MINISTRY OF FOREIGN AFFAIRS OF DENMARK

DANIDA | INTERNATIONAL DEVELOPMENT COOPERATION

Danish Organisation Strategy

for

International HIV/AIDS Alliance

2014-2017

September 2014

1. Objective

1.1. Objective of strategy

This strategy for the cooperation between Denmark and the International HIV/AIDS Alliance (hereafter referred to as 'the Alliance') forms the basis for the Danish core contributions to the Alliance and is the central platform for dialogue and partnership with the organisation. It follows the guidelines for short organisation strategies for organisations receiving less than DKK 35 million in annual contribution. It outlines the Danish priorities and related results for the Alliance's performance within the framework established by the organisation's own *HIV, Health and Rights: Sustaining Community Action – Strategy 2013 – 2020*. The timeframe for the Danish organisation strategy is 2014 to end 2017[1].

1.2. Objectives of organisation

The International HIV/AIDS Alliance is a global partnership – or alliance - of nationally-based, independent civil society organisations with the objective of securing the human rights of all people affected by HIV/AIDS in low and middle income countries, with a particular emphasis on vulnerable and marginalised population groups. It is particularly concerned with the access to health services of groups exposed to stigmatisation and discrimination, such as commercial sex workers, men having sex with men etc.

The overall objective of the organisation is to stop the spread of HIV and to end AIDS. It is pursued through actions to promote health and human rights via direct engagement with and through local communities.

2. The organisation

2.1. Basic data and management structure

Organisational background facts	
Established	24 December, 1993
Headquarters	Brighton, United Kingdom
Regional offices	6 Regional Technical Support hubs in Kenya, Burkina Faso, India, Cambodia, Peru and Ukraine.
Collaborations	36 linking organisations, one country office, 6 tech. hubs, working in 40 countries.
Executive Director	Alvaro Bermejo
Human resources	94 employees at the secretariat: 4 representatives in Washington D.C., 2 in Brussels and 1 in Geneva. An additional 13 staff are based in Africa, Asia, Latin America and the Caribbean region.
Previous Danish funding	• **2012-2015:** DKK 25 mill. earmarked funding: Sexual Health & Rights Programme (SHARP) • **2012-2013:** DKK 20 mill. core contribution • **2010-2011:** DKK 20 mill. core contribution • **2007-2009:** DKK 30 mill. core contribution • **2004-2006:** DKK 6 mill. earmarked funding to: Regional African HIV/AIDS Youth Programme • **1999-2000:** DKK 3 mill. earmarked funding: Community action on AIDS in developing countries.

The Alliance was set up in 1993 to support communities in developing countries to play an active role in the global response to AIDS. Today it is a global partnership working in 40 countries through a network of 36

[1] Aligning to the Alliance strategy requires a 7-8 year timeframe for the present organisation strategy. The MFA guidelines for Management of Multilateral Development Cooperation recommend 3-5 years' duration. A 4-year timeframe (2014-2017) enables a mid-term stock taking.

national, independent organisations, termed "linking organisations", a country office in Myanmar and six regional technical support hubs in Africa, Asia, Eastern Europe, Latin America and the Caribbean[2]. The hubs consist of teams of technical support providers and regional experts, who work with the linking organisations, community-based organisations and governments to strengthen their leadership and technical capacity. The international secretariat, based in Brighton, United Kingdom, connects the linking organisations and the technical support hubs, providing financial and technical support, and promoting intra-organisational learning.

The organisation is governed by a Board of Trustees composed of ten trustees with a recognised international expertise within the field of HIV/AIDS, health and human rights. The Board includes people living with HIV. Donors are not represented on the Board. The Board oversees the work of the Financial and Audit Committee, the Policy and Advocacy Committee and the Accreditation Committee. It is the responsibility of the Board to approve the strategic framework of the Alliance and to ensure that the policies and strategies are in adherence with the values and mission of the organisation. The Trustees also authorise annual operational plans, funding requests and programme priorities at the meetings twice a year. The daily management of the secretariat is the responsibility of the Executive Director assisted by the Senior Management Team. Under these teams are the departments of Field Programmes, Corporate Services and External Relations as well the Legal, Risk and Compliance team.

2.2. Mission and mandate

The Alliance mission is to work with communities through local, national and global action on HIV, health and human rights. The mission contributes to the Alliance vision of a world without AIDS. Through this, the Alliance focuses on the protection of the *rights* of people affected by HIV; the right to equal access to information and services without facing stigmatisation and discrimination. With this follows a particular focus on population groups at higher risk of HIV, termed 'key populations'.

Who are key populations?
Key populations are population groups at higher risk of HIV infection. They vary according to the local context, but are usually marginalised because of their HIV status, sexual orientation or social identities and underserved by mainstream HIV/AIDS programmes. Key populations include a.o. HIV positive people, their partners, people who buy or sell sex, men who have sex with men, people who use drugs, transgender, children affected by HIV/AIDS, migrants, displaced people and prisoners.

In addition, the Alliance also focuses on the needs of women and young girls in particularly Sub Saharan Africa. Women and young girls are disproportionally hard hit by the HIV epidemic due to cultural, biological and social factors, such as early marriage and sexual violence making them vulnerable and at increased risk of infection.

The Alliance's mission is based on a comprehensive theory of change (Annex 2). The theory of change outlines a chain of action in which strong community mobilisation and engagement will contribute to informed communities who know and are able to claim their rights. The informed communities will seek and access health services and be able to advocate with policy makers nationally and globally for receptive and effective, integrated HIV programmes, increased funding and

[2] See annex 1 for details of geographical distribution.

not least decriminalisation. Long term outcomes include healthy people reducing their own risks, whose health needs are being met – including those of key populations and women and young girls – as well as a stronger civil society able to secure accountability and influence. Ultimately contributing to the goal of ending AIDS.

2.3. Achievements and mode of operation

Achievements

The Alliance is at the forefront of putting the *rights of key populations* on the international agenda by advocating for anti-stigmatisation and decriminalisation. The Alliance has a strong track record in the area of ensuring equal and non-discriminatory access to services and information and is uniquely placed as a strategic partner for Denmark in this regard.

