



Evaluation of the IFRC HIV Global Alliance Programme

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The Red Cross Red Crescent Global Alliance on HIV



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Acronyms and Abbreviations

| | |
|--------|---|
| AIDS | Acquired immunodeficiency syndrome |
| ARCHI | African Red Cross and Red Crescent Health Initiative |
| ART | Antiretroviral therapy |
| ARV | Antiretroviral |
| CBHFA | Community-Based Health and First aid in Action |
| CHBC | Community Home Based Care |
| CCM | Country coordination mechanism |
| FGD | Focus Group Discussion |
| GFATM | Global Fund for AIDS, Tuberculosis, and Malaria |
| GIPA | Greater and Meaningful Involvement of PLHIV principle |
| GNP+ | Global Network of People Living with HIV/AIDS |
| HIV | Human immunodeficiency virus |
| HIV GA | IFRC Global Alliance on HIV |
| IDU | Injecting drug user |
| IEC | Information, education and communication |
| IFRC | International Federation of Red Cross and Red Crescent Societies |
| KAP | Knowledge, attitudes and practices |
| KAPB | Knowledge, attitudes, practices and behaviour survey |
| KII | Key Informants Interview |
| MDG | Millennium Development Goals |
| MF | Masambo Fund |
| M&E | Monitoring and evaluation |
| MoU | Memorandum of Understanding |
| MSM | Men who have sex with men |
| MTCT | Mother-to-child transmission |
| NAC | National AIDS Commission |
| NGO | Non-governmental organization |
| NS | National Societies |
| ONS | Operating (or Host) National Society |
| OVC | Orphans and Vulnerable Children |
| PATS | Planning, Performance management and Accountability Tracking System |
| PLHIV | People living with HIV |
| PMER | Planning, monitoring, evaluation and reporting |
| PNS | Participating National Society |
| PR | Principle Recipient (of Global Fund grants) |
| RCRC | Red Cross Red Crescent |
| RCRC+ | Red Cross Red Crescent Network of People Living with HIV |
| SGBV | Sexual and gender-based violence |
| SR | Sub-Recipient (of Global Fund grants) |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TOR | Terms of Reference |
| TOT | Training of Trainers |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNGASS | United Nations General Assembly Special Session |
| UNICEF | United Nations Children's Fund |
| VCT | Voluntary counselling and testing |
| WHO | World Health Organization |



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Executive Summary

Introduction

1. This report presents the findings, conclusions and recommendations of an external evaluation of the International Federation of Red Cross and Red Crescent (IFRC) Global Alliance on HIV programme (HIV GA). The evaluation purpose was to assess to what extent the HIV GA framework mobilized capacities and resources to provide harmonized, effective support to National Societies (NSs) and partners for the achievement of their HIV programs within the framework of the IFRC's Global Agenda. The evaluation was commissioned by the IFRC Secretariat and was carried out between September 2012 and March 2013.
2. The IFRC was among the very first organizations to engage in the global response to the HIV/AIDS epidemic. The first IFRC AIDS Programme was established in 1988 with the objective of providing NSs with guidance, coordination, technical advice and training. IFRC's work on HIV/AIDS gradually expanded globally and by 1993 more than 110 of the Federation's 151 NSs had implemented HIV/AIDS activities. In 2001, the IFRC joined all major international organization in renewing the commitment to fight HIV/AIDS of UNGASS. During 2000-2005, the IFRC Global Programme on HIV/AIDS built the foundation for a coordinated HIV/AIDS response. A large scaling-up of activities occurred, particularly in prevention programmes for young people and in fighting stigma and discrimination.
3. In 2006, the IFRC launched the Global Alliance on HIV, "*Rising to the Challenge*" and appointed a HIV/AIDS Special Representative. The Alliance aimed at scaling-up the Federation's collective efforts and to double IFRC HIV programming by the end of 2010. The programme expanded rapidly and by the end of 2008, 57 NSs had adopted the Global Alliance approach, developed comprehensive HIV programmes and were implementing HIV prevention, support and care activities. In 2009, the HIV Special Representative role was ended and, following an internal restructuring of the Secretariat, the HIV GA was integrated into a newly established HIV, Malaria & TB Unit in the Health & Social Services department.

Evaluation methodology

4. This evaluation was external, summative in scope and focused on assessing IFRC corporate performance around programme output 4 and IFRC Secretariat support to NSs. Five evaluation objectives and forty-four key evaluation questions framed the evaluation. Mixed methods were used, consisting of desk-review of secondary data, an online survey, telephone and face-to-face key informants' interviews, and videoconferencing focus group discussions. No country visit was conducted due to time and funding limitations.
5. Fifty-two HIV GA-related documents, publications, plans and reports were scanned for specific indicators relevant to the objectives of the evaluation using a standardized checklist. Seventy-five respondents participated in the online questionnaire and forty-nine key informants were interviewed in person or over the telephone in the course of the evaluation. Focus group discussions were organized to validate initial findings of the evaluation. Potential methodological limitations of the evaluation include the availability of limited secondary data, the lack of a HIV GA mid-term review, and possible measurement and selection bias.

FINDINGS

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HIV GA Programmatic Achievements 2006-2011

6. **The analysis of the available data shows that the RCRC contributes substantially to the global response to the HIV epidemic through HIV NS programs implemented in more than 60 countries.** In 2008-2011 alone, the IFRC and NSs mobilized 125 million CHF and Red Cross Red Crescent volunteers contributed an estimated 80 million hours, reaching and serving almost 90 million people. The main asset of the Federation is the decentralized network of volunteers and the capacity of taking action directly with families and communities while at the same time having access to decision-makers and participating in national, regional and global partnerships. A large number of IFRC volunteers and staff have been trained and mobilized in the fight against HIV.
7. **The HIV GA strategic approach through the four programmatic outputs is comprehensive and remains valid.** Currently, the approach does not include NSs contribution to blood safety and it has not been updated since 2006. Meanwhile new prevention and treatment strategies and approaches have been introduced at international level.
8. **The HIV GA prevention strategies have evolved.** Awareness raising has shifted from increasing the knowledge of the general public, (especially youth), to the more effective approach of addressing the specific needs of target populations at higher risk of HIV transmission. The care and support provided by IFRC volunteers and staff to orphans, vulnerable children, and PLHIV and their families have extended and improved the lives of hundreds of thousands of people across the world. In light of increased access to ART, NS are now placing more emphasis on psychosocial support and promoting adherence to treatment.
9. **Results in fighting stigma and discrimination have been mixed.** The RCRC+ network provided greater impetus in making the RCRC a better home for PLHIV. However, the closure of the Masambo Fund and the much reduced collaboration with GNP+ and UNAIDS signal a worrying reduction in attention to this important problem. Limited and fragmented progress is seen in addressing gender and violence issues.
10. **The HIV GA succeeded in establishing an HIV performance monitoring system across the IFRC and mobilizing a large number of volunteers. However, results in resource mobilization have been disappointing.** Only an estimated third of the funding requested through the HIV GA appeals was actually mobilized. However, a few National Societies have been quite successful in mobilizing resources and scaling up HIV activities, demonstrating the potential for the IFRC to “do more and do better” in HIV programming. Nevertheless, overall Red Cross Red Crescent HIV programming shows a worrying decline since 2010.

Evaluation objective 1 –overall effectiveness and impact of the Global Alliance

11. **The HIV GA did not achieve its target of doubling HIV programming between 2006 and 2010.** The HIV GA also failed to increase the number of NS with active HIV programmes, and several NS with on-going large and active HIV programmes never joined the Alliance. It is important to note, however, that aggregated global data hides important differences as some countries and regions where HIV programming increased and even doubled in some instances. Southern Africa has seen recently the sharpest decline in resources and activities driving the global figures, while the Americas and Europe have seen substantial increases, demonstrating the potential for the Red Cross Red Crescent to play a larger role in the global fight against HIV.
12. **A combination of external and internal factors contributed to the failed mobilization of additional financial resources for the HIV GA.** Difficulties in resource mobilization were due in part to a changing international environment driven by the global financial crisis and shifting donors’ priorities, and in part to the lack of a HIV GA resource mobilization strategy and a major misunderstanding of who should be responsible for fundraising. This led to confusion,

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misunderstanding, frustration and eventually reduced interest in the programme. In the process, several NS missed important opportunities to raise resources locally.

13. **The HIV GA failed to build a functional partnership with the Global Fund, the main source of HIV funding at country level.** Attempts to develop an agreement at global level with the GF were not successful. Regional and country initiatives did not always receive the required technical support. NSs have become dangerously dependent on PNSs and IFRC funding for HIV activities. As funding is being reduced globally, HIV activities are now at risk.
14. **Some NSs have been quite successful in mobilizing resources for HIV activities, including from the Global Fund.** This was the result of improved capacities in resource mobilization, greater involvement of NS leadership in national HIV coordination mechanisms, and technical support from the IFRC zone offices. It demonstrates the large potential for the IFRC to “do more and better” in resource mobilization.
15. **The HIV GA had a positive effect on the IFRC response to HIV, improving the quality and effectiveness of NS HIV programs through strengthening PMER.** This included developing long term programmes aligned with country plans, standardizing administrative processes, documenting good practices and lessons learned, providing opportunities to exchange experiences and regional reviews and evaluations. The guiding principles of the HIV GA remain valid and relevant and there is convincing evidence that their implementation can benefit the work of the IFRC through improved harmonization, coordination and managerial processes.
16. **The HIV GA failed to capitalize on the established partnerships with UNAIDS and the Network of People Living with HIV/AIDS (GNP+).** However, the RCRC+ Network has been instrumental in reducing stigma and discrimination within the IFRC and setting an example of adherence to GIPA. The positive impact of the HIV in the workplace policy has been felt across the IFRC, leading to improved acceptance of volunteers and staff living with HIV.

Evaluation objective 2 –IFRC Secretariat programme management and support

17. **The level of human and financial resources of the Secretariat continues to decrease and is now insufficient to ensure all the functions of the global HIV programme.** The HIV GA was initially supported by a sufficiently large HIV team based in Geneva and in the Regions. However, after 2009, most of the HIV positions were either abolished or transferred to integrated health teams, the position of Special Representative was closed and HIV positions in the zone offices were terminated or transferred to integrated health programs.
18. **The HIV GA Steering Committee and IFRC HIV Governance Group did not provide the expected policy guidance and oversight to the programme and were dismantled.** This not only deprived the HIV GA of much needed guidance but also signalled a shift in policy and a reduced IFRC commitment to HIV. The Forum of stakeholders met twice and provided a useful platform to exchange experiences and lessons learned.
19. **The Global Alliance on HIV was essentially structured and implemented as a “vertical” programme.** The Red Cross Red Crescent is progressively moving towards integrating HIV resources and activities with other health development programmes. **Integration can be cost-effective and bring important potential gains but also carries risks and challenges.** Benefits of integration include effectiveness and efficiency gains, reduced transaction and operational costs, improved coverage and accessibility of interventions, and better chances of ensuring long-term sustainability. The major risks are a possible dilution of the HIV interventions, which might decrease their effectiveness, and a reduced attention to the social and personal impact of the HIV epidemic. Some specific HIV interventions are difficult to integrate and may still require specific approaches and dedicated resources.

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20. **The HIV GA improved coordination of the IFRC Secretariat in Geneva with zone teams, National Societies and the other key HIV/AIDS actors.** Through the HIV GA, the NS started speaking “the same language” on HIV and reporting against the same common indicators, which led to greater uniformity in the work of the NS. However, the reduction in IFRC staff and resources could limit coordination efforts and lead again to a fragmentation of the IFRC HIV response. **IFRC cooperation and partnerships with international organization have not increased significantly under the HIV GA**, in part due to reduced IFRC capacities and in part to reluctance by some NS to engage with local and international partners.

Evaluation objective 3 –national society capacity development for HIV/AIDS programmes

21. **Support provided by the IFRC was effective in building NS technical and managerial capacities.** Training improved managerial and technical capacities in HIV programming of IFRC staff and volunteers. Capacity building in PMER received special attention to ensure the development of robust NS HIV plans and the regular reporting on the performance of HIV programs. Sustainability of the gains made is under question in light of the reduced availability of resources for capacity building and high staff turnover.
22. **Capacity building for resource mobilization was insufficient and often ineffective.** Efforts by zone teams to support NS in this essential area were sporadic and not systematic, particularly in relation to the Global Fund. Strengthening governance, accountability and leadership of NS was a priority at the start of the Alliance but received much less attention and support after 2009 in light of shifting priorities and the reduced capacities of the Secretariat.
23. **Documentation and guidance produced by the HIV GA were initially useful and appropriate**, though production of materials and their dissemination eventually decreased with the reduction in Secretariat resources. There is an urgent need for guidance on best practices for the integration of HIV activities in community health programmes as well as on approaches to gender issues, working with vulnerable populations, addressing sexual diversity, promoting human rights and addressing stigma and discrimination. **Regional networks are very effective for sharing knowledge and experience, improving NS HIV programming capacities, and ultimately increase the quality and effectiveness of HIV interventions.**

Evaluation objective 4 –the “seven ones”

24. **The application of the “seven ones” principles succeeded in promoting a more harmonised, coordinated and results-focused approach within the IFRC and with external partners.** However, the principles have not been generalized to other programs or institutionalized within the NS or IFRC structures. They remain valid and relevant but the gains made could be lost if commitment and support to their implementation is not maintained.
25. **NS HIV needs assessments were usually conducted using standardized approaches in coordination with national authorities and partners.** Robust needs assessments allow allocating scarce resources where they are most needed and effective, building synergies and efficiencies with other partners, and reducing the risk of duplication and wastage. NS do not require specific needs assessment tools or studies as the information is usually available from the government or local partners.
26. **NS HIV programme documents were usually aligned with IFRC GA Global Strategies, coherent with national AIDS strategies and developed in consultation with other national or international partners.** However, due to the pressure to meet the Alliance launch deadlines, it was not always possible to complete all steps of a robust and consultative planning process. It is also worth noting that an excess of standardization might have led to plans that did not adapt completely to the specific country context and/or NS implementing capacities.



27. **The HIV GA division of labour led to some increase in efficiency but did not have the required support, or last long enough, to make a real difference and ensure its sustainability. The HIV GA division of labour clearly failed in resource mobilization,** where a major misunderstanding on roles and responsibilities for fundraising led to frustration and disappointments, and missing of potential funding opportunities.
28. **The HIV GA was not successful in establishing a common financial framework** as demonstrated by the difficulties in accessing detailed information on the mobilization and utilization of HIV financial resources. The scope and functioning of the financial framework was unclear and might have contributed to the misunderstanding in terms of resource mobilization.
29. **The HIV GA performance monitoring system can be considered a success, though it has limitations and could be simplified and improved.** Establishing a common global performance tracking system was one of the most innovative and successful aspects of the HIV GA. Its implementation in more than 60 countries proved its benefits but also identified limitation and weaknesses. Reduction in funds and dedication staff are threatening the sustainability of the reporting system.
30. **Attempts to reduce the NS reporting burden through a common reporting mechanism had limited success.** While some PNS agreed to a common format for HIV GA reporting, extending the common system to other donors proved difficult. Use of electronic data collection tools is not widespread and data collection and reporting continues to be major burden for NS volunteers and staff.

Evaluation objective 5 –harmonization and sustainability with IFRC secretariat

31. **The HIV GA provided a “proof of principle” on the benefits of improved harmonization and coordination between the Secretariat and NS.** However, this requires the commitment and support from the IFRC management and governance. Though Strategy 2020 supports the role of strategic and operational alliances, there is no evidence of plans to establish new global alliances. Except for the area of performance monitoring and evaluation, IFRC is not taking advantage of the HIV GA experience to redirect its work on HIV/AIDS or expand the application of its guiding principles.
32. **Planning, monitoring and evaluation of the Secretariat-level HIV activities were poorly developed when compared to the structured approach applied to NS HIV programs.** The Secretariat did not develop detailed strategic and operational plans with activities, targets and monitoring indicators. Regular reviews and mid-term evaluations were not planned. Better planning might have facilitated resource mobilization and the sustainability of the programme by securing commitment at senior level.
33. **The HIV GA ended in 2011 and no formal decision about the possible extension or termination of the programme for 2011-2015 has been communicated.** Consequently, there is uncertainty among staff, volunteers and partners about the future of HIV work in the IFRC. Many of the activities included in the HIV GA framework are being scaled down or have stopped altogether. The current human and financial resources of the Secretariat do not allow the provision of much needed support to NS, nor ensure the continuation and expansion of collaboration with partners and donors.
34. **There is concern and frustration with the perceived reduced attention and commitment to HIV work by the IFRC.** This is related to and reflected in the uncertainty about the status of the programme, the reduction in staff and funding for HIV activities, and the much reduced emphasis on HIV/AIDS in the most recent IFRC public statement and official documents, including IFRC Strategy 2020. **There is an urgent need to clarify the status of the HIV Global Alliance and the strategic direction for the future IFRC involvement in HIV/AIDS.**



CONCLUSIONS AND RECOMMENDATIONS

35. The Global Alliance on HIV was an ambitious, well-structured attempt to scale-up and expand IFRC contribution to the global fight against HIV/AIDS while at the same time improving and harmonizing some of the internal IFRC working mechanisms. Initially, the HIV GA progressed quickly supported by the Secretariat staff, IFRC senior management and NS leaderships. The Alliance developed the programme strategic and operational approaches, supported the development of harmonized NS HIV Programme Documents, organized regional launches and appeals, and established the HIV performance tracking system.
36. **The HIV GA introduced important positive changes to the way in which the IFRC worked collectively on HIV, but the programme was short-lived, making it unlikely that these changes will be institutionalized and become sustainable over time.** By moving quickly, the HIV GA somehow failed to ensure the full ownership and commitment to the programme by PNs and NSs leadership. From 2009, commitment to the HIV GA faded away as priorities within the IFRC senior management shifted and the promised financial resources did not materialize. The HIV GA organizational structure was progressively dismantled and HIV resources and activities were scaled down.

The overall effectiveness and impact of the Global Alliance

37. **The HIV GA was successful in improving the quality and effectiveness of Red Cross Red Crescent work in HIV.** Several NS modified their approaches to increase effectiveness of the interventions, for example by focussing on vulnerable populations or promoting adherence to treatment once most of the PLHIV are provided with antiretroviral therapy. **The HIV GA strategic approach through the four programmatic outputs is quite comprehensive and remains valid** but requires updating on the basis of the lessons learned and of new international guidance.

Recommendation 1: The IFRC should review and update its HIV strategic framework on the basis of the lessons learned from the implementation of the Global Alliance and of new interventions and approaches recommended at international level. Consideration should also be given to:

- ***including in the prevention strategies the role of Red Cross Red Crescent in ensuring blood safety and the recruitment of safe, voluntary and non-remunerated blood donors;***
- ***expanding the output 4 strategies to include approaches for improving the Secretariat's own capacities, resources and accountability, and address the issue of integration and mainstreaming of HIV activities at Secretariat and NS levels.***

38. **The HIV GA failed to mobilize the resources required for scaling up HIV programming, to exploit existing funding opportunities at country level and to establish a functional partnership with the Global Fund.** Declining global IFRC HIV funding puts at risk many established NS HIV programs. Some NSs were successful in mobilizing resources due to improved NS fundraising capacities, a greater involvement of NS leadership in national HIV coordination mechanisms, and technical support from the IFRC zone offices.

Recommendation 2: The IFRC should develop an integrated resource mobilization strategy for HIV, TB and malaria aimed at diversifying the sources of funding, in particular at country level, and building programme sustainability. This will require engaging IFRC and NS governance and leadership in resource mobilization and exploring ways for an efficient approach to fundraising for integrated health programs.

Recommendation 3: The IFRC should establish closer links with the GF Secretariat at global level and encourage NS leadership to engage with CCMs and PRs to identify opportunities

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for NS participation in HIV grants implementation. The Secretariat should update regularly Zones and NS staff on new GF funding opportunities and application modalities.

39. The IFRC failed to capitalize on the established global partnerships with GNP+ and UNAIDS and lost its global leadership role in fighting stigma and discrimination. The RCRC+ network has been instrumental in promoting the involvement of PLHIV in the design and implementation of HIV intervention, making them more responsive to the needs of the target populations.

Recommendation 4: The IFRC should consider re-energizing the global partnerships with GNP+ and UNAIDS based on clear common objectives and practical operational plans. The IFRC should use its mandate and credibility at national and international levels as a leading defender of human rights to reaffirm the importance of the fight against stigma and discrimination of PLHIV and of populations at increased risk of HIV infection.

Recommendation 5: The IFRC should actively support the RCRC+ network and continue promoting the adoption of the Greater and Meaningful Involvement of PLHIV (GIPA) principles by NS worldwide, in collaboration with national and regional networks of PLHIV.

IFRC Secretariat program management and support

40. The organizational structure of the HIV GA in Geneva and in the regions has been dismantled leaving the IFRC with insufficient human resources to ensure that the functions of the IFRC global HIV programme can be adequately performed.

Recommendation 6: The IFRC should review its organizational structure and resource plans to ensure that the Secretariat can ensure the minimum core level of staff and resources to effectively perform the required functions in supporting NS HIV programmes, managing global and regional partnerships, and providing the IFRC with the required strategic and technical guidance on HIV.

Recommendation 7: The IFRC should consider the need to re-establish an oversight and policy advisory body to guide the Secretariat and NS on HIV/AIDS work, with particular attention to sensitive areas like working with vulnerable populations, fighting stigma and discrimination of PLHIV, or the integration of HIV with other health programs.

41. The on-going process of integration of HIV activities with other health programmes carries many potential benefits but also potential risks. Some HIV activities are more amenable to integration while for activities that are highly HIV specific, like working with highly marginalized and vulnerable groups like IDUs or MSM, or tackling the issue of stigma and discrimination, integration could result in reduced effectiveness and impact.

Recommendation 8: The IFRC should assess and document the impact of the on-going process of integration of HIV in health programmes on the efficiency and outcome of HIV interventions. These experiences should be translated into appropriate guidance for NS on how to integrate effectively HIV activities with other health and non-health Red Cross Red Crescent activities and programs, taking into consideration the requirements of some HIV-specific activities.

National Society capacity development for HIV/AIDS

42. The HIV GA was initially successful in building NS technical and managerial capacities supported by the development of quality technical materials and guidance documents. HIV GA regional networks are very effective in sharing knowledge and experience, improving NS HIV programming capacities, and ultimately increase the quality and effectiveness of HIV interventions. With the reduction in staff and resources, particularly at zone level, the support by the Secretariat to capacity building has greatly diminished.

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Recommendation 9: *In light of resource constraints, the IFRC should focus on the most cost-effective approaches to capacity building. This might include continuing to support regional HIV networks, integrating training activities where feasible (e.g. PMER, resource mobilization) and prioritizing support to countries and programmatic areas where the needs are greater and more urgent.*

Recommendation 10: *The IFRC should continue developing technical guidance and documentation in collaboration with partners and based on best practices, assessed needs and specific requests by implementers. There is an urgent need for guidance on best practices for the integration of HIV activities in community health programmes and on approaches to gender issues, working with vulnerable populations, addressing sexual diversity, promoting human rights and fighting stigma and discrimination*

The "Seven Ones"

43. The application of the HIV GA “seven ones” principles improved coordination and harmonization between the IFRC Secretariat, Zone teams, National Societies and other HIV/AIDS actors. NS HIV programme documents were based on robust needs assessments, aligned with IFRC GA Global Strategies, coherent with national AIDS strategies, and developed in consultation with other national or international partners.

Recommendation 11: *The IFRC Secretariat should support and encourage National Societies to update NS HIV Programme Documents as they are essential tools for planning, implementation and monitoring programs, for harmonization and alignment with national AIDS strategies and with corporate priorities, and for resource mobilization. Revised guidance for the preparation of NS HIV Program Documents should be developed based on the acquired experience, revised HIV strategies, and the new institutional framework.*

44. Establishing a common global system to track performance was one of the most innovative and successful aspects of the HIV GA but did not succeed in reducing the burden of reporting to donors. The system could benefit from simplification of some indicators and the addition of measures for outcome and quality. Data quality and sustainability of data collection are becoming major concerns in light of the reduction in dedicated funds and staff.

Recommendation 12: *The IFRC should conduct an in-depth assessment and revision of the HIV GA performance tracking system to document its strengths and weaknesses and draw lessons for future implementation of a Federation-wide performance monitoring system. The review should consider ways for improving the list of indicators and adding measures of quality of services and outcome of interventions, simplifying the data flow including through the use of electronic data collection tool, and integrating HIV reporting with a common IFRC monitoring and evaluation system. As the routine implementation of a universal, reporting system is labour intensive, simpler and cost-efficient sampling methodologies could be considered for collecting HIV specific data.*

Harmonization and sustainability with IFRC Secretariat

45. The HIV GA formally ended in 2011 and no formal decision has been announced on its extension or termination. The perceived reduced IFRC commitment to HIV work is cause of concern among Red Cross Red Crescent staff, volunteers and partners. Activities included in the HIV GA framework are being scaled down or have stopped altogether. Redesigning its global HIV programme would seem the most sensible and best possible way forward.

Recommendation 13: *There is an urgent need to clarify and possibly reaffirm the Red Cross Red Crescent engagement, role and commitment to the fight against HIV/AIDS. The IFRC*

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governance should consider initiating a broad process of internal consultation on the strategic and operational aspects of its HIV work, with the participation of all key players and stakeholders, to build the basis for the development of a new IFRC global HIV programme. The design of the new programme should take into consideration the specific role and mandate of the Red Cross Red Crescent movement, the successful experience of many NS HIV programs, the lessons learned from the implementation of the HIV GA, the changed international funding environment, and the move towards integrated health development approaches.

1. Background and context of IFRC involvement in HIV/AIDS response

1.1 The International Federation of Red Cross and Red Crescent was among the very first organizations to engage in the global response to the HIV/AIDS epidemic. Barely one year after WHO established its Global Programme on AIDS, the 6th General Assembly held in 1987 urged, “...all Red Cross and Red Crescent societies actively to support and ensure cooperation and consistency with their government AIDS control programme” and “...to prevent discrimination against and offer humanitarian support to people who are carriers of HIV, people living with AIDS and their families”. This marked the beginning of the large scale involvement of the Federation in the fight against HIV/AIDS and provided the policy framework for Red Cross Red Crescent’s work in AIDS over the years. The initial commitment towards HIV/AIDS was reinforced by the following General Assemblies in 1991 and in 1993.¹

1.2 The first IFRC AIDS Programme was established in 1988 with the objective of providing NSs with guidance, coordination, technical advice and training. Initially, the Federation’s principal aim was to provide clear and credible information about AIDS to young people in order to change their individual and collective behaviour, a natural choice given that young people make up the largest part of Red Cross Red Crescent volunteers. This was followed by a move towards addressing stigma and discrimination and working in close collaboration with People Living with HIV/AIDS (PLHIV). This was consistent with the IFRC principles and was therefore readily accepted as a policy in 1990, providing a clear mandate to prevent discrimination and to offer humanitarian support to PLHIV, their families and their communities. The IFRC Secretariat was the first international organization in Geneva to establish a workplace policy on HIV/AIDS

1.3 Between 1990 and 1996 the Federation’s work on HIV/AIDS gradually expanded globally through collaboration with the regional delegations and NSs. The strategic plans 1990 - 1996 reoriented the work towards clearly defined areas of operation: training and capacity building, developing IEC materials, control of STIs, blood donor counselling, fighting human rights violations, stigma and discrimination against PLHIVs, networking, monitoring and evaluation. Efforts were made to integrate HIV/AIDS within existing major IFRC activities, including first aid, refugees, and relief health interventions. By 1993 more than 110 of the Federation’s 151 NSs had implemented HIV/AIDS activities.¹

1.4 However, the commitment towards HIV/AIDS started to fade in the second half of the 1990s when only a very few NSs remained truly engaged in HIV/AIDS work. This shift has been attributed in part to competing large emergency relief operations. The consequences of the decline in commitment included the loss of expertise due to the turnover of staff, the lack of systematic institutional memory and a loss of motivation among those working in the field.²

1.5 In 2000, the IFRC joined all major international organizations in renewing the commitment to fight HIV/AIDS that culminated in the 2001 UN General Assembly Special Session on HIV/AIDS

¹ Rapid desk review of HIV/AIDS policies, strategies and programmes of the IFRC.

² 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005.

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(UNGASS). Members of the Federation delegation were very active and visible during UNGASS, which resulted in the IFRC being the only civil society organization mentioned by name in the “Declaration of Commitment”, the UNGASS call to action in recognition of the devastating impact of the pandemic in Sub-Saharan Africa and the threat that it posed to human development.³

1.6 The increased attention to HIV/AIDS was also the result of the *African Red Cross and Red Crescent Health Initiative 2010 (ARCHI)* process, a systematic assessment of African National Societies’ needs and priorities.⁴ ARCHI led to the “Ouagadougou Declaration”, adopted by the 5th Pan African Conference in 2000 and the “Algiers Plan of Action” issued in 2004, committing African NSs to massively scaling-up their responses to the HIV pandemic. Meanwhile, IFRC leadership championed the fight against HIV/AIDS. In November 2000, a position paper on HIV/AIDS was approved by the Board, and the Steering Committee adopted the following decisions:

- to make HIV/AIDS an institutional priority;
- to implement peer senior management education;
- to create a cross-divisional task force;
- to work towards having HIV/AIDS included in all relevant policy by the General Assembly;
- to include HIV/AIDS considerations in all emergency appeals for countries where the HIV/AIDS prevalence is more than 1 % in the adult population.

1.7 At its 13th General Assembly in 2001, the IFRC acknowledged the need for scaling-up HIV/AIDS activities and decided to update its old 1987 HIV/AIDS policy. The new 2002 IFRC policy “addresses the strong recommitment of the International Federation to continuing and scaling-up prevention, de-stigmatization, advocacy and provision of health care and other services related to HIV/AIDS, in particular to vulnerable population.”⁵ The IFRC Governing Board adopted critical policies in sensitive areas such as harm reduction and treatment, established the HIV Governance Group and the Global Programme on HIV/AIDS, and created the “Masambo Fund” to provide access to anti-retroviral therapy and basic health monitoring for Red Cross and Red Crescent staff and volunteers living with HIV. (Box 1)

Box 1: The Masambo Fund

An initiative of the IFRC Governing Board, the Masambo Fund was officially created in 2003 to provide access to anti-retroviral (ARV) treatment as well as related medical care, and social support to RCRC staff and volunteers living with HIV, who would otherwise have no alternative treatments available.

From 2003 to 2012, the Fund mobilized 900,000 CHF from National Societies and staff. It received 219 applications and provided support to 162 applicants through four grant channels: Grant 1 (Antiretroviral therapy and basic Medical monitoring); Grant 2 (Basic health coverage standard); Grant 3 (nutritional support); and Grant 4 “Make a case” to offer specific help if an applicant could not access ART, or was in need of a particular treatment.

The number of applications to the Fund increased consistently over the years, due in part to active promotion by the IFRC, in part to the adoption of the HIV workplace policy by NS. As a result, in 2011 the Masambo Fund was receiving more applications than it could support. Consequently, in April 2011 the MF Board took the decision to freeze any new applications until the pending ones were honoured.

Due to recent changes, in particular the provision of free antiretroviral treatment and basic medical care to PLHIV by Ministries of Health of the countries from which the applicants come, the Masambo Fund Board took the decision to amend the existing granting system. The restructuring consisted of removing grants 1 and 2, reducing the funding period from five to two years, reducing the amount of the grant, and focusing on vulnerable groups when limited funding is available, and prioritizing women as recipients of grants.

³ United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. Paragraph 34.

⁴ African Red Cross and Red Crescent Health Initiative 2010 (ARCHI 2010).

⁵ International Federation of the Red Cross and Red Crescent Societies 2002 HIV/AIDS policy. (Annex B)

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HIV/AIDS Global Programme 2000-2005

1.8 During 2000-2005, the Federation's Global Programme on HIV/AIDS built the foundation for a coordinated HIV/AIDS response within the IFRC.⁶ The programme emphasized the importance and relationship between prevention, the fight against stigma and discrimination and access to care; promoted the importance of PLHIV involvement, and developed programme objectives and target budgets to reinforce a coordinated IFRC response.

1.9 Supported by the Global Programme, a large scaling-up of activities occurred, particularly in prevention programmes for young people and in fighting stigma and discrimination. An innovative global partnership, brokered by UNAIDS, was established with the Global Network of People Living with HIV/AIDS (GNP+) and aimed at joining forces to eliminate stigma and discrimination. This led to the launch on World Red Cross Day 2002 of the anti-stigma campaign "*The truth about AIDS. Pass it on.*" to raise awareness and promote change in attitudes and policies towards PLHIV.⁷

1.10 However, following an initial period of high engagement and considerable effort both by the Secretariat and the field structures, the collective commitment towards HIV/AIDS started declining once again. The decline was attributed to changing priorities, internal restructuring, very high expectations with limited financial support from few committed National Societies, and the priority given to the response to the 2004 Tsunami Emergency.⁸

1.11 The 2005 evaluation Global Programme on HIV/AIDS identified several important weaknesses in its structure and functioning, including the lack of a systematic approach to capacity building; constraints in terms of manpower and resources; the lack of a quality assurance systems; limited progress in mainstreaming of HIV/AIDS, high staff turnover, and limited financial sustainability. The evaluation's recommendations included:

- Ensuring that the IFRC leadership would play a greater role in advocating internally for HIV/AIDS to reinforce the collective commitment of the Secretariat and NSs;
- Continuing to support capacity building, quality assurance, and knowledge management;
- Developing a 5 year strategic plan and yearly operational plans with clear indicators and a functional system for monitoring and evaluation;
- Intensifying efforts in resource mobilization;
- Revising the IFRC operational concept and organizational structures for HIV response;
- Appointing a Special Representative on HIV/AIDS to assist in scaling-up and mainstreaming HIV/AIDS and being responsible for internal and external advocacy.⁸

The IFRC HIV Global Alliance programme "Rising to the Challenge"

1.12 In response to the 2005 evaluation, the Federation entered a new phase with the launch, on World AIDS Day 2006, of the Global Alliance on HIV, "*Rising to the Challenge*" and with the appointment of a HIV/AIDS Special Representative attached to the Office to the Secretary General. In November 2007, the 16th Session of the General Assembly in Geneva "*endorsed the HIV Global Alliance approach which should continue to be rolled out as quickly as possible in all regions*" and called for a broader mobilization of the Red Cross Red Crescent movement to fight HIV/AIDS. Combating HIV/AIDS globally was adopted as a key priority of the Federation's Global Agenda 2006-2010,⁹ recognizing that mobilizing the power of the world's largest voluntary network with

⁶ 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005.

⁷ A Vital Partnership: The Work of GNP+ and the International Federation of Red Cross and Red Crescent Societies. UNAIDS ,2003

⁸ 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005.

⁹ "Rising to the Challenge." IFRC; 2007

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millions of members and volunteers among 187 National Societies could make a difference in the response to the HIV epidemic.

1.13 Recognizing that before 2005 the NS HIV response was often based on the availability of specific donor funding, rather than on a strategic and coordinated plan and activities were rarely integrated with other NS programmes, the main purpose of the Alliance was to provide “An enabling framework to mobilize capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programmes within the framework of the International Federation’s Global Agenda”.¹⁰ By establishing the Global Alliance on HIV and implementing a number of innovative operational principles (Annex C), the IFRC aimed at achieving three broad objectives:

1. Scaling up and expanding the IFRC HIV programming effort in reducing vulnerability to HIV and its impact through three programmatic outputs (i.e. preventing further infection; expanding care, treatment, and support; reducing stigma and discrimination).
2. Strengthening Red Cross Red Crescent national and regional capacities to deliver and sustain scaled up programmes (Fourth “enabling” output).
3. Pilot the new IFRC “global alliances” approach, improving the quality, efficiency and effectiveness of HIV interventions through the application of the “seven ones” principles and the “key guiding principles in HIV GA implementation”.

1.14 During 2006-2008 the programme expanded rapidly, supported by the Secretariat staff in the office of the Special Representative, the HIV/AIDS Unit in Geneva and the zone offices. By the end of 2008, the Global Alliance was launched officially in all the regions (except MENA) and 56 National Societies had adopted the Global Alliance approach, had developed comprehensive HIV programmes and were implementing HIV prevention, support and care activities including tackling stigma and discrimination of PLHIV.¹¹

1.15 In 2009, following an internal restructuring of the Secretariat, the mandate for the Global Alliance on HIV was integrated into a newly established HIV, Malaria & TB Unit in the Health & Social Services department. The office of the Special Representative was dissolved, funding from donor PNS to support the GA secretariat were reduced and staff positions assigned to HIV/AIDS were gradually terminated or transferred to other units.¹² This signalled a policy shift and the commitment of the IFRC to fighting HIV/AIDS seemed to be fading once again.

