AIDS and International Development. We were asked to map funding mechanisms for the community response to HIV and AIDS.
- As an associate member of 3ie, the global funding body and think tank on impact evaluation, we support 3ie in its goal to fill the gap in good quality and cost effective impact evaluation.

Building Stronger Relationships

Recognising that no single organisation or approach can tackle the HIV epidemic alone, we actively engage in key partnerships – for example:

- Through the *Stop AIDS Alliance* joint initiative, we advocate with the European Parliament, European Commission and the Council on the development and implementation of comprehensive HIV policies and financing mechanism in EU partner countries.
- Through the *Stop AIDS Campaign* (SAC), an initiative of the UK Consortium on AIDS and International Development, we raise awareness in the UK about global HIV/AIDS epidemic and campaign for urgently scaled up international action.
- Through *Action for Global Health* we influence the UK Government and the European donors to maintain their aid commitments for health, ensure it is delivered effectively, and encourage increases in resources for health for developing countries.
- Through BOND, we influence key stakeholders and policy-makers and we also co-chair the DFID Funding Group.

Specifically describe innovative learning, e.g. specific knowledge generation about

new issues encountered or discovery of new means of solving specific problems

The global health landscape – and HIV in particular – has learnt and moved significantly since we entered this PPA partnership with DFID. The Alliance has contributed to this learning, adapted rapidly and helped to shape the AIDS sector accordingly.

From our participation (Callisto Madavo, Trustee and Alvaro Bermejo) in the AIDS2031 Finance Working Group, we have learned that we shall still have 1.2 million new infections in 2031 and a response that costs about 19 billion per year. If the spread of HIV continues along the current trends, we'll have 2.1 million new infections and a response that costs double what the current response costs. In response, we have adjusted our strategy to include campaigning for a Currency Transaction levy and broader Financial Transactions Tax that could be used to finance global health initiatives and developed an Alliance wide 'prevention campaign' to ensure prevention is prioritised in national programmes and that resources are allocated to where they are most needed. We have also learned that while progress on microbicides and vaccines has been slower than anticipated, we need to continue to support initiatives that generate continued investment and momentum in these areas.

An increased international focus on MDG 4 and 5 has brought into sharper focus the contribution of HIV to maternal mortality and child health and provided opportunities for shared learning and greater co-operation. We have advocated strongly for responses that reflect the inter-connectedness of the health MDGs through our role in the IHP+ and Action for Global Health and helped bring the HIV and MCH communities together through initiatives such as Women Deliver where we led the HIV track in June 2010.

Building on our experience of community mobilisation, we have focused on learning from programmes in Uganda and Zambia about how communities can best contribute to strengthening health systems. In Zambia, this learning has been strengthened through the DFID funded Evidence for Action research initiative which includes a finding that home based care programmes are most effective when driven by a community-led approach. Working with the Global Fund and others, we have supported efforts to learn what community systems strengthening means through developing a framework for Community Systems Strengthening (CSS) and accompanying M&E guidelines. This will support a better understanding of CSS amongst civil society, country coordinating mechanisms, government ministries and the UN family and therefore increase communities' role in Global Fund programmes.

Through innovative programming in Myanmar and the Caribbean, we have learned how to work with the private sector to deliver effective treatment programmes and how the private sector can be mobilised to support action on HIV and AIDS.

In addition, we have collaborated with International Council of AIDS Service Organisations to

develop a toolkit to support civil society organisations evaluate HIV and AIDS related advocacy and therefore improve learning from our experience of national level advocacy work.

Throughout this process we have continued to learn about the power of community action in tackling HIV and other health issues. We have also learned that only through greater collaboration and a shared commitment between communities, governments and civil society will we be able to change the tide of the AIDS epidemic and make progress on all the MDGs.