In 2013 key achievements in the area of addressing *human rights related issues* included strengthening the Alliance's human rights monitoring and response systems with local civil society organisations equipped to collect data about human rights related barriers to accessing HIV services. The data will inform targeted efforts in hostile country environments. In addition, linking organisations implemented law reform initiatives and monitored human rights-related barriers to accessing health services. The Alliance reached more than 700,000 people with stigma and discrimination reduction activities, an increase of 80% compared to 2012. As an example, in Bangladesh 300 young people were trained to address social and cultural taboos. This includes training on gender-based violence, HIV prevention and sexual and reproductive health and rights issues which peer leaders will take up with youth groups.

Denmark supports the Alliance's work on this through core support as well as through targeted project funding (2012-2015) to address the sexual health and rights of men having sex with men in Kenya, Tanzania, Uganda and Zimbabwe[3]. In 2013, the Alliance supported key populations advocacy in 24 countries and supported in-country partners in 31 countries to advocate for the participation of key populations on national HIV/AIDS funding and planning mechanisms, such as the Global Fund Country Coordinating Mechanisms etc.

In addition, in 2013 1.1 million people were offered *care and support* – a doubling compared to 2012. The Alliance ensured access to antiretroviral treatment and followed people to ensure adherence. It also provided voluntary counselling and testing to almost 950,000 people representing an increase of 60% compared

Reaching out to men who have sex with men

Through the Men's Sexual Health and Rights Programme in Africa (SHARP), the Alliance has demonstrated innovative approaches to reach this specific target group with services.

Kenya: An interactive radio show on men's health and HIV developed by an Alliance partner was broadcasted by a regular radio station. Listeners were invited to call in or send text messages with their concerns resulting in 820 calls and 1,500 text messages. The audience was estimated at 10,000.

Tanzania: The local partner conducted a community mapping in Dar es Salaam in order to identify the best spots to conduct outreach services. The local Alliance partner linked up with the National Referral Hospital and used a mobile van to place outreach clinics in spaces which were considered to be safe. The van offered information, voluntary counselling and testing and delivered health kits. 392 men from the target group used the van.

[3] The targeted project support is covered by a separate agreement, not by the organisation strategy.

to 2012 and a defined package of targeted HIV prevention activities to more than 760,000 people from key populations. Through these and other activities, the Alliance reached 6.7 million people in 2013 (up from 4.6 in 2012), including 3.7 million women and girls[4].

Outreach services to affected communities have been increased by scaling up integrated HIV/sexual and reproductive health and rights and HIV/ tuberculosis programmes, addressing people's broader health needs. It provided 1.2 million people, primarily in Sub Saharan Africa, with these services. The risk connected to injecting drug use is an area which is neglected in Sub Saharan Africa, yet contributing to the spread of HIV. In Kenya, the Alliance supported the establishment of needle exchange programmes, enabling people who inject drugs to access clean needles and syringes. In spite of the modest number of drug users reached through this initiative (140 in 2012) such a programme contributes to breaking the taboos surrounding drug use and HIV.

The Alliance has a strong track record of *capacity building* of local partners. The secretariat and technical support hubs have provided technical assistance to often young and inexperienced civil society organisations equipping them with the skills and competences to become a part of the national response. Capacity building of local partners plays a key role in enabling the Alliance achieve the above increased achievement rates.

Through its work and related data collection mechanisms, the Alliance contributes with reliable and comparable *data on social behaviour and social change indicators*. Such data is much need in a situation where studies based on randomised controlled trials – testing medical efficacy or the effect of e.g. safe male medical circumcision – dominate the debate [5]. This ability to maintain a focus on evidence based work with behaviour change makes the Alliance a valuable partner in the global HIV/AIDS response.

Mode of Operation

The Alliance model is based on so called 'Community Action' programmes. This means that people and communities are engaged to deliver services, take leading roles and are mobilised socially and politically; that programmes are responding to community priorities. The Alliance grants funds to linking organisations, which then support other non-governmental and community-based organisations within their countries. On occasion, the Alliance can also choose to grant funds directly to programme-implementing organisations. The Alliance has a comprehensive onward granting policy which pertains to the linking offices. A procedures manual outlines the criteria for awarding grants to non-governmental and community based organisations.

Alliance linking organisations are assessed every four years on a set of standards covering governance and sustainability, organisational management and HIV programming. The *accreditation system*, established in 2008, is performed by an assessment team from peer organisations and is overseen by an Accreditation Committee with members from the Alliance's senior management and the linking organisations. The system guides the admission of new linking organisations and maintains standards for existing ones (see Annex 3 for a graphic illustration of the accreditation process). By the end of 2013, 82% of the Alliance's linking organisations

[4] 'Strategic Results 2013' International HIV/AIDS Alliance, June 2014.

[5] Hsieh A. C. *et al*. (2014). Community and service provider views to inform the 2013 WHO consolidated antiretroviral guidelines: key findings and lessons learnt In *AIDS* 2014, Vol. 28 (Suppl 2).

had been accredited. In addition to the accreditation system, the Alliance uses a due diligence approach to review new organisations considered as implementing partners for the delivery of particular programmes.

The Alliance Contract and Agreements team overseas programme delivery. The Contracts and Agreements team works closely with other teams including the Legal Risk and Compliance team (which includes internal audit and accreditation) and the Best Practice Unit to ensure capacity gaps are addressed.

The Alliance Finance and Audit Committee monitors the organisation's financial performance and assesses organisational risk. The Committee oversees the Alliance internal audit, risk management functions and the statutory audit. The Alliance Critical Risk Register is updated regularly. The Alliance completes risk assessments on all large or complex contracts. Risk management approaches and systems are introduced to Alliance linking organisations via a programme of training and mentoring. Instances of fraud or mismanagement are investigated on a case by case basis, overseen by the Alliance Legal, Risk and Compliance team and reported to the relevant donor. Alliance organisational policies, including Anti-fraud and Whistle Blowing policies, ensure that there are safeguards in place to minimise fiduciary and corruption risk.