Summary of the global response to the HIV epidemic 2005-2010¹³

1.16 The implementation of the IFRC Global Alliance on HIV coincided with a period of major developments in the HIV epidemic and in the global response to HIV/AIDS. During 2005-2010, the global incidence of HIV infection stabilized and begun to decline in many countries with generalized epidemics. As shown in Table 1, a total of 2.7 million people acquired HIV infection in 2010, down from 2.8 million in 2005, contributing to the total number of 34 million people living with HIV at the end of 2010, including 3.4 million children less than 15 year. The sharpest declines in the numbers of people acquiring HIV infection occurred in the Caribbean and sub-Saharan Africa, while the number of people newly infected increased in the Middle East and North Africa and in Eastern Europe and Central Asia. Despite these gains, sub-Saharan Africa accounted for 70% of

¹⁰ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 19

¹¹ Consolidated HIV programme performance Global report for 2008.

¹² IFRC HIV GA Comprehensive HIV programme delivery Global report for 2009

¹³ UNAIDS/WHO/UNICEF Epidemic update and health sector progress towards Universal Access. Progress Report 2011

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the adults and children newly infected in 2011, underscoring the importance of continuing and strengthening HIV prevention efforts in the region

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Table 1: Key indicators for the HIV epidemic 2005-2010

| | 2005 | 2010 |
|---|------------------|------------------|
| Number of people living with HIV (in millions) | 31.0 | 34.0 |
| Number of people newly infected with HIV (in millions) | 2.8 | 2.7 |
| Number of people dying from AIDS-related causes (in millions) | 2.2 | 1.8 |
| % of pregnant women tested for HIV | 8% | 35% |
| Number of facilities providing antiretroviral therapy | 7 700 | 22 400 |
| Number of people receiving antiretroviral therapy | 1 330 000 | 6 650 000 |
| Number of children receiving antiretroviral therapy | 71 500 | 456 000 |
| Coverage of antiretroviral medicines for PMTCT (%) | 14% | 48% |
| <small>Source: UNAIDS/WHO/UNICEF Global HIV/AIDS Response Epidemic update and health sector progress towards Universal Access. Progress Report 2011</small> | | |

1.17 Extraordinary progress has been achieved in the global response to HIV. The number of people receiving antiretroviral therapy increased five-folds to reach 6.65 million in 2010, resulting in substantial decline in the number of people dying from AIDS-related causes. Access to evidence-informed HIV prevention, testing & counselling, treatment and care services expanded dramatically. Scientific evidence from clinical trials confirmed the powerful impact antiretroviral drugs have on HIV transmission and, in 2007, WHO and UNAIDS recommended including male circumcision as an additional HIV prevention component in settings with high HIV prevalence and low levels of male circumcision.

1.18 Despite these advances, still too many people are acquiring HIV infection, too many people are getting sick and too many people are dying. Globally, more than 50% of the PLHIV eligible for treatment do not have access to antiretroviral therapy and the majority of PLHIV in low- and middle-income countries still do not know their serostatus. Of particular concerns are trends affecting Eastern Europe and Central Asia, where the numbers of people acquiring HIV infection and dying from HIV-related causes continue to increase. The epidemic disproportionately affects sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners and migrants in both concentrated and generalized epidemics. Too often national AIDS plans omit these people, who face formidable legal and other structural barriers to accessing HIV services.

1.19 The decade 2000-2010 has seen a historically unprecedented global response to the threat of the HIV epidemic. Networks of people living with and affected by HIV, civil society organizations and partners continued to demand and mobilize political leadership. This has led to increased funding, technical innovation and international collaboration that has saved millions of people's lives and changed the trajectory of the epidemic. However, after years of significant increases, funding for international AIDS assistance declined by 10 per cent over the 2009-2010 period, due to reductions in direct bilateral funding by several governments as well as currency fluctuations. Disbursements for HIV rose by more than six-fold between 2002 and 2008 before levelling in 2009 to US\$7.6 billion and dropping to US\$ 6.9 billion in 2010

1.20 This trend is threatening the impressive progress to date and must be reversed for the international community to meet its commitments on HIV. The 2011 UNGASS Political Declaration on HIV/AIDS and other global UN strategies will guide national and global efforts to respond to the epidemic and move from an emergency response to a long-term, sustainable model of delivering HIV services. These global strategies emphasize the need to better tailor national HIV responses to the local epidemics, to decentralize programmes to bring them closer to people in need and to integrate with other health and community services to achieve the greatest impact.



2. Evaluation methodology

Evaluation issues

2.1 In accordance with the evaluation audience and purpose¹⁴, this evaluation was external, summative in scope and focused on assessing IFRC corporate performance, including its mechanisms and processes, at different levels (Secretariat, regional/zone offices and NS). Measuring corporate performance in a development programme is challenging since appropriate and measurable indicators of performance are usually not available, forcing the evaluation to rely substantially on qualitative opinions of implementers and beneficiaries. Equally challenging was the task of measuring effectiveness and impact, given the difficulties in attribution (multiplicity and turnover of actors), the relatively long amount of time required before impact becomes measurable, and the paucity of accurate baseline data.

2.2 To address these shortcomings, this evaluation used multiple survey tools and triangulation of data collected from both quantitative and qualitative (mixed) methods and supported by available secondary data. This resulted in quantitative and qualitative responses of participants' own perceptions of the Global Alliance. Review and validation of the results with the relevant stakeholders increased the rigor and accuracy of the findings and the strength of the recommendations. In addition, this evaluation also used well-established evaluation criteria derived from those adopted in the IFRC Framework for Evaluation.¹⁵

Evaluation framework

2.3 This evaluation is framed around five broad objectives described in the Terms of Reference and listed in Table 2. These objectives and the related forty-four evaluation questions were used as the basis for the development of the evaluation framework, the online survey questionnaires, the key informant interviews checklists and the evaluation report.

Table 2: Evaluation objectives

| | |
|------------------------------------|---|
| Overall Evaluation Purpose: | To what extent the framework mobilized capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programs within the framework of the IFRC's Global Agenda. |
| Objective 1 | Assess the overall effectiveness and impact of the Global Alliance |
| Objective 2 | Assess IFRC Secretariat program management and support |
| Objective 3 | Assess National Society capacity development for HIV/AIDS programs |
| Objective 4 | Assess the "Seven Ones" |
| Objective 5 | Assess harmonization and sustainability with IFRC Secretariat |

2.4 To translate the evaluation objectives into a structured programme of work, an Evaluation Framework was developed that matched the issues and key evaluation questions with measurable indicators and specific data collection methods. (Annex D). In this process, a number of evaluation questions were refined in close consultation with the IFRC Secretariat to ensure clarity on the elements being evaluated and to limit redundancies. Appropriate, specific and measurable indicators for each key evaluation question were identified and matched with one or more data collection methods considered most appropriate for measuring the required information.

¹⁴ See Annex A: TOR HIV Global Alliance evaluation 2012

¹⁵ The full IFRC Framework for Evaluation can be accessed at www.ifrc.org/mande



Evaluation methodology

2.5 This evaluation used mixed methods for data collection, consisting of desk-review of secondary data, an online survey, telephone and face-to-face key informants' interviews, and videoconferencing focus group discussions. No country visit was conducted due to time and funding limitations. Each method is described in more detail below.

2.6 **Analysis of secondary data sources** was a main element of the evaluation and consisted of a desk review of fifty-two HIV GA-related documents, publications, plans and reports listed in Annex E. All documents were reviewed for specific indicators relevant to the objectives of the evaluation using a standardized checklist. Information was entered in a spread sheet for ease of analysis. Financial analysis was limited to the budget presented in the regional HIV GA Appeals and other programmatic documents and to the overall amounts of funds raised (or spent) included in the tracking indicators reported by NS to the secretariat. The accuracy of this information could not be assessed.

2.8 The **online survey questionnaire** was a major source of both quantitative and qualitative information. A multiple survey questionnaire (Annex F) was developed in three languages (English, French and Spanish). The anonymous survey was administered online and data was collected and analysed using a commercially available survey tool (SurveyMonkey®). Respondents were selected using a purposeful sampling methodology, with the initial mailing list identified by the Secretariat among current and past IFRC staff involved in the HIV GA programme. To enlarge the pool of respondents, a snowball sampling (or respondent-driven sampling) methodology was attempted by asking respondents to suggest up to three names of individuals who they believed could contribute to the evaluation.

2.9 Online data collection started on 30 October 2012 and ended on 30 November 2012. Invitations to participate in the online survey were sent to an initial 175 potential respondents, i.e. 70% of the targeted sample size of 250 respondents. Nine additional names were suggested during the survey, of which five were already included in the initial mailing list. In eight cases the invitation bounced back and it was not possible to identify the correct email address, leaving a total number of 172 invited survey participants. **Seventy-five respondents filled in the online questionnaire, with a participation rate of 43.6%.** NS staff formed the majority of respondents (30.7%) followed by IFRC staff at the regional/zone level and UNAIDS field staff. The full breakdown of respondents based on their function is shown in table 3. A complete summary of all the responses to the online survey is included as Annex G.

Table 3: Role/profile of respondents in the context of the IFRC HIV GA. (n.75)

| Role | n. | % |
|--|----|-------|
| Staff Member of the Secretariat of the Federation | 10 | 13,3% |
| Staff Member of a zone/regional office of the Federation | 16 | 21,3% |
| Staff from an implementing National Society (e.g. Health and care coordinators, Health and HIV programme officers) | 23 | 30,7% |
| Staff from a participating National Society supporting the implementation of HIV GA in another country | 5 | 6,7% |
| Senior management at country level (e.g. Secretary General, programme coordinators) | 9 | 12,0% |
| Staff of an IFRC partner organization | 12 | 16,0% |

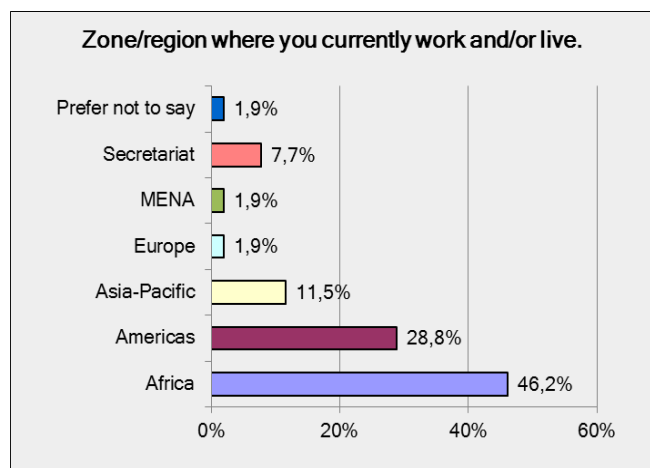
2.10 To preserve anonymity, participants were asked to provide only limited personal information on a voluntary basis. 52 respondents (69%) agreed to answer these additional questions. Respondents were equally divided by gender (50% male and 50% female) and 92.3%

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were aged between 30 and 59 years old, corresponding to the usual working age range in international organizations. The majority of respondents belonged to the 40 to 49 age group (38.5%) but the younger 30-39 age group was well represented with a robust 28.8%.

Figure 1: Zone/region of origin of respondents



2.11 As shown in Figure 1, the majority of respondents were based in the Africa region (46.2%) followed by the Americas (28.8%). They have worked for the Federation for 6 to 10 years (35.5%) and have been involved with the Global Alliance on HIV for more than 5 years (41.9%), i.e. from the very beginning of the programme. There were very few responses from the European and MENA regions, but also from the Secretariat in Geneva. It should be remembered that the MENA region never officially joined the Global Alliance on HIV.

2.12 Key informant interviews (KII)

included a purposeful sample of a selected number of individuals jointly identified by the consultant and the evaluation team. Semi-structured interviews were conducted in person or over the phone, guided by question checklists to ensure consistency. A total of 51 key informants were interviewed (19 from NS and country partners, 10 from the IFRC Secretariat in Geneva, 9 from the zone offices, 5 from PNS, 8 from partners. Key informants at country level included the NS SG or Programme Director, the Head of the Health Department, the HIV Programme Coordinator and the UNAIDS Country staff. Table 4 summarizes key informants by country, and Annex H provides a complete list of people interviewed.

Table 4: Summary of Key Informants

| Zone/Region/Agency | NS participating in HIV GA | Countries/Offices | N. people interviewed |
|------------------------------|----------------------------|---|-----------------------|
| Eastern Africa Zone | 9 | Rwanda, Uganda | 4 |
| Southern Africa Zone | 10 | Lesotho, Malawi | 3 |
| West and Central Africa Zone | 5 | Central African Republic, DR Congo | 3 |
| Asia and Pacific Zone | 15 | Cambodia, Nepal, Thailand | 4 |
| Americas Zone | 10 | Argentina, Ecuador | 2 |
| Europe Zone | 7 | Kazakhstan, Ukraine | 3 |
| IFRC Secretariat | | Geneva | 10 |
| | | Asia Pacific Zone | 1 |
| | | Americas | 3 |
| | | Africa | 5 |
| PNS | | Australia, Finland, Norway, Sweden, USA | 5 |
| IFRC partners | | UNAIDS | 4 |
| | | Global Fund | 1 |
| | | GNP+ | 1 |
| | | RCRC+ | 2 |
| TOTAL | | | 51 |

2.13 **Focus group discussions (FGD)** were organized to validate initial findings of the evaluation and to generate new information to confirm or refute initial conclusions. FGD focused on selected key issues identified during the desk review, the online questionnaires and the key informant interviews. Since country visits were not planned, “virtual” focus group discussions were conducted through videoconferencing to generate and capture group opinion from zone and field staff. Participants were selected using a purposeful sample determined by the evaluation consultant and the Secretariat. Due to limitations in time and availability of field staff, only three FGD sessions could be organized: one with staff of the Secretariat in Geneva and two with staff



from the different zones to accommodate different time zones. The list of people participating in the focus group discussion is also included in Annex H.

Data Management and Data Analysis

2.14 Data was managed using standard spreadsheets and database software. Both quantitative and qualitative data was entered onto spreadsheets by the consultant as the work progressed. Analysis consisted of frequency distributions of responses and aggregations of findings from desk reviews and interviews. Data was summarized and presented through charts, graphs and tables. All raw data and databases were provided to the IFRC Secretariat at the end of the evaluation.

Validation of findings

2.15 In line with the principles of the IFRC Framework for Evaluation, relevant stakeholders have been given the opportunity to review the findings, conclusions and recommendations of the evaluation for accuracy and to provide comments and feedback. Before the final release of this evaluation report, a Lessons Sharing Workshop will be conducted with key stakeholders to review evaluation findings, conclusions and recommendations. This will be done to check for accuracy of findings, to collect any additional feedback, and to foster understanding and ownership for the evaluation process. Differences in opinion among stakeholders and/or with the evaluator that emerged during the workshop will be accurately noted in the final version of the evaluation report.

Methodological limitations

2.17 It is inevitable for an evaluation of this nature to have methodological limitations. This was discussed during the planning of the evaluation, and informed the inception report. The main limitations identified are listed below:

- a. **Limited Secondary Data.** Limited programme documentation, in particular evidence-based programme data and financial information, prevented accurate measurement of results based on the objectives and targets defined at the launch of the Alliance in 2006.
- b. **Lack of mid-term review.** Though evaluations of the regional HIV GA programmes were extremely useful and informative, no mid-term review or evaluation of the HIV GA global programme was conducted. This reduced considerably the amount of information available, in particular on the initial implementation phase of the Alliance in light of high staff attrition and the loss of institutional memory.
- c. **The evaluation did not perform any country visits,** limiting the possibility of exploring in more depth the impact on of the HIV GA on HIV programming at field level and on building NS capacities. This limitation was only in part addressed through Key Informant Interviews and the “virtual” Focus Group Discussions.
- d. **Measurement bias.** The study findings are based primarily, though not exclusively, on survey data from current or past IFRC staff. Retrospective information, like all self-reported data, has several potential sources of bias: limited memory recall, selective memory, telescoping and attribution bias.

In this evaluation measurement bias is particularly important in light of the long time span between the launch of the alliance in 2006 and the timing of the evaluation (6-7 years). The HIV GA went through major changes during this period making it difficult to determine whether respondents refer to the initial “launch” period of the Alliance (until 2009), its later implementation phase, or to the more recent events occurring after 2011.

- e. **Selection Bias.** The vast majority of respondents are among those initially suggested by the IFRC Secretariat. This might have introduced a selection bias towards people directly involved



in the design and implementation of the HIV GA programme, with an individual interest in the outcome of the evaluation. In addition, due to the longevity of the programme and the timing of the evaluation, a potential pool of stakeholders was no longer available.

- f. **Attribution.** The attribution of impacts and effects to the HIV GA programme is particularly challenging as there are many other stakeholders involved in the implementation of the programme and delivery of services. The assessment was limited only to the intermediary steps (input/output) that could be linked directly to the activities of the Federation, making inference on its potential impact on the beneficiaries and the HIV epidemic.

3. Summary of HIV GA programmatic achievements

3.1 A comprehensive and in-depth assessment of the programmatic impact of the HIV GA is beyond the scope and capacity of this evaluation.¹⁶ Such assessment would require a greater amount of field work to assess NS programme delivery and evaluate the level and quality of services provided to the target populations. Nevertheless, a general overview of the HIV programming achievements during 2006-2011 is provided below as it would seem essential in evaluating the performance of the Alliance. This information should be considered with caution. This overview is based mostly on secondary data reported by NS to the IFRC Secretariat, whose accuracy and completeness has not been validated. In addition, attributing programmatic results solely to the HIV Global Alliance is problematic.

The HIV GA performance tracking system

The HIV GA successfully established a global performance monitoring system that shows the substantial contribution by the IFRC to the global fight against HIV/AIDS.

3.2 The design of the Global Alliance on HIV included a detailed system for tracking progress and monitoring performance meant to pioneer a Federation-wide approach to planning, performance management and accountability (PATS).¹⁷ Tracking indicators for each programmatic output were developed based on internationally agreed Global Indicators for HIV/AIDS and are described in detail in the HIV GA Programme Manual. To provide a baseline, 2006 HIV programming data was collected from 63 National Societies using a standardized data collection tool.¹⁸ This baseline information was then used to develop 2010 global targets for the IFRC based on the principle of “100% commitment”, i.e. “(at least) to double our world-wide HIV programming effort by the end of 2010 compared to what we were doing at the end of 2006”.¹⁹

3.3 **The Global Alliance GA was quite successful in ensuring the regular reporting from NS on the HIV tracking indicators.** During 2008-2011, the IFRC received regular yearly reports through the zone offices on selected performance tracking indicators²⁰ from an average of 67 National Societies (including a few NS that were not formal members of the Alliance). Since they represent the majority of all NS involved in implementing HIV programmes, the reported data provides a good estimate of the volume of HIV work done by the IFRC worldwide.

3.4 Organizing and sustaining a global reporting system is challenging and requires substantial time and investment in building skills and capacities. That the Global Alliance programme managed to run such an extensive global data collection effort for several years in spite of limited financial and human resources is in itself a statement to the commitment of Red Cross Red

¹⁶ As stated in the ToR for the evaluation of the IFRC HIV Global Alliance Programme, 2012, Annex A

¹⁷ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1). Page 27

¹⁸ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1). Guidance note 6

¹⁹ Global Alliance on HIV Newsletter n. 1, November 2007.

²⁰ Only 8 of the proposed 19 HIV GA tracking indicators have been reported to the Secretariat (see also annex L)

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Crescent staff and volunteers around the world. However, there are concerns over the possible low level of completeness and quality of reported data and on the sustainability of the reporting system in light of the reduction in staff and funding dedicated to HIV monitoring.

3.5 This evaluation identified several issues with the data collection and reporting system that could affect the validity of the information. These limitations, described in Annex L, should be kept in mind when analysing and attempting to draw conclusions from the data. However, **the data set seem robust enough to provide an overview of the global IFRC HIV activities and of global and regional trends.** A summary of the information, compiled by the Secretariat and disseminated via consolidated global reports,²¹ is presented in Table 5 and in Annex I.

Table 5: HIV GA Programme Achievements 2008-2011

| HIV GA Tracking Indicator | 2008 | 2009 | 2010 | 2011 | Total 2008-11 |
|--------------------------------------|------------|------------|-------------|------------|--------------------|
| NS that adopted the HIV GA approach | 56 | 56 | 57 | 57 | |
| Number of reporting NS | 72 | 70 | 63 | 65 | |
| Total population reached and served | 22 697 293 | 18 644 009 | 30 163 347* | 12 094 845 | 83 599 494 |
| Number of people reached with IEC | 22 436 500 | 18 361 133 | 25 204 824* | 11 047 748 | 77 050 205 |
| Most at risk population reached | | | 3 742 548 | 931 117 | 4 673 665 |
| Number of PLHIV supported | 132 560 | 147 700 | 109 676 | 63 863 | 453 799 |
| Number of orphans supported | 128 233 | 135 176 | 115 054 | 52 117 | 430 580 |
| No of volunteers trained and engaged | | 119 370 | 63 588 | 56 402 | 239 360 |
| Volunteer hours mobilized in a year | 27 453 216 | 17 572 924 | 8 569 771 | 26 408 815 | 80 004 726 |
| Resource mobilized for HIV (CHF) | 46 186 117 | 36 117 976 | 26 011 323 | 16 053 015 | 124 368 441 |
| Master trainers trained | 81 | 20 | 39 | 40 | 180 |

** The figure does not include 300 million reported contacts in China through web-based information sharing (i.e. the number of visitors to the NS HIV webpage)*

3.6 Globally, the IFRC reached and served during 2008-2011 almost 90 million people, volunteers contributed an estimated 80 million hours to the fight against HIV/AIDS, and almost 125 million CHF were mobilized by the Secretariat and by NSs. Though some of the cumulative figures over the period can be misleading due to the risk of double counting²², these results are nevertheless impressive and **demonstrate the substantial contribution by the IFRC to the global fight against HIV/AIDS.** The main asset of the Federation is the decentralized network of volunteers and the capacity of taking action directly with families and communities where resources have been made available, National Societies have shown the true meaning of the statement “mobilizing the power of humanity”. This is an undeniable achievement for the HIV GA programme and the IFRC as a whole. The data also show, however, a **substantial and worrying decline in the number of people reached and supported, and in resources being mobilized, starting from 2010.**

²¹ IFRC Global Alliance on HIV reports 2008, 2009, 2010 and 2011.

²² For example, PLHIV and OVC supported and volunteers engaged could include the same individuals over several years.



Output 1: Preventing further HIV infections

The HIV GA prevention strategies are becoming more effective but do not include the IFRC important contribution to preventing HIV transmission through blood

3.7 This objective aimed at reducing HIV transmission through a combination of prevention strategies summarized in Box 2. HIV prevention approaches may differ between countries, driven by expertise, needs and the dynamics of the epidemic. However, **peer education, community mobilization and Information, Education and Communications (IEC) targeting youth groups have been traditionally the preferred IFRC approaches.** Assessing the actual impact of these activities is difficult. They might have provided a number of young people with the basic tools to protect themselves but, as noted elsewhere, it is impossible to say with certainty if this has actually contributed to reducing the incidence of new infections.²³

Box 2: HIV GA Prevention Strategies:

- Working at community level to reduce vulnerability to acquiring or transmitting HIV by conducting peer education and community mobilization;
- Promoting information, education and communication (IEC) for general population and targeting vulnerable groups so as to increase knowledge, influence attitudes and change behavior;
- Promoting voluntary counseling and testing (VCT);
- Promoting the prevention of parent-to-child transmission (PPTCT);

3.8 Over time, and particularly in countries with concentrated HIV epidemics, **NS have gradually expanded their scope of work to reach key vulnerable populations** such as men who have sex with men (MSM), trans-gender, sex workers and injecting drug users (IDUs) including harm-reduction interventions. This is in line with international efforts to direct HIV prevention towards populations where most new infections are expected to occur. **The positive shift has been attributed to the more structured and strategic approach promoted by the Global Alliance on HIV.**

“There is evidence that the GA HIV has been responsible for profound changes in the way some of the National Societies address the HIV/AIDS epidemic. Awareness-raising and training activities have led to more open attitudes towards the key populations for the HIV epidemic.”²⁴

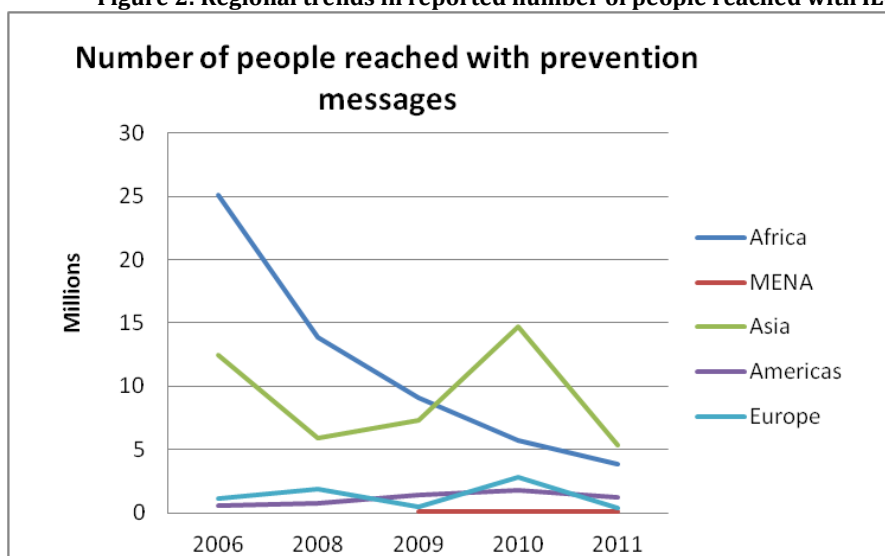
3.9 **NS reported reaching 77 million people with IEC messages during 2008-2011 and an additional 4.6 million most at risk population during 2010-2011.** Regional trends shown in Figure 2 suggest a steady decline in the number of people reached with IEC in Africa and a consistent increase in the Americas. Trends in Asia and Europe are of more difficult interpretation. Prevention was the largest component in the HIV GA regional appeals in Asia, Europe and the Americas, though globally it accounted for only 12% of the overall HIV budget due to the very large funding request for treatment and care for Southern Africa

²³ Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation. 2010

²⁴ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011



Figure 2: Regional trends in reported number of people reached with IEC



3.10 **The HIV GA prevention strategies have not been updated since 2006.** Meanwhile, new interventions and approaches to HIV prevention have been introduced at international level, including the role of circumcision and antiretroviral treatment in reducing HIV transmission. **An important additional contribution of the IFRC to the prevention of HIV/AIDS (and other blood borne diseases) is through the role that NS are playing in many countries in support to blood transfusion services.** Whether NS have the full responsibility for running blood transfusion centres and for ensuring the screening of donated blood, or whether they are only involved in blood donation campaigns and the recruitment of voluntary non-remunerated blood donors, these activities are essential in reducing the risk of HIV transmission through blood and increasing knowledge about HIV prevention in blood donors and their families. The support provided by IFRC to ensuring the availability and safety of blood and blood products is much appreciated by national governments and national and international partners. Surprisingly, **this important IFRC role was not specifically included in the HIV GA strategies and is not documented in HIV GA global or regional reports.**

Output 2: Expanding care, treatment and support

The support provided by IFRC to PLHIV and to orphans and vulnerable children has improved their quality of life and increased their chances of survival and healthy living.

3.11 This second output focused on increasing access to antiretroviral treatment in developing countries and providing care and support to people living with HIV, their families and their communities. In addition, the programme would support families and communities in addressing the special needs of orphans and other children made vulnerable by HIV. (Box 3)

3.12 Since very few NS are actually running clinical services and providing antiretroviral treatment (ART), **the Alliance initially focused on increasing coverage and improving quality of the Community Home Based Care (CHBC) activities.** CHBC involves trained volunteers and peer educators visiting people at home to ensure that they have access to priority needs like food and medicines, to refer them to the hospital if their health deteriorates, to provide

Box 3: HIV GA Care, Treatment and Support Strategies:

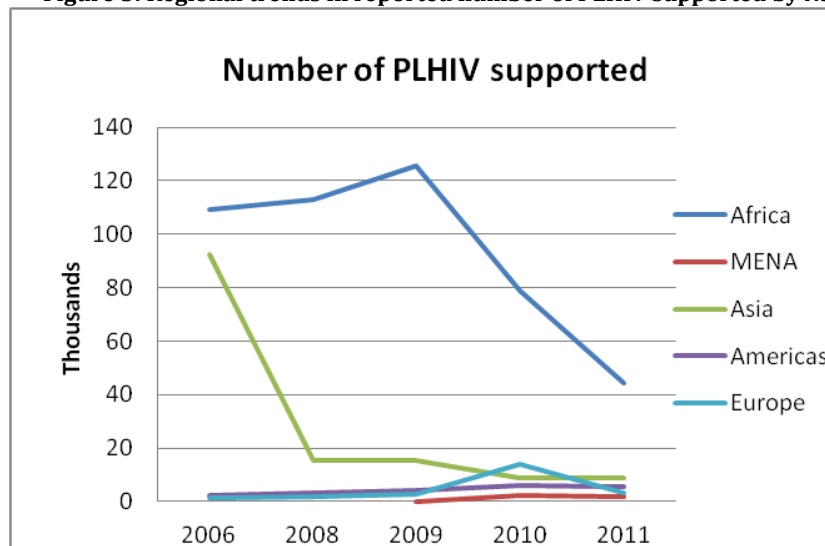
- Assisting HIV and AIDS orphans and vulnerable children (OVC);
- Providing home-based treatment, psychosocial support and HBC for PLHIV;
- Promoting community support groups and networks;
- Promoting livelihood and food support for the most vulnerable

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psychosocial support for the person living with HIV and family members, and to promote adherence to antiretroviral therapy and tuberculosis (TB) treatment. The recent increase in access to ARV therapy in sub-Saharan Africa has led to a major reduction in the number of clients enrolled in CHBC programmes. In response, **NS are now placing more emphasis on psychosocial support and promoting adherence to treatment.** Adherence is a critical component of treatment programmes as it reduces costs, increases sustainability, and prevents the emergence of antiretroviral drug resistance.

Figure 3: Regional trends in reported number of PLHIV supported by NS



3.13 NS have reported providing support to an average of 107,000 orphans and 113,000 PLHIV every year between 2008 and 2010. The largest number of beneficiaries for care, treatment and support activities is found in Southern Africa, due to the higher burden of HIV and the larger amount of resources available. As pictured in Figure 3, regional trends present a dramatic decrease in the number of PLHIV and OVC supported in the Africa region in 2010, attributed to both reduced needs for home based care and reduced funding. However, thanks to a stable flow of funds, coverage of care and support activities in the Americas and Europe regions more than doubled between 2008 and 2011.

“For those HIV-infected who have been involved in Red Cross Red Crescent activities this has often improved their quality of life. For many PLHIV it has sometimes been the difference between life and death. The provision of livelihood support has provided a sense of economic security to the infected people as well as to the affected families.”²⁵

²⁵ Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation. 2010



Output 3: Reducing HIV stigma and discrimination

The HIV GA had mixed results in terms of fighting stigma and discrimination that were not well documented through the performance tracking system.

3.14 Since 1990, the IFRC has been at the forefront of global efforts to reduce the stigma and discrimination associated with HIV/AIDS. The HIV GA put special emphasis on this component by presenting it as a separate output with comprehensive strategies. (Box 4). In addition, the HIV GA continued to promote increased access to ART by Red Cross Red Crescent staff and volunteers through the Masambo Fund and developed a specific strategy to mainstream gender in all IFRC HIV programmes. However, only 7% of the total budget requested in HIV GA appeals was destined to activities aimed at reducing stigma and discrimination.

3.15 **The four specific tracking indicators for this output described in the HIV GA Programme Manual were not included in the NS reporting system.** Key informants noted that specific indicators on stigma and discrimination are difficult to identify and report separately since these activities are often cross-cutting and integrated with other prevention and care activities.

Reports on the number of volunteers trained in HIV prevention and in fighting stigma and discrimination are available but the data is too fragmented to allow any meaningful analysis. Therefore, an assessment of this output can only be based on qualitative assessment from informants and global and regional reports.

3.16 In general, **the HIV GA performed poorly in terms of global and national partnership with networks of PLHIV.** At global level, a staff freeze blocked the Principles and Values Department recruiting a PLHIV to develop stigma and discrimination work. The established partnership with the Global Network of People living with HIV, very active during 2000-2005, came to an almost complete halt after 2008. The Collaborative Centre agreement with UNAIDS was renewed in 2008 but little implementation followed and it was finally terminated in 2011.²⁶ **Activities aimed at fostering national partnerships and the inclusion and active participation of PLHIV in the work of the NS were also scaled down in many countries.** In for Southern Africa, for example, *“partnerships with PLHIV networks, strong at the beginning of the programme, were reported to have weakened significantly in the course of the programme.”*²⁷

3.17 **A positive development was the official launch, in May 2008, of the Red Cross Red Crescent Network of People Living with HIV (RCRC+).** The RCRC+ Network has been instrumental in reducing stigma and discrimination within the IFRC by promoting a greater involvement of PLHIV in the activities of National Societies. The RCRC+ network also contributed greatly to the adoption and implementation of HIV in the workplace policies aimed at making NS a friendly workplace and a home for staff and volunteers living with HIV. While putting these policy into practice proved challenging, **the positive impact of the HIV in the workplace policy has been felt across the Red Cross Red Crescent movement, leading to improved acceptance of volunteers and staff living with HIV.**

3.18 **An important achievement of the GA is the large number of volunteers and staff who have been sensitized on issues of stigma and discrimination.** In 2009 and 2010, over 16,000 staff and volunteers in the Americas were trained to provide quality HIV-related services and/or

²⁶ UNAIDS IFRC Collaborating Center Agreement, 2008

²⁷ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010. End Of Programme Evaluation Report

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fight HIV-related stigma and discrimination. Many of these training sessions have been conducted with the active participation of PLHIV and supported with IEC materials on stigma produced by the IFRC Secretariat.²⁸ Red Cross Red Crescent volunteers can play an invaluable role in increasing knowledge and reducing stigma directly at community level.

“Many more have benefited indirectly from the reduction of stigma and discrimination in families, communities and health care settings where the RCRC awareness-raising activities have contributed to imparting knowledge and changing attitudes. There has thus been an increase in knowledge about HIV/AIDS within the communities, accompanied by a corresponding reduction in the discrimination, which in most cases was based on previous fear of transmission.”²⁹

3.19 Though several NS have developed activities addressing gender inequalities and Sexual and Gender-based Violence (SGBV), the overall response remains limited and fragmented. For example, HIV data collected by the IFRC is still not disaggregated by gender. The 2005 Evaluation of the HIV Global Programme recommended *“the development of specific approaches toward fighting HIV/AIDS, violence against women, and rape victims in camp situations in cooperation with the ICRC and other stakeholders”*. The HIV GA expanded the scope to addressing SGBV at household and community level as well. As a result of the development of a comprehensive regional strategy,³⁰ there have been good practices in some countries in Southern Africa. Malawi RC initiated a GBV programme in refugee camps and in 15 districts, establishing anti-GBV committees and a reporting system for GBV incidents. A new GBV training module has been developed, field-tested and finalized in 2011 in order to be integrated as part of the overall IFRC/WHO/SAfaids training on HIV Prevention, Treatment, Care and Support for community volunteers.

Output 4: Strengthening Red Cross Red Crescent national and regional capacities

The HIV GA successfully mobilized a large number of volunteers and established a performance tracking system but failed to mobilize the required financial resources to scale up HIV programming

3.20 The fourth output of the HIV GA aimed at strengthening Red Cross Red Crescent national and regional capacities in several key technical and managerial areas, including governance, accountability, leadership, programme management and resource mobilization, with special emphasis on improving capacities and management of volunteers. (Box 5) Though the description of the output does not include strengthening of the IFRC Secretariat capacities at global level, these are covered extensively in the Programme Manual.

3.21 Overall, 20% of the HIV GA appeals budget was destined to institutional strengthening and NS capacity building, with an additional 13% allocated for the support by the Secretariat. Three tracking indicators were identified for monitoring progress in this area: the number of volunteers engaged and volunteer hours mobilized, the coverage of HIV appeals and the percentage of NS that regularly report as per standard guidelines.

Box 5: HIV GA Strategies for Strengthening RCRC NS Capacities:

- Improving governance, accountability and leadership of Red Cross Red Crescent national societies for discharging planned commitments;
- Improving volunteer and staff support and management;
- Strengthening programme cycle management;
- Widening partnerships and expanding resource mobilization.

3.22 The Global Alliance GA was quite successful in ensuring the regular reporting from NS on the HIV tracking indicators. During 2008-2011, the IFRC received regular yearly reports through the zone offices on selected performance tracking indicators from an average of 67 National Societies (including a few NS that were not formal members of the Alliance) using a standardized reporting format.