Part D – Partnership with DFID[14]

Partnership with DFID
The Alliance has had a long standing partnership with DFID and engaged strategically with the thematic teams over the years to provide input into strategies on HIV/AIDS, treatment and sexual and reproductive health and rights. In particular, we contributed to DFID HIV/AIDS strategy 'Taking Action: The UK's strategy for tackling HIV and AIDS in the developing world' and more recently *Achieving Universal Access.* As well as inputting into the consultation stages of *Universal Access* to ensure the strategy reflected evidence from Alliance programming and prioritised reaching marginalised communities, we supported DFID to develop indicators to monitor and evaluate the strategy. The Alliance Executive Director, Alvaro Bermejo then gave evidence at a parliamentary committee hearing on the new strategy. The strategic partnership we have with DFID through the PPA has enabled us to explicitly support DFID's leadership in the global HIV/AIDS response and we have welcomed the opportunities we have had to engage with DFID to advance both organisations policy goals. For example, in partnership with the Global AIDS Alliance, we provided a 'special briefing' for the All Party Parliamentary Group on HIV/AIDS, MPs and members of the House of Lords on US AIDS policy and the potential for policy change following the election of President Obama and wrote a briefing paper for Kerry McCarthy, Parliamentary Private Secretary to the Secretary of State for International Development, Douglas Alexander on 'The role DFID can play to secure policy coherence to support evidence based HIV prevention for injecting drug users' prior to Douglas Alexander's visit to the US. In March 2009, Alvaro Bermejo shared a panel with Mike Foster for a Stop AIDS Campaign 'day of action' event to highlight the 'Push for the Pool' campaign and the funding needs of the Global Fund in advance of the replenishment meeting. In November 2009, we welcomed Nick Dyer (Director of the Policy Division) to the Alliance for a discussion on our work, with a particular emphasis on how we report our results and demonstrate performance of Alliance programmes. This gave us the opportunity to showcase our 'MRS Interactive' – an online, interactive Monitoring and Reporting system that captures data from Linking Organisations and allows them to contextualise their performance within national and regional contexts. At the beginning of February 2010, the Alliance held its annual donor consultation meeting which was attended by Will Niblett and Sally Chakawhata (AIDS and Reproductive Health Team) and

[14] Again, we wanted to focus on partnership over relationship here and have left this section open to interpretation by each organisation, however, you might want to consider issues such as learning, accountability and communication with other parts of DFID beyond the Civil Society team.

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.

Roy Trivedy (Head of the Civil Society Team). The primary focus of this years meeting was to consult with our strategic donors on the direction of our new strategic framework, and to highlights some of our achievements in 2009. It was invaluable for us to have DFID's participation in this process to develop a common understanding of the challenges and opportunities for the AIDS response going forward, and how the Alliance can best position itself to address these.

As a result of this meeting, Sam McPherson, (Head of Planning, Analysis and Learning at the Alliance) was invited to present "The experience of the Alliance in evaluating impact" to members of DFID and other PPA agencies at a Portfolio Review Meeting.

Through our role as Co-Chair of the BOND DFID Funding Working Group, we have been able to meet with Roy Trivedy on a number of occasions to discuss to a joint PPA agency in-country study of DFID's support to civil society. Through this initiative, we have been able to participate in the broader Portfolio Review process.

In March 2010, Alvaro Bermejo was invited to attend a meeting with DFID on Universal Access to ensure that HIV and AIDS are not forgotten amongst the competing agendas for the G8, G20 and MDG Summit in September. In particular, the meeting focused on response and challenges in the hyper-endemic countries of Southern Africa and countries in Eastern Africa where the infections are still rising.

Our strategic relationship has been highlighted through our communications work with a case study of our work with transgenders in Latin America being published on the DFID website and on-going coverage of DFID on our website in response to government announcements. We have reached UK audiences through a number of news outlets including the Guardian, Times, Telegraph and Financial Times newspapers. In September 2009, a journalist trip was organised with DFID to film Alliance work in Bolivia unfortunately however, DFID pulled out citing insufficient funds to do the trip. This was unfortunate as the Alliance team had already invested significant effort into planning the trip.