2.4. Effectiveness of the organisation

The work of the Alliance has been subject to a number of external evaluations and assessments. The most recent being DFID's *The Independent Progress Review* (Oct. 2012). The review found that the cascade of interventions facilitated by the Alliance secretariat, linking offices and partners are highly relevant for the hard-to-reach populations and that the data generated by the Alliance are 'credible, valid and reliable'. Furthermore the review assessed the Alliance to be a leading global player in addressing the rights of key populations and that the Alliance had 'enormous impact' on the capacity development of its partner organisations. The review called for a better qualification of the aggregated 'number of people reached by Alliance activities' and this concern has been addressed in 2012 when the Alliance began to develop an enhanced strategic results framework with indicators aimed to build an evidence base around coverage (outreach to key populations through a defined package of services), access to services; retention in care, behavioural outcomes, vulnerability (e.g. violence, social integration, family support) and financial independence and leadership.

A 2013 World Bank evaluation of the impact of the community response to HIV/AIDS[6] found that community mobilisation is vitally important in the achievement of long term HIV and health outcomes – particularly in reaching people at higher risk of HIV and changing social norms and practices. This supports the Alliance theory of change. The World Bank evaluation highlighted that investments in communities have produced significant results including improved knowledge and behaviour, use of health services and decreased HIV incidence.

In 2007, 75% of Alliance total income was channelled via the secretariat. Today more than two thirds of funding is allocated directly to linking organisations representing an increase from 60% (2011) to 72% (2013). This is a reflection of changing donor preferences and of increased capacity of the linking organisations in direct resource mobilisation, grant management and effectiveness. In order to adjust to a changed funding environment and to invest in Southern institutions, the Alliance restructured in 2013. Through this exercise the

[6] Rosala Rodriguez-Garcia, David Wilson, Nick York, Corrine Low, N'Della N'Jie and Rene Bonnel: 'Evaluation of the community response to HIV and AIDS: Learning from a portfolio approach' AIDS Care: Psychological and Socio medical Aspects of AIDS.

cost base was reduced in line with the anticipated level of non-earmarked funding. The secretariat was reduced from 110 to 94 staff members representing a cost saving of US $ 1 million a year. Secretariat administrative costs have also declined in terms of percentage of total spending and in absolute terms from 10% (2009) to 5% (2013). The additional funds were invested in initiatives to enhance organisational effectiveness and efficiency.

3. Key strategic opportunities and challenges

3.1. Relevance and justification of future Danish support

There is a solid concord between Danish priorities and the Alliance's mission. As stipulated in *The Right to a Better Life: Strategy for Denmark's Development Cooperation* (2012), Denmark will be at the forefront of international efforts to address HIV and to promote sexual and reproductive health and rights. In *Strategy for Denmark's Support to the International Fight against HIV/AIDS* (2005) emphasis is put on a human rights-based approach. The 2011 *Review of Denmark's Support to the Response to HIV/AIDS* recommended direct support to population groups at high risk of HIV rather than mainstreaming support to broader population groups. The Alliance's work is based on the principle that these groups should participate fully in decisions affecting their health and be able to claim and exercise their human rights. Vulnerable, marginalised and socially excluded groups are actively and openly supported by the Alliance to participate in decision-making and to take action against punitive laws, stigma, discrimination and vital inequalities. This approach is in line with the *Strategic Framework for Gender Equality, Rights and Diversity in Danish Development Cooperation* (2014).

The Alliance also contributes to the fulfilment of the Danish strategy The Promotion of Sexual and Reproductive Health and Rights (2006). Over the past years, the Alliance has increased efforts at integrating HIV and sexual and reproductive health and rights, tuberculosis etc. and linking civil society provision of care to the national health care system. The Alliance is in the process of strengthening its partnership with Marie Stopes Int. to reach more people with integrated services.

3.2. Major challenges and risks

Stigma and discrimination remains a major challenge for the response to the HIV pandemic in low and middle income countries. At global and national level, there is increasing hostility towards the human rights of population groups most affected by HIV including homosexuals, people who inject drugs, commercial sex workers and prisoners. Punitive laws hinder those most at risk from seeking essential services such as testing and counselling. It constitutes an impediment to a human rights based approach to delivery of HIV services. The Alliance addresses this challenge through global advocacy and through the work of linking organisations and other civil society partners on the ground, working to minimise stigmatisation and discrimination.

Working with and for the rights of marginalised, stigmatised and at times criminalised population groups runs the risk of unintentionally exposing those intended as beneficiaries as well as the civil society organisations working to improve conditions for the most marginalised to risks in the form of threats, negative attention by the public and/or authorities etc. These risks are factored into the risk analysis performed when planning specific initiatives and monitored closely by the Alliance and its partners.

A challenge in terms of maintaining the global HIV response lies in the level of funding available, both in terms of donor funding and domestic resources. There are signs that donor funding commitments specifically for

AIDS are declining as donor assistance for the pandemic have reached a plateau. These changes have occurred in tandem with an economic downturn and an increasingly aid sceptic public discourse globally. At the same time there is little evidence to indicate that countries are using their own resources to meet particularly the needs of key populations. The Alliance advocacy and community mobilisation approach equips particularly marginalised and vulnerable groups, including women and youth to demand health services and information.

Whilst these challenges remain, the Alliance strategic advantage can be found in the growing evidence base to support work with key populations (most recently in the UNAIDS 2014 *The Gap Report*). The Alliance's unique experience with capacity development of civil society organisations and communities and human rights based approach puts the organisation in a strategic position to become a partner for donors.

4. Priority results to be achieved

HIV, Health and Rights: Sustaining Community Action 2013-2020

	Result	Response
1	**Healthy people**	*Increase access to HIV and health integrated programmes;*
2	**Strong health and community systems**	*Support community-based organisations to be connected and effective elements of health systems;*
3	**Inclusive and engaged societies**	*Advocate for HIV, health and human rights;*
4	**Making it happen**	*Build a stronger Alliance.*

The priority results for the Danish organisation strategy focus on the Alliance's contribution to *The Right to a Better Life* and to the Danish HIV/AIDS strategy. Under the Alliance strategy's four results and responses, the involved communities will be given a chance to contribute to ending AIDS through local, national and global action on HIV, health and human rights (MDG 6), and through this contribute to maternal and child health (MDG 4 and 5).