²⁸ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011

²⁹ Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation

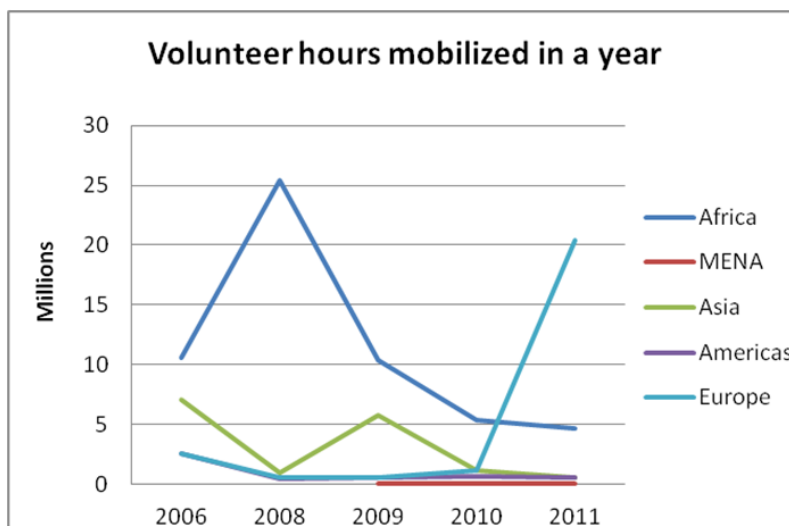
³⁰ Towards an integration of Gender-based Violence into the Federation's Global Alliance HIV Programme for Southern Africa



3.23 An estimated 240,000 volunteers were trained and engaged in HIV work during 2008-2011, contributing more than 80 million hours to HIV/AIDS activities.³¹ The regional trends

illustrated in Figure 4 show an important reduction in the number of volunteer hours mobilized in the African region after the initial peak in 2008. They also show a major increase in volunteer hours mobilized in Europe and Central Asia during 2011, possibly the result of a major contribution received by the Russian RC from the national government. Unfortunately, detailed breakdown of the hours contributed by the volunteers to the different activities or programmatic areas is not available.

Figure 4: Regional trends in volunteer hours mobilized



3.24 To estimate the coverage of HIV appeals, we compared the amounts requested through the HIV

GA regional and global appeals with the funds actually mobilized by the Secretariat and NSs. Table 6 presents a summary of the funding requests from HIV GA appeals between 2006 and 2008. Overall, the HIV GA plans combined total budget was 539 million CHF, 70 million (13%) of which were already pledged or available at the time of the appeal. The remaining unfounded balance was 469 million CHF, the largest proportion being destined to the Southern Africa Region (67%), followed by East Africa (13%) and Asia/Pacific (6.7%). The funding requested by the Secretariat amounted to only 1.6% of the overall budget.

Table 6: Summary of HIV GA Regional and Global Appeals.

| | S Africa 2006 ^a | WC Africa 2008 ^b | E Africa 2008 ^c | Americas 2008 ^d | Asia/Pacific 2008 ^e | Europe 2008 ^f | IFRC 2008 ^g | TOTAL | % |
|------------------------------------|----------------------------|-----------------------------|----------------------------|----------------------------|--------------------------------|--------------------------|------------------------|-------------|-----|
| Prevention | 18 660 505 | 6 342 539 | 18 437 246 | 10 551 450 | 9 979 406 | 3 647 936 | 0 | 67 619 082 | 12% |
| Care, support and treatment | 213 691 199 | 5 747 498 | 27 920 262 | 3 301 982 | 4 463 125 | 2 757 826 | 0 | 257 881 892 | 48% |
| Reducing stigma and discrimination | 19 599 285 | 658 464 | 6 537 821 | 2 822 706 | 5 145 333 | 416 931 | 0 | 35 180 540 | 7% |
| Institutional strengthening | 89 706 202 | 3 232 517 | 6 260 038 | 2 795 099 | 5 972 380 | 1 302 457 | 0 | 109 268 693 | 20% |
| Federation secretariat support | 43 238 806 | 5 075 909 | 4 353 306 | 2 921 555 | 6 039 161 | 149 469 | 8 205 800 | 69 984 006 | 13% |
| Total Planned Budget | 384 895 997 | 21 056 927 | 63 508 673 | 22 392 792 | 31 599 405 | 8 274 619 | 8 205 800 | 539 934 213 | |
| Appeal Funding Request | 317 127 648 | 21 056 927 | 61 723 852 | 22 392 792 | 31 599 405 | 8 274 619 | 7 409 000 | 469 584 243 | |
| % | 67.5% | 4.6% | 13.2% | 4.7% | 6.7% | 1.8% | 1.6% | | |

^a Southern Africa: Regional HIV And AIDS Programme Appeal No. MAA63003 (2006-2010)

^b West And Central Africa HIV Programme Appeal (2008-2010)

^c Eastern Africa HIV programme (2008-2010) of the red cross and red crescent global alliance on HIV Appeal

^d Americas HIV Programme (2008-2010) of the Red Cross and Red Crescent Global Alliance on HIV Appeal

^e Responding to HIV/AIDS in Asia Pacific 2006-2010

^f Total budget of HIV National plans (Armenia, Belarus, Kazakhstan, Kyrgyzstan, Russia, Uzbekistan)

^g Secretariat-wide Resourcing Framework Budget 2008-2009 For The Global Alliance on HIV

³¹ The peaks in volunteers' hours shown for Africa (2008) and Europe (2011) are probably linked to additional funding for these regions.

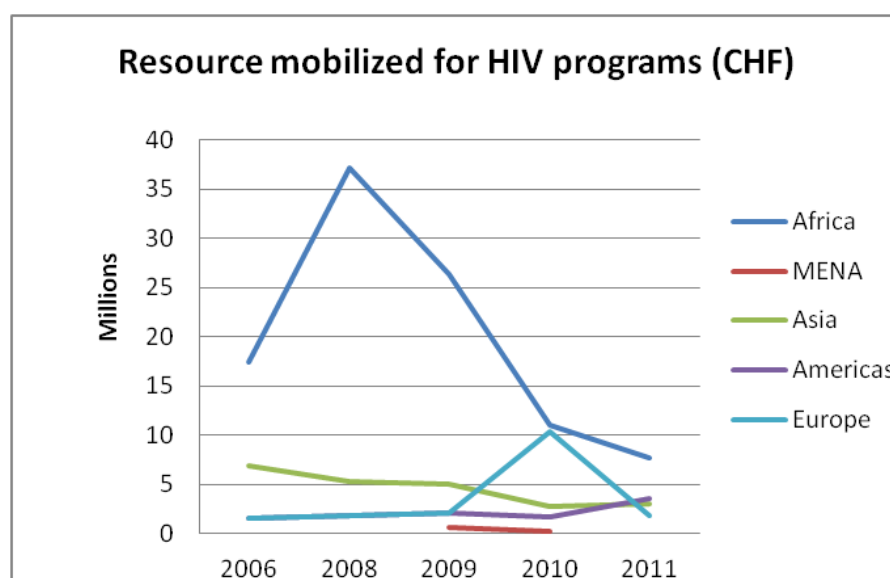
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3.25 Globally, most the planned budget was destined to care, support and treatment activities (48%), followed by institutional strengthening, (20%), prevention (12%) and reducing stigma and discrimination (7%). However, this distribution is skewed by the very large budget for care and support for Southern Africa, justified by the higher level of programming and the high burden of HIV disease. In most other regions, funding requested for prevention is actually larger than the budget allocated for care.

3.26 According to the HIV GA published data, **approximately 162 million CHF were raised for NS HIV activities during 2007-2011.**³² More than 65% of the total resources were raised for the Africa region, followed by Asia and Europe (12% each) and the Americas (7%). Since 2008, resources mobilized for NS HIV programmes in the Africa and Asia regions have declined substantially, while they have increased in the Americas and in Europe.³³ (Figure 5)

Figure 5: Regional trends in resources mobilized for HIV programs



3.27 **The overall coverage of the appeals was therefore only about one third of the 469 million CHF requested.** It was not possible to estimate the coverage by region or by output as no detailed breakdown of the funding received and spent was available from the Secretariat. The HIV GA Resource Tracking System should have provided detailed information on the HIV funds received and spent.³⁴ During this evaluation, it became clear that **the HIV GA had real difficulties in providing detailed information on the mobilization and utilization of HIV financial resources**, as confirmed by the fact that the majority of regional HIV GA evaluation reports did not include a detailed analysis of financial data, suggesting similar problems in accessing updated financial information.³⁵ For example, the Southern Africa team did establish a financial monitoring system to track resources mobilized. However, it did not include an analysis of this information in the 2011 evaluation report.³⁶

3.28 **At global level, the HIV GA failed to mobilize additional financial resources from traditional or new donors.** Several requests for financial support to the HIV GA Secretariat were

³² This amount includes 37.6 million CHF raised for Southern Africa in 2007.

³³ The peak in HIV resources in the European region in 2010 is reportedly linked to a contribution by the Russian Government to the Russia RC.

³⁴ IFRC HIV GA Consolidated HIV programme performance Global report for 2008

³⁵ With the exception of the "Southern Africa: Regional HIV and AIDS Programme Annual Report 2009" and the "Red Cross and Red Crescent Societies Regional HIV and AIDS Programme in South Asia Mid-term Evaluation Report 2008" which include detailed financial information.

³⁶ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010. End Of Programme Evaluation Report

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made through global and regional appeals and specific funding requests.^{37,38,39} In spite of all these efforts, the funding available for the HIV GA Global Team continued to decrease as traditional PNS reduced their contributions, leading to reductions in IFRC staff and activities.

3.29 At national level, the picture is mixed with some NS experiencing substantial funding cuts and others having managed to increase funding and engage new donors. Both bilateral and multilateral funding available for NS HIV activities has decreased in most regions (though not in every country). In spite of these constraints, some NS have been quite successful in increasing the pool of donors and the resources available for HIV programming. They attribute their success to building their NS image and credibility, establishing linkages and partnerships, developing capacities in administration and resource mobilization, and the support from the IFRC Zone teams.

Conclusions on the HIV GA achievements in the four programmatic outputs

- The IFRC is a major contributor to the global response to the HIV epidemic through HIV programs implemented by NS in more than 60 countries. In 2007-2011 alone, the Federation and NSs mobilized 162 million CHF and Red Cross Red Crescent volunteers contributed an estimated 80 million hours, reaching and serving almost 90 million people.
- The HIV GA strategic approach through the four programmatic outputs is comprehensive and remains valid. However, it does not include NSs contribution to blood safety and it has not been updated since 2006. Meanwhile new prevention and treatment strategies and approaches have been introduced at international level.
- IFRC prevention strategies have shifted from educating youth and the general public to more focused activities aimed at preventing HIV infection in groups at higher risk or transmission.
- The care and support provided by Red Cross Red Crescent volunteers and staff to orphans, vulnerable children, and PLHIV and their families has extended and improved the lives of hundreds of thousands of people across the world. In light of increased access to ART, NS are now placing more emphasis on psychosocial support and promoting adherence to treatment.
- Results in fighting stigma and discrimination have been mixed. The RCRC+ network provided greater impetus in making the Red Cross Red Crescent a better home for PLHIV. However, the closure of the Masambo Fund and the end of collaboration with GNP+ and UNAIDS signal a worrying reduction in attention to this important problem. Limited and fragmented progress is seen in addressing gender and violence issues.
- The HIV GA was successful in mobilizing large number of volunteers and in setting up a global performance tracking system. However, results in resource mobilization have been disappointing. Only about a third of the funding requested through the HIV GA appeals was actually mobilized.

³⁷ Secretariat-wide Resourcing Framework Budget 2008-2009 for The Global Alliance on HIV

³⁸ IFRC Global Alliances Plan 2008-2009

³⁹ Letter from the HIV GA Steering Committee to all NS dated 1 December 2007



4. Evaluation findings

This section presents the main findings of this evaluation structured according to the evaluation objectives and key evaluation questions. The information summarized below comprises data obtained from the online survey, key informants interviews and review of secondary data. A summary of the conclusions is included at the end of each section.

4.1 Objective 1 – Assess the overall effectiveness and impact of the Global Alliance

4.1.1 To assess the effectiveness and impact of the Global Alliance, we reviewed both the reported programmatic achievements against the HIV GA 2010 targets and qualitative information on the impact of the Alliance on the quality and performance of NSs HIV Programmes. This assessment is somewhat limited by the fact that the HIV GA performance tracking system includes mainly input and output indicators, more suitable for monitoring programme implementation than evaluating its effectiveness and impact. In addition, the HIV GA did not develop specific indicators for quality of services or for monitoring the performance of the Secretariat.

HIV GA achievements against targets

The HIV GA did not achieve its 2010 programmatic targets though some countries and regions did succeed in scaling up and even doubling HIV programming.

4.1.2 To measure the HIV GA performance against the ambitious target of “doubling our worldwide HIV programming effort by the end of 2010 compared to what we were doing at the end of 2006” we compared reported 2010 results with the baseline estimates for 2006 (Table 5). This would seem the correct way to assess performance, though we noted that some regional evaluation reports used cumulative achievements for the period 2006-2010 against the 2010 targets to assess performance of regional programs. Achievements for outputs 3 (Stigma), 4 (NS capacity strengthening) and on quality of services could not be measured due to uncertainty about the indicator used for the baseline estimate and/or lack of specific reporting from NS.

Table 7: HIV GA Programmatic achievements against targets

| | Baseline 2006 ⁴⁰ | Target 2010 ⁴⁰ | Achieved 2010 | change (+ or -) over 2006 baseline |
|--|-----------------------------|---------------------------|---------------|------------------------------------|
| Overall Coverage | 57 million | 137 million | 30 million | - 47% |
| Output 1 (prevention) | 56 million | 128 million | 29 million | - 48% |
| Output 2 (care) | 450,000 | 2 million | 224,000 | - 50% |
| Output 3 (Stigma) | 13,000* | 5 million | N/A** | |
| Output 4 (NS capacity) | 612,000* | 2 million | N/A* | |
| Quality index | Variable* | 90% | N/A** | |
| Resources (raised or spent) CHF | 36 million | 270 million | 26 million | - 27% |

* Unclear baseline indicators and/or no data reported.
** indicators for outputs 3 and quality index have not been included in NS reports

4.1.3 **The reported data suggests that HIV GA failed to meet all its 2010 global scaling up targets.** In fact, after an initial increase, the overall volume of IFRC HIV programming, the global amount of resources raised and number of beneficiaries of RCRC HIV activities

⁴⁰ Global Alliance on HIV Newsletter n. 1, IFRC, November 2007. (Note: A review of all NS baseline reports by this consultant resulted in slightly lower figures. However, the final figures have most likely been corrected/clarified between the HIV GA Secretariat and NSs)

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declined substantially between 2008 and 2010 across all measured programmatic outputs. However, this comparison should be taken with caution due to the uncertainty about the validity of 2006 estimates, which might include cumulative data for some NS, and the accuracy of 2010 reports. The observed decrease in HIV programming is probably due to a combination of overestimated 2006 baseline data, reduced NS HIV activities, and reduced reporting to the Federation. In any case, an important reduction in resources available for NS HIV programming since 2009 has been confirmed during the key informants' interviews.

4.1.4 The Alliance also failed to increase the number of NS with active HIV programmes to reach the additional target of “rolling out the Alliance to approximately 100 National Societies by the end of 2009, and 120 by the end of 2010”⁴¹. All the 56 initial GA members already had on-going HIV programmes and only one additional NS joined the Alliance after 2008.⁴² In addition, **several NS with on-going large and active HIV programmes have never joined the Alliance.**⁴³ The reasons suggested for not joining included “not being invited”, “not knowing how to apply”, and “not being willing to accept the conditions for “membership” set by the HIV GA”.

4.1.5 Aggregated global data can hide important differences between countries and regions. As shown in Annex I, the global picture is biased by trends in the African region due to its large volume of activities and funding compared to other regions. In particular, the **Southern African region**, that includes some of the largest NS HIV/AIDS programmes and generates the bulk of the Federation's HIV activities, has suffered a major reduction in funding since 2009, resulting in massive scaling down of activities.⁴⁴ In **West, Central and Eastern Africa**, the launch of the HIV Global Alliance had a limited impact as it failed to generate the additional funds required to support scaling up of activities.

4.1.6 In Asia and the Pacific, NS benefitted initially from substantial funding from the Regional HIV Programme 2005-2009 and the Global Fund but reportedly failed to build a sustainable base, casting a serious doubt over the future of NS HIV/AIDS activities in the region as resources become scarcer.⁴⁵ On the other hand, **in the Americas, the launch of the HIV GA in 2008 had a very positive impact on the commitment and level of activities of NS.**⁴⁶ This led to major improvements in the nature, quality and quantity of HIV/AIDS work in the region, where HIV programming has continued to increase thanks to a relatively stable flow of financial support. In fact, **the Americas did achieve the objective of doubling HIV Programming for several of the HIV GA indicators** like the number of people reached with IEC, the number of PLHIV supported and the resources mobilized for HIV work.

4.1.7 Setting global targets is unusual for the IFRC and was criticized by several respondents who felt that the goal of doubling HIV programming by 2010 was an unrealistic target from the very beginning⁴⁷. Setting very ambitious global targets is not new in HIV/AIDS⁴⁸ and can be useful for global advocacy, visibility, and fundraising. However, failing to deliver can be quite damaging to the image of the organization and create disappointment and frustration among implementers. The potential for scaling up IFRC HIV work is demonstrated by the success of several NS in increasing their HIV Programming. However, reaching the HIV GA global target would have required a major scaling up in Southern Africa, a region that had probably already reached its expansion limits in terms of implementation capacities.

⁴¹ IFRC Global Alliances Plan 2008-2009

⁴² Trinidad and Tobago Red Cross Society, in 2010.

⁴³ E.g. Thailand, Papua New Guinea, and Bahamas

⁴⁴ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006–10 End Of Programme Evaluation Report. 2011

⁴⁵ Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation. 2010

⁴⁶ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008–11.

⁴⁷ “Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation. 2010

⁴⁸ For example, WHO “3 by 5” and UNAIDS “getting to zero” or “reaching 15 million people living with HIV with ART by 2015”.



4.1.8 Suggestions have been made that the IFRC should focus more on quality of interventions and impact, rather than numerical targets reached. The Australian Red Cross in particular commented that “*The (HIV GA) framework appears fixated on numbers and quantitative data with not enough attention to qualitative findings which often capture the successes of NSs in a better way. We believe that ONS should be encouraged where possible to measure the outcomes of their work rather than focus on activity numbers.*”⁴⁹ **In fact, both measurements are needed: numerical input and output indicators are most useful for programme management and monitoring of implementation, while outcome and impact indicators, though more difficult and expensive to collect, are essential for measuring effectiveness, quality and impact of interventions.**

HIV GA main failure: resource mobilization

The HIV GA failed to mobilize the financial resources required for scaling up HIV programming due to a changed international environment, misunderstanding between the Secretariat and NS, and failure to engage with national and international partners.

4.1.9 Lack of funds was clearly the main reason for not achieving the scaling-up targets and is the cause for the recent reduction in HIV programming, as suggested by the good performance of countries that managed to maintain or increase external funding. The withdrawal of support from several “traditional” PNS that had contributed significantly to NS HIV Programs was particularly damaging as it signalled a lack of commitment and trust in the work of the Federation and reduced the IFRC Secretariat’s own capacities to support NS in resource mobilization. Indeed some PNSs did express dissatisfaction with the performance of the Secretariat, though the reasons for the reduced funding did not depend only on the Global Alliance.

“Funding has not really followed the programme planning of HIV GA even after we launched these programmes. Vulnerable people were targeted but could not benefit from our involvement. It ended up as a national disgrace.” (Online survey)

4.1.10 Mobilizing a large amount of resources is a complex exercise and failure cannot be attributed to a single factor, individual or managerial decision. It is rather a corporate failure and in the case of the HIV GA was the result of a combination of both “external factors”, independent from the International Federation, and “internal” decisions or actions taken by the HIV GA programme or the IFRC management and Governance.

4.1.11 External factors include the reduction in global resources for health development following the 2008 global financial crisis, the new focus by international health agencies on “horizontal” integrated health system approaches as opposed to “vertical” disease specific programs, and donors’ fatigue with funding global HIV programmes. In fact, funding for international AIDS assistance provided by donor governments declined by 10 per cent over the period 2009-2010, marking the first time support has fallen in more than a decade.⁵⁰ It is therefore not surprising that donors and PNS, responding to their own national donors, have also increasingly shifted resources away from HIV programmes, possibly towards more integrated health projects.

4.1.12 Internal factors included the lack of a clear resource mobilization strategy, an initial misunderstanding on roles and responsibilities in fundraising, the failure to establish a working partnership with the Global Fund and excessive reliance on PNS funding.

⁴⁹ Global Alliance for HIV & AIDS – ARC Observations

⁵⁰ UNAIDS and Kaiser Foundation. Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010

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4.1.13 The HIV GA lacked a clear resource mobilization strategy. The need for a HIV resource mobilization strategy had already been clearly identified. The 2005 Evaluation recommended to “develop a comprehensive resource mobilization strategy, placing responsibility for resource mobilization on the highest level of the organization; developing attractive and innovative funding proposals; and developing relationships with new donors.”⁵¹ The HIV GA Steering Committee discussed the development of a resource mobilization strategy as a priority at its first meeting⁵² though with no follow up. The strategy would have been instrumental in assisting IFRC and NSs in identifying opportunities for raising additional funds from existing and new donors, developing approaches to fundraising that would take into consideration donors’ specific interests and requirements, supporting NS capacity building for resource mobilization and defining a system to ensure regular monitoring and reporting of results to funding agencies.

*“There has been no fund- raising or resource mobilization strategy as part of this programme, and therefore no trainings on local fund -raising either, that could have made the programme independent or at least less dependent of external donor funding”.*⁵³

4.1.14 The initial misunderstanding between the Secretariat, PNSs and NSs on who was responsible for fundraising and who would provide the resources for scaling up caused great frustration and disappointment. Apparently, due to confusing messaging, NSs were under the impression that the IFRC would raise funds on their behalf to cover the totality of the HIV GA plans. The Secretariat clarified later that “*It is not the intent of the GA HIV to provide all of the NS’s HIV/AIDS funding, but rather to complement and facilitate the acquisition of other types of funding. It is vitally important that the participating NS’s be proactive in seeking funding sources other than the one’s provided under the HIV GA and actively seek strategic alliances with other potential funding partners.*” Indeed, NS HIV Programme Documents should have included a resource mobilization action plan and identified “*traditional and new potential donors in-country, regionally and globally.*”⁵⁴ However, none of the NS HIV Programme Documents reviewed during this evaluation included such plan.⁵⁵ In any case, by the time this issue was clarified, the damage was already done, NSs were frustrated, high expectations had been disappointed and opportunities for local fundraising had been lost.

“The HIV Global alliance did not increase funding to NS partners as expressed by the lead of the alliance and as support to the process stopped with minimal communication there was confusion and frustration at the leadership and messaging regarding this.” (Online survey)

4.1.15 The HIV GA failed to establish a working partnership with the Global Fund (GF). The GF is the main provider of resources for HIV programming at country level but only a relative small amount of GF resources are being channelled through the Red Cross Red Crescent National Societies. (Box 6) **Attempts made by the HIV GA and the Federation to attract additional GF resources at global or regional level were not successful.** The Southern Africa Team developed in 2008 a multi-country HIV proposal that was not approved for funding. This negative outcome is not surprising, given the very strict conditions set by the GF Technical Review Panel for approving multi-country proposals. The IFRC Secretariat also tried repeatedly to negotiate a global agreement with the GF that would establish closer links and mobilize GF resources in support for IFRC HIV activities, including in disaster situations.⁵⁶ Unfortunately, the GF Board never approved mechanisms for funding international organizations at global level. These failed attempts suggest that, despite early involvement with Governance of the GFATM (Senior IFRC governance members were alternate GF Board members at that time), the IFRC was slow to adapt to the GF funding mechanisms and particularly to the need to raise and utilize funds directly at country level.

⁵¹ 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005

⁵² Meeting of the HIV Global Alliance Steering Committee Federation Secretariat, Geneva - 18 November 2007

⁵³ Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation

⁵⁴ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Note 5.

⁵⁵ NS Programme Documents reviewed include Cambodia, Kenya, Lesotho, Malawi, Nepal, Uganda.

⁵⁶ *Global Alliance on HIV Comprehensive HIV programme delivery Global report 2011*

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“The main funding opportunity was always GFATM at country level. Senior management insisted on the idea that the IFRC could negotiate a special deal with GFATM so that NS did not have to become competent and compete effectively at national level though the GFATM was never going to accept that. Holding out a false hope of easy global level funding meant that the hard work of truly supporting NS to be credible at national level was avoided.” (Online survey)

Box 6: The IFRC and the Global Fund

A recent mapping of NS current involvement with the GF at country level undertaken by the Global Health team found that out of 58 National Societies that reported to be implementing HIV programmes, only 18 are member of the GF CCM and only 2 are Principal recipients of GF grants in HIV. The precise number of NS that are or have been implementing GF HIV grants as sub-recipients (SR) is unknown.

The nature of a National Society (i.e. a civil society organization active at community level, with a credible image and an international supporting network) would seem quite attractive for local donors and fully in line with GF policies of enhancing participation of civil society in HIV, TB and malaria programme implementation. The Red Cross Red Crescent ability to become a GF Principal Recipient was questioned in a recent assessment by the Swiss Tropical Institute. However, NSs could well qualify as sub-Recipients. Indeed, NSs that decided to engage with the GF mechanisms, participate in the activities of the CCM, and submit robust HIV proposals have benefitted substantially from GF resources.

More recently, at the initiative of the IFRC malaria programme, the Secretariat produced a position paper outlining potential opportunities and challenges for the IFRC and National Societies should they engage more closely with the Global Fund. An IFRC Round 11 orientation workshop to engage with GFTAM was organised for NS from Botswana, Liberia, Laos, Malawi and Togo who were planning to submit HIV proposals. It seems essential for the IFRC to continue exploring options for accessing GF resources, particularly now that the GF is planning major modification to its granting mechanisms, and share the information with zone offices and NS for greater engagement with GF work at country level.

4.1.16 The availability or the promise of “easy” money has made NSs HIV activities dangerously dependent on PNS and IFRC funding. The expectation of large contributions coming from the PNSs and the HIV GA has discouraged many NSs from investing in local resource mobilization. As a result, fundraising opportunities might have been missed and NSs capacities and experience in building partnership and fundraising have not been developed. As PNS funding is increasingly being scaled down, all these activities are now at risk.

“We were very successful in mobilizing funds for the region and for NS programmes but as can be seen now that outside funding through IFRC for HIV programmes has almost stopped, NSs came to rely on the HIV funding for many things in their NS such as salaries and capital costs. . NS are not in the CCM and do not seek (additional) funding when it comes in “free” from PNS”. This cannot be sustained and many NS in the region are now in trouble.” (Online survey)

4.1.17 Though overall results in resource mobilization have been disappointing, a few National Societies have been quite successful in mobilizing resources and expanding their network of partners and donors, demonstrating the potential for the RCRC to “do more and better” in HIV resource mobilization. Success was often the result of NS leadership and staff becoming more engaged in coordination mechanisms and strengthening partnerships at country level. In Southern Africa, *“some NS have managed to raise significant resources outside the traditional funding Partner or Donor National Societies However, this effort needs to be strengthened.”*⁵⁷ In the Americas, one example of a successful approach was the contracting of a marketing agency to assist in building the image and credibility of NSs and facilitate resource mobilization efforts, including with the private sector.

“Given that most HIV funding is now channelled to country level, NS should take responsibility for raising most of the programme funds at national level. This will require NS leadership to more effectively capitalize on the seats they have in CCMs and key government technical working groups.” (Online survey)

⁵⁷ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010 End Of Programme Evaluation Report



4.1.18 Attributing both positive and negative results in resource mobilization solely to the efforts by the HIV GA is difficult. Some of the funding reported by NS to the Alliance might have already been included in projects and funding agreements signed before the launch of the HIV GA appeals. In addition, several respondents suggested that successful fundraising was in fact more the result of personal efforts by IFRC staff in approaching bilateral donors than the result of the corporate fundraising on the HIV GA appeals. On the other hand, **the coherent and costed NS HIV Programme Document included in the regional appeals could greatly facilitate local and international fundraising by providing a solid basis for approaching donors and partners.**

Impact on quality and effectiveness of the IFRC response to HIV

The HIV GA working framework improved the quality and effectiveness of the IFRC response to HIV.

4.1.19 Failure in reaching its global targets does not necessarily mean that the HIV GA also failed in the other objectives of building NS capacities and implementing a framework for improving quality and effectiveness of IFRC HIV work. Quality and effectiveness might be more difficult to measure but are equally important for delivering better and more cost effective services to the population. Many people interviewed felt that the HIV GA additional objectives of piloting a new “global alliance” approach and exploring new ways for the Federation and NS to work together towards common, agreed goals were as important if not more important than the numerical targets. They were in fact the main reasons for setting up in 2006 a new HIV Global Alliance as opposed to continuing with the previous Global Programme on HIV/AIDS.⁵⁸

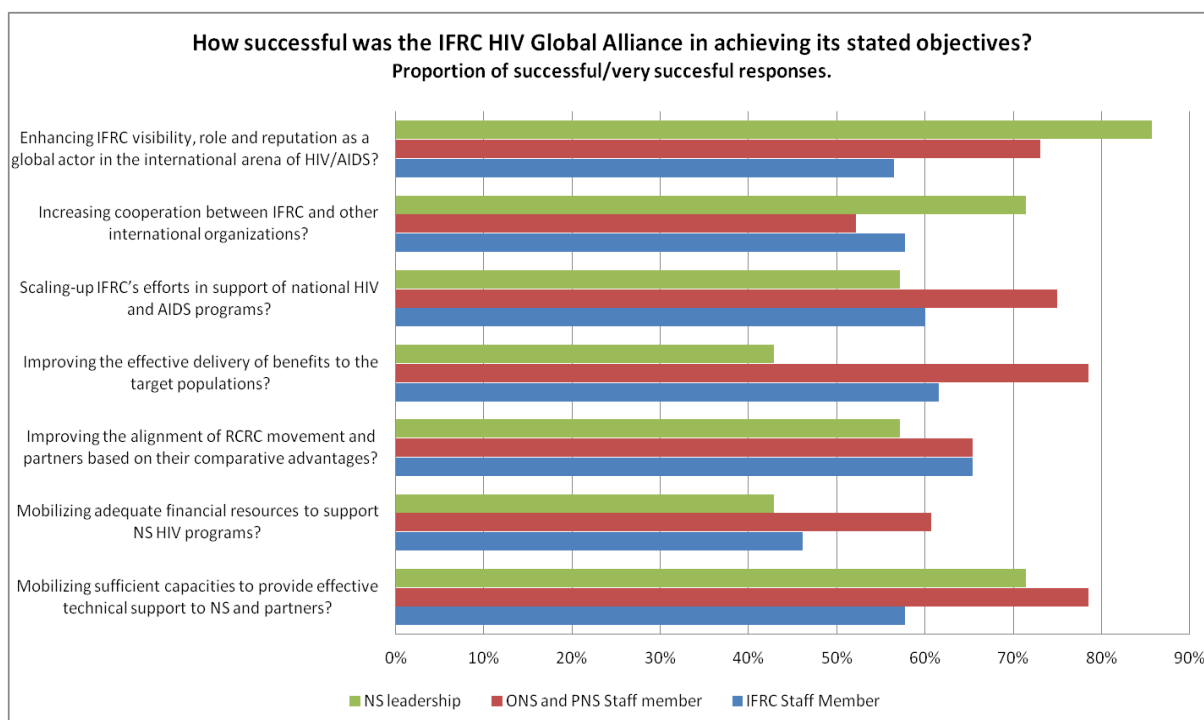
“The HIV GA was supposed to be about a working framework, not about money.”(Key informant)

4.1.20 The majority of respondents found the HIV GA to be successful or very successful in achieving its stated objectives, including in scaling up HIV programming. (Figure 6) In general, NSs leadership and staff had a more positive view of the Global Alliance than IFRC staff members. The Alliance received the highest scores in “enhancing IFRC visibility, role and reputation” and in “providing effective technical support to NS and partners.” **More than 80% of respondents also stated that the changes introduced by the HIV GA in the way the IFRC HIV global programme was organized and provided support to NS had a positive or very positive effect on the Federation response to HIV.** Only the support to resource mobilization received poor ratings by the majority of respondents.

⁵⁸ HIV programmes have often been used to experiment new organizational and institutional approaches, the WHO Global Programme on AIDS (GPA), the WB Country HIV/AIDS Programme for Africa (MAP), UNAIDS and the Global Fund being just some examples.



Figure 6: Overall rating of success by HIV GA in achieving its stated objectives



4.1.21 With few exceptions, this evaluation found an almost unanimous agreement in support of the principles of the HIV GA. 71% of respondents stated that all HIV Global Alliance strategic and/or operational approaches should be retained for future IFRC HIV programming. Respondents praised in particular:

- The move from a fragmented project approach to a more structured, long term and needs based planning process with regular follow-up.
- The support provided by the Secretariat, in particular the zone teams, to the NSs for the development of standardized and harmonized NS HIV programmes and plans.
- The attempt to build a culture of performance monitoring and accountability through the use of tracking indicators.
- The increased acceptance by the NS governance of the importance of fighting stigma and discrimination and implementing the IFRC HIV in the workplace policy.
- The increased opportunities for sharing of experiences and lessons learned.
- The emphasis on building partnerships with other HIV/AIDS partners.

4.1.22 Unfortunately, NS did not report on the quality of NS HIV services because of the lack of appropriate tracking indicators. Plans by the HIV GA to develop monitoring tools for this and other aspects of HIV programming, including stigma and discrimination, gender, and sexual and gender-based violence, did not materialize.⁵⁹ However, **73% of respondents to the online survey agreed or strongly agreed with the statement that the HIV Global Alliance has led to improvements in the quality of IFRC work in HIV.** Survey respondents suggested that the main contributions to improving quality in HIV programming came from:

- strengthening programme planning, monitoring, evaluation and reporting;
- moving from piecemeal HIV projects to five year long term programmes aligned with country plans;
- standardizing administrative processes and financial management at the local level;

⁵⁹ Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 12.



- d. documenting good practices and lessons learned;
- e. providing opportunities for NS to exchange experiences and ideas through regional and global networks;
- f. regional HIV GA reviews and evaluations;
- g. the greater involvement of PLHIV in the design and implementation of NS HIV activities.

Critical voices

The HIV GA is not without critics within the IFRC, though criticism seems to be mainly directed at the way in which the programme was implemented rather than at its principles.

4.1.23 This evaluation recorded some strong criticism of the Global Alliance on HIV, both from IFRC staff and NS and PNS representatives. In general, field staff were particularly disappointed by the failure by the HIV GA to mobilize the resources required to scale up HIV programming, while IFRC and PNS staff were more concerned about leadership and managerial issues. **Criticism concentrated around a few important issues: the launch of very ambitious plans not supported by sufficient resources, the perceived lack of commitment and leadership at IFRC and NS senior management level, the failure in resource mobilization, and abandoning the IFRC leadership role in fighting stigma and discrimination.**

“The HIV GA was created as a powerful new global tool and high ambition - seducing on the paper but proved to be poorly effective in strongly positioning the RCRC as a major player on HIV, attracting donors or contributing to NS development and capacity strengthens. It might be reinvigorated as an effective coordination and partnership tool but without any budget management implication or vague ambition to become kind of RCRC global fund on HIV.” (Online survey)

“The HIV Global Alliance was a good initiative but it did not go too far in terms of achievements. The launch in the different target countries was done in grand style with the involvement of many actors, including civil society, national and international partners, which created a lot of expectation from these partners that have not been fulfilled.” (Online survey)

4.1.24 For example, though the HIV GA was successful in ensuring that all 57 member NSs developed comprehensive HIV plans based on a standardized format, **several respondents felt that the plans did not always take into account the local context or NS implementing capacities.** The short time given to NS to develop the HIV Programme Documents did not always allow for a comprehensive needs assessment, full consultation with partners and the actual buy-in by the NS senior management. **This might have resulted in plans that did look nice on paper but that did not reflect the actual priorities at country level and were not “owned” by the NS concerned.** The pressure to increase the number of NS joining the HIV GA might have come at the expense of the quality of the NS HIV plans and the limited consultation with national partners might have undermined the possibility of raising funds locally for its implementation.

“I believe the GA moved HIV programming in the wrong direction; it was a top down approach which did not build on the capacities that NS had developed. It set unrealistic expectations among NS for funding that failed to materialize”. (Online survey)

“Too much too soon, too top down, not building on the good areas of work already happening in NS and gradually growing the programmes, not looking at the NS health programming as a whole and how HIV can best fit and what the NS is best positioned to do. Encouraging broader partnerships with MoH and other agencies and Red Cross to play a role in the response, not try to do everything. Too much hype in the launch and not enough thinking around what NS really need to do and to have in place to be able to scale up HIV work. NS did not lead the process, so there was poor ownership.” (Online survey)

4.1.25 **The changes introduced by senior management in the HIV GA programme in 2009 also attracted strong criticism.** Respondents saw the reduction in staff, the abolition of the

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position of Special Representative, and the dismantling of the HIV Governance group as clear indication of the loss of support and commitment by the IFRC Senior Management. These decisions had a major impact on the capacity of the Secretariat to continue promoting the HIV GA approach and to provide the technical and programmatic support to NS. Combined with the poor results in resource mobilization, they led to widespread disappointment and much of the initial momentum was lost. **Many respondents expressed great concern at the future of IFRC HIV work in light of the reduction in funding from the traditional donors and a perceived lack of commitment and support at the Secretariat level.**

“The Global Alliance on HIV has clearly helped to clarify the concept of Red Cross support but in the end, the IFRC headquarters did not walk the talk to sustain the initiative and after 2-3 years the programme is a ghost in the NS and zone offices, there were no consistent back-up support from Geneva and no political will to provide the right means for effective actions.” (Online survey)

4.1.26 The apparent contradiction between the generally positive view of the Alliance recorded through our online survey and the poor performance against the global targets combined with some fairly strong criticisms collected during the interviews could be explained in part by the fact that **the Global Alliance has probably meant different things to different people and at different times.**⁶⁰ The actual capacities and performance of the programme was indeed quite different during the initial “launch” phase, supported by resources, staff and high visibility, and towards the end when attention and resources were diverted elsewhere. Also, the level of activities and support received in the Southern Africa region, and more recently the Americas, was very different from what has been experienced in East or West Africa, or in Central Asia.