In terms of building a more effective partnership, we would welcome the opportunity to have closer interaction with the DFID communications team in order to identify opportunities for collaborative/linked communications work. We recognise that in times of economic cuts and greater scrutiny of budgets, there will be a greater need to maintain UK public support for international development and believe that we could leverage our partnership with DFID to a greater extent to support the UK Government commitment to meeting the MDGs.

Part E – Corporate Governance and Organisational Change[15]

Provide evidence of how your organisation demonstrates good corporate governance, whether this has changed as a result of the PPA, and if so how.
The Alliance Secretariat is governed by a Board of 10 Trustees, which meets twice a year. The Trustees authorise the organizations strategy, annual work plans, funding requests and programme priorities, decide annual budgets, approve accounts and review organisational risk. The Finance and Audit Committee (FAC) 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, 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. The Alliance internal audit function is managed by an Internal Audit and Compliance Manager who sits within 'Legal, Risk and Compliance' team. This team is responsible for the daily management and oversight of legal and compliance issues, including ongoing monitoring of the Organisations Risk Register and indirectly report into the (FAC). 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. The Alliance complies with all UK equalities legislation. We have also produced an Environmental Sustainability Statement to guide our response to environmental issues through our working practices and programmes. In addition, the Alliance has registered with 10:10, *"a project to unite every sector of British society behind one simple idea: that by working together we can achieve a 10% cut in the UK's carbon emissions in 2010"* www.1010uk.org We are committed to identifying opportunities, particularly in air travel, to

[15] 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.

reduce our carbon footprint by the10% target by the end of 2010. One of the ways we will meet this target is through investing in information technology which allows us to communicate virtually. These investments have been made possible through our PPA.

Our commitment to promoting good governance within the Alliance family is demonstrated by the investments we have in our accreditation system – investments which were made possible through our PPA. The accreditation system (launched in 2008) is used to assess Alliance members (including the Brighton based Secretariat) against agreed institutional and programmatic standards. The 38 standards fall within 10 component areas of governance, strategic planning, Alliance values, programming, monitoring and evaluation, policy and advocacy, financial management, resource mobilisation, human resources and security, communication and knowledge sharing. The accreditation system prioritises good governance as the first standard to ensure that Alliance Linking Organisations are well managed, credible, transparent and accountable organisations. It puts into practice the Code of Good Practice for NGOs Responding to HIV/AIDS (www.hivcode.org) In this way, the PPA has enabled us to build a robust culture of good governance across the partnership.

Please provide any evidence to show how PPA funding allows you to take risks and innovate (if at all).

With investment from the PPA, the Alliance has built a strong reputation for providing technical support to civil society organisations working in HIV and AIDS. In recognition of the significant capacity that exists in the South and the experience of Alliance Linking Organisations in providing technical support to implementing partners, we took a decision in 2008 to move the point of technical support away from the Secretariat to the regions and established 6 Regional Technical Support Hubs within some of the strongest Alliance Linking Organisations. The regional technical support hub mechanism uses a mix of Alliance Linking Organisation staff and consultants to deliver technical support to other Linking Organisations and civil society organisations. One of the risks in this approach is that when using consultants there is less 'quality control' of the standard of 'Alliance technical support' and therefore a greater risk to the Alliance reputation. One of the ways we are mitigating this risk is through investing PPA resources in the development of a series of 'Best Practice Guides' and 'Standards' that cover key thematic areas of HIV programming such as HIV prevention, human rights, sexual and reproductive health and rights, TB, children and drug use. There is a dissemination plan in place to roll out the guides and standards across the technical support hubs through a variety of mechanisms including e-learning modules and workshops. The first workshop for technical support providers on working with people who use drugs, for example, was held in Cambodia in 2009.

The MRS Interactive (described in Section C of this report) has enabled us to improve the

way we monitor, evaluate and report results to our stakeholders. Developing it into an increasingly sophisticated monitoring tool and reporting tool has required innovative thinking and investment – made possible through our PPA. We have continued to build the levels of data that we can collect and report for example, tracking patterns of technical support and programme interventions by population group. We are also expanding it beyond quantitative data to include more qualattiive features such as narratives and case studies to support enhanced learning within and between Linking Organisations, and enable them to maximsie the information as a communication tool through their own websites and for e-learning.