In support of the above four Alliance result areas, Denmark will place its strategic focus on.

a) **Continued support to the Alliance's work with key populations and marginalised groups.** Denmark will work with and through the Alliance to address the rights of key populations and other marginalised groups including women and youth to access information and services on equal terms as everyone else.

b) **Provision of quality and integrated HIV and health services:** Denmark will support the efforts of the Alliance to promote integrated services, comprehensive sexuality education and youth friendly services and to provide a defined package of targeted HIV prevention activities with a focus on key populations.

c) **Continued institutional reform process with the aim of creating a stronger Alliance.** Denmark will follow the Alliance's ongoing efforts at improving the efficiency, effectiveness and added value of the organisations towards the linking organisations and local civil society, incl. optimisation of systems and resources; support the accreditation process of linking organisations and to continue the improvements in linking organisation governance, organisational development and standard of programming.

d) **Sustained efforts to combat corruption and misuse of funds.** Denmark will support Alliance efforts to ensure increased rigour and transparency in grant-making through the consistent implementation of the onward granting policy; the continued work with accreditation procedures; and continued work with reviewing the systems and controls put in place to mitigate risks of grant-making.

5. Monitoring and reporting

In accordance with the MFA guidelines for Management of Danish Multilateral Development Cooperation, Denmark will use the Alliance monitoring and reporting framework, including financial reporting and not produce specific Danish progress reports. The Alliance will submit an annual report on its strategic results as well as annual, audited accounts. The current Alliance strategy runs until 2020. Given this rather long time-frame, targets are set for three years at a time. Current targets cover 2013-2015 upon which new targets are set. This allows the Alliance to adjust its course of action in light of the rapid development of the HIV pandemic.

Donors are not represented on the Alliance Board of Trustees, hence limiting direct influence on the strategic choices of the Alliance. However, a combination of formalised and non-formalised dialogue between the Alliance and its donors presents the avenues of influence. A donor meeting is held on an annual basis. The meeting is typically attended by technical staff from the development policy and the technical advisory departments of the Ministry of Foreign Affairs. The annual donor meeting is a key opportunity for the Ministry of Foreign Affairs to pursue the strategic dialogue with the Alliance senior management and technical teams. This is coupled with ad-hoc telephone/video conferences on specific issues when required. The donor meetings also offer an opportunity for strategic discussions with the other donors to the organisation. Denmark will work closely with like-minded countries towards the achievement of the specific priorities.

The Alliance's general M&E system has been developed over the past ten years and has in particular focused on supporting linking organisations in the efforts to improve M&E capacity according to the standards set in the accreditation process (such as collection of financial data and on evidence of outreach and impact). Due to the diversity of the linking organisations and their working environment, a so-called segmented approach is taken by the Alliance. This means that more detailed requests are being made to the eight largest linking organisations compared to the smaller ones.

6. Budget

The proposed budget for the Danish core contribution to the Alliance 2014-2017 is shown below with indication of commitments and annual releases.

Indicative budget for Denmark's engagement with the Alliance[7]

	2014	2015	2016	2017
Commitments in DKK millions	20		20	
Disbursements in DKK millions	10	10	10	10

[7] The numbers for 2016-2017 are preliminary and subject to parliamentary approval.

In addition to the core funding covered by the present organisation strategy, Denmark provides earmarked funding (DKK 25 million 2012-15) for the implementation of the Sexual Health and Rights Programme (SHARP). The earmarked support was provided to enable the Alliance pilot new approaches to working with key populations; approaches which may subsequently be scaled up and integrated into the Alliance main programme of action. Denmark's ability to work pragmatically through a combination of support modalities has been key to Alliance strategic learning in this regard.

In 2013 the wider Alliance global partnership spending (the collective finances of the Charity and the independent linking organisations) was split between the secretariat (28%) and the linking organisations, technical support hubs etc. (72%). The total income of the Alliance Secretariat was 37.3 million USD in 2013. Denmark's contribution in 2013 was 7% of the Alliance total income[8]. Other donors include DFID, USAID, the Netherlands, Sweden, Norway, EU and the Global Fund (see annex 5 for details).

6. Summary results matrix

This framework is based on the Alliance's own results framework, but only reflects aspects which will be used to monitor the Danish core support.

	Intended Results	**Indicators**	**Baseline**
Goal: To contribute to the end of AIDS through local, national and global action on HIV, health and human rights			
Priority Area 1: Support the efforts at offering quality HIV and health services.			
Objective 1: Improved health outcomes for key populations and those most affected by HIV/AIDS as a result of community action	1a) Increase in % of people living with HIV who initiate treatment early and adhere to ART in a sample of 5 Alliance countries by 2015 1b) Decrease levels of unmet family planning needs among youth (10-24s) affected by HIV in a sample of Alliance countries by 2015	1a) % of people living with HIV who initiate treatment early and adhere to anti-retroviral treatment. 1b) A sample of Alliance countries experience a decrease in unmet need for family planning among youth affected by HIV	1a) % of people living with HIV in 2012 who initiate treatment early and adhere to ART in a sample of 5 Alliance countries. 1b) Levels of unmet family planning needs among youth affected by HIV in a sample of Alliance countries
Output 1.1 Increased access to HIV and health services by key populations and those most affected by HIV/AIDS	1.1.1) 1,000,000 people in key populations in 2015	1.1.1) Number of people reached with a defined package of targeted HIV prevention activities[9], with a focus on key population groups	1.1.1) 478,927 people in key populations (2012)
	1.1.2) 800,000 adults and children in 2015	1.1.2) Number of adults and children with HIV enrolled in HIV care services.	1.1.2) 455,637 adults and children (2012)
	1.1.3) 740,000 women and men 15-49 in 2015	1.1.3) Number of women and men 15-49 who received an HIV test.	1.1.3) 588,700 women and men 15-49 (2012)