Partnerships with PLHIV: successful experiences and missed opportunities

4.1.27 Fighting stigma and discrimination and promoting partnerships with PLHIV at global, zonal and country levels have been central to the IFRC involvement in HIV work since 1990. During 2000-2005, IFRC became a UNAIDS Collaborating Centre on Stigma and Discrimination and established formal partnerships with GNP+ and Regional Networks of PLHIV. The 2005 evaluation recommended to *“further develop partnership with GNP+ and base regional and country level partnership on joint activities”*.⁶¹ The HIV GA reaffirmed this commitment by developing a specific output and strategies to the fight against stigma and discrimination as well as tackling gender inequalities and sexual and gender-based violence.

4.1.28 **The HIV GA failed to capitalize on the established global partnerships with GNP+ and UNAIDS.** Little progress is recorded at global level after the participation of the International Federation in the organizing committee of the “Living 2008 Summit” in Mexico City. The established partnership with the Global Network of People living with HIV, very active during 2000-2005, came to an almost complete stop after 2008 to the disappointment of many of the people involved. The Collaborative Centre agreement with UNAIDS was renewed in 2008 but little implementation followed and it was eventually terminated in 2011.⁶²

“A critical failure was that the 8000 Everyday evaluation recommendation to appoint a PLHIV to work in the Principles and Values department on Stigma and Discrimination (and the UNAIDS Collaborating Centre agreement) was not implemented due to a freeze in the staff size in Geneva. That reneged on the expectations created with UNAIDS, and seriously undermined the credibility of the IFRC with key vulnerable populations who took this as a lack of real commitment.” (Online survey)

4.1.29 **Activities aimed at fostering national partnerships and the inclusion and active participation of PLHIV in the work of the NS were scaled down in some regions.** The HIV GA evaluation for Southern Africa states that: *“partnerships with PLHIV networks, strong at the*

⁶⁰ Other possible reasons are detailed in the section on the limitations of the study.

⁶¹ 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005

⁶² UNAIDS IFRC Collaborating Center Agreement, 2008

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beginning of the programme, were reported to have weakened significantly in the course of the programme.”⁶³ Informants mentioned that a major obstacle was the reluctance by some NS staff to be involved in activities with vulnerable populations.

“Many NS’s reported that initial efforts with key populations had met with resistance from within the NSs itself. This resistance originated at times from the leadership or governance and more frequently from staff and volunteers.”⁶⁴

4.1.30 A positive development was the official launch, in May 2008, of the Red Cross Red Crescent Network of People Living with HIV (RCRC+). The RCRC+ initial objective was to facilitate the Federation’s input into the “Living 2008” Summit of PLHIV. The network is mandated to provide feedback on the Federation’s performance in implementing the Greater and Meaningful Involvement of PLHIV (GIPA) principle, to ensure that the rights of PLHIV who have joined the Red Cross Red Crescent as volunteers are respected and that they are not discriminated against, and to advocate for more involvement of people living with HIV as volunteers and peer educators. This helped National Societies create an environment where PLHIV who need treatment feel comfortable enough to identify themselves and apply for support from the Masambo Fund.⁶⁵

4.1.31 The RCRC+ Network has been instrumental in reducing stigma and discrimination within the IFRC by setting an example of inclusion and adherence to GIPA. For NS with RCRC+ focal points this has meant a greater involvement of PLHIV in their activities and possibly the delivery of more effective and higher quality services through a better understanding of the specific needs of PLHIV. Supported by the RCRC+ network and by the mandate from the IFRC governance, the HIV GA put special emphasis on implementing HIV in the workplace policies aimed at making NS a friendly workplace and a home for staff and volunteers living with HIV. However, putting the policy into practice proved challenging. Reports suggest that workplace policies have been adopted by the majority of NS but they are not always being implemented. In some countries there still seems to be little openness or tolerance about HIV among NS staff, particularly in local branches.⁶⁶ **Still, the positive impact of the HIV in the workplace policy has been felt across the IFRC, leading to improved acceptance of volunteers and staff living with HIV.** In the Americas, with the support of internal advocates who are themselves PLHIV, NSs have successfully pioneered progressive HIV in the workplace policies.

⁶³ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010. End Of Programme Evaluation Report

⁶⁴ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011

⁶⁵ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011

⁶⁶ 17th Session of Governing Board Geneva, May 2008. Item 12th of the Agenda. Report of the HIV Governance Group



Conclusions on the overall effectiveness and impact of the Global Alliance

1. The HIV GA was not successful in reaching its ambitious target of doubling HIV programming between 2006 and 2010. More worryingly, HIV programming across all regions, with the exception of the Americas and Europe, have been declining substantially since 2010, mainly due to reduction in funding. The HIV GA also failed to increase the number of NS with active HIV programmes and several NS with large HIV programmes have not joined the Alliance.
2. Global figures hide significant differences between countries and regions. Southern Africa has recently seen the sharpest decline in resources and activities, driving the global figures, while the Americas and Europe have seen substantial increases, demonstrating the potential for the Red Cross Red Crescent to scale up and play a greater role in the global fight against HIV.
3. The HIV GA failed to mobilize the resources required for scaling up HIV programming. The difficulties in resource mobilization were due in part to a changing international environment driven by the global financial crisis and shifting donors' priorities, and in part to the lack of a HIV GA resource mobilization strategy and a major misunderstanding of who should be responsible for fundraising.
4. The HIV GA failed to establish a functional partnership with the Global Fund. Attempts to develop an agreement at global level were not successful. Regional and country initiatives did not always receive the required technical support. The GF continues to be the main provider of HIV funding at country level and a potential partner for the IFRC.
5. NSs have become dangerously dependent on PNSs and IFRC funding for HIV activities. As funding is being reduced globally, HIV activities are now at risk.
6. Some NSs have been quite successful in mobilizing resources for HIV activities including from the GF. This was the result of improved capacities in resource mobilization, greater involvement of NS leadership in national HIV coordination mechanisms, and technical support from the IFRC zone offices. It demonstrates the large potential for the IFRC to "do more and better" in resource mobilization.
7. The HIV Global Alliance has led to improvements in the quality and effectiveness of IFRC work in HIV through strengthening PMER; developing long term programmes aligned with country plans; standardizing administrative processes; documenting good practices and lessons learned; providing opportunities to exchange experiences; and regional reviews and evaluations.
8. The guiding principles of the HIV GA are valid and relevant and there is convincing evidence that their implementation can benefit the work of the IFRC through harmonization, coordination and improved managerial processes.
9. Criticism of the HIV GA is directed mainly at the way in which some of its aspects were implemented, the failure to mobilize the expected financial resources, the perceived lack of IFRC commitment and the reduction in dedicated Secretariat staff and resources, the reduced attention to fighting stigma and discrimination.
10. The HIV GA failed to capitalize on the established partnerships with UNAIDS and the GNP+. However, the RCRC+ Network has been instrumental in reducing stigma and discrimination within the IFRC and setting an example of adherence to GIPA.



4.2 Objective 2 – Assess IFRC Secretariat programme management and support

Organizational structure of the HIV GA programme

Following its restructuring in 2009, the human and financial resources of the Programme are largely insufficient to ensure the delivery of all the required services and support to NSs.

4.2.1 The initial organizational structure of the HIV GA included the **NS HIV programmes**, responsible for managing and implementing HIV-related work at country level, and an **IFRC global programme** comprised of staff based in the Secretariat in Geneva and in the zone offices.⁶⁷ Following the recommendation of the 2005 evaluation, the Global Programme included the **Office of the Special Representative**, reporting directly to the Office of the IFRC Secretary General, and the **HIV Team** reporting to the Head of the Health Department. The global programme was responsible for, “*generating services and products (such as provision of policy, monitoring, and reporting frameworks, advocacy and resource mobilization; specialized forms of technical assistance that are in short supply) that are of common worldwide benefit to achieve the Global Alliance on HIV objectives.*”⁴⁸ (Box 7)

4.2.2 It was envisaged that staffing in Geneva would include the HIV Programme Manager and several Technical Officers with additional support provided by key staff from other IFRC departments (e.g. Organizational development; Finance; Administration; Communications; PMER; Resource mobilization). Each zone was expected to identify at least one HIV Focal Point/Manager with additional staff envisaged for regions with larger programmes like Africa or Asia/Pacific.⁶⁸

Box 7: Role of the International Federation’s Secretariat

To provide leadership and facilitation to achieve Alliance objectives and specifically to provide the following:

- Policy and strategic guidance.
- Coordination at global and zonal level.
- Advocacy.
- Resource mobilization.
- Knowledge and good practice sharing.
- Technical support to enable achievement of objectives.
- Performance tracking - framework for monitoring, reporting, accountability.
- Management of a global financing system..

4.2.3 **During the initial launch phase, thanks to generous contributions from a few PNSs, the HIV GA programme was supported by a fairly large global team.** In February 2008 there were 10 staff working on HIV/AIDS in the IFRC Secretariat in Geneva: four assigned to the office of the Special representative (the Special Representative, one coordinator, one adviser and one administrative staff) and five working in the IFRC HIV Team (one HIV Programme Manager, three Advisors for Prevention, Care, and Stigma, and one HIV Media & Public Relations officer). In addition, twenty-five staff members were working on HIV in the Zone Teams.⁶⁹

4.2.4 Following a reorganization of the Secretariat and changes in global IFRC leadership, **the Office of the Special Representative was closed in 2009 and the HIV team in Geneva was reorganized bringing the responsibility for the Alliance under the Manager of the newly established “HIV, TB and Malaria Unit”.** From the interviews it appears that the separation of the two offices (Office of the Special Representative and HIV Team) had resulted in communication and coordination difficulties within the Secretariat. During the following months, staff and funds allocated to the HIV global programme were increasingly reduced, in part due to a shift in corporate priorities and in part due to reduced support from the PNSs. At the same time, the process of decentralization of the IFRC Secretariat towards the zone offices also impacted on the capacities of the programme by diluting increasingly scarce resources.

“Internally, the Secretariat’s decentralization process that started since 2008 jeopardized the GA on HIV implementation with IFRC health staff spread over different locations not necessarily with similar goals and

⁶⁷ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance note 2

⁶⁸ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 35.

⁶⁹ Global Alliance on HIV Newsletter n. 3 February 2008

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objectives. Additionally, mobilizing human and financial resources proved to be quite challenging leading to a depletion of human resources dedicated to support the GA on HIV implementation.” (Online survey)

4.2.5 As of December 2012, there was only one full-time HIV position left in Geneva (HIV Advisor) supported by a part-time (30%) Administrative Assistant. Most regional/zone HIV positions have been either abolished or integrated into the zone health teams. The only remaining full time position on HIV in the Southern Africa Team is also due to be abolished in 2013. Funds available to the Federation at global level for the coordination of HIV response have been dramatically reduced, from an estimated 3 million CHF per year in 2006 to a (planned) 630,000 CHF in 2013 (including staff costs).⁷⁰

“The HIV GA started with good, quality staff. However, no funds were earmarked for secretariat support and the reduced PNS support led to reduced Secretariat staff and reduced attention to HIV. There’s been a lack of political commitment and the momentum was lost with the abolition of HIV Governance Group, closing down of the HIV unit and of the Masambo Fund.” (Online survey)

4.2.6 The reduction in staff and funds dedicated to HIV was compensated in part by the process of integration of HIV activities within the global, zone and NS health teams and mainstreaming with other health and non-health programmes (e.g. TB, malaria, community resilience, or the Community-Based Health and First aid in Action (CBHFA)). The effectiveness of this integration process has yet to be assessed. What seems clear is that **with such reduced funding and workforce, it is not possible for the Secretariat to effectively provide all the services and support to NS envisaged in the HIV GA design in terms of strategic direction, technical guidance, PMER support and resource mobilization.**

“Yes, the direction of the HIV GA is right but there is not enough capacity to do the job and to sustain the coordination.” (Online survey)

HIV GA policy and strategic guidance

With the possible exception of the HIV GA Forum, the Alliance oversight bodies were dismantled too soon and failed to provide the expected guidance and support to the programme.

4.2.7 The HIV GA global programme also included two oversight bodies: the Steering Committee and the Forum of stakeholders. Together with the pre-existing IFRC HIV Governance Group they were expected to provide policy and strategic guidance on HIV to the Governing Bodies, to guide the HIV GA on priorities and strategic approaches, to facilitate the exchange of ideas and experiences, and to advocate for a greater IFRC involvement in HIV work.⁷¹

4.2.8 The HIV GA Steering Committee included one NS representing each zone, the three major contributors to Red Cross Red Crescent HIV programmes, the Chair of the HIV Governance Group, a representative of PLHIV and, controversially, a representative from all NS which had contributed directly more than 50,000 CHF per annum to the HIV GA Secretariat.⁷² This last requirement was not well received by some PNS that refused to participate in the committee. In 2008, the Steering Committee consisted of the NS from Australia, Canada, India (co-chair), Malawi (co-chair), the Netherlands, Sweden (co-chair), the United

Box 8: Terms of Reference of the HIV GA Steering Committee:

- Provide guidance on the allocation of available resources;
- Provide guidance on the setting of priorities;
- Provide views on the performance of those responsible for implementation and delivery;
- Promote compliance with the modalities of global alliance working;
- Resolve problems and disagreements, as necessary.

⁷⁰ Bernard Gardiner and Patrick Couteau (personal communication).

⁷¹ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Note 2.

⁷² Letter from the HIV GA Steering Committee to all NS dated 1st December 2007

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Kingdom, and the United States, as well as the Special Representative of the Secretary General (co-chair).

4.2.9 The main functions of the HIV GA Steering Committee were to provide strategic guidance and managerial oversight to the Programme, as described in its terms of reference. (Box 8). The Committee was supposed to meet twice a year but it reportedly met only three times before being dismantled. Only the report of the first meeting held in November 2007 was available for this evaluation. Several organizational issues were addressed including: a review of progress made; a quarterly plan for activities; the Committee membership and modus operandi; and the development of communication and resource mobilization strategies. **No information is available on the actual follow-up to the decisions taken in this initial meeting, including on the crucial issue of resource mobilization.** Several respondents expressed the view that **decisions regarding the HIV GA were being taken elsewhere and that the Steering Committee never really managed to play its oversight role in guiding the work of the Alliance.**

4.2.10 Since 2000, the **IFRC HIV Governance Group** had been very active in advocating for increased Red Cross Red Crescent involvement in HIV. In its 2008 report to the Governing Board, the HIV Governance Group strongly recommended that the Board sent a clear signal that stigma and discrimination and lack of respect for key populations vulnerable to HIV will not be tolerated. It also requested the Board to acknowledge the strategic importance of the HIV GA to the whole organization and to ensure that lesson learnt are fully utilized for IFRC organizational change.⁷³

4.2.11 Two additional meetings of the HIV Governance Group were held in 2009 before the group was dismantled. The responsibility to advise the Federation on HIV issues has now been delegated to the less influential IFRC Health and Sustainable Development Commission. Several people interviewed suggested that **the decisions to dismantle the HIV Governance group and the HIV GA Steering Committee are evidence of a decrease in interest and commitment by the IFRC to HIV/AIDS work.**

“The phasing out of the Federation’s HIV and AIDS special representative in 2009, the dissolution of the HIV governance group, the dismantling of the HIV unit as a single entity and staffing downsizing from 3 staff to 1 have certainly reduced focus and attention to the Federation’s global HIV and AIDS programme and jeopardized the smooth implementation of the GA on HIV with some PNS shifting back to favour bilateral programming.” (Online survey)

4.2.12 **The HIV GA Forum** included representatives of all Red Cross Red Crescent NS and “entities” that had joined the Global Alliance, the members of the HIV Governance Group and representatives of HIV regional networks. The Forum was supposed to meet yearly and according to its terms of reference, listed in Box 9, it was expected to provide an opportunity for all HIV GA members to review progress made in the implementation of the programme and share experiences and lessons learned. Only two meetings of the Forum were held during the period under evaluation, as side events of the international AIDS conferences in Mexico (2008) and Vienna (2010).⁷⁴ Participation in the meetings was limited to NS and IFRC staff who attended the international conferences.

Box 9: Terms of Reference of the HIV GA Forum:

- Provide a platform for information exchange and coordination;
- Provide advice on strategies and technical content;
- Provide peer review to improve compliance with the “Seven one”;
- Provide critical scrutiny to improve the quality of programming;
- Provide a culture of performance, accountability, reporting, and lesson learning;
- Provide a forum for the consideration of performance reports and assessment of results and impact;
- Promote and advocate for the Alliance in relevant fora;
- Provide resources, and conduct resource mobilization.

⁷³ 17th Session of Governing Board Geneva, Switzerland, 21-23 May 2008. Report of the HIV Governance Group

⁷⁴ A third meeting of HIV GA participating NSs was held during the 2012 International AIDS conference held in Washington, D.C.



4.2.13 Except for a short summary published in the 2010 HIV GA global report and summarized in Box 10,⁷⁵ no official record or report on the discussions and conclusions of the meetings of the HIV GA Forum is available, limiting the possibility of assessing the actual contribution of this body in guiding the work of the Alliance. However, **several respondents confirmed the value of these opportunities to meet and share experiences and lessons learned in improving quality and efficiency of HIV activities and reaffirm the commitment to the HIV GA approach.**

Box 10: the HIV GA Forum held in Mexico City in 2008. This was the first Forum organized by the GA on HIV and was deliberately timed and located alongside the International AIDS Conference in Mexico City to maximize participation and minimize costs. Overall, some 70 Red Cross Red Crescent participants from some 45 National Societies worldwide and the Federation Secretariat took part in one or more of these events, including the immediately preceding “Living 2008 Summit” (of HIV+ people).

After much lively discussion, participants agreed on key priorities for the immediate future, actions which were to (a) improve programme monitoring and reporting; (b) give particular attention to quality including developing consistent standards for the key approaches under the four outputs; (c) boost resource mobilization. At the end of the Forum, the participants, led by Vice-President of the International Federation, took part in the first International March against Stigma, Discrimination and Homophobia.

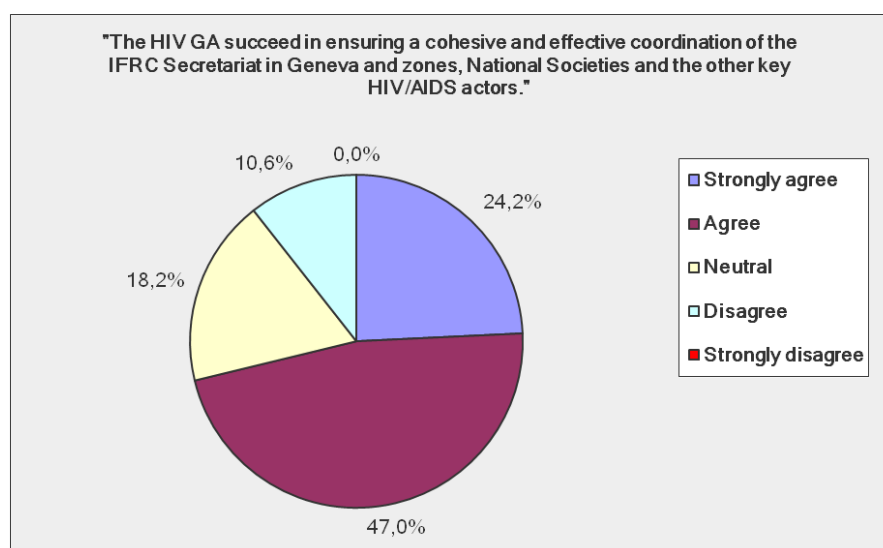
(HIV GA Consolidated HIV programme performance Global report for 2008)

Coordination at global and zone levels

The HIV GA success in ensuring a cohesive and effective coordination of the IFRC HIV/AIDS actors is threatened by the reduced human and financial capacities of the Secretariat

4.2.14 The Alliance aimed at providing a framework by which the goals of the IFRC in HIV/AIDS can be achieved collectively and efficiently. **The HIV GA was seen as successful in ensuring a cohesive and effective coordination of the IFRC Secretariat in Geneva with zone teams, NSs and the other key HIV/AIDS actors** by 71% of respondents to the online survey. Only 10% of respondents disagreed with the statement. (Figure 7) A few respondents qualified their responses in stating that the programme was more effective in providing coordination at regional level and during the initial launch phase of the Alliance.

Figure 7: Success of HIV GA in ensuring a cohesive and effective coordination



⁷⁵ Global Alliance on HIV Comprehensive HIV programme delivery Global report 2010

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4.2.15 Many respondents saw the application of the “seven ones” principles and the increased opportunities offered to NS to meet and exchange information and experiences as quite effective in improving coordination. Through the HIV GA, the NS started speaking “*the same language*” on HIV and reporting against the same common indicators, which led to greater uniformity in the work of the NS. The regional/zone teams played an essential role in facilitating communication and coordination between NS and the Secretariat in Geneva.

“The GA alliance allowed a framework to make the work more coherent, enabled NSs to work in areas that they previously did not (e.g. treatment and testing) or with at risk groups that they previously did not, and enabled the IFRC to report on aggregate results globally.” (Online survey)

4.2.16 **However, there is now a widespread concern among implementers that those positive gains may not be sustained over time due to the reduction in dedicated IFRC staff and resources, which could lead again to a fragmentation of the Red Cross Red Crescent HIV response.** Many reported that coordination is becoming increasingly difficult in spite of the individual commitment and dedication of the few remaining staff of the Secretariat.

“Given (that) co-ordination was so poor before, and most key players in Red Cross prefer to do their own thing rather than take a multi-lateral approach, the GA was a bold and brave attempt to change the organizational culture. It was not fully successful of course, but it was more successful than any other attempt at this scale of change.” (Online survey)

Integration and mainstreaming of IFRC HIV activities

Integration is now an established IFRC policy that can be cost-effective and bring potential gains but also has risks and challenges. Some specific HIV interventions are difficult to integrate and may require specific approaches and dedicated resources.

4.2.17 **The HIV GA strategic approaches included integrating and mainstreaming HIV into other health and non-health IFRC programmes,** one of the main recommendations of the 2005 Evaluation. The Alliance Programme Manual states that “*Interventions must be mainstreamed, wherever feasible.. Thus HIV activities may be carried out jointly with maternal and reproductive health, tuberculosis (TB), safe blood and other related interventions.*”⁷⁶ The HIV GA Manual also included a separate Technical Note on Programming on joint TB/HIV programming.⁷⁷

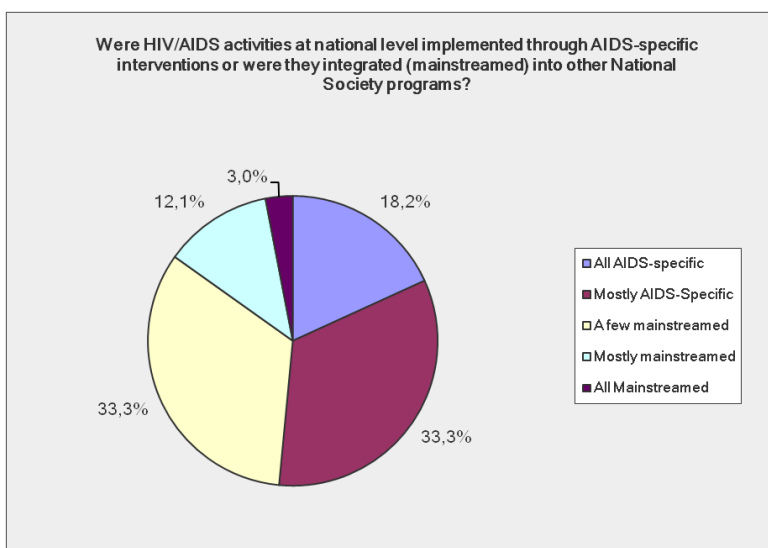
4.2.18 **However, the Global Alliance on HIV was essentially structured and implemented as a “vertical” programme.** As confirmed by our informants, integrated or mainstreamed HIV programmes remained the exception rather than the norm, including when addressing HIV/TB issues. As shown in Figure 8, only 15-16% of respondents in the online survey agreed that all or most HIV GA activities were integrated or mainstreamed into other programmes. **The level of integration seems more advanced at country level, with twice as many NS respondents stating that at least a few HIV activities were mainstreamed.**

⁷⁶ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 16.

⁷⁷ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Note n. 10.



Figure 8: Integration or mainstreaming of HIV/AIDS activities



4.2.19 Integration is now an established IFRC policy and most NS are moving towards integration of HIV with other health development activities, in particular with the Community-Based Health and First aid in Action (CBHFA) programme. The majority of PNSs are also increasingly shifting their support from HIV specific activities to integrated health programmes. Several respondents reported positive experiences with integration of HIV activities with programmes like TB, malaria, immunization, maternal and child health, reproductive health, youth, blood safety, emergency health, violence prevention, water and sanitation. Integration of activities is being pursued also in high-burden countries where HIV is considered a top priority and NS continue running separate HIV operational structures.

“It depends of the regions and how important is the HIV problem in a given country whether it should be a specific programme or an integrated programme. The trend of the past years is to integrate HIV activities in all programmes (food security, health, humanitarian diplomacy, gender, youth, migration, DRR...) and this is the most effective way to sustain the efforts.” (Online survey)

4.2.20 **The potential benefits of integration in terms of efficiency and effectiveness of programmes are well known.** They include economies of scale and reduction of overall costs, enabling cost-sharing, allowing the pooling of resources, contributing to building sustainability, reaching people who may not participate in a HIV specific activity, transferring knowledge and building skills within the National Society.⁷⁸ **Possibilities of integration of HIV activities exist with many NS programmes.** The recent evaluation of the HIV GA in the Americas noted that: *“HIV prevention can easily be incorporated into the information activities such as promoting the reduction of violence. It can also involve psychosocial support especially with vulnerable communities who often suffer psychological wounds because they are stigmatized. It can also be included in training on community-based health and first aid. Promoting messages on safer sexual practices can also be integrated into other youth programmes and initiatives.”*⁷⁹

“Vertical programming has detrimental consequences at the community level. RCRC should continue the process of integration of HIV response with other health programmes, to increase efficiency, reduces costs and ensures sustainability in an environment of scarce resources.” (Online survey)

4.2.21 However, **there is also awareness about the challenges of effective integration** and concerns were expressed during this evaluation about the possible dilution of HIV human and financial resources and the loss of visibility and support for the HIV programs. In particular, **there**

⁷⁸ Reducing vulnerability to HIV and its impact in four Pacific Island Countries. Findings from the Mid-term Evaluation of the IFRC component of GFATM Round 7

⁷⁹ Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011



is a fear that integration might lead to reduced commitment and reduced attention to some interventions that are HIV-specific and therefore less amenable to integration. For example, working with marginalized and highly vulnerable populations or addressing stigma and discrimination are essential components of the HIV response but of much lesser relevance to other health programmes. Recent reviews of the experience made by the Federation in attempting to mainstream HIV in other non-health programmes have highlighted both the potential benefits and challenges.

“IFRC experiences the same challenges as other organizations in mainstreaming HIV into its work and disaster response. On the whole, HIV is not integrated into disaster work. This seems to be largely due to the view that addressing HIV is not a priority in a disaster because it is not recognized as an immediate, lifesaving intervention.”⁸⁰

Cooperation and partnership with other international organizations

Partnerships with international organizations did not increase significantly under the HIV GA.

4.2.22 This evaluation found that the HIV GA had mixed results in the efforts to improve cooperation and partnership with other international organizations. Sixty per cent of respondents to the online survey agreed that the HIV GA was successful in ensuring a cohesive and effective coordination with partners based on comparative advantages. The Alliance emphasized the role of partnership in resource mobilization and the importance of strengthening partnership with PLHIV but lacked a clear strategic approach to international partnerships, in particular with GNP+, the Global Fund and UNAIDS.

4.2.23 At global level, there is little evidence of increased cooperation and partnership with other international actors under the HIV GA with the exception of IFRC participation in global events. During the initial “launch” phase, the image of the IFRC in the international HIV/AIDS arena has probably gained from the high profile given to the programme, the expression of commitment by the Federation Governing bodies, and the official launches held in the different regions. The IFRC participated actively in the International AIDS conferences (Mexico, 2008; Vienna, 2010); the UN HIGH Level meeting on AIDS (New York, 2011) and other regional and global HIV-related events. IFRC side events were organized in these occasions to disseminate information and promote the work of the Federation in HIV. The IFRC also participated, in partnership with GNP+, in the planning for the 'LIVING 2008 - The Positive Leadership Summit' that took place in Mexico City just before the 2008 International AIDS Conference.⁸¹ At global and zone levels, IFRC is part of the Inter-agency task team on HIV in Humanitarian settings and supported the mainstreaming of HIV into the Federation’s emergency response.

4.2.24 However, the HIV GA failed to negotiate a working partnership and funding agreements with the Global fund, to define possible mechanisms for collaboration at regional and country level. Commitments made under the partnership agreement with the GNP+ network were not kept, which led to the end of this long established collaboration. The Collaborating Centre agreement with UNAIDS produced little results and was terminated in 2011. No other collaborative agreement has been negotiated with relevant partners, including with UNAIDS.⁸² The progressive reduction in staff and the closing of the office of the Special Representative has reduced considerably the capacities of the Secretariat to participate actively in the many international HIV events or maintain the required regular contacts with international partners.

4.2.25 At country level, the NS HIV Programme Document served as the main tool to facilitate cooperation and partnership with local partners, including in resource

⁸⁰ Review of IFRC material on HIV and AIDS and sudden-onset emergencies

⁸¹ Global Alliance on HIV report 2008.

⁸² Discussions on a new cooperative agreement with UNAIDS have resumed at the end of 2012.

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mobilization. Some of the NSs surveyed in this evaluation (e.g. Rwanda, Uganda, Ecuador and Thailand) have been very proactive in reaching out to other partners, participating in the work of the National AIDS Commission and the Global Fund CCM, supporting local networks of PLHIV, and in building their own image and credibility. Not surprisingly, this often resulted in increased access to funds from the local donors, including from the Global Fund.

“The Global Alliance on HIV promoted the creation of strategic alliances with key players, both locally, regionally and nationally. This strengthens the basic social cohesion for an effective HIV response, avoiding duplication of efforts, promoting the efficient use of resources and horizontal cooperation and the creation and deployment of local capacities.” (Online survey)

“With the support of the Federation, my national society remained operational and visible and permanent in the fight against HIV - AIDS over the past three years in my country. Health authorities began to take an interest in my company and national actions against HIV - AIDS. PLHIV discover the Red Cross and enjoy the activities carried my national society.” (Online survey)

4.2.26 Some NSs have been sometimes quite passive in their approach to cooperation and partnerships. The Red Cross Red Crescent is often seen as working in isolation, in an “*ivory tower*”, not open towards collaboration with other partners. Some NSs are described as simply waiting for the IFRC and PNSs to provide them with the financial resources, not seeing the need to engage with other local national or international partners, leading to NS work being “invisible” at country level and to missed opportunities for partnerships and resource mobilization.

“Very little cooperation and partnership with governmental structures, almost no connection with the Global Fund and its principal recipient(s), other NGO’s or international organizations and no internal fundraising has led to a lack of secured continuation of a programme that has finally taken off. Coordination with international NGO’s has been negligible”⁸³

⁸³ Red Cross and Red Crescent Societies Regional HIV and AIDS Programme in South Asia Mid-term Evaluation Report



Conclusions on the IFRC Secretariat programme management and support

- The HIV GA was initially supported by a sufficiently large HIV team based in Geneva and in the Regions. After the restructuring of the programme, the abolition of the position of Special Representative and the reduction in dedicated HIV staff in the zone offices the few human resources remaining are not sufficient to ensure all the basic functions of the global HIV programme.
- The HIV GA Steering Committee and HIV Governance Group did not provide the expected policy guidance and oversight to the programme and were dismantled. These decisions not only deprived the HIV GA of much needed guidance but also signaled a reduced IFRC commitment to HIV. The Forum of stakeholders was partially successful in facilitating sharing of information and lessons learned.
- The HIV GA improved coordination of the IFRC Secretariat in Geneva with zone teams, National Societies and the other key HIV/AIDS actors. Through the HIV GA, the NS started speaking “the same language” on HIV and reporting against the same common indicators, which led to greater uniformity in the work of the NS. However, the reduction in IFRC staff and resources could limit coordination efforts and lead again to a fragmentation of the IFRC HIV response.
- The Red Cross Red Crescent is progressively moving towards integrated approaches to health development. Integration can be cost-effective and bring potential gains but also has risks and challenges. Some specific HIV interventions are difficult to integrate and still require specific approaches and dedicated resources.
- IFRC cooperation and partnerships with international organizations has not increased significantly under the HIV GA, in part due to reduced commitment and Secretariat capacities, and in part to the reluctance by some NSs to engage with partners.



4.3 Objective 3 – Assess National Society capacity development for HIV/AIDS programmes

NS capacity building

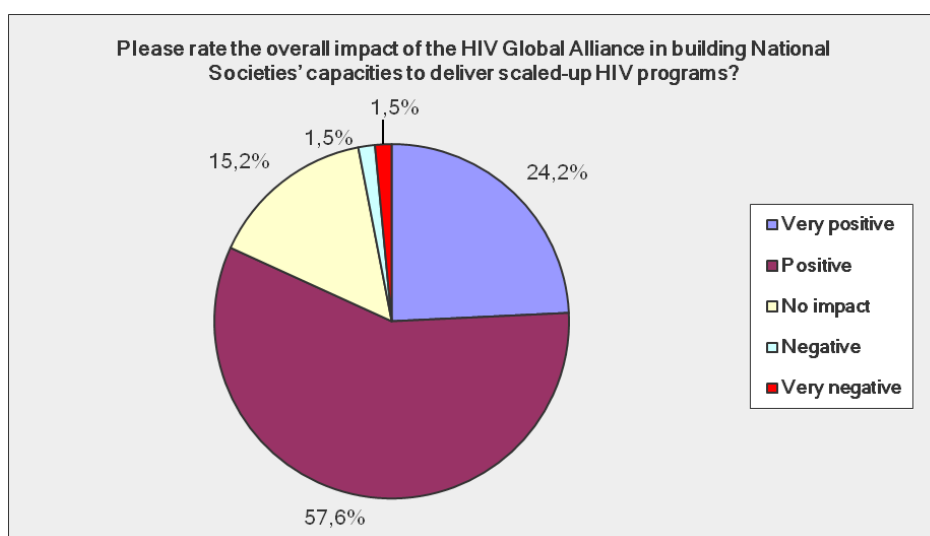
HIV GA support was effective in building NS technical and managerial capacities for delivering HIV/AIDS programs but failed to improve NS capacities in resource mobilization.

4.3.1 Building capacities of National Societies was considered an essential component of an effective Global Alliance on HIV and features prominently among the activities of the IFRC global and zones HIV teams. Capacity building aimed at providing Red Cross Red Crescent volunteers and staff with the relevant HIV technical knowledge and with competence in programme management, planning, monitoring, advocacy, communication, and resource mobilization. A large share (20%) of the budget requested in NS HIV Programme Documents was destined to institutional strengthening and capacity building.

4.3.2 The HIV GA supported NS in different aspects of programme planning, implementation, monitoring and evaluation. Support was provided in the form of technical missions to countries, training workshops, and the development and dissemination of technical guidance and best practices. The HIV GA Forum, the meeting of the regional Health Networks and other regional and global meetings provided opportunities to share experience and strengthen planning and implementation capacities. One of the major achievements was the support provided by the Secretariat to 57 National Societies in developing comprehensive HIV National Programme Documents based on a common HIV GA format.⁸⁴

4.3.3 A total of 180 Master Trainers have been trained in Africa (96), in Asia and the Pacific (20), in the America's (22), in the Middle East (17) and in Europe/Central Asia (25) using the IFRC/SAfAIDS/WHO Training Package on Prevention, Treatment, Care and Support for community volunteers. Master Trainers have the skills and capacities for conducting training of trainers course (TOT) of branch facilitators at country level, thus contributing significantly to building the capacity of the National Societies. It is estimated that the trainers organised an average of 6 volunteer training courses per year, reaching out to a total of more than 119,000 volunteers in 2009-11.⁸⁵

Figure 9: Impact of the HIV GA on NS capacities for HIV Programming



⁸⁴ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Note n. 5.

⁸⁵ Global Alliance on HIV report, 2011.