There is an inherent risk in the Alliance model itself given that Linking Organisations are independent national organisations and its reputation is borne out by the increasing number of diverse organisations wishing to join the partnership. Continued investments in horizontal learning, partnership annual meetings, and technology that improve relationships among Alliance partners help to mitigate that risk. In 2009 the Alliance carried out a survey of all its members to measure and ultimately monitor the value of the Alliance partnership. The survey found that the most important value for members is the credibility and prestige that being part of the Alliance brings. Alliance members also placed great value on the opportunities for regional and international knowledge sharing among members.

Part F – Cross –cutting issues

Describe any work your organisation has done on Gender and Faith if applicable (this question will be limited for the period 2008-2011)
All Alliance programmes aim to be gender sensitive in terms of building the capacity of women and men to provide services and manage organizations; reaching women and men with information and services and ensuring that women and men are equally represented in international, national and local fora. Through our monitoring and reporting system (MRS), we are able to disaggregate by sex at project, country and global levels, allowing us to use the data as a management tool, and recognise trends. In 2009, over 50% of people reached by Alliance programmes were women. Gender is prioritised within the accreditation system with a specific Gender Standard which requires each Linking Organanistion to demonstrate that it has *"gender-sensitive organisational policies and integrates a gender approach in its programs"*. The assessment tool's gender component addresses the following: • Gender equity in the organization; • Equitable participation and access of women and men to program interventions; • Gender sensitive programming which acknowledges the roles of women and men and addresses those that make women and men vulnerable to HIV and SRH problems;

- Working to ensure that national policies and laws exist and are implemented that protect women and girls and support their empowerment and gender equality.
- Implementing programs that increase gender equality and empower women.

A good example of how the Alliance has undertaken specific work around gender is with our work with young people in Zambia and Swaziland where harmful gender and cultural norms and practices have put both girls and boys at risk of HIV and SRH problems. The programme targets young people between 10 and 20 to increase their capacity to protect themselves from the risk of HIV infection, including preventing and dealing with the increasing levels of violence against women and children. Lessons learned from this programme will be shared across Alliance programmes in Africa.

In Cambodia, working with the faith community has been crucial in tackling stigma and discrimination against people living with HIV. Alliance Linking Organisation Khana has been working with Monks for a number of years as part of the Home Based Care teams. The status given to Monks in Cambodia means that they can play an effective role as outreach workers in providing information, education and care and support to people living with and affected by HIV and have acted as an important entry point for working with communities to tackle stigma and discrimination.

Building on their work with faith based organisations in Barbados, St Kitts and Nevis, the Caribbean HIV/AIDS Alliance (CHAA) has worked with the University of California in San Francisco, to carry out an assessment of FBOs to undertake HIV/AIDS programming within four countries of the Eastern Caribbean: Antigua and Barbuda, Barbados, St. Kitts and Nevis and St. Vincent and the Grenadines.

The assessment found that while FBOs may play a key role and their efforts to address the HIV epidemic are important, there are limitations and constrains based on doctrine and beliefs to what FBOs may do, or may be expected to do in terms of HIV prevention, and the potential reach of their HIV prevention messages. The challenge for FBOs is how to harness their potential and reconcile doctrine and faith with HIV prevention messages that may need to include condom use and the reality and acceptance of sexual activity outside the traditional boundaries of institutionalised marriage and thus better address sexual behaviours, HIV prevention, other health-related issues and better respond to the needs of the FBO congregants and the population in general in St Kitts and Nevis.

The conclusion was that messages and programmes must be tailored to the ability and willingness of the individual FBO to implement these programmes. Initial programmes should specifically target the youth within the FBOs. More long-term efforts should be directed towards the development of a uniform national and regional programme with respect to HIV and AIDS. The findings of the study will be presented at the International AIDS conference in Vienna in June 2010 and shared amongst the Alliance partnership.