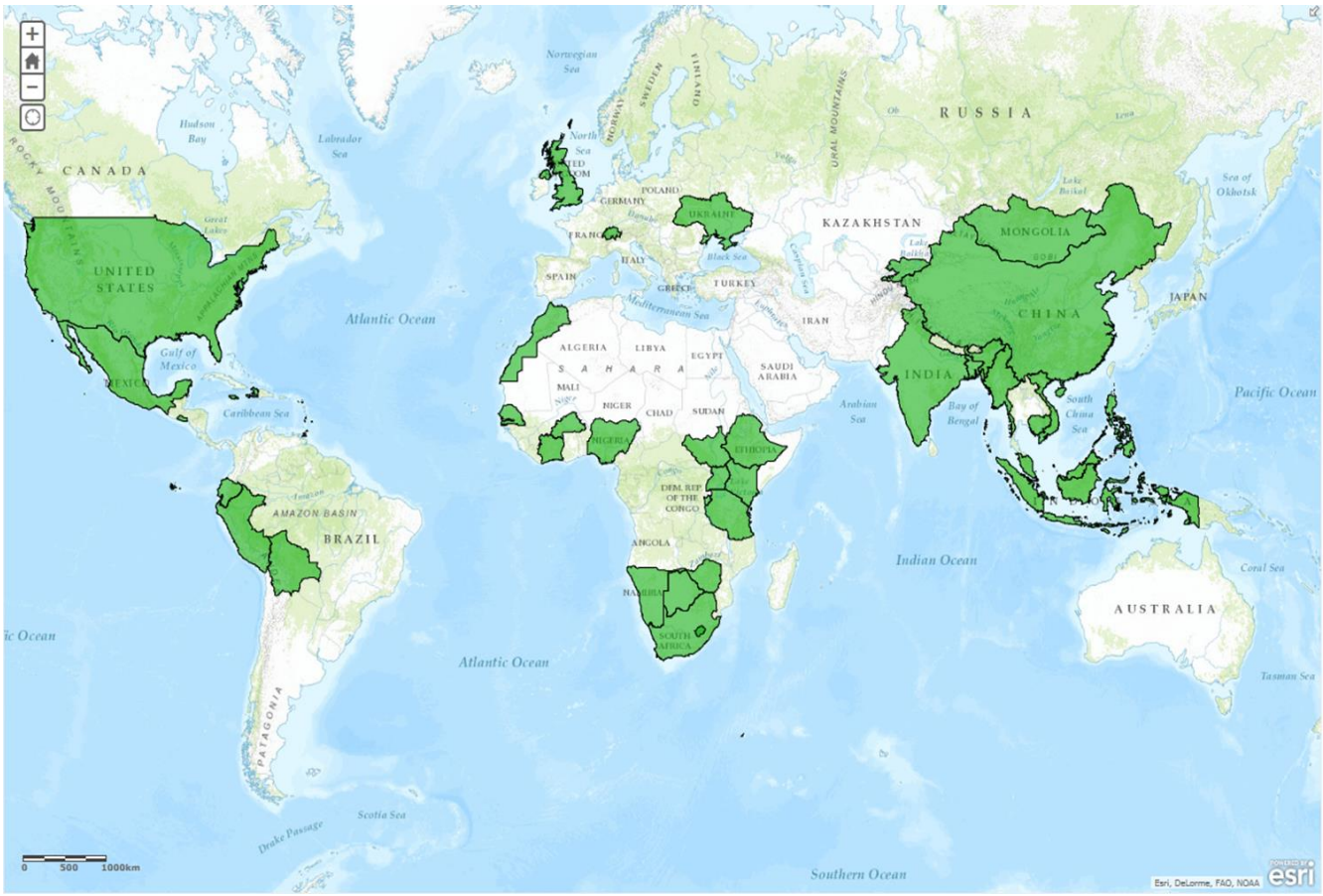
[8] Includes both core (66%) and earmarked, SHARP contribution (34%).

[9] This will be disaggregated by the following four groups: MSM, transgender, sex workers, or injecting drug users

Output 1.2 Increased integration of HIV programmes into broader health services, particularly SRHR and TB Services	1.2.1) 1,100,000 in 2015	1.2.1) Number of people / key populations reached with an integrated HIV/ SRHR/TB services	1.2.1) 757,910 (2012)
Priority Area 2: Continued support to the Alliance's work with key populations.			
Objective 2: Greater inclusivity and engagement around the rights of key populations and those most affected by HIV/AIDS	3.a) 10 Alliance countries by 2015	3. a) Globally and in a number of Alliance countries, the Alliance's community and global action achieves verifiable progress towards policy goals related to HIV, health and rights	1) 0 Alliance countries[10] (2012)
Output 2.1: In more Alliance countries, communities advocate for changes to improve access to quality, affordable health services and promote human rights	24 countries supported by 2015	Number of countries where the Alliance has supported key populations' advocacy for HIV, health services and rights	14 countries supported (2012)
Output 2.2: Violence and discrimination against key populations recognised and addressed	21 CBOs and networks by 2015	Number of CBOs and networks supported by the Alliance to monitor and report on human rights-related barriers to access to HIV and health services	3 CBOs and networks (2012)
Priority Area 3: Continued institutional reform process with the aim of creating a stronger Alliance			
Objective 3: Stronger Alliance partnership of accredited national LOs that are improving, learning and innovative	70% in 2015	% of LOs that show documented improvements in their governance, organisational development, or standard of programming	60% (2012)
Priority Area 4: Sustained efforts to combat corruption and misuse of funds			
Objective 4: Improvement with regard to minimising risk of corruption and misuse of funds.	To ensure increased rigour and transparency in the management of funds through the consistent implementation of the monitoring and reporting system.	1) Results of internal controls conducted; (internal audits available on request); 2) Results of regular reviews of LOs spending and on-site audits; 3) Results of annual financial audits.	