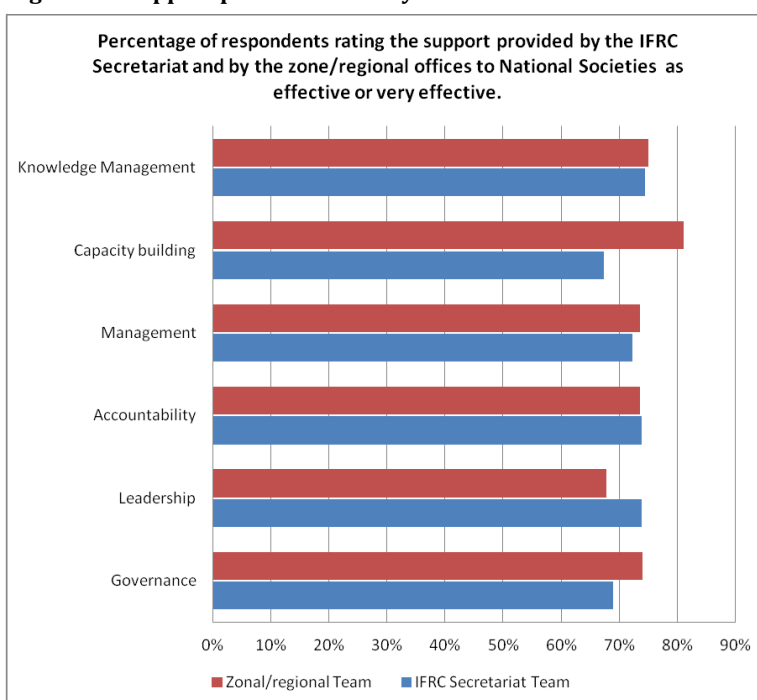


4.3.4 Except for the total number of Master Trainers trained, no other specific indicator for capacity building was collected, limiting the possibility of documenting the total number of NS volunteers and staff trained, the nature of the training or its outcome. **However, four out of five respondents to the online survey thought that the HIV GA had a positive or very positive impact in terms of building NS capacities for HIV programming.** (Figure 9) Only 2 respondents felt that impact was negative or very negative. The most disappointing area in capacity building was resource mobilization, with 40% of respondents stating that the support from the HIV GA did not increase NS capacities in fundraising.

“The training of trainers, peer educators, supervisory staff and others to raise their capacity and to transform theoretical knowledge into activities was an impressive effort.”⁸⁶

4.3.5 **The support provided by the IFRC Secretariat was rated effective or very effective by more than two thirds of respondents.** (Figure 10) Support included technical advice, backstopping in implementation, establishing links with international partners, provision of training opportunities, sharing of experiences, and financial support. Capacity building efforts by the Zone teams received the highest scores with more than 80% rating it as effective or very effective.

Figure 10: Support provided to NS by the IFRC Secretariat



4.3.6 **The HIV GA paid special attention to strengthening NS capacities in planning, monitoring, evaluation and reporting.** Weak PMER capacities at country level are recognized as an important barrier for HIV programming and regional reviews and evaluations recommended urgent actions to strengthen NS capacities in this area. Efforts included support to the planning for the development of NS HIV programme documents and on establishing the performance tracking system. Collecting, validating and reporting programmatic data to the IFRC and the different donors is a heavy burden and requires well trained staff dedicated to this task. Some regions were very proactive in supporting NS through technical guidance, training and the funding of PMER positions. **Unfortunately, sustainability proved difficult as most of these positions have been closed due to budgetary cuts and the related expertise has now in part been lost.**

4.3.7 **The majority of respondents to the online survey rated the HIV GA support to governance, management, accountability and leadership of participating NS as effective or very effective.** Efforts by the HIV GA in this area were supported by the the former IFRC Secretary General in his report to the 16th Session of the General Assembly in Geneva and the endorsement by the same General Assembly of the HIV Global Alliance approach “*which should continue to be rolled out as quickly as possible in all regions*”.⁸⁷ The Office of the Special Representative coordinated efforts to increase awareness and commitment to the HIV GA by NS, including through the launches of the Alliance in the different regions attended by many senior NS

⁸⁶ Red Cross and Red Crescent Societies Regional HIV and AIDS Programme in South Asia Mid-term Evaluation Report

⁸⁷ Global Alliance on HIV Newsletter n. 2, December 2007.

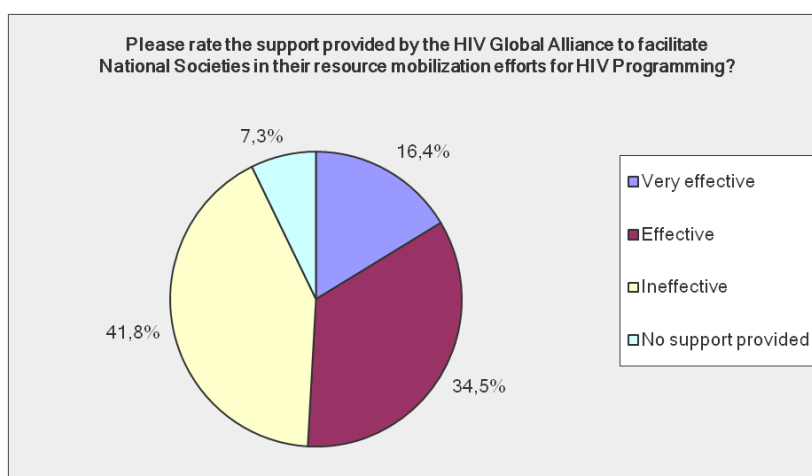


representatives. The HIV Governance Group also emphasized the strategic importance of the HIV GA to the Governing Bodies and the NS leadership.⁸⁸

4.3.8 However, support was much reduced following the HIV GA reorganization in 2009, the reduction in HIV staff and the shift of IFRC attention to other corporate priorities. **There is no evidence of regular follow-up with NS leaderships after the HIV GA launches or of specific activities aimed at building the relevant capacities of the NS senior staff for improved governance, accountability and leadership.** There is also no information of how many NSs have actually endorsed and applied the 2004 *Code of Good Practice for NGOs Responding to HIV* which was developed in collaboration between the IFRC and GNP+.

4.3.9 **The HIV GA failed to provide the required support to NS in building capacities for resource mobilization.** As shown in Figure 11, the support was rated ineffective by 42% of respondents to our online survey, with an additional 7% stating that no support at all was provided to their NS. Though regional teams assisted NS in resource mobilization, there is no record of structured efforts to build NS capacities in resource mobilization skills, including on how to approach donors, how to develop robust funding proposals or how to prepare accurate technical and financial reports that fulfil donors' requirements.

Figure 11: Support provided to NS in resource mobilization



4.3.10 **Particularly disappointing is the lack of specific efforts to increase knowledge and improve capacities of NS staff to access resources from the Global Fund,** the main source of financial support to HIV/AIDS programmes at country level and the best option for scaling up IFRC HIV programming. The GF has a unique grant proposal mechanism and strict grant reporting requirements that are often poorly understood by country stakeholders. Application procedures are often modified based on GF Board decisions, requiring a regular updating of field staff. Though IFRC regional teams did provide technical support to NS in developing GF proposals⁸⁹, these were neither systematic nor institutionalised.

“Technical support is required for the development of resource mobilization strategies and the acquisition of capacity for resource mobilization at all levels. NS need to be open to new partnerships and strategic alliances that may facilitate future funding. Support and commitment at the senior management level of the NS’s will be required to assist in identifying new sources of funding and allocate appropriate resources to bolster the GA HIV programmes as necessary.” (Online survey)

⁸⁸ 17th Session of Governing Board Geneva, 21-23 May 2008. Item 12th of the Agenda. Report of the HIV Governance Group

⁸⁹ For example, an IFRC Round 11 orientation workshop to engage with GFTAM was organised for NS from Botswana, Liberia, Laos, Malawi and Togo who were planning to submit HIV proposals.



4.3.11 Though prioritization criteria were suggested,⁹⁰ **the HIV GA did not prioritize support to NS capacity building on the basis of assessed needs.** Clearly the Southern Africa region, with the highest HIV burden, received the majority of funds and support and developed larger HIV programmes. However, support from the Secretariat did not focus particularly on the Southern Africa region possibly due to the consideration that regional capacities were already well developed. **Support seemed to follow opportunities and availability of funds rather than strategic or epidemiological considerations.** Some informants commented that the initial focus of the HIV GA Secretariat was on expanding quickly the programme to as many NS as possible, resulting in a dispersion of limited resources and a reduced impact on capacity building.

4.3.12 **Capacity building needs to be a continuous effort in order to reinforce competencies and compensate for the loss of expertise due to staff mobility.** Priority areas for future support include the provision of policy and operational guidance on the integration of HIV in community health programmes and building NS capacities in resource mobilization and in planning, monitoring, evaluation and reporting. **The reduction in HIV resources and dedicated staff, in particular at regional/zone levels, are seen as the main obstacles in continuing to build the required NS capacities.**

“Despite the challenges, the programme has effectively built the capacity of NS to deliver services. The capacity building activities have nurtured an active interaction between finance and programme staff and improved financial management and reporting. NS are now seen as reliable and trusted partners by governments and other national stakeholders. The major challenge for NS is the high staff turnover.”⁹¹

Knowledge management and technical guidance

The HIV GA produced valuable documentation and guidance. Regional networks are most effective in improving NS capacities and increasing the quality and effectiveness of HIV interventions

4.3.13 Documentation produced by the HIV GA included technical and programmatic guidance, best practices, newsletters, global reports and meeting reports. Five global HIV GA newsletters were published between 2007 and 2009 and yearly global programme reports were produced between 2008 and 2011. Most technical documents were produced during the initial launch phase of the Alliance. These documents were translated in different languages and disseminated widely through zone and NS offices. **Both production and dissemination of information materials decreased considerably after the initial launch phase, probably as a result of the reduction in Secretariat staff and funds.**

4.3.14 The HIV GA Secretariat produced several guidance documents and technical tools aimed at improving managerial and programmatic capacities at country level. These include:

- “*RCRC Global Alliance on HIV programme manual*” providing the rationale and the strategic and operational basis for the HIV GA approach.
- “*HIV prevention, Principles and guidelines for programming*” (2007) providing strategic and practical guidance to National Societies working in the area of HIV prevention;
- “*Global Alliance on HIV marketing tools per region*” (2007-2008);
- “*HIV prevention treatment, care and support, a training package for community volunteers*”, a pioneering community-based training package;
- “*Inequalities fuelling HIV pandemic*”(2009) with a focus on the response of NS in Latin America and the Caribbean;

⁹⁰ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Note n. 2

⁹¹ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010 End Of Programme Evaluation Report

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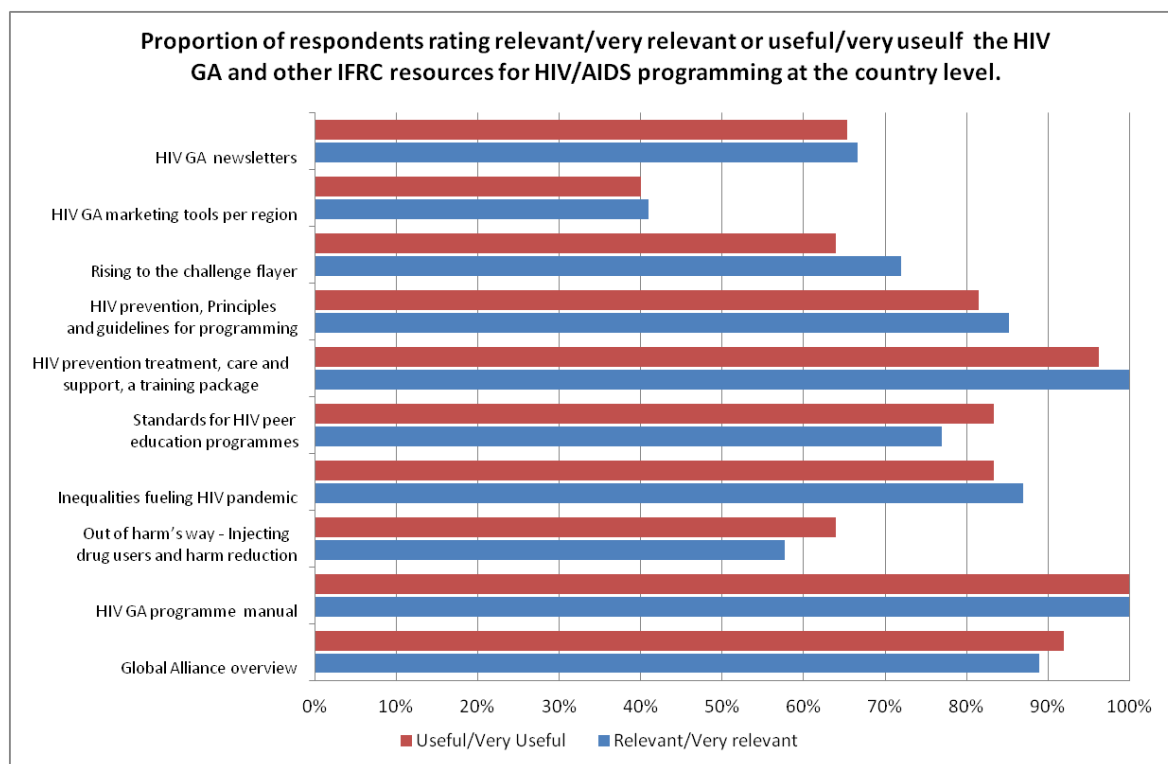


- “Standards for HIV peer education programmes” (2009) providing a common framework for National Societies implementing and supporting HIV peer education programmes;
- “Out of harm’s way - Injecting drug users and harm reduction” (IFRC, 2010) with a special emphasis on Eastern Europe and Central Asia.
- ”Eliminating health inequities” with a focus on women and children.
- “The Ties That Keep Us Together” (2011) to motivate interest in the Masambo Fund

4.3.15 Respondents were in general very satisfied with both the quantity and quality of guidance material produced by the HIV GA, though some complained about the limited number of best practices documentation produced and the quality of some meeting reports. As shown in Figure 12, HIV GA documents were rated both relevant and useful by more than 80% of respondents to the online survey. Only one publication, the “Global Alliance on HIV marketing tools per region” was considered unsatisfactory, with only 40% of respondents rating it useful or relevant. However, some doubts were raised on the actual impact of the HIV GA documentation in light of the limited number of copies available for distribution to local branches of the NS and limited funding for translation, which reduced the amount of material available in local languages. **The development of specific IFRC guidance on best practices for the integration of HIV activities in community health programmes is now considered the top priority.** Additional requirements include guidance on approaches to gender issues, working with vulnerable populations, addressing sexual diversity, promoting human rights and addressing stigma and discrimination.

“One of the key areas for capacity development was development and/or rolling out of guidelines and materials for prevention, treatment, care and support, and stigma reduction.”⁹²

Figure 12: Usefulness and relevance of HIV GA guidance documents



⁹² Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010 End Of Programme Evaluation Report



4.3.16 Providing opportunities for sharing of experiences and lessons learned among NS are seen as the best way to improve the technical quality of NS HIV Programmes. HIV GA efforts to expand regional networks are seen as a very effective way to share knowledge and improve NS HIV programming capacities. Several respondents suggested that the IFRC should expand its support to HIV specific regional network meetings and/or ensure that HIV/AIDS issues are regularly discussed at the meetings of the regional Health Networks.

“We have an excellent experience in our region. Several meetings of NS were held to share experiences and country visits to other NS were organized to learn from their experiences. These are the most important activities at Federation level but funds are often limited.” (Online survey)

Conclusions on National Society capacity development for HIV/AIDS programmes

- Support provided by the HIV GA was effective in building NS technical and managerial capacities. Sustainability of the gains made is under question in light of the reduced availability of resources and high staff turnover.
- Capacity building in PMER received special attention to ensure the development of robust NS HIV plans and the regular reporting on the performance of HIV programs. Training also aimed at improving the technical capacities in HIV programming of IFRC staff and volunteers mainly through the use of Master Trainers.
- Strengthening governance, accountability and leadership of NS is essential in scaling up and was a priority at the start of the Alliance. However, it received much less attention and support after 2009 in light of shifting priorities and the reduced capacities of the Secretariat.
- Capacity building in resource mobilization was the only component rated as insufficient and often ineffective by the majority of respondents. Efforts by zone teams to support NS in this essential area were sporadic and not systematic, particularly in relation to the Global Fund.
- The HIV GA produced valuable documentation and guidance for NS though production of new materials and dissemination slowed down with the reduction in Secretariat resources. There is an urgent need for guidance on best practices for the integration of HIV activities in community health programmes.
- Regional networks are very effective for sharing knowledge and experience, improving NS HIV programming capacities, and ultimately increasing the quality and effectiveness of HIV interventions. They are considered a good investment for the scarce IFRC HIV resources.



4.4 Objective 4 – Assess the “Seven Ones”

4.4.1 The “Seven Ones” principles provided the operational framework for the implementation of the HIV GA Alliance.⁹³ The aim of the principles was to achieve the “*harmonized, disciplined and results-focused approach*” within the IFRC that would have enabled the planned scaling up and doubling of HIV programming by the end of 2010. The Principles also formed the “*legal basis for the responsibilities and obligations of the Global Alliance on HIV membership.*” NS wishing to join the HIV GA were expected to support and subscribe to the “Seven Ones” while all NS and IFRC entities working on HIV were encouraged to adopt one or more of the principles.⁶³

One set of needs analysis

NS HIV needs assessments were conducted using standardized approaches in coordination with national authorities and partners.

4.4.2 This first principle aimed at building a “*common understanding of the HIV problems being addressed*” through the use of a standardized and objectively-verifiable needs assessment approach. **More than 80% of NS-based respondents to the online survey agree or fully agree that the HIV needs assessment in their country was conducted using standardized approaches and tools.** There were only a few dissenting views, suggesting regional or country differences in the application of the principle.

“The GA planning was not based on any real evidence base or needs assessment process. It was a very rapid process with branches being informed at the last minute and much of the data was unreliable.” (Online survey)

4.4.3 In general, NS did not use IFRC specific assessment tools but took advantage of existing analysis of the HIV needs taken from the National HIV Strategic plan and from HIV surveillance and behavioural studies and vulnerability assessments of key population groups conducted by national or international partners. NS identified specific needs to be addressed by the Red Cross Red Crescent in consultation with key national stakeholders. **This approach facilitated the alignment of the NS HIV Plans with national strategies and the coordination with other national and international implementers.**

“The South Asia Regional Programme was based on several needs assessment instruments that included mapping of the health programmes of all the six NS, human resources in the health and HIV programmes, in collaboration and networking with development partners including UN agencies and Ministry of Health.”⁹⁴

One set of objectives and strategies.

NS HIV plans were usually aligned with the objectives and strategies of the HIV GA but did not always take fully into consideration the local contextual issues.

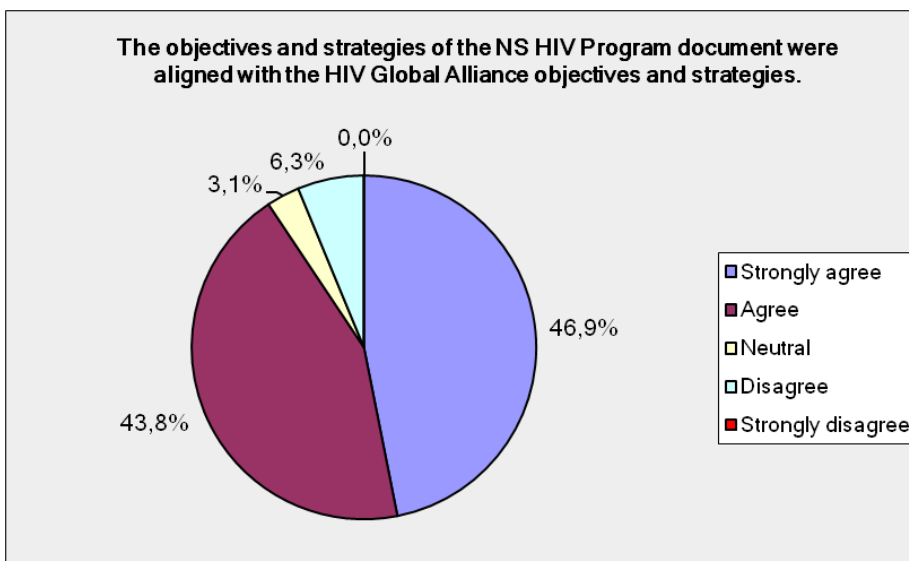
4.4.4 The application of this principle required that country-based HIV programming be harmonized with the core objectives and strategies of the IFRC Global Alliance on HIV. Feedback from the online survey, the review of selected national HIV Programme Documents and the interviews conducted confirmed that **NS national HIV plans were usually aligned with the objectives and strategies of the HIV GA, covering all four programme outputs and proposed implementation principles.** (Figure 13)

⁹³ Probably an extension of the UNAIDS “Three Ones principles” i.e. One agreed HIV/AIDS Action Framework for coordinating the work of all partners, One National AIDS Coordinating Authority, and One agreed country level Monitoring and Evaluation System.

⁹⁴ Red Cross and Red Crescent Societies Regional HIV and AIDS Programme in South Asia Mid-term Evaluation Report



Figure 13: Alignment of NS plans with HIV GA objectives



4.4.5 The importance and benefits of promoting a more aligned and coordinated approach across the Federation is fully understood. It allows all IFRC entities to “speak the same language” in HIV programming, facilitates advocacy and resource mobilization, simplifies monitoring of performance and allows comparisons across countries and regions. However, **some criticized what they saw as a prescriptive, “one size fits all” approach, developed on the basis of the specific experience of Southern Africa and that did not take into sufficient consideration contextual issues** like local needs, existing resources, and NS comparative advantages.

“Plans were too generic/broad/standardized/prescriptive. NS should be allowed to decide where and how to invest in HIV.” (Online survey)

4.4.6 The danger of a “one size fit all” approach was acknowledged by the Alliance. *“The Global Alliance on HIV is intended to be a “platform” and not a “prison”. In other words, the diversity of our NS is seen as strength to turn the broad principles of global alliances into practical arrangements for coherent and cooperative working, according to locally prevalent realities. Not all the Global Alliance on HIV outputs and approaches have to be reflected in all country programmes – but the outputs and approaches selected in any particular NS plan should be taken from among those listed in the Strategy of the Global Alliance on HIV.”⁹⁵*

4.4.7 NS could therefore choose from the list of HIV GA strategies those that they considered relevant on the basis of their assessed needs and priority areas but this might not always have been the case. At least one NS reported that the NS HIV programme document had to be rewritten as it was duplicating activities already supported by the Global Fund. **It is possible that NS might have opted for the “standardized” list of HIV GA strategies in order to raise more funds or because of perceived pressure from the Alliance.** Some NS reportedly rushed to develop the NS HIV plan in order to meet the regional launch deadline and this might also have impacted on the robustness of the planning exercise and the quality of the resulting HIV Programme Document.

One HIV country plan with expectation of long term commitment to ensure sustainability

Comprehensive NS HIV strategic and operational plans were a major contribution of the HIV GA to the harmonization within the IFRC and with national partners

⁹⁵ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 26.



4.4.8 According to this principle, the basis for delivery of all NS HIV activities at country level was the NS HIV Programme Document developed according to a common GA template and inclusive of all contributions by NS and Alliance members. The HIV GA promoted the alignment of the IFRC HIV work with partners to ensure a more effective and efficient programme implementation. By consulting and actively involving the national HIV programme and relevant national and international partners in the development of the plan, NS could identify gaps, build synergies and avoid duplication of efforts or ineffective interventions

4.4.9 **The development of comprehensive NS HIV strategic and operational plans is seen as a major contribution of the HIV GA to the harmonization of the HIV work within the IFRC.** The NS HIV Programme Document ensured coherence and alignment with the objectives and strategies of the multi-sectorial National AIDS Strategic Plan, which is usually developed by the National AIDS programme in collaboration with all national and international partners.

“IFRC through the GA on HIV subscribes to the UNAIDS principles of the “three ones” at country level. Programmes implemented at country levels are guided by local needs and realities, and the assigned role of National Red Cross or Red Crescent Societies as part of coordinated National HIV and AIDS Programmes. According to context, NS are represented and coordinating their work with the CCM for the Global Fund, National AIDS Control programmes and Ministry of Health technical committees.”⁹⁶

4.4.10 **A review of a sample of HIV Programme documents suggests that they followed in general the format suggested by the Alliance, though with some regional differences.** Key informants confirmed the importance and usefulness of the HIV Programme Document for strategic guidance and harmonization of the implementation of the NS HIV activities. They also confirmed that usually the Programme Documents included all HIV/AIDS activities implemented by the Alliance partners, though there were exceptions of partners, including PNS, developing their own HIV projects and plans. Online survey participants unanimously stated that **the objectives and strategies of the National Society HIV Programme document were coherent with the National AIDS Strategic Plan.** This is not surprising as in most countries Red Cross Red Crescent staff participated actively in the preparation of the National AIDS Strategic Plans.

4.4.11 **Developing and approving the NS HIV Programme Documents was expected to generate the commitment to its implementation by both the IFRC and the NSs, fostering long term sustainability of the programme.** However, the failure to generate the financial resources required to implement the plans and the perceived reduced interest and commitment at the IFRC global level compromised these objectives. Many NS staff and managers, lacking the capacities and resources to implement the ambitious plans developed with the support from the Secretariat, felt let down and abandoned.

4.4.12 HIV continues to be a priority NS program in many countries, supported by the commitment and dedication of NS staff and leaders. In other countries the commitment to the HIV program has now vanished and the ambitious objectives of the HIV GA plans have been abandoned. **With reduced support capacities from the Secretariat and without the incentive of possible funding, the robust HIV GA planning process conducted in 2006-2008 might remain a “one off” exercise.** Indeed, there is no indication that the IFRC is preparing for a new global planning exercise now that the majority of the NS HIV Programme Documents have come to an end.

One shared understanding of the division of labour among entities of the Red Cross Red Crescent Movement

⁹⁶ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 14.

The Red Cross Red Crescent Global Alliance on HIV

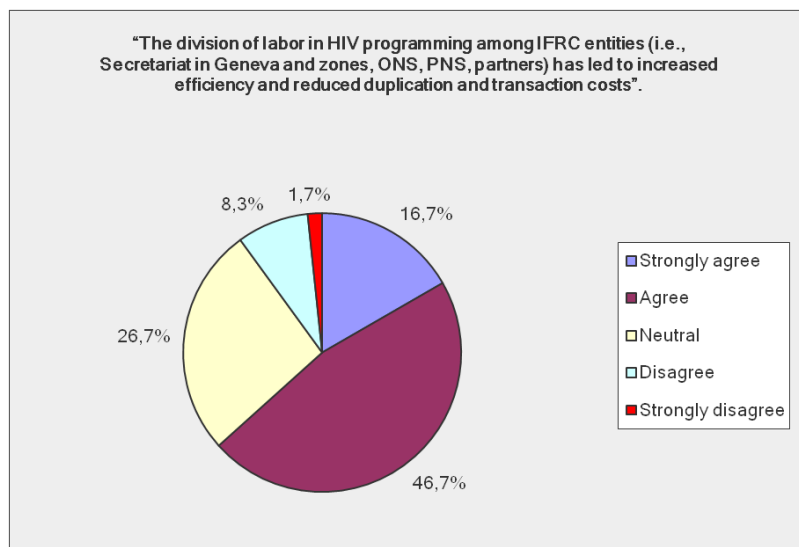


The HIV GA proposed division of labour led to some increases in efficiency but failed in resource mobilization and did not have the required support, or last long enough, to make a long-lasting difference.

4.4.13 The HIV GA proposed division of labour assigned specific responsibilities to members and levels of the IFRC according to their roles, competencies and capacities. NS were expected to provide leadership and take responsibility for programme implementation at country level, PNS would provide resources, capacities and specific support as required, while the Secretariat would play a leadership role at global level while also facilitating the implementation of the programme by all members. This dual scope of the IFRC Secretariat (*“Firstly, it provides core, common services, as listed above. Secondly, it might actually be asked to provide direct programming input at country level”*)⁹⁷ was criticized by a few PNS representatives who felt that the Secretariat should not be involved in direct implementation of activities at country level.

4.4.14 As described in a recent UNAIDS policy document⁹⁸, a division of labour in HIV programming aims at *“leveraging respective organizational mandates and resources to deliver results, including strengthening joint working and maximizing partnerships.”* The division of labour was expected to facilitate IFRC entities working collectively to take forward the HIV GA agenda and vision, based on comparative advantages, and to enhance programme efficiency and effectiveness. As shown in Figure 14, **the majority (63%) of respondents to the online survey agreed or strongly agreed that the division of labour in HIV programming has led to increased efficiency and reduced duplication and transaction costs.** 27% of respondents neither agreed nor disagreed with the statement, while 10% did not agree with it.

Figure 14: Division of labour



4.4.15 **The HIV GA proposed division of labour was a good attempt to clarify roles within the Red Crescent Red Cross, which led to some increase in efficiency but did not have the required support, or last long enough, to make a real difference.** Organizational changes of this scope in a large international organization require time and sustained efforts with a full backing from the organization’s senior management and governance. In the end, NS still seemed to cherish their independence while PNS would prefer working on a bilateral basis and the Secretariat’s reduced capacities do not allow it to continue playing the much needed leadership and coordinating role.

⁹⁷ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 23.

⁹⁸ UNAIDS Division of Labour, Consolidated Guidance note, UNAIDS, 2010

The Red Cross Red Crescent Global Alliance on HIV



“(Division of labour) still needs massive improvement as the organization is complex and because alignment takes time to set up even when all are committed to it. Donor NS need to get their back donors to accept the GA standard indicators and report, rather than each requiring fiddly differences that dilute focus. However, existing contract have to been delivered which means alignment will take years to occur. PNS need sustained discipline to be ensured the principles of good donorship are adhered to.” (Online survey)

4.4.16 The HIV GA division of labour failed in the area of resource mobilization, where confusion in roles and responsibilities led to disappointment and frustration. The Programme Manual assigns responsibility for advocacy and resource mobilization to both the Secretariat and NS. The Secretariat did try unsuccessfully to raise resources globally through advocacy and negotiations with PNSs and partners like the GF, though it was clear that most of the funding had to be mobilized at country level. Many NS were confused, being under the impression that funds would be raised by the IFRC at global level. Some even thought that they were already available at the time of the regional launches. This confusion led to frustration and inaction, and eventually to missing the opportunities to mobilize resources that were available at country level.

“NS made very elaborate and ambitious plans without being clear on how they would mobilize funds for them, promises were made with government counterparts which could not be met. It was not clear for NS at the outset that they would be expected to generate their own funding base. This was too big a shift for many NS who were used to getting funds through PNS partners and when they realized that this was what they had to do, many abandoned their GA plans. No real support was given to help NS to mobilize funds.” (Online survey)

One results-based funding framework

NS HIV Programme Documents usually included all contributions to the NS HIV programme but the implementation of the funding framework failed to generate the required information to facilitate monitoring of financial flows

4.4.17 With this principle the HIV GA aimed at establishing a common financial framework that would record all resources (bilateral or multilateral) allocated to support a NS HIV programme. The objective was to increase transparency on the use of available resources, to assess costs and benefits, to enable the identification of gaps and overlaps, to ensure the most efficient use of funds, to reduce the administrative costs and to decrease the burden of reporting. Respondents confirmed that in general the **NS HIV Programme Documents did include all contributions, which was usually facilitated by the relatively small number of donors.**

“This new Eastern Africa HIV Programme Appeal is innovative in that it reflects all bilateral and multilateral Red Cross activities and thus shows a complete picture of Red Cross and Red Crescent HIV action in each country. Thus, the Appeal forms a strong base for effective cooperation and coordination at country level, through the concerned National Societies. This is anticipated to maximize programme efficiency and impact”.⁹⁹

4.4.18 **The common funding framework was not successful in allowing a constant monitoring of the flow of resources,** as demonstrated by the difficulties in collecting updated and detailed information on the mobilization and utilization of HIV financial resources through the HIV GA Resource Tracking System. In fact, it is not clear if the financial framework was supposed to assist NS in managing the contributions received at country level, or assist the IFRC Secretariat in distributing in a more transparent and equitable way multilateral resources received at IFRC level. As shown in the quote below, this confusion might have contributed to the misunderstanding on the responsibility for resource mobilization, suggesting that the IFRC intended to build a “central pot” for distribution of funds to NS members of the Alliance.

⁹⁹ Eastern Africa HIV programme (2008-2010) of the Red Cross and Red Crescent global alliance on HIV Appeal



“A common funding framework does not mean that all resources have to be channelled through the Secretariat. Bilateral and multilateral funding approaches are compatible with each other provided that they ultimately contribute to the common resourcing framework and also, provided that the reasonable costs of common, desired Secretariat services are properly and predictably funded in a manner that promotes equitable burden-sharing. The contribution of PNS and other donors channelling additional (non-core) resources through the Secretariat will be given due visibility and acknowledgement and not subsumed within a Federation label. This is to ensure transparency and facilitate advocacy within the country of the PNS and with their back donors.”¹⁰⁰

4.4.19 The definition of the funding framework as “result-based” is also confusing as it suggests that NS would receive funding based on programmatic results. How this would work is not described in the HIV GA Programme manual. The limited financial information available and the lack of analysis of the financial data in the regional evaluations do not allow drawing any conclusion on whether the proposed funding framework increased efficiency or reduced transaction costs. **The principle of a common funding framework is clearly beneficial for programme management and accountability purposes, but its implementation by the HIV GA was insufficient and incomplete and did not achieve the expected results.**

One performance tracking system

The HIV GA successfully established a global performance tracking system but failed to address the initial teething problems and the issue of its long-term sustainability

4.4.20 Establishing a common global performance tracking system, aimed at “*pioneer(ing) the International Federation-wide approach to planning, performance management and accountability tracking (PATS) to demonstrate objectively the value of what the RCRC are doing together*”, was one of the most innovative aspects of the HIV GA. The Programme Manual assigns specific reporting responsibilities to the different programme implementers and provides a detailed description of programme targets, performance tracking indicators, standardized tools for data collection and reporting.¹⁰¹

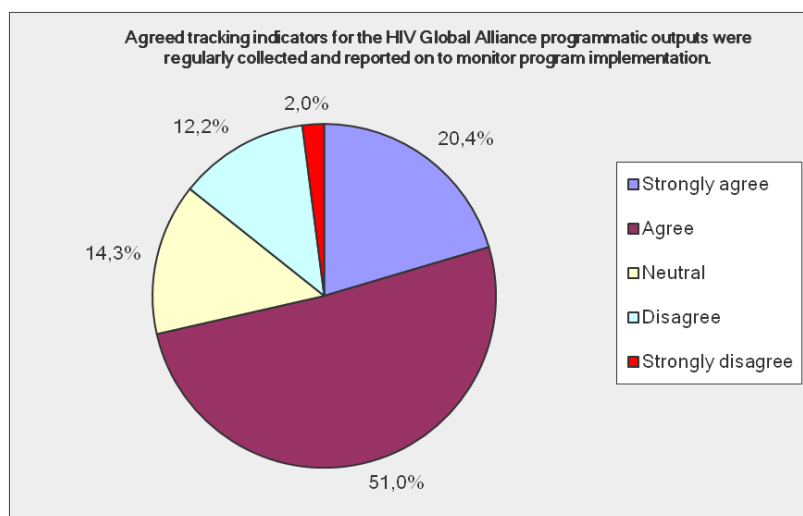
4.4.21 Implementation of the HIV GA performance tracking system can be considered a success, with more than 60 NS reporting regularly on selected HIV tracking indicators and the Secretariat producing yearly programme implementation reports. Compliance with the reporting system has been fairly high. In our online survey, 70% of respondents agreed that “tracking indicators for the HIV Global Alliance programmatic outputs were regularly collected and reported on to monitor programme implementation” and that NS are continuing to collect regularly and report the information to the Secretariat. (Figure 15)

¹⁰⁰ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 23.

¹⁰¹ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Guidance Notes 3, 7, 8 9 and 12



Figure 15: Regular reporting of tracking indicators



4.4.22 The implementation of the PATS faced considerable challenges, starting from the limited NS capacities in monitoring and evaluation, the lack of an established performance evaluation culture, the difficulty in collecting some of the proposed indicators, and the lack of sufficient human and financial resources to allow the system to establish itself as a routine IFRC activity. Several respondents suggested that some of the tracking indicators had confusing definitions that could be interpreted differently (e.g. “people reached”) or were difficult to collect (e.g. indicators on stigma and discrimination). The system relied heavily on the motivation of staff and volunteers in manually collecting and reporting data. However, most of the NS PMER positions that were established with support from the HIV programme have now been cut due to budgetary constraints, resulting in the loss of acquired skills and expertise and the possibility of reduced completeness and quality of the data.

“Some found reporting requirement difficult. Baseline data collection was done in a rush, with poor quality assurance. Cumulative data was used in some countries. The system could be institutionalized but should be improved. Indicators were too broad, leading to double counting and confused interpretations. Global summary data may be useful but should be simpler and more specific.” (Online survey)

4.4.23 While praising the HIV GA approach to tracking programme performance, respondents acknowledged problems and suggested ways to improve quality and sustainability of the system. These include:

- The need to revise and possibly simplify the HIV tracking indicators to make them easier to collect and more relevant to the programme;
- The need to add to the system some measures of outcome, impact and quality of services.
- The need to integrate the HIV tracking indicators into a generic IFRC PMER system;
- The need to continue building NS capacities and to establish full-time NS PMER positions to ensure the regular collection, validation and quality assurance of data and reports;
- The need to make better use of an electronic data collection system.