[10] Baseline is 0 due to new Alliance approach to measuring policy goals

Annex 1: Alliance Secretariat and Linking Organisations 2014



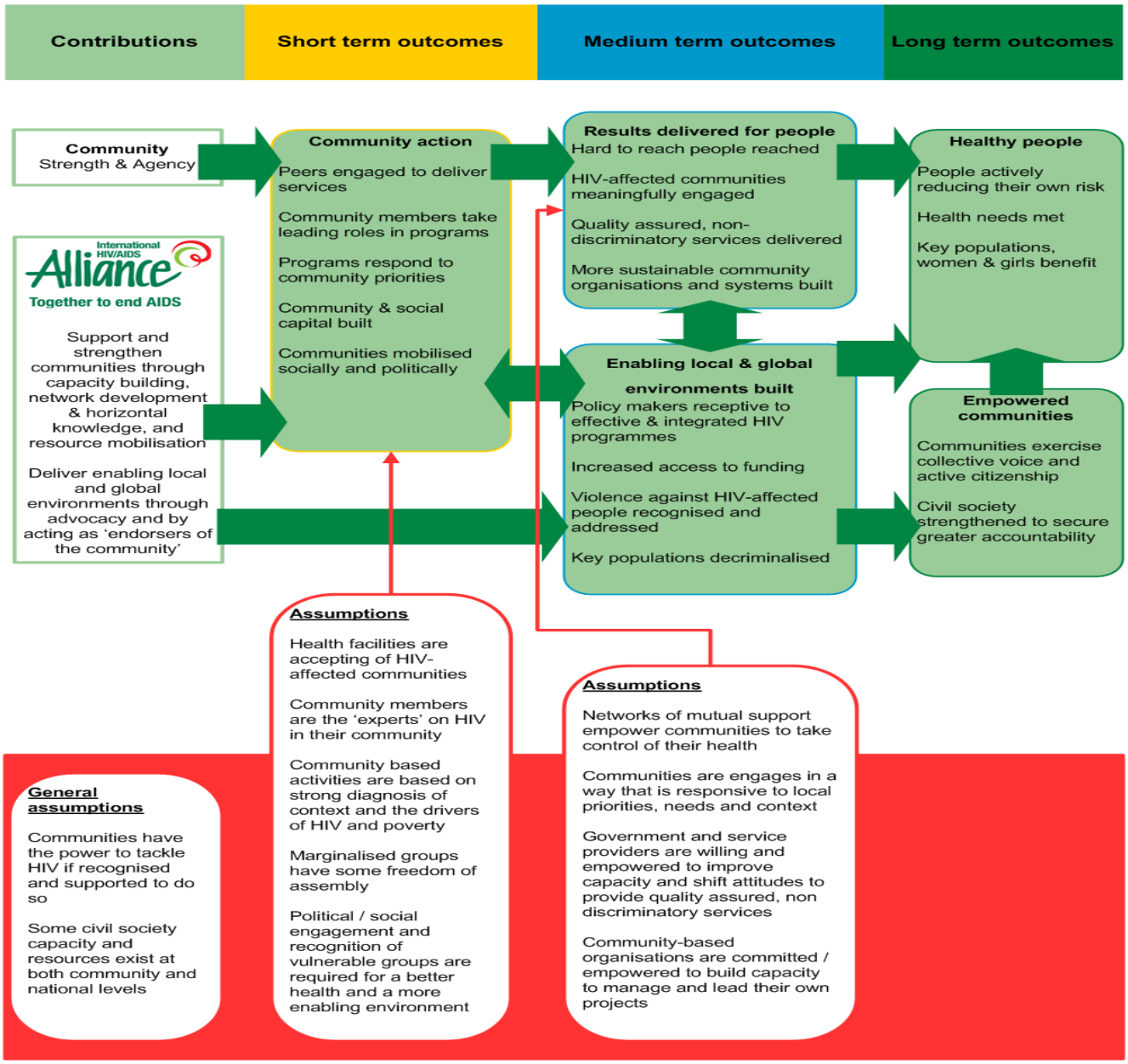
Alliance Country Offices
International HIV/AIDS Alliance in Myanmar

Alliance Linking Organisations	Country
HASAB (HIV/AIDS and STD Alliance Bangladesh)	Bangladesh
Instituto para el Desarrollo Humano (IDH)	Bolivia
Botswana Network for Ethics, Law & AIDS (BONELA)	Botswana
*Initiative Privée et Communautaire Contre le VIH/SIDA (IPC)	Burkina Faso
Alliance Burundaise Contre le SIDA (ABS)	Burundi
*Khmer HIV/AIDS NGO Alliance (KHANA)	Cambodia
Caribbean HIV/AIDS Alliance (CHAA)	Caribbean
AIDS Care China	China
Alliance Nationale contre le SIDA en Cote d'Ivoire (ANS -CI)	Cote d'Ivoire
Corporacion Kimirina	Ecuador
Atlacatl	El Salvador
Organization for Social Services for AIDS (OSSA)	Ethiopia

Promoteurs de l'Objectif Zerosida (POZ)	Haiti
Humsafar Trust	India
*India HIV/AIDS Alliance	India
LEPRA Society (LEPRA)	India
Health Institute for Mother and Child (MAMTA)	India
Vasavya Mahila Mandali (VMM)	India
Rumah Cemara	Indonesia
*Kenya AIDS NGOs Consortium (KANCO)	Kenya
Anti-AIDS Association (AAA)	Kyrgyzstan
Malaysia AIDS Council (MAC)	Malaysia
Colectivo Sol (ColSol)	Mexico
National AIDS Foundation (NAF)	Mongolia
Association Marocaine de Solidarité et Développement (AMSED)	Morocco
Positive Vibes	Namibia
Network on Ethics, Law, HIV/AIDS, Prevention, Support & Care (NELA)	Nigeria
*Via Libre	Peru
Philippines NGO Support Program (PHANSuP)	Philippines
Alliance Nationale Contre le Sida (ANCS)	Senegal
AIDS Consortium	South Africa
Alliance Community Health Initiatives (ACHI)	South Sudan
TACOSODE	Tanzania
*Alliance Ukraine	Ukraine
Community Health Action Uganda (CHAU)	Uganda
SCDI	Viet-Nam
Zimbabwe AIDS Network (ZAN)	Zimbabwe
Instituto para el Desarrollo Humano (IDH)	Bolivia

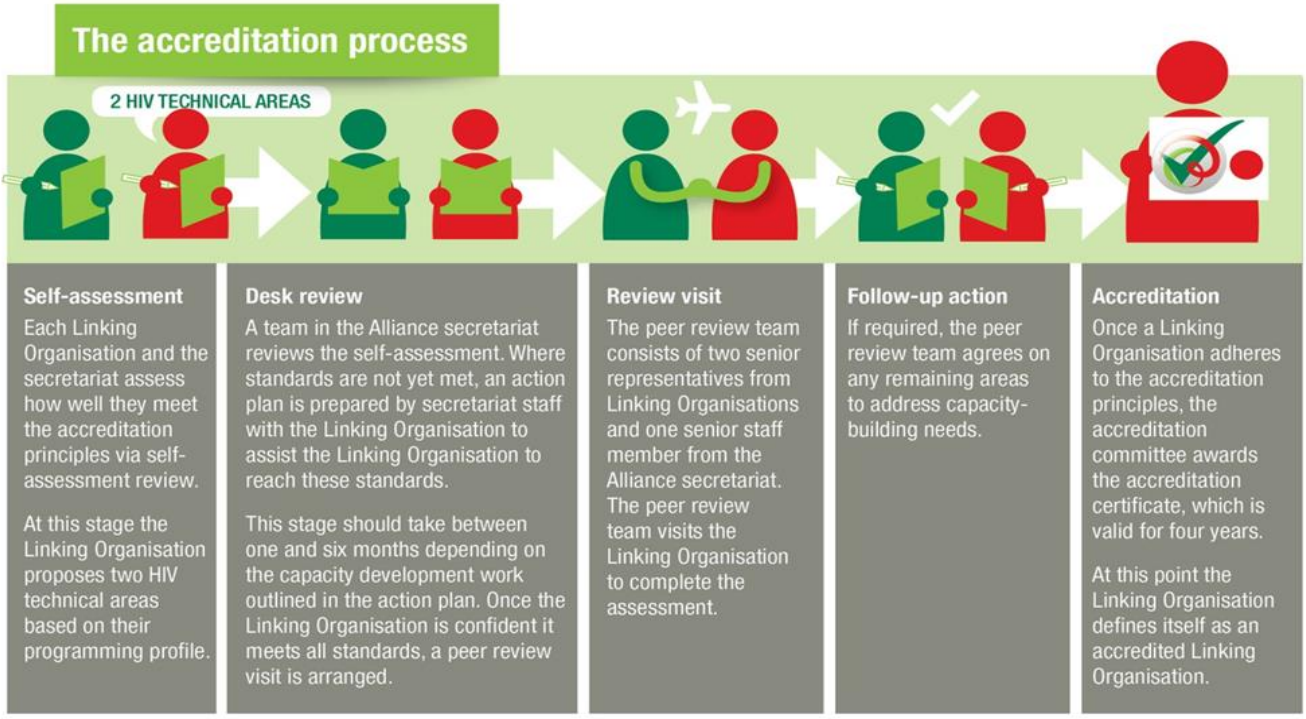
**Linking Organisations hosting a regional Technical Support Hub.*

Annex 2: The Alliance Theory of Change



Source: IHAA & LSE (2012).Towards a theory of change: Report on an interview study of the International HIV/AIDS Alliance.

Annex 3: The accreditation process



Annex 4: Financial forecast and expected expenditure 2014-2016

The financial forecast shows an anticipated reduction in income from 2014 – 2016. These conservative projections are based upon the Alliance scenario analysis model, which aims to forecast income for the next three years. This model is updated every 6 months. The projections are based upon both signed funding agreements and expected future funding pipeline analysis. The pipeline only contains known future funding opportunities, as opportunities become available projected income in 2015 and 2016 will grow. Therefore, the total funding gap in 2015 and 2016 will reduce as funding is secured. These figures are based on the April 2014 Alliance Finance and Audit Committee reports.

Financial forecast International HIV/AIDS Alliance Secretariat 2014-2016 in USD

	International HIV/AIDS Alliance		
	2014 (Forecast)	**2015 (Forecast)**	**2016 (Forecast)**
Expected Annual Income	**50,109,000**	**40,950,307**	**35,722,257**

Secured income and funding gap 2014-2016 in USD

Year	Total secured income*	Total funding gap	Secured funding + funding gap
2014	47,085,000	-3,024,000	50,109,000
2015	28,978,000	-11,972,307	40,950,307
2016	6,563,000	-29,159,257	35,722,257

* Already signed agreements only. The Danish contributions under the present organisation strategy will contribute to minimizing the gap.

Earmarked vs. core support 2014

Expenses (indicative budget categories by expense item)	Total Budget 2014 $000	Unrestricted 2014 $000	Restricted 2014 $000
Unrestricted grants			
DFID Programme Partnership Arrangements	6,268	6,268	
Sida	3,078	3,078	
Norad	621	621	
Danida	1,829	1,829	
Other unrestricted income	**193**	**193**	

Restricted grants and contracts		-	38,120
Total income	**50,109**	**11,989**	**38,120**