“Managers identified a need to strengthen the PMER system, clarifying definitions of indicators and strengthening the data collection system, as well as creating a more comprehensive and results-oriented monitoring and evaluation system.”¹⁰²

4.4.24 Sustainability of the HIV performance monitoring system can only be assured if the system is institutionalized within the NS structure and integrated as much as possible with

¹⁰² Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011



other reporting systems. Regular data collection is resource intensive and can be made more efficient if resources are shared across programmes and generic capacities are developed within the NS core structure. Integration of the HIV monitoring system with other health programs could reduce the reporting burden on NS staff and volunteers.¹⁰³

4.4.25 Key informants admitted that reporting to the HIV GA was considered like any other reporting requirement from an external donor. It is seen as being of limited use for NS internal managerial purposes or for reporting to other donors. A monitoring system has more chances of succeeding if the information it provides is useful for the people implementing the programme, as this is the incentive for investing time and resources in data collection and validation. Without this internal ownership (and sufficient human and financial resources), a regular data collection system has little chances of becoming sustainable.

“Data is collected specifically for the HIV GA and is not used by NS or for reporting to other donors.”
(Online survey)

One system of accountability and one reporting mechanism

The HIV GA did not succeed in reducing the burden of donors’ reporting by agreeing on a common reporting mechanism.

4.4.26 The last principle aimed at reducing the burden on NS and the Secretariat from multiple reporting requirements to donors by using a common monitoring, reporting and evaluation framework accepted by all Alliance partners, even for bilateral programmes. Achieving this objective required a robust monitoring and evaluation system and building sufficient levels of trust and confidence with partners. Experience shows that multiple reporting to donors on different formats and using different performance indicators can indeed be a heavy burden on NS.

“Reporting can be overwhelming and unnecessarily complicated. For example in the Cook Islands the HIV Officer reports to four donors and reporting on the GFATM project was said to be the most difficult.”¹⁰⁴

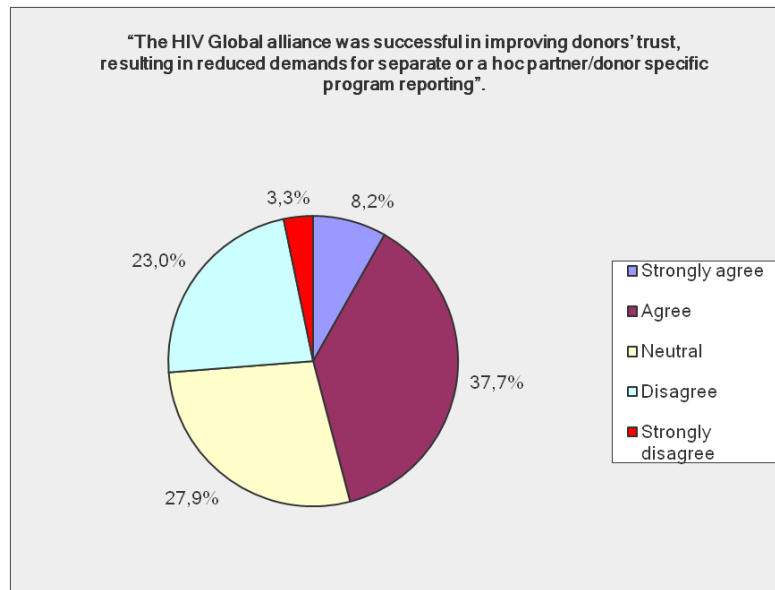
4.4.28 As shown in Figure 16, only 46% of respondents agreed with the statement that the alliance was successful in improving donors’ trust, resulting in reduced demands for separate or ad hoc partner/donor specific programme reporting. Several informants felt that the credibility of the HIV GA was undermined in particular by two factors: a) the damage to the image of the IFRC among partners when the high expectations raised with the development of the HIV Programme Document for the delivery of agreed scaled-up HIV programmes were not fulfilled; b) the limited capacities of NS to provide accurate and timely financial accounting and reporting, which are essential in particular when responding to “demanding” donors like the Global Fund.

¹⁰³ Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010 End Of Programme Evaluation Report

¹⁰⁴ Reducing vulnerability to HIV and its impact in four Pacific Island Countries. Findings from the Mid-term Evaluation of the IFRC component of GFATM Round 7



Figure 16: Improving donors' trust



4.4.27 Informants interviewed reported “some success” in using the HIV GA tracking indicators data for reporting to other donors, even if it had to be adapted to different reporting formats. While PNSs seemed to be more open and ready to accept the principle of using common indicators and formats, many found it quite difficult to convince external donors to accept harmonization concepts and principles that are specific to the IFRC. In addition, the need to maintain good relationship with the donors for continuation of funding made it very difficult for the NS to be assertive in negotiating reporting requirements with external donors. **The evidence suggests that producing numerous reports for the different donors continues to be a heavy burden for most NS.**



Conclusions on the HIV GA “seven ones” principles

1. The “seven ones” principles formed the basis of the HIV GA implementation framework and succeeded in promoting a more harmonised, coordinated and results-focused approach within the IFRC and with external partners.
2. Robust needs assessments allow allocating scarce resources where they are most needed and effective, building synergies and efficiencies with other partners, and reducing the risk of duplication and waste of resources. NS do not require specific needs assessment tools or studies as the information is usually available from the government or partners. A comprehensive consultative process with relevant national stakeholders can improve the assessment, foster partnerships and provide opportunities for resource mobilization.
3. NS HIV programme documents were usually aligned with IFRC GA Global Strategies, coherent with national AIDS strategies and developed in consultation with other national or international partners. Due to the pressure to meet the Alliance launch deadlines, it was not always possible to complete all steps of a robust and consultative planning process. An excess of standardization might have led to plans that did not adapt completely to the specific country context and/or NS implementing capacities. In light of reduced funding, NS HIV plans often had little impact on the sustainability of the NS HIV programme.
4. The HIV GA division of labour led to some increase in efficiency but did not have the required support, or last long enough, to make a real difference and ensure its sustainability. The HIV GA division of labour clearly failed in resource mobilization where a major misunderstanding on roles and responsibilities for fundraising led to frustration and disappointments, and missing of potential funding opportunities.
5. The HIV GA did not succeed in establishing a functional financial framework as demonstrated by the difficulties experienced in accessing updated detailed information on the mobilization and utilization of HIV financial resources. The actual scope and functioning of the system was unclear and might have contributed to the misunderstanding in resource mobilization.
6. Establishing a common global reporting system to track performance was one of the most innovative and successful aspects of the HIV GA. Its implementation in more than 60 countries proved its benefits but also identified its limitation and weaknesses. Sustainability of the system is under threat as funds and dedicated staff are being reduced.
7. The attempt to reduce the burden of reporting on NS staff by establishing a common reporting mechanism had limited success. While some PNS agreed to a common format for HIV GA reporting, extending the common system to other donors proved difficult and reporting continues to be major burden for NS volunteers and staff.



4.5 Objective 5 – Assess harmonization and sustainability with IFRC Secretariat

Lesson learned from the Global Alliance on HIV

Many useful lessons learned from the experience of the HIV GA could be applied to other IFRC programs.

4.5.1 The HIV GA was the first and so far the only comprehensive and coordinated attempt to apply the concept of “global alliances” to an IFRC programme.¹⁰⁵ In spite of the short and somewhat troubled implementation, the HIV GA did provide a “proof of principle” of the benefits of the Secretariat and NSs using a common framework and working together towards joint objectives. **The experience of the HIV GA carries important lessons not only for HIV programming but also for other IFRC health and non-health programs.** To what extent they will be applied depends on the commitment of the IFRC to continue implementing the global alliances approach.

4.5.2 **This evaluation collected a large number of different suggestions on lessons learned from the HIV GA and recommendations on how to improve IFRC HIV programming in future.** This is not surprising given the diversity of views and experiences concerning the Alliance across the IFRC. They do converge, however, around a few critical themes that most respondents found important for consideration in future HIV programming and that are briefly summarized below.

- a. **The importance of robust planning, monitoring, evaluation and reporting.** Standardized programme development and alignment with national plans can improve quality in programming and increase efficiency. Good monitoring and reporting are essential for advocacy, visibility, programme management, fundraising, and accountability.
- b. **The benefits of a coordinated and harmonized approach to programme implementation** through mechanisms that enhance partnerships and participation. A good implementation framework increases the quality of the programmes and brings in more accountability.
- c. **The importance of building the capacity of implementing NSs** through well-developed training programme, opportunities for exchanges of informational and experiences, and relevant policy and technical guidance and documentation.
- d. **The possibility for NSs to mobilize substantial resources at country level to diversify the sources of funding and reduce dependency towards external donors.** This requires commitment of NS leadership to engage in partnership and fundraising, building NS capacities for resource mobilization, and develop strong management systems for programme implementation and reporting to donors.
- e. **The importance of integration and mainstreaming of HIV in other NS programs** to increase efficiency and ensure sustainability of the programme.
- f. **The need provide HIV (or health) programs with sufficient resources for a sufficient time to be able to achieve measurable results, and to secure the complete and lasting commitment and support by NS and IFRC senior management.**

Is there a future for the IFRC Global Alliance on HIV?

IFRC staff and partners are confused about the status of the HIV GA. In operational terms, the Alliance cannot function with the current resources and support. The IFRC needs to clarify its strategy and commitment in terms of HIV/AIDS work.

4.5.3 **There is uncertainty about the status of the Global Alliance on HIV.** The first implementation cycle of the Alliance covered the period 2006-2010 and has therefore ended in 2011. However, **no formal decision about the possible extension of the HIV GA programme**

¹⁰⁵ The attempt to establish a second “IFRC Global Alliance on Disaster Reduction” was unsuccessful.



for 2011-2015, or its termination, has been formally communicated to staff and partners. In addition, little if any mention is made of the HIV GA in the recent official statements and publications by the IFRC. For example, there is no mention of the Alliance in the statement made by the Head of the IFRC Delegation at the 2011 UN GA High-Level meeting on AIDS.¹⁰⁶ A Google search for the “HIV Global Alliance” keywords yields almost no results after 2010.

4.5.4 In operational terms, many of the activities included in the HIV GA framework are being scaled down or have stopped altogether. The strategic approach through the “four outputs” has not been updated since 2006. Most of the NS HIV Programme Documents covered the period 2008- 2010 and have not been replaced with new and updated plans. NS continue to report on the HIV tracking indicators but the completeness of reporting is decreasing and sustainability of the system with reduced resources and incentives is questionable. The current human and financial resources of the Secretariat do not allow it to provide the necessary support to NS, nor to ensure the continuation and expansion of collaboration with partners and donors.

4.5.5 Many of the people interviewed expressed concern and frustration at what they perceive as reduced attention and commitment to HIV by the Senior Management of the Federation and its governing bodies. As evidence, they pointed to the uncertainty about the status of the programme, the reduction in staff and funding for HIV activities, and the much reduced emphasis on HIV/AIDS in the most recent IFRC public statement or official documents. Many admitted that they were unclear about the actual status of the HIV GA programme, whether it was still functioning or not. **Several felt the programme should be considered closed and that the only uncertainty was on what would be the next phase in IFRC HIV work.**

4.5.6 HIV continues to be a priority programme for many NS, particularly in countries with high HIV burden, and at regional or zone level, particularly in Africa and the Americas. Many NS and regional teams continue to be very active and fully committed to the principles and operational approaches of the Global Alliance on HIV. The Regional Health Network of the Americas has recently reaffirmed the commitment to continue implementing the HIV GA approach, albeit with some modifications. Elsewhere, including in Southern Africa, NS are trying to cope with the funding cuts and concentrating on saving what can be saved from the existing HIV programs.

4.5.7 The uncertainty about the status and functioning of the Global Alliance on HIV and the IFRC HIV programme is damaging for the image and credibility of the Red Cross Red Crescent movement. It generates confusion and complicates efforts by IFRC and NSs staff, volunteers and partners to build partnership and develop or expand HIV programmes. It hampers efforts for resource mobilization, raises questions on the IFRC commitment to HIV, and jeopardizes the many gains made by the IFRC HIV programme during the last decade. **The need to clarify the status of the HIV Global Alliance and the strategic direction for the future involvement of the IFRC in HIV/AIDS is undeniably urgent.**

IFRC Strategy 2020

HIV/AIDS is hardly mentioned in the IFRC Strategy 2020, a clear indication of reduced attention and commitment to the programme. Though building global alliances continues to be an important IFRC strategic direction, little implementation has followed.

4.5.8 IFRC Strategy 2020 only mentions HIV/AIDS as one of the several health problems the IFRC is confronting in the implementation of its global agenda under the strategic aim of “enabling healthy and safe living”.¹⁰⁷ The Strategy states that “*tackling HIV and TB is our continuing priority along with focused efforts on malaria, immunizations, epidemic and pandemic*

¹⁰⁶ Statement by Mr Marwan Jilani, Head of Delegation, Permanent Observer of IFRC to the 2011 UN GA High-Level Meeting on AIDS

¹⁰⁷ Saving Lives, changing minds. Strategy 2020

The Red Cross Red Crescent Global Alliance on HIV



preparedness, reproductive health and child care". Little emphasis is given to the role of IFRC in the fight against stigma and discrimination of PLHIV. **This is far cry from the priority given to HIV work in ARCHI 2010,¹⁰⁸ the International Federation's Global Agenda (2006–2010) or in earlier statements by the IFRC senior management or governing bodies,** suggesting a major policy shift since the General Assembly identified HIV/AIDS as an organizational priority in 2001.

4.5.9 Strengthening individual and community "resilience" is one of the main goals of Strategy 2020, a resilient community being defined, among others characteristics, as "knowledgeable and healthy".¹⁰⁹ There is no question that HIV infection can increase individual and community vulnerability, particularly in high burden countries or communities. In these settings, fighting HIV/AIDS is an essential and effective intervention to strengthen individual and community resilience.

4.5.10 **Strategy 2020 does emphasize the role of strategic and operational alliances, modelled around the HIV GA, in building more effective and efficient working modalities for the IFRC.** The Strategy states that: *"Global alliances are formed at inter-country level – usually coordinated by the IFRC's secretariat – to establish standards and norms on particular topics, project our collective voice through representing and advocating the Red Cross Red Crescent's position, and mobilize global commitments and resources for a specified cause. The secretariat may be invited to help the National Societies concerned to manage their partnerships and alliances when this is needed because of local capacity constraints."*⁸²

4.5.11 However, **this evaluation could find no evidence of concrete plans to establish new global alliances or adapting and expand the principles and approaches of the HIV GA to other areas of work of the IFRC. The only possible exception is the plan to generalize the concept of performance monitoring and evaluation on a Federation-wide basis,** led by the IFRC Planning and Evaluation Department. The Department has developed "key proxy indicators" similar in design to the HIV GA tracking indicators, and plans to collect information and report globally on the overall results of the work of the IFRC. The initiative also plans to continue investing in building NS capacities and developing a better understanding within the IFRC of the importance of measuring results and monitoring performance.

Planning, monitoring and evaluation under the HIV GA

The HIV GA did not apply to the Secretariat planning processes the same rigorous approaches recommended for NS HIV programs.

4.5.12 The HIV GA aimed at implementing the Programme Cycle Management (PCM) as an approach to develop, implement and evaluate NS HIV programmes.¹¹⁰ In addition, the Planning and Appeals System (PAS) included the overall arrangements for programme design and resource mobilisation. PCM and PAS provided rigorous approaches to programme management but were only utilized during the early stages of the HIV GA, in particular at the time of NS Programme Documents development and for the launches of the regional appeals. **Due to the time lag, staff turnover and the lack of information from regional reports, it was not possible to assess compliance with the PCM and PAS and identify lessons learned from their implementation.**

4.5.13 **The HIV GA did not apply to the Secretariat-level planning processes the same rigorous approaches recommended for NS HIV programs.** The 2005 Evaluation recommended the development of a 5-year strategic plan and yearly operational plans with target indicators for the IFRC HIV global programme. While detailed planning took place at country level, **the HIV GA**

¹⁰⁸ African Red Cross and Red Crescent Health Initiative 2010 (ARCHI 2010)

¹⁰⁹ The road to resilience. Bridging relief and development for a more sustainable future. IFRC discussion paper on resilience.

¹¹⁰ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) Page 29.

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Secretariat did not develop its own strategic and operational plans detailing activities, targets and performance indicators.¹¹¹ Yearly work plans and budgets were prepared as part of the internal IFRC planning but the only documentation available includes simply a list of services to be provided and the indicative budget, hardly sufficient for monitoring progress or performance.¹¹²

4.5.14 No mid-term review or evaluation of the HIV GA at the global level was conducted during the initial five years of implementation of the programme. Programme reviews and evaluations of the HIV GA regional programs were conducted in Southern Africa (2009 and 2011), South Asia (2008 and 2010), Pacific (2011), and the Americas (2009 and 2011). These quality reports provide extremely useful insights and information, suggest lessons learned from the implementation of the Alliance activities at country level and include recommendations to improve programme effectiveness. **However, the HIV GA did not envisage a mid-term review and did not produce a final comprehensive report on the implementation of the global programme at the end of the planning period (in 2010).** This was unfortunate as a mid-term review could have identified some of the problems faced by the Alliance and the growing concerns among PNSs about the implementation of the programme, and suggested timely corrective actions.

“(A) major missing element was the mid-term review of the Alliance. It could have responded to issues by PNS and ensured better expansion of the programme and more PNS engagement.” (Key informant)

4.5.15 The HIV GA produced yearly programme delivery reports and organized informal reviews through the meetings of the HIV GA Forum that gave National Societies and the Secretariat staff the opportunity to share their experiences and lessons learned. However, these efforts cannot be seen as a valid substitute for proper planning, a robust monitoring system and regular programme evaluations in directing programme implementation. **Better planning, monitoring and evaluation at the Secretariat level might have identified and addressed the initial teething problems, built trust and credibility with partners, facilitated resource mobilization, and fostered the sustainability of the programme by securing commitment at senior level.**

¹¹¹ The” number of Master Trainers being trained.” which was not included in the initial list of HIV GA tracking indicators.

¹¹² Secretariat-wide Resourcing Framework Budget 2008-2009 For The Global Alliance on HIV



Conclusions on harmonization and sustainability with IFRC Secretariat

- The HIV GA provided a “proof of principle” on the benefits of an improved harmonization and coordination within IFRC. Many of the lessons learned from the HIV GA can be applied to other IFRC programs. However, this requires the commitment and support from the IFRC management and governance.
- There is uncertainty among staff, volunteers and partners about the future of the HIV GA and of HIV work in the IFRC. The HIV GA formally ended in 2011 and no decision has been communicated on its extension or termination. Operational planning and resource mobilization have not been initiated. Many of the activities included in the HIV GA framework are being scaled down or have stopped.
- There is concern and frustration for the perceived reduced attention and commitment to HIV work by the IFRC as signalled by the uncertainty about the status of the programme, the reduction in staff and funding for HIV activities, and the much reduced emphasis on HIV/AIDS in the most recent IFRC public statement or official documents including IFRC Strategy 2020.
- IFRC Strategy 2020 does emphasize the role of strategic and operational alliances, modelled around the HIV GA, though there is no evidence of plans to establish new global alliances or generalize the lessons learned from the HIV GA, except for the area of performance monitoring and evaluation.
- Planning, monitoring and evaluation of the Secretariat HIV activities were poorly developed when compared to the comprehensive approach applied to NS HIV programs. Better planning, monitoring and evaluation might have facilitated resource mobilization and programme sustainability by securing commitment at senior level.



5. Conclusions and Recommendations

5.1 The Global Alliance on HIV was an ambitious, well-structured attempt to scale-up and expand IFRC contribution to the global fight against HIV/AIDS while at the same time improving and harmonizing some of the internal working mechanisms between the IFRC, NSs and donors. It was built on the successful experience of the IFRC Southern Africa HIV program and on the expectation that the Red Cross Red Crescent could at the same time benefit more from the increased resources available globally for HIV/AIDS and contribute more from the work of its extended network of volunteers and staff.

5.2 Initially, the HIV GA progressed quickly thanks to the engagement of the Secretariat staff and the commitment of IFRC senior management and of NSs, which was linked in part to the expectation of relevant additional funds for HIV programming. The Alliance developed the programme strategic and operational approaches detailed in the Programme Manual, supported the development by all member NSs of harmonized NS HIV Programme Documents, organized regional launches and appeals, and established the HIV performance tracking system.

5.3 By moving quickly, the HIV GA somehow failed to ensure the full ownership and commitment to the programme by PN and NS leadership. From 2009, commitment to the HIV GA faded away as priorities within the IFRC senior management shifted and NSs became increasingly frustrated and disappointed when the promised financial resources did not materialize. The HIV GA organizational structure was progressively dismantled and, with the reduction in HIV funding from the traditional PNS donors, HIV activities were scaled down at the Secretariat level and in many countries. **The HIV GA introduced important positive changes to the way in which the IFRC worked collectively on HIV, but the programme was short-lived, making it unlikely that these changes will be institutionalized and become sustainable over time.**

The overall effectiveness and impact of the Global Alliance

5.4 **The IFRC is a major player in the global response to the HIV epidemic through HIV programmes implemented by NS in more than 60 countries.** IEC and peer education activities have contributed to increasing awareness and preventing HIV infection and the care and support provided by volunteers and staff have extended and improved the lives thousands of PLHIV and orphans. The main asset of the Red Cross Red Crescent is the decentralized network of volunteers and the capacity of taking action directly with families and communities while at the same time having access to national decision-makers and participating in national, regional and global partnerships.

5.5 **The HIV GA was not successful in reaching its ambitious target of doubling HIV programming between 2006 and 2010.** Globally the volume of IFRC HIV programming in 2010 was probably lower than in 2006 across all performance tracking indicators. However, **global cumulative figures hide significant differences between countries and regions.** Southern Africa has recently seen the sharpest decline in resources and activities while the Americas and Europe have seen substantial increases, demonstrating the potential for the Red Cross Red Crescent to play an even larger role in the global fight against HIV.

5.6 **The HIV Global Alliance has been successful in improving the quality and effectiveness of Red Cross Red Crescent work in HIV.** The standardization of the HIV interventions the alignment with national AIDS plans, the support to capacity building, networking and sharing of experiences, the focus on performance monitoring and the involvement of PLHIV in programme design and implementation have all contributed to improving the quality HIV programs. Several NS modified their approaches to increase effectiveness of the interventions, for example by focussing on vulnerable populations where most of the new infections are occurring, or promoting adherence to treatment once most of the PLHIV are provided with antiretroviral therapy.

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5.7 **The HIV GA strategic approach through the four programmatic outputs is quite comprehensive and remains valid but needs to be updated on the basis of the lessons learned and of new international guidance.** New strategic approaches to be considered include the role of circumcision in HIV prevention, combination prevention, treatment, and care packages, “treatment 2.0” strategies, and approaches to the integration of HIV interventions.

Recommendation 1: The IFRC should review and update its HIV strategic framework (the Four Outputs) on the basis of the lessons learned from the implementation of the Global Alliance and of new interventions and approaches recommended at international level. Consideration should also be given to:

- a. including in the prevention strategies the role of Red Cross Red Crescent in ensuring blood safety and the recruitment of safe, voluntary, non-remunerated blood donors;
- b. expanding the output 4 strategies to include approaches for improving the Secretariat’s own capacities, resources and accountability, and address the issue of integration and mainstreaming of HIV activities at Secretariat and NS levels.

5.8 **The HIV GA failed to mobilize the resources required for scaling up HIV programming.** The difficulties in raising additional resources and identify new donors can be attributed in part to a changing international environment driven by the global financial crisis and shifting donors’ priorities, and in part to the lack of a clear HIV GA resource mobilization strategy compounded by a major misunderstanding between the Secretariat and NS on who should be responsible for fundraising and where the funding would come from. **Worryingly, IFRC HIV funding continues to decline putting at risk many established NS HIV programs**

5.9 **The HIV GA failed to establish a functional partnership with the Global Fund and to capitalize on existing funding opportunities at country level.** However, a few National Societies have been quite successful in mobilizing resources, including from the GF, demonstrating the large potential for NSs “do more and better” in resource mobilization. Success was based on improving NS fundraising capacities, a greater involvement of NS leadership in national HIV coordination mechanisms, and technical support from the IFRC zone offices.

Recommendation 2: The IFRC should develop urgently an integrated resource mobilization strategy for HIV, TB and malaria aimed at diversifying the sources of funding, in particular at country level, and building programme sustainability. This will require engaging IFRC and NS governance and leadership in resource mobilization and exploring ways for an efficient approach to fundraising for integrated health programs.

Recommendation 3: The IFRC should establish closer links with the GF Secretariat at global level and encourage NS leadership to engage with CCMs and PRs and to identify opportunities for NS participation in HIV grants implementation. The Secretariat should update regularly Zone and NS staff on new GF funding opportunities and application modalities.

5.10 **The HIV GA failed to capitalize on the established global partnerships with GNP+ and UNAIDS.** Though it is in line with its mandate as the largest humanitarian organization devoted to the protection of the most vulnerable people, **the IFRC lost in recent years its global leadership role in fighting stigma and discrimination. The RCRC+ network has been instrumental in making the Red Cross Red Crescent a better home for PLHIV and reaffirming the fundamental values and principles of the IFRC.** The involvement of PLHIV in the design and implementation of HIV intervention can improve their quality and effectiveness by making them more responsive to the needs of the target populations.



Recommendation 4: The IFRC should consider re-energizing the global partnerships with GNP+ and UNAIDS based on clear common objectives and practical operational plans. The IFRC should use its mandate and credibility at national and international levels as a leading defender of human rights to reaffirm the importance of the fight against stigma and discrimination of PLHIV and of populations at increased risk of HIV infection.

Recommendation 5: The IFRC should actively support the RCRC+ network and continue promoting the adoption of the GIPA principles by NS worldwide, in collaboration with national and regional networks of PLHIV.

IFRC Secretariat program management and support

5.11 The organizational structure of the HIV GA in Geneva and in the regions has been dismantled. The restructuring of the programme in 2009, the closing of the office of the Special Representative and of the HIV GA Steering Committee and the HIV Governance Group, the abolition of most HIV position and the progressive integration in the health team of the remaining staff has left the IFRC with **insufficient human resources to ensure that the functions of the global HIV programme can be adequately performed.** It also signalled a policy shift towards reduced attention and commitment by IFRC to working on HIV.

Recommendation 6: The IFRC should review its organizational structure and resource plans to ensure that the Secretariat can count on the minimum core level of staff and resources to effectively perform the required functions in supporting NS HIV programmes, managing global and regional partnerships, and providing the IFRC with the required strategic and technical guidance on HIV.

Recommendation 7: The IFRC should consider the need to re- establish an oversight and policy advisory body to guide the Secretariat and NS on HIV/AIDS work, with particular attention to sensitive areas like working with vulnerable populations, fighting stigma and discrimination of PLHIV, or the integration of HIV with other health programs.

5.12 The ongoing process of integration of HIV activities with other health programmes carries many potential benefits but also potential risks. Benefits of integration include effectiveness and efficiency gains, reduced transaction and operational costs, improved coverage and accessibility of interventions, and better chances of ensuring long-term sustainability. The major risks are a possible dilution of the HIV interventions, which might decrease their effectiveness, and a reduced attention to the social and personal impact of the HIV epidemic.

5.13 Some HIV activities are more amenable to integration than others. For example, the administrative, logistics and communication functions and some prevention and care activities could benefit greatly from the integration. However, integration of HIV-specific activities like working with highly marginalized and vulnerable groups like IDUs or MSM, or tackling the issue of stigma and discrimination could be difficult and even potentially damaging for the programmes.

Recommendation 8: The IFRC should assess and document the impact of the on-going process of integration of HIV in health programmes on the efficiency and outcome of HIV interventions. These experiences should be translated into appropriate guidance for NS on how to integrate effectively HIV activities with other health and non-health Red Cross Red Crescent activities and programs, taking into consideration the requirements of some HIV-specific activities.



National Society capacity development for HIV/AIDS

5.14 **The HIV GA was initially successful in building NS technical and managerial capacities but sustainability of the gains made is now under question in light of the reduced resources and high staff turnover.** With the reduction in staff and resources, particularly at zone level, the IFRC support to capacity building has greatly diminished. Given the high turnover of IFRC staff and volunteer, it opened gaps in technical and managerial capacities that are affecting programme implementation, performance reporting and efforts to mobilize additional resources.

5.15 **HIV GA capacity building was supported by the development of quality technical materials and guidance documents but production of new materials slowed down following the reduction in Secretariat staff and resources.** There is an urgent need for IFRC guidance on best practices for the integration of HIV activities in community health programmes and on approaches to gender issues, working with vulnerable populations, addressing sexual diversity, promoting human rights and fighting stigma and discrimination

5.16 **HIV GA regional networks are very effective in sharing knowledge and experience, improving NS HIV programming capacities, and ultimately increase the quality and effectiveness of HIV interventions.** Regional networks allow NSs to exchange experiences and lessons learned, harmonize interventions, and provide feedback to the Secretariat on issues and problems in implementation. Networking contributes to team building and individual commitment by developing a sense of belonging to a like-minded operational group as opposed to the feeling of working in isolation.

Recommendation 9: In light of resource constraints, the IFRC should focus on the most cost-effective approaches to capacity building. This might include support to regional HIV networks, integrating training activities where feasible (e.g. PMER, resource mobilization) and prioritizing support to countries and programmatic areas where the needs are greater and more urgent.

Recommendation 10: The IFRC should continue developing technical guidance and documentation in collaboration with partners and based on best practices, assessed needs and specific requests by implementers. There is an urgent need for guidance on best practices for the integration of HIV activities in community health programmes and on approaches to gender issues, working with vulnerable populations, addressing sexual diversity, promoting human rights and fighting stigma and discrimination

The "Seven Ones"

5.17 **The HIV GA "seven ones" principles improved coordination and harmonization of the IFRC Secretariat, Zone teams, NSs and other HIV/AIDS actors.** Through the Alliance, NSs started speaking "the same language" on HIV and reporting against the same common indicators. This led to greater uniformity, improved the quality, efficiency and effectiveness of interventions, and allowed a regular monitoring of progress and evaluation of performance. However, with the exception of performance monitoring, **the "seven ones" principles have not been generalized to other programs or institutionalized within the NS or IFRC structures.**

5.18 **The HIV GA systematic and structured approach improved NS planning processes, producing NS HIV programme documents that were based on robust needs assessments, aligned with IFRC GA Global Strategies, coherent with national AIDS strategies, and developed in consultation with other national or international partners.** However, most NS HIV Programme Documents have ended and there is no systematic IFRC process in place for their update. This might undermine the progress made under the HIV GA in improving the harmonization and coherence of HIV programming across the Red Cross Red Crescent movement.

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Recommendation 11: The IFRC Secretariat should support and encourage National Societies to update NS HIV Programme Documents as they are essential tools for planning, implementation and monitoring programs, for harmonization and alignment with national AIDS strategies and with corporate priorities, and for resource mobilization. Revised guidance for the preparation of NS HIV Program Documents should be developed based on the acquired experience, revised HIV strategies, and the new institutional framework.

5.19 The HIV GA division of labour was partially successful in increasing efficiency and effectiveness by clarifying roles and responsibilities in HIV programming within the IFRC but did not have the required consensus and support by all actors, or last long enough, to make a lasting impact on the way the IFRC works.

5.20 Establishing a common global reporting system to track performance was one of the most innovative and successful aspects of the HIV GA but did not succeed in reducing the burden of reporting to donors. The system could benefit from a simplification of some indicators and the addition of measures for outcome and quality. Data quality and sustainability of the data collection are becoming major concerns in light of the reduction in dedicated funds and staff. The planned Federation-wide implementation of a PMER system might help ensure sustainability by providing additional support and building NS capacities in monitoring and evaluation.

Recommendation 12: The IFRC should conduct an in-depth assessment of the HIV GA performance tracking system to document its strengths and weaknesses and draw lessons for future implementation of a Federation-wide performance monitoring system. The review should consider ways for improving the list of indicators and adding measures of quality of services and outcome of interventions, simplifying the data flow including through the use of electronic data collection tool, and integrating HIV reporting with a common IFRC monitoring and evaluation system. As the routine implementation of a universal, reporting system is labour intensive, simpler and cost-efficient sampling methodologies could be considered for collecting HIV specific data.

Harmonization and sustainability with IFRC Secretariat

5.21 The HIV GA was the first attempt to apply the concept of “global alliances” to an IFRC global programme. It was only partly successful but it did provide a “proof of principle” on the potential benefits of improved harmonization and coordination between the Secretariat, PNs and NSs. Many of the lessons learned from the HIV GA could be applied to other IFRC programs provided there is commitment and support from the IFRC senior management and from donors. **HIV continues to be a priority programme for many National Societies, in particular in countries with high HIV burden.** These National Societies will continue implementing their HIV programs with or without the support from the IFRC depending on the availability of funds. Many established NS HIV programmes are in jeopardy due to the reduction in funds made available through the “traditional” PNS donors.

5.23 The HIV GA formally ended in 2011 and no formal decision has been announced on its extension or termination, leaving Red Cross Red Crescent staff, volunteers and partners confused about the future coordination of IFRC HIV work. Meanwhile, many of the activities included in the HIV GA framework are being scaled down or have stopped altogether. **The perceived reduced IFRC commitment to HIV work is cause of concern and frustration among Red Cross Red Crescent staff.** If confirmed, the current disengagement might be misplaced as the HIV epidemic is far from over and the reduction in external funding might actually increase the demand to mobilize all active national partners to support the populations affected by the disease. In addition, confused messages and uncertainty about the actual commitment of the IFRC in fighting HIV carry a “reputational risk” and may be damaging for the image of the IFRC.



5.24 **The IFRC HIV programme is once again at a crossroads.** The original approaches and objectives of the HIV GA seem ill suited to the changed internal and external environment and the new IFRC priorities. On the other hand, HIV continues to be a priority programme for many NSs and, in light of its mission and mandate, the Red Cross Red Crescent movement cannot contemplate retreating from the essential and unique role it plays in the response to the HIV epidemic. **Redesigning its global HIV programme, based on new integrated approaches and the new international environment, taking into consideration the lessons learned from the implementation HIV GA, and building on the foundations of many successful NS HIV programmes would seem the most sensible and best possible way forward.**

Recommendation 13: There is an urgent need to clarify and possibly reaffirm the Red Cross Red Crescent engagement, role and commitment to the fight against HIV/AIDS. The IFRC governance should consider initiating a broad process of internal consultation on the strategic and operational aspects of its HIV work, with the participation of all key players and stakeholders, to build the basis for the development of a new IFRC global HIV programme. The design of the new programme should take into consideration the specific role and mandate of the Red Cross Red Crescent movement, the successful experience of many NS HIV programs, the lessons learned from the implementation of the HIV GA, the changed international funding environment, and the move towards integrated health development approaches.

Annexes

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| Annex A: | TOR HIV Global Alliance evaluation 2012 |
| Annex B: | IFRC 2002 HIV AIDS Policy |
| Annex C: | Principles of the IFRC Global Alliance on HIV |
| Annex D: | Evaluation Framework |
| Annex E: | List of Documents Reviewed |
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Annex A

Terms of Reference (TOR) for:
IFRC HIV Global Alliance Program

1. Summary

1.1 Purpose: The International Federation of Red Cross and Red Crescent Societies (IFRC hereafter) is undertaking an evaluation to assess the impact and effectiveness of its HIV Global Alliance program. The evaluation will assess to what extent the framework mobilized capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programmes within the framework of the IFRC's Global Agenda. The evaluation upholds IFRC commitment to accountability and organizational learning, and will be used to inform future IFRC programming in HIV/AIDS..

1.2 Audience: the IFRC Secretariat, National Societies, donors and partner organizations, and other key stakeholders the HIV Global Alliance program.

1.3 Commissioners: This evaluation is commissioned by the Health department in compliance with IFRC evaluation Policy and framework.

1.4 Duration of consultancy: 45 days

1.5 Time frame : September 24 2012 to January 24th 2013

1.6 Location: Based at IFRC Secretariat in Geneva – potential travel involved.

2. Background

2.1 Purpose of the HIV Global Alliance program

The HIV Global Alliance program was implemented between 2006 and 2010 as, “(A)an enabling framework to mobilise capacities and resources to provide harmonised, effective support to National Society and partners for the achievement of their HIV programmes within the framework of the International Federation’s *Global Agenda*.”¹¹³ An effective IFRC Global Alliance on HIV is expected to:

- Improve the quality of RCRC work through systematic peer involvement and knowledge sharing.
- Improve efficiency through greater coherence and reduced transaction costs.
- Attract more resources from traditional and new donors.
- Expand the volume of programming.
- Ensure that National Society capacity building is given central emphasis.

Combating the HIV/AIDS global catastrophe is a major goal of the United Nations *Millennium Declaration*¹¹⁴, and a key priority of the IFRC's *Global Agenda for 2006-2010*. As the world's largest voluntary network, with millions of members and volunteers among 187 National Societies (NS), living in communities in every corner of the globe, it was felt that mobilizing the power of its Federation will

¹¹³ The Red Cross and Red Crescent Global Alliance on HIV Programme Manual

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make a difference to scale up its response to the HIV epidemic. IFRC recognized the magnitude of the HIV challenge and acknowledged that its far-reaching and complex social impact needs concerted effort by all sectors.