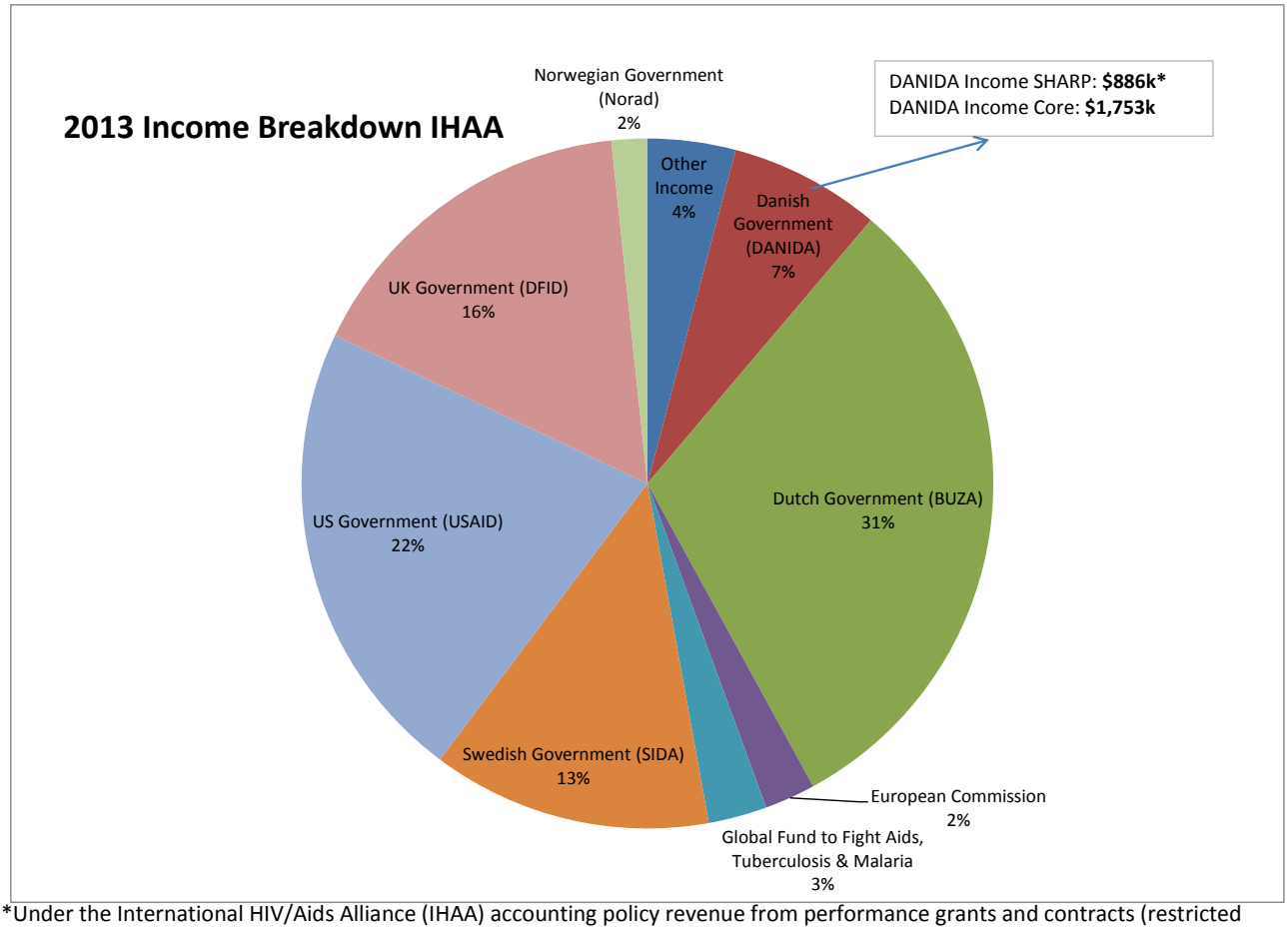
In addition to the above mention donors, the Alliance's donor base include the Dutch government, the European Commission, the German Government, the Global Fund to Fight AIDS, Tuberculosis & Malaria, Iteract Worldwide, Open Society Foundations, the Swiss Government, the Us Government and others.

Administration/overhead cost

In 2013 the Alliance Secretariat overhead cost (Indirect Cost Recovery) was 27.74% as established through USAID audits and broadly accepted by donors providing core funding to the Alliance. Indirect Cost Recovery covers a broad range of important administrative and programme related costs, including 1) overall management, strategic leadership and coordination; 2) external relations (policy, communications, business development, programme impact functions etc.) which are critical to the support of linking organisations, development of best practice interventions, research and global, national, regional and local advocacy; 3) field programmes co-ordination, covering capacity building and organisational development of linking organisations, Alliance accreditation, Technical Support Hubs, grant management, technical and advisory support and lastly 4) corporate services, i.e. IT, finance and HR functions, including support for linking organisations within the Alliance.

Following a restructuring exercise, the IHAA secretariat was reduced from 110 to 94 staff members representing a cost saving of US $ 1 million a year. Secretariat administrative costs have declined in terms of percentage of total spending and in absolute terms from 10% (2009) to 5% (2013).

Annex 5: Donor distribution



*Under the International HIV/Aids Alliance (IHAA) accounting policy revenue from performance grants and contracts (restricted agreements such as SHARP) is recognised only when funds have been utilised to carry out the activity stipulated in the agreement. This is generally equivalent to the sum of the relevant expenditure incurred during the year and any related contributions towards overhead costs. Denmark represented 7% of IHAA income in 2013, 34% of this contribution was through SHARP and 66% through core funding.

2013 income – detailed information for the above chart

Grouped			Grouped	
Australian Government (AusAID)	1000	0%	Other Income	1532913
Big Lottery Fund	50000	0%	Danish Government (DANIDA)	2639063
Danish Government (DANIDA)	2639063	7%	Dutch Government (BUZA)	11515000
Dutch Government (BUZA)	11515000	31%	European Commission	886000
European Commission	886000	2%	Global Fund to Fight Aids, Tuberculosis & Malaria	1022000
German Government (GIZ)	105000	0%	Swedish Government (SIDA)	4879317
Global Fund to Fight Aids, Tuberculosis & Malaria	1022000	3%	US Government (USAID)	8142000
Interact Worldwide	138000	0%	UK Government (DFID)	6069845
Irish Aid	29000	0%	Norwegian Government (Norad)	622861.6
Levi Strauss Foundation	48000	0%		
Open Society Foundations	13000	0%		37309000

Swedish Government (SIDA)	4879317	13%		
Swiss Government	418000	1%		
Uganda HIV Prevention Advocacy Fellowship	8000	0%		
United Nations	102000	0%		
US Government (USAID)	8142000	22%		
Viiv Healthcare	321000	1%		
World Health Organisation	13000	0%		
Other restricted funds	6000	0%		
Other contract income	95000	0%		
UK Government (DFID)	6069845	16%		
Other unrestricted income	185913	0%		
Norwegian Government (Norad)	622861.6	2%		
	37309000			