The HIV Global Alliance program sought to double the Red Cross Red Crescent (RCRC) contribution to the worldwide effort against HIV by 2010. The program sought to achieve this through mobilizing its collective capabilities more efficiently so that it could provide technical and capacity building assistance to RCRC National Societies to develop scaled-up efforts in the prevention, treatment, care and support, and reduction of stigma and discrimination of HIV/AIDS – as part of their own contributions to their respective National HIV/AIDS programs.

2.2 Origin and evolution of the HIV Global Alliance program

The HIV Global Alliance program was built upon its IFRC predecessor, the “HIV/AIDS Global Program,” which began in 2002. In 2005, the HIV/AIDS Global Program was evaluated. Findings were that the HIV/AIDS Global Program had established the foundation for a coordinated HIV/AIDS response, but it was recommended to reinforce the collective commitment of the IFRC Secretariat and member National Societies (NS), and to strengthen support for National Society to address HIV/AIDS.

Therefore, in 2006, the HIV/AIDS Global Program entered in a new phase in 2006 with the appointment of a HIV/AIDS Special Representative attached to the Office to the Secretary General. The Special Representative’s mission was to drive forward the mainstreaming and scale-up of the IFRC response to HIV/AIDS through all core programs, member National Society and community volunteers. The Special Representative was expected to advocate for an evidence-based response, the inclusion of the marginalized and vulnerable communities, and expand the IFRC partnership with people living with HIV/AIDS.

World AIDS Day 2006 called for a broader mobilization against HIV and AIDS , with a 100 per cent increase in the IFRC global commitment to fight HIV and AIDS through the strategy of the Global Alliance on HIV, “Rising to the Challenge.” Just as combating global HIV/AIDS was a major goal of the United Millennium Declaration, it was adopted as a key priority of the Federation’s Global Agenda 2006-2010.

The HIV Global Alliance program operated through a Global Alliance appeal of CHF 694,000, the 2008-2010 Health and Care appeal, and through health and care appeals at the zonal level between 2008 and 2010, except in southern Africa where an HIV single appeal of CHF 230,000,000 was launched for the period 2006-2010. Together, this funding was to enable the Secretariat to strengthen co-operation within the membership of the HIV Global Alliance in line with the “seven ones” principles

At the end of 2010, 56 National Societies in four Federation Zones had adopted the Global Alliance on HIV approach, developed comprehensive HIV programs and started implementation. To date, the achievements registered by National Societies vary depending on the volume of resources mobilized. Specific implementation times have varied according to location: Southern Africa 2006-2010; East Africa 2008-2010; West Africa 2008-2010; Americas 2008-2010; Europe 2008-2010; Asia and Pacific 2008-2010. In total 67 National Societies (participating and host National Society) have participated in the HIV Global Alliance program between 2006-2010.

In 2008, the world confronted a severe economic crisis which jeopardized funding promises to HIV/AIDS programs, a time when the HIV Global Alliance program was in the middle of its efforts to scale up its response to the HIV epidemic. Subsequently, financial resources declined annual thereafter.

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Today, the world and IFRC confronts a clear choice: maintain current efforts and make incremental progress, or invest smartly, build upon the foundation laid by the HIV Global Alliance program, and achieve rapid success in the AIDS response.

2.3 Program objectives and principles of the HIV Global Alliance program

Stated program outputs are summarized below for the HIV Global Alliance program, and a more complete program framework can be found in Annex 1:

- **Overall Purpose:** To scale-up the International Federation's efforts in support of National HIV and AIDS Programs to reduce vulnerability to HIV and its impact.
- **Output 1:** Preventing further HIV infection.
- **Output 2:** Expanding HIV treatment, care, and support.
- **Output 3:** Reducing HIV stigma and discrimination.
- **Output 4:** Strengthening National Red Cross / Red Crescent Society capacities to deliver and sustain scaled-up HIV program.

2.4 Program "Seven Ones" principles

Funding for the HIV Global Alliance program was to enable the IFRC Secretariat to strengthen co-operation within the its National Society membership (Global Alliance) in line with the "**Seven Ones**" principles identified for the program:

1. One set of needs analysis.
2. One set of objectives and strategies
3. One HIV country plan (for each operating National Society) with expectation of long term commitment to ensure sustainability
4. One shared understanding of the division of labour among entities of the Red Cross Red Crescent Movement
5. One results-based funding framework in which multi and bilateral financing channels can co-exist.
6. One performance tracking system
7. One accountability and reporting mechanism

The Seven Ones principles sought to mobilize the RCRC collective capabilities more efficiently so that it could provide technical and capacity building assistance to a target 100 National Society for scaled-up efforts in their respective National HIV/AIDS Program in HIV prevention, treatment, care and support, and reduction of stigma and discrimination. The actual program delivery to beneficiaries is the responsibility of the National Society. This evaluation will not focus on the individual National Society and program delivery at the national level. However, this will be an important consideration in order to best assess the overall impact, efficiency, and effectiveness of the Global Alliance on HIV.

Another important operating premise of the Global Alliance on HIV is the three **key guiding principles its implementation**:

1. Interventions must be evidence-based, i.e. they must be informed by locally-prevalent patterns of HIV risk, vulnerability, and impact, and driven by a demonstrable understanding of what is effective in a particular context.
2. Interventions must be main-streamed, wherever feasible, i.e. not only within the structures and programs of the International Federation, but importantly, they should be integrated into and seek to strengthen community and institutional systems for health, education, social care, and livelihood promotion. Thus HIV activities may be carried out jointly with maternal and reproductive health, TB, safe blood and other related interventions.
3. Interventions must seek out the most vulnerable and build resilience i.e. in line with the fundamental principles of the Red Cross Red Crescent, they must prioritize reaching and empowering the people that are most in need.

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2.5 Program key commitments

Another important element of the Global Alliance on HIV is its principle towards “**100% Commitment.**” Its strategy and the Federation Alliance that underpins it were designed with a 100% core commitment to address the challenge of HIV:

- a. 100% of Red Cross Red Crescent National Societies active in HIV in low and middle income countries will be working to advocate and enable 100% access by their clients to prevention, treatment, care and support.
- b. 100% scale-up (at least) in resources programmed for HIV work by Red Cross Red Crescent National Societies in low and middle income countries.
- c. 100% increase (at least) in numbers of participants and beneficiaries in Red Cross Red Crescent prevention, treatment, care, support, and anti-stigma initiatives in low and middle income countries.
- d. 100% increase in gender equity in access to, and participation in, Red Cross Red Crescent HIV programs in low and middle income countries.

2010 Federation-wide targets for the program were set against the 2005 baseline, summarized in the following table:

| | Baseline 2005 | Target 2010 |
|--|--------------------------|-------------------------|
| Coverage (% of population) | 57 million (1%) | 137 million (2%) |
| Output 1 (prevention) | 56 million | 128 million |
| Output 2 (care) | 450,000 | 2 million |
| Output 3 (stigma) | 13,000 | 5 million |
| Output 4 (capacity) | 612,000 | 2 million |
| Quality | variable | 90% of quality index |
| Resources spent (% of global HIV spend) | CHF 36 million (0.4%) | CHF 270 million (2%) |

3. Evaluation Purpose & Scope

3.1 Evaluation Purpose & Audience

The International Federation of Red Cross and Red Crescent Societies (IFRC) is undertaking this evaluation to assess the impact and effectiveness of its HIV Global Alliance program. The evaluation will assess:

To what extent the framework mobilized capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programmes within the framework of the IFRC's Global Agenda.

The evaluation upholds IFRC commitment to accountability and organizational learning, and will be used to inform future IFRC programming in HIV/AIDS. The evaluation is in accordance with the initial program agreement for the HIV Global Alliance program, which states that the program should be evaluated at the end of the initial funding cycle in 2010. This evaluation also upholds the

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IFRC Framework for Evaluation, which mandates that all Secretariat programs/projects exceeding 1,000,000 Swiss franc should have an independent, final evaluation.

The audience for this evaluation includes the IFRC Secretariat, National Societies, donors and partner organizations, and other key stakeholders the HIV Global Alliance program.

3.2 Evaluation Scope

This evaluation will focus on Output 4 in the four IFRC zones that have adopted the HIV Global Alliance program during the period of 2006 – 2010. Specific implementation times have varied according to location: Southern Africa 2006-2010; East Africa 2008-2010; West Africa 2008-2010; Americas 2008-2010; Europe 2008-2010; Asia and Pacific 2008-2010. At the end of 2010, 56 National Societies in four Federation Zones have adopted the Global Alliance on HIV approach, developed comprehensive HIV programs and started implementation. To date, the achievements registered by National Societies vary depending on the volume of resources mobilized. Following is a summary of participation by region:

- **Eastern Africa Zone (9):** Djibouti, Ethiopia, Kenya, Madagascar,, Rwanda, Somalia, Sudan, Tanzania, Uganda
- **Southern Africa Zone (10):** Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe
- **Western and Central Africa Zone (5):** Burkina Faso, Central African Republic, Democratic Republic of Congo, Guinea, Nigeria
- **Asia and Pacific Zone (15):** , Bangladesh, Cambodia, China, Cook Islands, India, Kiribati, Laos, Micronesia, Mongolia, Myanmar, Nepal, Philippines, Samoa, , Sri Lanka,
- **Americas Zone (10):** Argentina, Belize, , Colombia, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Jamaica
- **Europe Zone (7):** Armenia, , Belarus,, Kazakhstan, Kyrgyzstan, Russian Federation , Ukraine, Uzbekistan

4. Evaluation Objectives and Criteria

This evaluation will focus on five objectives that frame the principal areas of inquiry. Together, these objectives focus primarily on program Output 4, (Strengthening National Red Cross/Red Crescent Society capacities to deliver and sustain scaled-up HIV programme), and IFRC Secretariat support, management, and harmonization with the Global Alliance program.

Key guiding questions have been framed for each objective. The questions are and the assessment of the objectives should be informed by the IFRC evaluation criteria, per the [IFRC Framework for Evaluation](#):

1. The Red Cross and Red Crescent Fundamental Principles, Code of Conduct, and the IFRC's Strategy 2020
2. Relevance and appropriateness.
3. Efficiency.
4. Effectiveness
5. Coverage
6. Impact.
7. Sustainability

It is important to note that program outputs 1-3 will not be directly assessed in this evaluation. It is beyond the scope and capacity to assess National Society direct implementation and service delivery in HIV/AIDS prevention, treatment, care and support, and reduction of stigma and discrimination. These outputs, however, will be reviewed as necessary to assess the overall evaluation purpose:

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To what extent the framework mobilized capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programmes within the framework of the IFRC's Global Agenda.

4.1 Objective 1 – Assess the overall effectiveness and impact of the Global Alliance

- a. To what extent has the Global Alliance framework mobilized capacities and resources to provide harmonized, effective support to National Societies and partners for the achievement of their HIV programmes within the framework of the IFRC's Global Agenda?
- b. To what extent has the Global Alliance been delivered in an efficient, cost-effective manner?
- c. To what extent did the Global Alliance program achieve its stated objectives according to schedule? To what extent did the Global Alliance uphold its principle of **"100% Commitment."**
- d. To what extent has the Global Alliance changed the ways the IFRC global programme on HIV has been operating over the last ten years?
- e. To what extent has the Global Alliance on HIV improved the quality of RCRC work through systematic peer involvement and knowledge sharing?
- f. To what extent was there a trend towards a comprehensive, contextualized and evidence based response to HIV and AIDS as indicated in the Global Alliance on HIV approach?
- g. To what extent was there increased cooperation and partnership on HIV/AIDS between IFRC and other international organizations?
- h. To what extent has the Global Alliance influenced IFRC's reputation as a global actor in the international arena of HIV/AIDS?

4.2 Objective 2 – Assess IFRC Secretariat program management and support

- a. To what extent were sufficient support and resources allocated in the Secretariat (Geneva and zones) to allow for an effective scaled up program implementation.
- b. To what extent was the Global Alliance program managed such that the IFRC Secretariat, National Societies, and other key HIV/AIDS actors were coordinated in a cohesive and effective manner?
- c. To what extent did structures within the Secretariat and its field structures efficiently support the objectives of the Global Alliance, (including adequate, professional project management)?
- d. To what extent have the IFRC Secretariat and the zone offices supported governance, accountability, and leadership of participating National Society for discharging planned commitments?
- e. To what extent did the global forum of stakeholders and the IFRC General Assembly (GA) steering committee provide sufficient leadership for the Global Alliance program?
- f. To what extent was there an efficient knowledge management, documentation and sharing of best practices and lessons learned within IFRC?
- g. Where there efficient mechanisms within the Secretariat to allow for integration and links to other program sectors?

4.3 Objective 3 – Assess National Society capacity development for HIV/AIDS programs

Output 4 is a primary focus of this evaluation: "Strengthening National Red Cross/Red Crescent Society capacities to deliver and sustain scaled-up HIV programme." In addition to key assessment questions below, closely related is the assessment of the "Seven Ones" in Objective 3.

- a. To what extent has there been wider impact of the Global Alliance on National Society capacity to deliver and sustain scaled-up HIV/AIDS programming? This includes both positive and negative results for National Societies, (direct or indirect, intended or unintended).
- b. To what extent did the overall volume of National Society programming in HIV/AIDS increase?
- c. To what extent has the Global Alliance been well-suited to the IFRC and National Societies to deliver improved, scaled-up HIV/AIDS programming to those in need?



- d. To what extent did the Global Alliance program included National Societies in its implementation, with attention to proportionality – support to National Societies provided proportionate to HIV/AIDS needs.
- e. To what extent was adequate emphasis and support provided to National Society in resource mobilisation?
- f. To what extent has National Society capacity been developed in planning, monitoring evaluation, and reporting (PMER)?
- g. Were the Global Alliance on HIV programme manual and other National Society resources relevant and useful?

4.4 Objective 4 – Assess the “Seven Ones”

An important component of Output 4 is the Seven Ones guiding principles for the HIV Global Alliance program to strengthen cooperation and capacity within the its National Society membership (Global Alliance) to deliver and sustain scaled-up HIV programme. The evaluation should assess the specific criteria identified for the Seven Ones in initial program documentation, “Using the Seven Ones Framework,” (Global Alliance on HIV, 24August2008).

Application of the “Seven Ones” principle should be assessed at two levels:

Compliance with the process: How well are the members of the Global Alliance cooperated in accordance with the “seven ones” rules?

Assessing overall benefit: How has working according to the “seven ones” delivering better results for all stakeholders?

Key guiding questions for each principle include:

- 1. One set of needs analysis.**
 - a. To what extent has there been coordination and alignment of needs analysis within the Global Alliance at global and national society levels?
- 2. One set of objectives and strategies.**
 - a. To what extent has there been alignment of objectives and strategies to Global Agenda policies (for global alliances) or the ONS Strategic Plan (for operational alliances)?
- 3. One HIV country plan (for each operating NS) with expectation of long term commitment to ensure sustainability**
 - a. To what extent has there been ONS ownership, and capacity to plan its programming and guide its partners have increased?
 - b. To what extent have projects and activities that fall outside the alliance framework been
- 4. One shared understanding of the division of labour among entities of the Red Cross Red Crescent Movement**
 - a. To what extent has there been ONS ownership, and capacity to implement its programming has increased?
 - b. The what extent has the division of labour reduced duplication and transactional costs for (i) the ONS and (ii) the PNS?
- 5. One results-based funding framework in which multi and bilateral financing channels can co-exist.**
 - a. To what extent has the financial management capacity of ONS been strengthened (including alignment of ONS and partner financial systems and acceptance of one audit system)?
 - b. To what extent did the Global Alliance attracted more resources from traditional and new donors?
 - c. To what extent did the Global Alliance improved efficiency through greater coherence and reduced transaction costs?
 - d. To what extent has the budgeted resource requirements of the alliance programme been reduced?
- 6. One performance tracking system**



- a. To what extent has the ONS information management and programme monitoring capacity improved?
- b. To what extent were the agreed tracking indicators monitored to track progress on implementation of the National Society HIV Programmes functioning under the framework of the Global Alliance?
- c. To what extent have the perceptions of mutual trust been improved (eg, resulting in reduced demands for separate or ad hoc partner/donor programme monitoring information)?

7. One accountability and reporting mechanism

- a. To what extent has ONS capacity for programme reporting been enhanced?
- b. To what extent have duplicate reporting burdens on ONS and partners been reduced?

4.5 Objective 5 – Assess harmonization and sustainability with IFRC Secretariat

- a. To what extent the Global Alliance will impact/influence National Society capacity and Secretariat strategic direction, partnerships, resource mobilization, and actual implementation in HIV/AIDS programming after 2010?
- b. Have the Global Alliance program strategies to involve National Society governance and engage leadership provided a strategic program vision throughout IFRC?
- c. To what extent has the Global Alliance program affected how HIV/AIDS is featured in the IFRC Strategy 2020?
- d. To what extent did the Global Alliance reflect the policies and priorities set by Secretariat governance up to 2010?
- e. To what extent did the Global Alliance framework incorporate key lessons and recommendations from the 2005 evaluation¹¹⁵ of the IFRC HIV/AIDS Global Program?

5. Evaluation Methodology

This evaluation will employ mixed methods. Specific methodological approaches and tools will be discussed in joint consultation with an IFRC evaluation management team that will manage the consultancy. An inception report will be used to demonstrate a clear understanding and realistic plan of work for the evaluation, checking that the evaluation plan is in agreement with the TOR and the overall IFRC vision for the evaluation. Primary evaluation methods will include:

5.1 Analysis of secondary data sources.

Secondary data will include but is not limited to: baseline data where available from 2005/010 for participating zones/National Societies; meta-analysis of existing Secretariat-commissioned evaluations (at global and regional and country levels) of Global Alliance program initiatives; Global programme plans, annual Global Alliance HIV reports; the Global Alliance programme manual, guidelines; policy and motions passed by Governing Board, General Assembly, HIV Governance Group, Global Alliance steering committee and Health Commission; annual IFRC appeals and global and regional planning documents and annual reports; communications packs, newsletters, Pass It On postings, and reports to UNAIDS; Reports on/of regional networks

5.2 Financial analysis

An important source of secondary data for review and analysis will be the financial records and related documentation for the program. This will include but is not limited to: funds received (multi-lateral, bilateral, in country); budgets and expenditures (Secretariat and field), including annual expenditure of all parts of Global Alliance programming, by country and (where available) by activity.

5.3 Key informant interviews

¹¹⁵ “8,000 Every day... Evaluation of the HIV/AIDS Global Program 2002-2005”



A selection of key informants will be identified jointly by the consultancy and the evaluation management team. Interviews will be conducted in person and over the phone.

5.4 **Focus group discussion**

Where appropriate, focus group discussions will be used to generate and capture group opinion. At a minimum, an extended focus group discussion (Lessons Sharing Workshop) will be conducted with key stakeholders to review the initial draft findings and recommendations for the evaluation report. This will be done to check for accuracy, collect any additional feedback/input for the evaluation, and to foster understanding and ownership for the evaluation process.

5.5 **Survey questionnaires**

Survey questionnaires can be developed targeting 1) Secretariat HIV/AIDS Advisers, and 2) field members of the Global Health team/ program. Additional questionnaires may target remaining IFRC field structure and National Societies. Questionnaire may be administered online, and/or through the HIV Advisers, and HIV/AIDS delegates.

should be selected for their empirical rigor to address the evaluation objectives and criteria.

6. Timeframe and deliverables (outputs)

The specific timeframe will be agreed in joint consultation with an IFRC evaluation management team and detailed in the inception report process. Related, deliverables may be revised according to the conception report. The consultancy is expected to be 22 weeks; actual start of the consultancy will depend on the recruitment process for suitable consultant/s.

7. Evaluation Quality & Ethical Standards

The evaluation consultant/s should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people involved, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards and specific, applicable practices outlined in the [IFRC Framework for Evaluation](#). The IFRC Evaluation Standards are:

1. **Utility:** Evaluations must be useful and used.
2. **Feasibility:** Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics & Legality:** Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
4. **Impartiality & Independence;** Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency:** Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy:** Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation:** Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **Collaboration:** Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will uphold the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at: www.ifrc.org/what/values/principles/index.asp

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8. Consultant/s Qualifications

- a. Public health expertise with advanced technical knowledge of HIV and AIDS programme delivery and global trends
- b. University degree/s at the post-graduate level in relevant field of study, PhD preferred, MPH minimum.
- c. Minimum of seven years experience in the review and evaluation of health and care community based programmes, and related capacity building mechanisms.
- d. Demonstrated competence in managing quantitative and qualitative data collection and analysis.
- e. Sound knowledge of the IFRC and it works preferred.
- f. Excellent analytical, writing and presentation skills.

9. Application Procedures

Interested candidates should submit their application material by May 15th 2012 to: Misgana Ghebreberhan, misgana.ghebreberhan@ifrc.org.

1. **Curricula Vitae** (or resume)
2. **Cover letter** clearly summarizing your experience as it pertains to this assignment, **your daily rate**, and **three professional references**.
3. At least one example of an **evaluation report** most similar to that described in this TOR.

Application materials are non-returnable, and we thank you in advance for understanding that only short-listed candidates will be contacted for the next step in the application process.

10. Annex

Annex 1 – HIV Global Alliance Program Framework

| APPROACHES | TRACKING INDICATORS |
|---|---|
| <p>PURPOSE OF RED CROSS RED CRESCENT HIV GLOBAL ALLIANCE: To scale-up the International Federation's efforts in support of National HIV and AIDS Programmes to reduce vulnerability to HIV and its impact</p> | <ul style="list-style-type: none"> ❖ People benefiting from Red Cross Red Crescent HIV services in targeted communities (number and %) ❖ Proportion of national programming in targeted countries conducted by Red Cross Red Crescent (%) <p>National Impact: <i>Prevalence of HIV; infants born to HIV infected mothers who are infected at 18 months; survival rates of antiretroviral therapy (ART) recipients.</i></p> |
| OUTPUT 1: Preventing further HIV infection | |
| <p>1.1 Peer education and community mobilization</p> <p>1.2 Information, education, and communication (IEC) for targeted vulnerable groups</p> <p>1.3 Voluntary Counselling and Testing (VCT)</p> <p>1.4 Preventing Mother to Child Transmission (PMTCT)</p> <p>1.5 Skills for personal protection,</p> | <ul style="list-style-type: none"> ❖ People reached by peer education programme (number and %) ❖ People reached by IEC programmes (number and %) ❖ People who were referred to VCT services (number and %) ❖ Pregnant women referred to PMTCT services (number and %) ❖ PLHIV supported on positive prevention (number) |

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| APPROACHES | TRACKING INDICATORS |
|---|--|
| including condom use | <p>National Outcome: % of people with correct knowledge on means of HIV prevention and rejection of major misconceptions; % of people with non-regular or multiple partners reporting consistent condom use.</p> |
| <p>OUTPUT 2: Expanding HIV treatment, care, and support</p> | |
| <p>2.1 Assisting children and orphans (OVC) made vulnerable by HIV</p> <p>2.2 Providing treatment, support and care (home or community based and through health institutions) for people living with HIV</p> <p>2.3 Developing community support groups and networks.</p> <p>2.4 Providing livelihood and food support for the most vulnerable</p> | <ul style="list-style-type: none"> ❖ OVC clients receiving RCRC services (number and %) ❖ HBC or treatment clients receiving RCRC services (number and %). ❖ School age OVCs supported by RCRC to attend school (number and %) ❖ PLHIV reached by RCRC support groups (number) ❖ HBC or treatment clients and OVC receiving livelihood support (number) <p>National Outcome: % of school age OVC attending school on a regular basis; % of ART (and TB treatment) clients with over 90% adherence to treatment.</p> |
| <p>OUTPUT 3: Reducing HIV stigma and discrimination</p> | |
| <p>3.1 Developing community support groups and networks of people living with HIV, and partnerships with PLHIV organisations</p> <p>3.2 Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent National Societies</p> <p>3.3 Tackling gender inequalities and sexual and gender based violence</p> <p>3.4 Peer education, community mobilisation, and population-based information, education and communication</p> | <ul style="list-style-type: none"> ❖ HIV+ RCRC staff and volunteers who received ART in last 12 months (number). ❖ Discrimination incident reports reported by HIV positive RCRC staff and volunteers with appropriate action (%) ❖ Number of sexual and gender- based violence incident reports received from served population and followed up with appropriate action ❖ National Societies with workplace policies, and staff participating in work place HIV education (number and %) <p>National Outcome: social attitudes to HIV and AIDS: % of marginalised groups and/or PLHIV who report that they can live openly and without discrimination.</p> |
| <p>OUTPUT 4: Strengthening National Red Cross / Red Crescent Society capacities to deliver and sustain scaled-up HIV programme</p> | |
| <p>4.1 Improving governance, accountability, and leadership of Red Cross Red Crescent National Societies for discharging planned commitments</p> <p>4.2 Improving volunteer and staff support and management</p> <p>4.3 Strengthening programme cycle management</p> <p>4.4 Widening partnerships and expanding resource mobilisation</p> | <ul style="list-style-type: none"> ❖ Number of volunteer hours mobilised ❖ National Societies that regularly report as per standard guidelines (number and %) ❖ HIV Appeals coverage (amount and %) <p>National Outcome: resources mobilised by NS through in-country approaches and partnerships; at least 80% achievement of specific targets within set timescales by country programmes.</p> |



Annex B



Federation HIV/AIDS Policy (2002)

Introduction

The International Federation of Red Cross and Red Crescent Societies (International Federation) has a long tradition of working in the area of health and care. National Red Cross and Red Crescent Societies have been supporting individual HIV/AIDS projects since the mid-1980s. Although national and international initiatives have been successful in helping many individual beneficiaries, they have lacked the consistency and scale to make a significant impact on the HIV/AIDS epidemic. At its General Assembly in 2001, the International Federation took a truly global approach to the fight against HIV/AIDS and called for its 1987 HIV/AIDS policy, which had been reviewed in 1991 and 1993, to be updated. This policy provides a framework to support National Society implementation according to local needs and feasibility.

Scope

The policy addresses the strong recommitment of the International Federation to continuing and scaling-up prevention, destigmatization, advocacy and provision of health care and other services related to HIV/AIDS, in particular to vulnerable populations, noting:

- the close relationship between health and human rights and the importance of involving people living with HIV/AIDS (PLWHA) in the fight against AIDS expressed in the International Federation's HIV/AIDS policies since 1987;
- that prevention, care, treatment, support and fighting stigma and discrimination are closely interrelated interventions and are inseparable in successful community responses to HIV/AIDS, as underscored by the 13th session of the International Federation's General Assembly which took place in November 2001;
- the need for scaling up the above-mentioned approaches in order to curb the epidemic as expressed in the Ouagadougou Declaration adopted at the Red Cross and Red Crescent Pan-African Conference in 2000;
- the need to develop further the scale and effectiveness of programmes in order to really focus where the Red Cross Red Crescent can make a difference, including reaching out to those groups most vulnerable to HIV/AIDS, as expressed in the Berlin Declaration adopted at the 6th European Red Cross and Red Crescent Conference in 2002;

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- the need for jointly and urgently addressing HIV/AIDS as a major global development and potential security problem as expressed in the Declaration adopted by the United Nations' General Assembly Special Session on AIDS in 2001 in which the International Federation is mentioned as one of the important players in the fight against HIV/AIDS (article 34);
- that health – which should be viewed as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (World Health Organization (WHO), 1948) – is an inalienable right of all people without any regard to race, religion, colour, nationality, sex or origin. Health of the individual is fundamental and is an indispensable prerequisite to global, national and individual development, as expressed in the International Federation's health policy (1999);
- HIV/AIDS is a major development problem, which exacerbates other health problems such as tuberculosis (TB), malaria and other common health problems;
- that the HIV/AIDS epidemic affects all sectors of society and in extreme cases erodes the social fabric of society, leaving the elderly and young people to fend for themselves;
- poverty, inequity, instability, the widening gap in social justice, gender inequity and lack of respect for human rights are important factors driving the HIV/AIDS epidemic; therefore

Statement

The International Federation and each individual National Society shall:

1. strive to be a strong and qualified voice of social conscience and knowledge in promoting and protecting the health of vulnerable populations, not least families and communities infected and affected by HIV/AIDS;
2. show leadership in fighting stigmatization and discrimination everywhere and by creating tolerant and supportive environments for PLWHA within the organization;
3. form and participate in relevant international forums and alliances, such as the International Partnership against AIDS in Africa and the Caribbean and working with GNP+ internationally;
4. as auxiliary to government advocate for government commitment and leadership at the highest political level in the fight against AIDS at all levels and participate actively in the Country Coordinating Mechanism for the Global Fund to fight AIDS, TB and Malaria, national AIDS committees and plans. Furthermore, to advocate for the rights of all vulnerable groups to information and protection and to live a full and dignified life;
5. within its mandate and competence, identify appropriate areas for addressing the true needs of vulnerable people and provide corresponding preventive, care and supportive services. The services thus provided shall be complementary to those of the government and/or the other partners in health care and shall be developed in such a manner as to promote effectiveness, efficiency and sustainability;
6. in the design of interventions give priority to integrated community-based programmes, thus ensuring sustainability and maximum benefit to the beneficiaries of these services. This requires joint planning and the direct participation of beneficiaries, not least PLWHA and young people, in identifying needs, planning, implementation and evaluation. Special attention shall be paid to the specific roles of women and men, as well as gender aspects of the epidemic. Particular emphasis shall be placed on sensitizing the target communities about their primary responsibility in maintaining and developing their health through means such as a healthy lifestyle, behavioural changes and mutual support;
7. ensure, to the extent possible, that the comprehensive community-based HIV/AIDS prevention and care programmes are part of or integrated into existing Red Cross and Red Crescent community-based health programmes and are coordinated with efforts aimed at other common health problems such as TB and malaria. Moreover, all possible efforts must be exerted to integrate HIV/AIDS programmes into all other feasible programmes;

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8. ensure that Red Cross and Red Crescent HIV/AIDS programmes put special emphasis on advocacy and health promotion (access to health, education, life skills, livelihood, workplace safety and support), prevention (information education and communication, peer education, mobilization of non-remunerated blood donors, harm reduction for injecting drug users (IDUs), condom promotion). Whenever possibilities and appropriate conditions exist, efforts must be exerted to promote access to voluntary counselling and testing. Home-based care, referral and community-based support to survivors (orphans, other affected children, the elderly, etc.) as well as to families living with HIV should complement the preventive efforts and be a mainstay of the Red Cross and Red Crescent's role;
9. promote and where appropriate facilitate access for vulnerable groups to prevention of mother-to-child transmission (MTCT), treatment of opportunistic infections and to anti-retroviral (ARV) drugs, according to international standards and the capacity of the Red Cross and Red Crescent, based on scientific studies of various community-based Red Cross and Red Crescent pilot schemes;
10. guided by sound public health and humanitarian principles, promote and where appropriate facilitate harm reduction strategies for high risk behaviours and traditional practices, including advocating for law reform as necessary. The secretariat will produce guidelines to assist National Societies with humanitarian advocacy work and programme development and to ensure that responses are tailored to what is feasible and needed in each country;
11. ensure that the Red Cross and Red Crescent programmes developed are within the context of government plans and of National Societies' role as auxiliary to their government and are complementary to the efforts of other organizations. Moreover, ensure that interventions are based on updated knowledge and experience and continuously adjusted and adapted to the special characteristics of their own countries and communities as well as to current and future trends as they affect the health of the vulnerable populations;
12. advocate for governments to take a proactive, well-informed and effective leadership role in provision of prevention, treatment, care and support, including, where feasible, prevention of MTCT, access to treatment and access to harm reduction programmes;
13. take all possible measures to ensure that utmost universal precautions are taken (sterilization of medical appliances, personal protection and precaution) to prevent nosocomial infections in all health care settings run by the International Federation's secretariat and National Societies;
14. ensure that all health services provided in emergency settings shall take into consideration all feasible HIV/AIDS-related programmes with the assurance that services provided in any prolonged emergencies shall develop into sustainable integrated community-based health care;
15. make a special and concerted effort to urgently ensure the availability of financial, material and high-quality human resources for advocacy and the provision of health-care services, including AIDS prevention and care, as described above;
16. show leadership in the global fight against HIV/AIDS and promote collaboration among relevant partners at all levels;
17. make a commitment to document and share lessons learned in the fight against AIDS within the International Red Cross and Red Crescent Movement, especially through strengthening and developing the Movement's own regional HIV/AIDS networks, and with other actors locally, nationally and globally.



Responsibilities

National Societies have the responsibility to develop their own HIV/AIDS and/or health policies and to ensure that their practices are in conformity with the prevailing standards set by WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) and to encourage their governments to adopt the policies established by said organizations.

National Societies are encouraged to incorporate HIV/AIDS into their resource mobilization plan, and enter into partnerships both within the Red Cross and Red Crescent Movement and beyond. The International Federation's secretariat should pay particular attention to supporting the coordination of such partnerships.

National Societies have the responsibility to identify their role in an overall country programme with regard to health while adhering to the International Federation's health policy, this HIV/AIDS policy and the International Federation's HIV/AIDS strategy.

National Societies and the International Federation have a responsibility to ensure that all health programmes adhere to the disease prevention, treatment and control protocols officially promulgated by WHO and UNAIDS and are in compliance with this policy; that all staff and volunteers participating in such programmes are aware of the rationale and details of this policy; and that, to the extent possible, all governmental, intergovernmental and non-governmental partners are adequately informed of this policy.

National Societies have the responsibility to develop, introduce and implement a mechanism for monitoring and verification of compliance with this policy, and the International Federation's secretariat shall take the lead in developing such mechanisms.

References

This policy was adopted by the Governing Board meeting on 6 November 2002.

The policy replaces all previously established HIV/AIDS policies, and will be operationalized through guidelines and manuals including:

1. *Guidelines on first aid and HIV/AIDS* (2001)
2. *Orphans and other children made vulnerable by HIV/AIDS – Principles and operational guidelines for programming* (2002)
3. *Home-based care guidelines* (2002)
4. *Harm reduction guidelines* (2003)
5. *AIDS, health and human rights manual* (with Harvard School of Public Health, 1995).
6. *Positive Development Manual* (Global Network of PLWHA, 1998)
7. *Action with youth: HIV and STD manual* (2000, second edition)
8. *Reducing household vulnerability to HIV/AIDS and other infectious diseases – Global Programme 2002-2005* (2002 and annual updates).
9. *ARCHI 2010 Volunteers and community health* (2001)
10. *ARCHI 2010 Toolkits* (2000-2002).



Annex C

Principles of the IFRC Global Alliance on HIV

Overall Purpose: To scale-up the International Federation's efforts in support of National HIV and AIDS Programmes to reduce vulnerability to HIV and its impact.

- **Output 1:** Preventing further HIV infection.
- **Output 2:** Expanding HIV treatment, care, and support.
- **Output 3:** Reducing HIV stigma and discrimination.
- **Output 4:** Strengthening National RC/RC Society capacities to deliver and sustain a scaled-up HIV programme.

An effective IFRC Global Alliance on HIV is expected to:

- Improve the quality of RCRC work through systematic peer involvement and knowledge sharing.
- Improve efficiency through greater coherence and reduced transaction costs.
- Attract more resources from traditional and new donors.
- Expand the volume of programming.
- Ensure that National Society capacity building is given central emphasis.

The "seven ones" principles:

1. **One** set of needs analysis.
2. **One** set of objectives and strategies
3. **One** HIV country plan (for each operating NS) with expectation of long term commitment to ensure sustainability
4. **One** shared understanding of the division of labour among entities of the Red Cross Red Crescent Movement
5. **One** results-based funding framework in which multi and bilateral financing channels can co-exist.
6. **One** performance tracking system
7. **One** accountability and reporting mechanism

The "three key guiding principles for implementation":

1. Interventions must be evidence-based, i.e. they must be informed by locally-prevalent patterns of HIV risk, vulnerability, and impact, and driven by a demonstrable understanding of what is effective in a particular context.
2. Interventions must be main-streamed, i.e. they should be implemented, not only within the structures and programmes of the International Federation but, wherever feasible, they should be integrated into and seek to strengthen community and institutional systems for health, education, social care, and livelihood promotion. Thus HIV activities may be carried out jointly with maternal and reproductive health, TB, safe blood and other related interventions.
3. Interventions must seek out the most vulnerable and build resilience i.e. in line with the fundamental principles of the Red Cross Red Crescent, they must prioritize reaching and empowering the people that are most in need.

The IFRC HIV Global Alliance "100% Commitment" (2010 targets):

1. 100% of Red Cross Red Crescent National Societies active in HIV in low and middle income countries will be working to advocate and enable 100% access by their clients to prevention, treatment, care and support.
2. 100% scale-up (at least) in resources programmed for HIV work by Red Cross Red Crescent National Societies in low and middle income countries.
3. 100% increase (at least) in numbers of participants and beneficiaries in Red Cross Red Crescent prevention, treatment, care, support, and anti-stigma initiatives in low and middle income countries.
4. 100% increase in gender equity in access to, and participation in, Red Cross Red Crescent HIV programmes in low and middle income countries.

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Annex D

IFRC HIV Global Alliance Evaluation Framework

NOTE: (DR= Desk Review; OQ= Online Questionnaires (type A = secretariat/zonal; type B=NS/partners); KII= Key Informant Interviews; FGD= Focus Group Discussions)

| Objective 1 – Assess the overall effectiveness and impact of the Global Alliance | | | | | |
|--|---|-----------------------|--------|-----|-----|
| Evaluation questions | Indicators | Data collection tools | | | |
| | | DR | OQ | KII | FGD |
| a. To what extent has the HIV GA framework mobilized capacities and resources to provide harmonized, effective support to National Societies and partners for the achievement of their HIV programs within the framework of the IFRC’s Global Agenda? | <ul style="list-style-type: none"> - % scale-up in resources available to the GA secretariat to support national programming and resource mobilization. - Number of IFRC staff working on HIV/AIDS at global and zonal level. - % of respondents agreeing with the statement | X | A B | X | X |
| b. To what extent has the HIV GA been successful in the objective of promoting the alignment of the RCRC Movement and partners, guided by their particular comparative advantages, to ensure the effective and efficient delivery of benefits for the world’s most vulnerable populations? | <ul style="list-style-type: none"> - % of respondents agreeing that the GA has improved alignment with partners and ensured the effective and efficient delivery of benefits. | | A B | X | X |
| c. To what extent did the HIV GA program achieve its stated objectives according to schedule? | <ul style="list-style-type: none"> - % of respondents agreeing that the GA was successful in scaling-up IFRC’s efforts in support of national HIV and AIDS programs to reduce vulnerability to HIV and its impact. - People benefiting from RCRC HIV services in target communities (number and %) - Volunteer hours mobilized (number). | X | A B | X | |
| d. To what extent did the Global Alliance uphold its principle of “100% Commitment” in scaling up HIV/AIDS service delivery. | <ul style="list-style-type: none"> - % scale-up in resources programmed for HIV work by RCRC NS in low and middle income countries. - % increase in numbers of participants and beneficiaries in RCRC prevention, treatment, care, support, and anti-stigma initiatives in low and middle income countries, | X | | X | |
| e. What changes has the HIV GA introduced to the way the IFRC global programme on HIV has been operating over the last ten years? | <ul style="list-style-type: none"> - Examples provided by respondents. | | A B | X | X |

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| f. To what extent has the HIV GA improved the quality of RCRC work through systematic peer involvement and knowledge sharing? | -% of respondents stating the GA improved the quality of IFRC HIV work. | | A B | X | |
|--|--|-----------------------|--------|---------|-----|
| g. To what extent has the HIV GA led to increased cooperation and partnership on HIV/AIDS between IFRC and other international organizations? | - Participation of IFRC staff in international meetings and consultations. -% of respondents agreeing with the statement. | X | | X | |
| h. To what extent has the HIV GA enhanced IFRC's role as a global actor in the international arena of HIV/AIDS? | -% of respondents stating the GA enhanced the role of IFRC at global level. | | | X | |
| Objective 2 – Assess IFRC Secretariat program management and support | | | | | |
| Revised Evaluation questions | Indicators | Data collection tools | | | |
| | | D R | C Q | K II | FGD |
| a. To what extent were sufficient support and resources allocated in the Secretariat (Geneva and zones) to allow for an effective HIV GA program implementation. | - Budget available to the Secretariat - HR pattern - N. of zones with 1 HIV Senior Officer and 100,000 CHF for activities. | X | | X | |
| b. To what extent the HIV GA program succeeded in ensuring a cohesive and effective coordination of the IFRC Secretariat, National Societies, and other key HIV/AIDS actors? | - Number of coordination meetings (global, zones). - Number of ONS participating. -% of respondents agreeing with the statement. | X | | X | |
| c. To what extent have the IFRC Secretariat and the zone offices supported governance, management, accountability, and leadership of participating NS for discharging planned commitments? | - People trained in programme management. -% of respondents agreeing with the statement. | X | A B | X | |
| d. To what extent did the GA Forum of stakeholders and the GA Steering Committee provide the required leadership for the program? | -% of respondents agreeing with the statement. - Minutes of meetings and meetings reports | | | X | |
| e. To what extent was there an efficient knowledge management, documentation and sharing of best practices and lessons learned on HIV/AIDS within IFRC? | - Production of guidance material, newsletter, reports. -% of respondents agreeing with the statement. | X | A B | X | |
| f. What mechanisms were established within the Secretariat to allow for effective integration and links to other program sectors? | -% of respondents agreeing with the statement. - Examples provided by respondents. | X | | X | |
| Objective 3 – Assess National Society capacity development for HIV/AIDS programs | | | | | |
| Revised Evaluation questions | Indicators | Data collection tools | | | |
| | | D R | C Q | K II | FGD |

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| a. To what extent did the Global Alliance program strengthen National Societies' capacities to deliver and sustain scaled-up and mainstreamed HIV programs (prevention, treatment, care and fighting stigma and discrimination)? | - Number of ONS staff trained in HIV programming and service delivery. - % of increase in programme delivery. - % of resources mobilized at local level - % of respondents agreeing with the statement. | X | A B | X | X |
|--|--|-----------------------|--------|---------|----------|
| b. To what extent the HIV GA has led to an increase in the overall volume of National Society programming in HIV/AIDS? | - Increased or decreased funding allocation to HIV programming. - % increase in numbers of participants and beneficiaries in RCRC prevention, treatment, care, support, and anti-stigma | X | | X | |
| c. To what extent the HIV GA provided adequate emphasis and support to National Society in resource mobilization? | - % of respondents agreeing with the statement. | | A B | X | |
| d. To what extent has National Society capacity been developed in planning, monitoring, evaluation, and reporting (PMER)? | - Number of ONS staff trained in PMER. - % of participating ONS that reported regularly (yearly) on implementation. | X | | X | |
| e. To what extent were the HIV GA programme manual and other resources relevant and useful for National Societies? | - % of respondents agreeing with the statement. | | B | X | |
| Objective 4 – Assess the “Seven Ones” | | | | | |
| Revised Evaluation questions | Indicators | Data collection tools | | | |
| | | R | D Q | C II | K FGD |
| 1. One set of needs analysis. a. To what extent has there been coordination and alignment of needs analysis within the HIV GA at global and national society levels? | - Proportion of NS that used a standardized and objectively-verifiable needs assessment approach | X | | B | X |
| 2. One set of objectives and strategies. a. To what extent has there been alignment of the HIV GA objectives and strategies to the IFRC Global Agenda policies? | - % of respondents agreeing with the statement. | | | B | X |
| b. To what extent has there been alignment of objectives and strategies of the ONS Strategic Plans to the HIV GA policies? | Proportion of ONS Strategic Plans which are 100% harmonized with HIV Global Alliance objectives and strategies. | X | | B | X |
| 3. One HIV country plan (for each ONS) with expectation of long term commitment to ensure sustainability a. To what extent the NS HIV Programme documents are consistent with the national strategies as developed by the NAC/NAP? | --% of respondents agreeing with the statement. - % of NS HIV programme objectives that are reflected in the National Strategy. | X | | B | X |
| b. To what extent have all activities that are related to HIV programmatic work (directly or mainstreamed) been included in the NS HIV Programme Document? | - % of respondents agreeing that the NS HIV <i>Programme document</i> form the basis of delivery at the country level? - % of respondents agreeing with the statement. | X | | B | X |

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| <p>4. One shared understanding of the division of labour among entities of the Red Cross Red Crescent Movement</p> <p>a. To what extent has the division of labour increased efficiency and reduced duplication and transactional costs for (i) the ONS, (ii) the PNS and (iii) the Secretariat?</p> | -% of respondents agreeing with the statement. | | A | X | |
|---|--|-----------------------|--------|---------|-----|
| <p>5. One results-based funding framework in which multi and bilateral financing channels can co-exist.</p> <p>a. To what extent the common framework for resource allocation reflected all available financial resources?</p> | - Proportion of HIV programmes with a common framework for resource allocation and recording. -% of respondents agreeing with the statement. | | B | X | |
| <p>b. To what extent did the HIV GA attract more resources from traditional and new donors?</p> | - HIV Appeals coverage (amount and %). - Proportion of funds channeled through Alliance partners. | X | A E | X | |
| <p>c. To what extent did the Global Alliance improve efficiency through greater coherence and reduced transaction costs?</p> | % change in the proportion of funding for administrative overheads. | X | | X | |
| <p>6. One performance tracking system</p> <p>a. To what extent were the agreed tracking indicators monitored and reported to enable monitoring of progress on implementation of the National Society HIV Programmes functioning under the framework of the HIV GA?</p> | - % NS that regularly reported as per standard guidelines. - % of participating NS that produced a yearly report on programme implementation. - % of programs implementing a common monitoring, reporting and evaluation framework | X | B | X | |
| <p>7. One accountability and reporting mechanism</p> <p>a. To what extent has the HIV GA led to an improvement in the partners' perception of mutual trust, resulting in reduced demands for separate or ad hoc partner/donor specific programme reporting?</p> | - % of donors requiring separate reporting. | X | A E | X | |
| Objective 5 – Assess harmonization and sustainability with IFRC Secretariat | | | | | |
| Revised Evaluation questions | Indicators | Data collection tools | | | |
| | | D R | C Q | K II | FGD |
| <p>a. In what ways the experience of the HIV GA might influence NS and IFRC Secretariat strategic direction, partnerships, resource mobilization, and actual implementation in HIV/AIDS programming after 2010?</p> | - listing by respondents | | A E | X | X |
| <p>b. Did the GA program strategic approach to involve NS governance and engage leadership succeed in securing a strategic program vision and sustainability throughout IFRC?</p> | -% of respondents agreeing with the statement. | | A E | X | |
| <p>c. To what extent has the HIV GA program affected how HIV/AIDS is featured in the IFRC Strategy 2020?</p> | - listing by respondents | X | | X | |
| <p>d. To what extent did the GA implement the Programme Cycle</p> | - % of participating NS that implemented PCM and PAS | X | | X | |

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| | | | | | |
|--|---|---|--|---|--|
| Management (PCM) and the Planning and Appeal System (PAS) approaches to programme management and resource mobilization? | approaches. | | | | |
| e. To what extent did the HIV GA framework incorporate key lessons and recommendations from the 2005 evaluation of the IFRC HIV/AIDS Global Program? | -% of recommendations that have been implemented. | X | | X | |

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Annex E

| Title | Authors | Date |
|---|--|-------------|
| African Red Cross and Red Crescent Health Initiative 2010 (ARCHI 2010) | IFRC | 2000 |
| Rapid desk review of HIV/AIDS policies, strategies and programs of the International Federation Of Red Cross And Red Crescent Societies | B. Westphal, S. Adu-Aryee, G. Tesfai, Dan Kase Je. | 2001 |
| IFRC HIV/AIDS policy | IFRC | 2002 |
| A Vital Partnership: The Work of GNP+ and the International Federation of Red Cross and Red Crescent Societies. | UNAIDS Best Practice Collection | 2003 |
| A seven country case study evaluating the International Federation's response to the challenges of the HIV/AIDS pandemic | B. Corcoran (Team Leader) J. V Hows, B. Wall. | 2003 |
| 8,000 Every Day: Evaluation of the HIV/AIDS Global Programme 2002-2005 | S. Seebacher et al | 2005 |
| Red Cross Red Crescent successes in global health | IFRC | 2006 |
| Southern Africa: Regional HIV And AIDSs Programme Appeal No. MAA63003 (2006-2010) | IFRC | 2006 |
| Responding to HIV/AIDS in Asia Pacific 2006-2010 | IFRC | 2006 |
| The Red Cross and Red Crescent Global Alliance on HIV Programme Manual (version 6.1) | IFRC | 2006 |
| Rising to the Challenge | IFRC | 2007 |
| Secretariat-wide Resourcing Framework Budget 2008-2009 For The Global Alliance on HIV | IFRC | 2007 |
| Health and Care Programme Updated 2007. Appeal No. MAA00001 | IFRC | 2007 |
| Global Alliance on HIV Newsletter n. 1,2,3,4 and 6 | IFRC | 2007-9 |
| Report of the Meeting of the HIV Global Alliance Steering Committee Federation Secretariat, Geneva - 18 November 2007 | IFRC | 2007 |
| IFRC HIV GA Consolidated HIV programme performance Global report for 2008 | IFRC | 2008 |
| Red Cross and Red Crescent Societies Regional HIV and AIDS Programme in South Asia Mid-term Evaluation Report | R. Neupane, C. Anshelm, B. Pratap | 2008 |
| Global Alliance for HIV & AIDS – ARC Observations | Australian Red Cross | 2008 |
| Review of International Federation of Red Cross and Red Crescent Societies (IFRC) material on HIV and AIDS and sudden-onset emergencies | Sara Simon | 2008 |
| Americas HIV Programme (2008-2010) of the Red Cross and Red Crescent Global Alliance on HIV Appeal | IFRC | 2008 |
| IFRC Global Alliances Plan 2008-2009 | IFRC | 2008 |
| West And Central Africa HIV Programme Appeal (2008-2010) | IFRC | 2008 |
| Eastern Africa HIV programme (2008-2010) of the red cross and red crescent global alliance on HIV Appeal | IFRC | 2008 |
| 17th Session of Governing Board Geneva, Switzerland, 21-23 May 2008 Item 12th of the Agenda. Report of the HIV Governance Group | IFRC | 2008 |
| Global Alliances Plan and Appeal 2008-2009 n. MAA00035 | IFRC | 2008 |
| UNAIDS IFRC Collaborating Center Agreement | UNAIDS/IFRC | 2008 |

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| | | |
|---|--|------|
| IFRC HIV GA Comprehensive HIV programme delivery Global report for 2009 | IFRC | 2009 |
| Inequalities fuelling HIV pandemic. Focus on Red Cross societies' response in Latin America and the Caribbean | IFRC | 2009 |
| Options for engagement IFRC, National Societies and The Global Fund (Position paper) | Sarah Hargreaves | 2009 |
| Strategy to integrate Gender-Based Violence in the HIV Alliance for Southern Africa | IFRC | 2009 |
| Review of IFRC Strategy 2010 | S. Seebacher | 2009 |
| Southern Africa: Regional HIV and AIDS Programme Annual Report 2009 | IFRC SARO | 2010 |
| Global Alliance on HIV Comprehensive HIV programme delivery Global report 2010 | IFRC | 2010 |
| Red Cross & Red Crescent Regional HIV/AIDS Programme in South Asia (2005-2009) final evaluation | B. Basant Patro, P. Pehrson | 2010 |
| Southeast Asia Annual report 2009 | IFRC | 2010 |
| Saving Lives, changing minds. Strategy 2020 | IFRC | 2010 |
| Global Alliance on HIV Comprehensive HIV programme delivery Global report 2011 | IFRC | 2011 |
| Sustaining Commitment. Southern Africa Regional HIV/AIDS Programme 2006 – 2010 End Of Programme Evaluation Report | E. Gomo (Lead Consultant), B. Gardner, S. Munyati, S. Matoka, P. Toto. | 2011 |
| Statement by MR MARWAN JILANI Head of Delegation, Permanent Observer of IFRC to the UNGASS 2011 High-Level Meeting on AIDS | IFRC | 2011 |
| Reducing vulnerability to HIV and its impact in four Pacific Island Countries. Findings from the Mid-term Evaluation of the IFRC component of GFATM Round 7 | Ann Mehaffey & Associates | 2011 |
| Global HIV/AIDS Response Epidemic update and health sector progress towards Universal Access. Progress Report 2011 | UNAIDS/WHO/UNI CEF | 2011 |
| HIV and livelihoods in Africa. What can National Societies do? | IFRC | |
| Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010 | UNAIDS and Kaiser Foundation | 2011 |
| HIV GA Norway Red Cross periodic result report 2009 - 2011 | IFRC | 2012 |
| Final NS assessment by Zone - Expanded collaboration with GF | | 2012 |
| Lessons Learned and Future Programming. Three Years of the Red Cross Global Alliance on HIV in the Americas 2008 - 2011 | V. Ward | 2012 |
| The road to resilience. Bridging relief and development for a more sustainable future. IFRC discussion paper on resilience. | IFRC | 2012 |
| Report on the global AIDS epidemic | UNAIDS | 2012 |
| | | |



Annex F

Annex V: IFRC HIV Global Alliance Evaluation Online Survey

Welcome page

You have been selected to take part in this online survey to help the International Federation of Red Cross and Red Crescent Societies (IFRC) evaluate the impact and effectiveness of its HIV Global Alliance program.

This survey should only take about 20-25 minutes of your time and your contribution will be completely confidential and your answers will be anonymous and not linked to your name or your email address. An external evaluation consultant will analyze the results for the IFRC.

While completing the questionnaire, you will find some questions requesting your comments on specific topics or to share examples taken from your experience with the HIV Global Alliance. While you have the option of not answering them, we would encourage you to do so as your views and your experience are very important to us.

In order to progress through this survey, please use the following navigation links:

- Click the **next** button to continue to the next page.
- Click the **previous** button to return to the previous page.
- Click the **exit this survey** button if you need to exit the survey.
- Click the **submit** button to submit your survey. Please note that after this step you will not be able to modify your answers any more.

- To avoid the risk of losing the data entered so far, if you access one of the external links, please use the “go back one page” arrow on the left top corner of your browser to go back to the questionnaire.

We would like to thank you for your valuable time and input.

If you have any questions or suggestion, please contact us at GAevaluation2012@gmail.com.

The Red Cross Red Crescent Global Alliance on HIV



Section 1: Introduction

The IFRC HIV Global Alliance program was implemented between 2006 and 2010 as, “An enabling framework to mobilize capacities and resources to provide harmonized, effective support to National Society and partners for the achievement of their HIV programs within the framework of the International Federation’s Global Agenda.”

The four broad objectives over this period were to:

- prevent further HIV infection,
- expand HIV treatment, care and support,
- reduce stigma and discrimination related to HIV,
- strengthen National Red Cross/Red Crescent Society (RCRC) capacities to deliver and sustain scaled-up HIV programs.

This evaluation will focus primarily on the last objective. We will assess how well the program contributed to strengthening national capacities and the level of support it provided to enhance management, facilitate resource mobilization and promote harmonization of HIV policies and strategies within the RCRC Movement and with National and International partners.

For more information regarding the overall objectives, strategies and structures of the IFRC HIV Global Alliance, please follow this link [HIV Global Alliance background](#)

1.1 Please indicate below your role/profile in the context of the IFRC HIV Global Alliance:

| | | | |
|---|-----------------------|---|---|
| Staff Member of the Secretariat of the Federation | <input type="radio"/> | ⇒ | A |
| Staff Member of a zonal/regional office of the Federation | <input type="radio"/> | ⇒ | A |
| Staff from an implementing National Society (Health and care coordinators, Health, HIV program officers...) | <input type="radio"/> | ⇒ | B |
| Staff from a participating National Society supporting the implementation of HIV GA in another country | <input type="radio"/> | ⇒ | B |
| Senior management at country level (Secretary General, programme coordinators) | <input type="radio"/> | ⇒ | C |
| Staff of an IFRC partner organization | <input type="radio"/> | ⇒ | D |

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Section 2: The overall effectiveness and impact of the IFRC HIV Global Alliance

The HIV Global Alliance program sought to double the RCRC contribution to the worldwide effort against HIV by 2010. The program sought to achieve this through mobilizing its collective capabilities more efficiently so that it could provide technical and capacity building assistance to RCRC National Societies to develop scaled-up efforts in the prevention, treatment, care and support, and reduction of stigma and discrimination of HIV/AIDS – as part of their own contributions to their respective National HIV/AIDS programs.

2.1 How successful was the IFRC HIV Global Alliance in achieving its stated objectives as listed below?

| Objective | Very successful | Successful | Neutral | Unsuccessful | Very Unsuccessful |
|--|-----------------|------------|---------|--------------|-------------------|
| Mobilizing sufficient capacities to provide effective technical support to NS and partners? | 0 | 0 | 0 | 0 | 0 |
| Mobilizing sufficient financial resources to support NS HIV programs? | 0 | 0 | 0 | 0 | 0 |
| Improving the alignment of RCRC movement and partners based on their comparative advantages? | 0 | 0 | 0 | 0 | 0 |
| Improving the effective delivery of benefits to the target populations? | 0 | 0 | 0 | 0 | 0 |
| Scaling-up IFRC's efforts in support of national HIV and AIDS programs? | 0 | 0 | 0 | 0 | 0 |
| Increasing cooperation between IFRC and other international organizations? | 0 | 0 | 0 | 0 | 0 |
| Enhancing IFRC visibility, role and reputation as a global actor in the international arena of HIV/AIDS? | 0 | 0 | 0 | 0 | 0 |

2.2 What changes has the HIV Global Alliance brought to the way the IFRC Global Programme on HIV has operated during the last 10 years?

| Very positive | Positive | No change | Negative | Very negative | Don't know |
|---------------|----------|-----------|----------|---------------|------------|
| 0 | 0 | 0 | 0 | 0 | |

2.3 The HIV Global Alliance has led to improvements in the quality of RCRC work in HIV.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----------------|-------|---------|----------|-------------------|
| 0 | 0 | 0 | 0 | 0 |

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(Optional) Please provide any additional comment on the above two questions.



Section 3: IFRC Secretariat program management and support

The implementation of the HIV Global Alliance at country level was supported by the global and zonal/regional programs within the IFRC Secretariat. Their role was to provide policy and strategic direction, required technical assistance to National Societies, tracking programme progress and performance, facilitate resource mobilization, and support regular reporting on progress and results.

3.1 The HIV GA succeeded in ensuring a cohesive and effective coordination of the IFRC Secretariat in Geneva and zones, National Societies and the other key HIV/AIDS actors.

| Strongly agree | Agree | Disagree | Strongly disagree | Do not know |
|----------------|-------|----------|-------------------|-------------|
| o | o | o | o | o |

3.2 Please rate the support provided by the IFRC Secretariat and by the zone/regional offices to National Societies in the areas of governance, management and leadership for HIV response?

| IFRC Secretariat | Very effective | Effective | Neutral | Ineffective | Very Ineffective | Do not know |
|------------------------|----------------|-----------|---------|-------------|------------------|-------------|
| Governance | o | o | o | o | o | o |
| Leadership | o | o | o | o | o | o |
| Accountability | o | o | o | o | o | o |
| Management | o | o | o | o | o | o |
| Capacity building | o | o | o | o | o | o |
| Knowledge Management | o | o | o | o | o | o |
| Zonal/regional offices | Very effective | Effective | Neutral | Ineffective | Very Ineffective | Do not know |
| Governance | o | o | o | o | o | o |
| Leadership | o | o | o | o | o | o |
| Accountability | o | o | o | o | o | o |
| Management | o | o | o | o | o | o |
| Capacity building | o | o | o | o | o | o |
| Knowledge Management | o | o | o | o | o | o |

3.3 Please rate the quantity and quality of guidance and information materials produced by the HIV Global Alliance?

| Quantity | Too many | Just right | Sufficient | Insufficient | Do not know |
|-----------------------------|-----------|------------|------------|--------------|-------------|
| Guidance materials | o | o | o | o | o |
| Best practice documentation | o | o | o | o | o |
| Newsletters, global reports | o | o | o | o | o |
| Meeting reports | o | o | o | o | o |
| Quality | Very good | Good | Average | Poor | Do not know |
| Guidance materials | o | o | o | o | o |
| Best practice documentation | o | o | o | o | o |
| Newsletters, global reports | o | o | o | o | o |
| Meeting reports | o | o | o | o | o |



(Optional) Please share any additional guidance or information materials that you feel could have been useful for HIV/AIDS programming and implementation?



Section 4: National Society capacity development for HIV/AIDS programs

Improving technical and managerial capacities of National Societies for HIV/AIDS programming is an essential component of the HIV Global Alliance. Through capacity building, the HIV GA was expected to improve the quality of RCRC work, improve efficiency through greater coherence and reduced transaction costs, attract more resources from traditional and new donors, and expand the volume of HIV programming.

4.1 Please rate the overall impact of the HIV Global Alliance in building National Societies' capacities to deliver scaled-up HIV programs?

| Very positive | Positive | No impact | Negative | Very negative | Do not know |
|---------------|----------|-----------|----------|---------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

4.2 Specifically, what was the result of the support received from the HIV Global Alliance on the following capacities within your National Society?

| Capacity | Much improved | Improved | No change | Reduced | Do not know |
|------------------------------|---------------|----------|-----------|---------|-------------|
| Technical skills in HIV work | 0 | 0 | 0 | 0 | 0 |
| Programme planning | 0 | 0 | 0 | 0 | 0 |
| Programme Management | 0 | 0 | 0 | 0 | 0 |
| Monitoring & Evaluation | 0 | 0 | 0 | 0 | 0 |
| Reporting | 0 | 0 | 0 | 0 | 0 |
| Resource mobilization | 0 | 0 | 0 | 0 | 0 |

4.3 Were the Global Alliance HIV/AIDS activities implemented through AIDS-specific interventions or were they integrated (mainstreamed) into other National Society programs?

| All AIDS-specific | Mostly AIDS-Specific | A few mainstreamed | Mostly mainstreamed | All Mainstreamed | Do not know |
|-------------------|----------------------|--------------------|---------------------|------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comment on the above question.

4.4 Please rate the support provided by the HIV Global Alliance to facilitate National Societies in their resource mobilization efforts for HIV Programming.

| Very effective | Effective | Ineffective | No support provided | Do not know |
|----------------|-----------|-------------|---------------------|-------------|
| 0 | 0 | 0 | 0 | 0 |

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(Optional) Please provide any additional suggestions or comments on what more could have been done to support the National Societies in its HIV resource mobilization efforts.

4.5 Please rate the relevance and usefulness of the HIV Global Alliance and other IFRC resources for HIV/AIDS programming at the country level.

| HIV GA resources | Relevance | | | | | Usefulness | | | | |
|---|---------------|----------|--------------|---------------|----|-------------|--------|------------|---------------|----|
| | Very relevant | Relevant | Not relevant | Never used it | /A | Very Useful | Useful | Not useful | Never used it | /A |
| IFRC, Global Alliance overview, 2006 | | | | | | | | | | |
| RCRC Global Alliance on HIV programme manual | o | o | o | o | | o | | | | |
| Inequalities fuelling HIV pandemic, IFRC, 27 November 2009 | o | o | o | o | | o | | | | |
| Standards for HIV peer education programs, IFRC, 25 June 2009 | o | o | o | o | | o | | | | |
| Out of harm's way - Injecting drug users and harm reduction, IFRC, 1 December 2010 | o | o | o | o | | o | | | | |
| HIV prevention treatment, care and support, a training package for community volunteers, IFRC/WHO/SAfAIDS, 2007 | o | o | o | o | | o | | | | |
| HIV prevention, Principles and guidelines for programming, IFRC, 2007. | o | o | o | o | | o | | | | |
| Rising to the challenge flyer, IFRC 2007 | o | o | o | o | | o | | | | |
| Global Alliance on HIV marketing tools per region (2007-2008). | o | o | o | o | | o | | | | |
| Global newsletters on HIV, IFRC (2007, 2008, 2009). | o | o | o | o | | o | | | | |



Section 5: the “Seven Ones” principles

The HIV Global Alliance program fully subscribes to the “seven ones” principles as a mechanism to facilitate scaling up of activities while ensuring that the work is conducted in the true spirit of IFRC shared principles and values. For more details on the “Seven Ones” principles, please follow the link [7 ones principles](#)

5.1 The HIV needs assessment in my country was conducted using standardized approaches and tools.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----------------|-------|---------|----------|-------------------|
| 0 | 0 | 0 | 0 | 0 |

(Optional) Please comment below on how the HIV/AIDS needs assessment was conducted?

5.2 The objectives and strategies of the National Society HIV Programme document were aligned with the HIV Global Alliance objectives and strategies.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----------------|-------|---------|----------|-------------------|
| 0 | 0 | 0 | 0 | 0 |

5.3 The objectives and strategies of the National Society HIV Program document were coherent with the National AIDS Strategic Plan.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree |
|----------------|-------|---------|----------|-------------------|
| 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comments on the alignment and coherence of the NS HIV Programme document.

5.4 All the HIV/AIDS activities implemented by the National Society and partners were included in the National Society HIV Program document.

| Strongly agree | Agree | Disagree | Strongly disagree | Do not know |
|----------------|-------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comments on the above question.

5.5 The division of labor in HIV programming among IFRC entities (i.e., Secretariat in Geneva and zones, ONS, PNS, partners) has led to increased efficiency and reduced duplication and transaction costs.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Do not know |
|----------------|-------|---------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

The Red Cross Red Crescent Global Alliance on HIV



| | | | | | |
|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 0 | 0 |
|---|---|---|---|---|---|

(Optional) Please provide any additional comment on the above question.

5.6 Six-monthly progress reports for internal monitoring and management were routinely sent by the National Society HIV Programme to the zonal office according to the HIV Global Alliance standardized format.

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Do not know |
|----------------|-------|---------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comments on the above question.

5.7 Agreed tracking indicators for the HIV Global Alliance programmatic outputs were regularly collected and reported on to monitor program implementation.

(For more information on the HIV Global Alliance tracking indicators, please click on the link [tracking indicators](#)).

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Do not know |
|----------------|-------|---------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comment on the above question.

5.8 The HIV Global alliance was successful in improving donors' trust, resulting in reduced demands for separate or a hoc partner/donor specific program reporting".

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Do not know |
|----------------|-------|---------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | |

(Optional) Please provide any additional comments on the above question.

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Section 6: Harmonization and sustainability with IFRC Secretariat

The Global Alliance on HIV pioneered the implementation of the RCRC global alliance approach. The lessons learned during the first 5 years of implementation of the HIV Global Alliance provide an important contribution to the design and guidance for the future of the HIV programme at the Federation, as well as for future Global Alliance initiatives. Your feedback below will be a most valuable contribution to the future of the HIV and other Alliances.

6.1 The HIV Global alliance was successful in engaging National Societies' governance and leadership to ensure sustainability of HIV /AIDS activities".

| Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Do not know |
|----------------|-------|---------|----------|-------------------|-------------|
| 0 | 0 | 0 | 0 | 0 | 0 |

(Optional) Please provide any additional comments on the above question.

6.2 What are the most important lesson that could be drawn from the implementation of the HIV Global Alliance during the last five years?

6.3 Do you feel any aspects of the HIV Global Alliance strategic and/or operational approaches should be retained for future HIV/AIDS programming? If yes, please describe them.

6.4 Do you feel any aspects of the HIV Global Alliance strategic and/or operational approaches should NOT be retained for future HIV/AIDS programming? If yes, please describe them.

Section 7: (Optional) Personal information

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While you do not have to fill this section, the information listed below will allow us to provide a description of the population surveyed in the final evaluation report. This will increase the validity and robustness of the survey results.

7.1 Zone/region where you currently work and/or live.

| Africa | Americas | Asia-Pacific | Europe | ME NA | Secretariat | Prefer not to say |
|--------|----------|--------------|--------|-------|-------------|-------------------|
| | | | | | | |

7.2 Please indicate your age and gender.

| Age | Under 20 | 20-29 | 30-39 | 40-49 | 50-59 | Above 60 | Prefer not to say |
|-----|----------|-------|-------|-------|-------|----------|-------------------|
| | o | o | o | o | o | o | o |

| Gender | Male | Female | Prefer not to say |
|--------|------|--------|-------------------|
| | o | o | o |

7.3 For how long have you been actively involved with the activities of the Federation of the Red Cross and Red Crescent Societies?

| Less than 1 year | 1-5 years | 6-10 years | 10-15 years | More than 15 years | Never |
|------------------|-----------|------------|-------------|--------------------|-------|
| o | o | o | o | o | o |

7.4 For how long have you been actively involved with the activities of the IFRC HIV Global Alliance?

| Less than 1 year | 1-2 years | 3-5 years | More than 5 years | Never |
|------------------|-----------|-----------|-------------------|-------|
| o | o | o | o | o |



8 End of questionnaire

You have reached the end of this questionnaire. You can now submit it by clicking on the "[submit](#)" button below.

We would like to thank you for taking the time to participate in this evaluation of the IFRC HIV Global Alliance program. Your feedback through this online questionnaire is very valuable to us and will contribute to the final evaluation report.

Data collection will be completed by end of November 2012. Data will be compiled and analyzed by the Evaluation Team. The conclusions and recommendations of the evaluation will be finalized in January 2013 and will be shared with all stakeholders and respondents.

To enlarge the pool of respondents, we would like to ask you to provide the contact details for colleagues that you believe could provide a useful contribution to this evaluation by participating in this online survey. You can enter their name and email address anonymously on the online table at the link [additional survey participants](#) or simply send their details to GAevaluation2012@gmail.com.

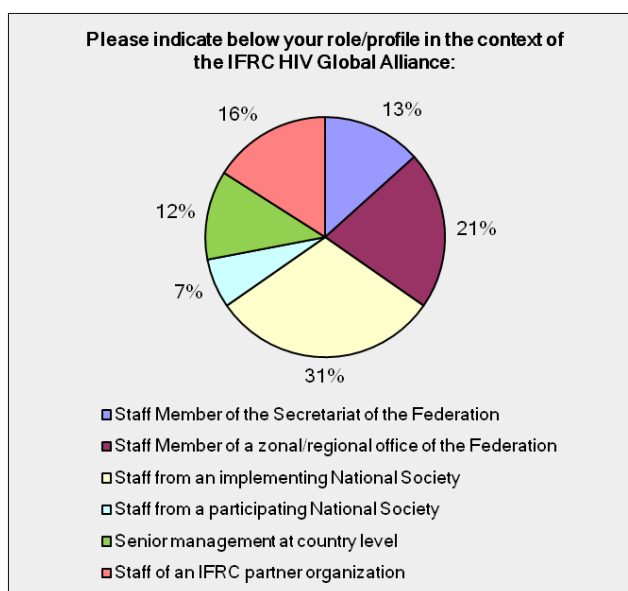


Annex G

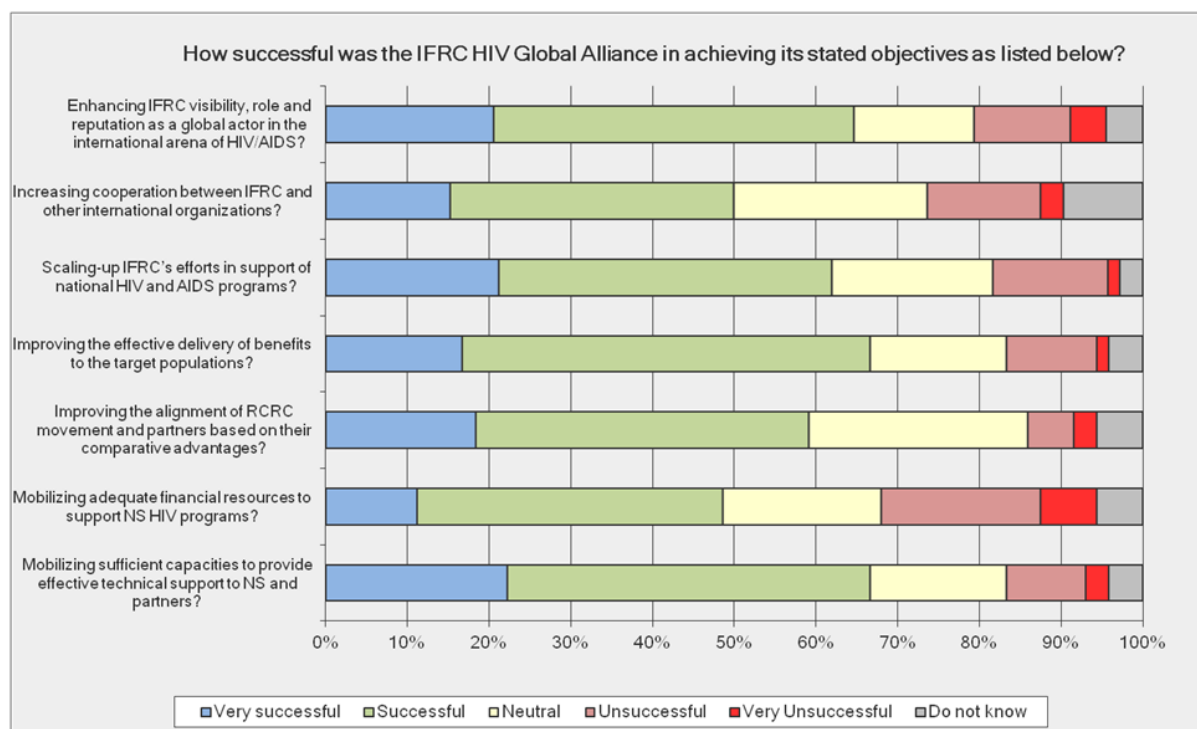
HIV Global Alliance Evaluation Online Questionnaire Summary of responses

1. Please indicate your role/profile in the context of the IFRC HIV Global Alliance. (n.75)

| | | | |
|--|----------|----------|------|
| Staff Member of the Secretariat of the Federation | 1 | 1 | 3,3% |
| Staff Member of a zonal/regional office of the Federation | 1 | 2 | 1,3% |
| Staff from an implementing National Society (e.g. Health and care coordinators, Health and HIV program officers) | 2 | 3 | 0,7% |
| Staff from a participating National Society supporting the implementation of HIV GA in another country | 5 | 6 | 7% |
| Senior management at country level (e.g. Secretary General, programme coordinators) | 9 | 1 | 2,0% |
| Staff of an IFRC partner organization | 1 | 1 | 6,0% |
| TOTAL | 7 | 5 | |

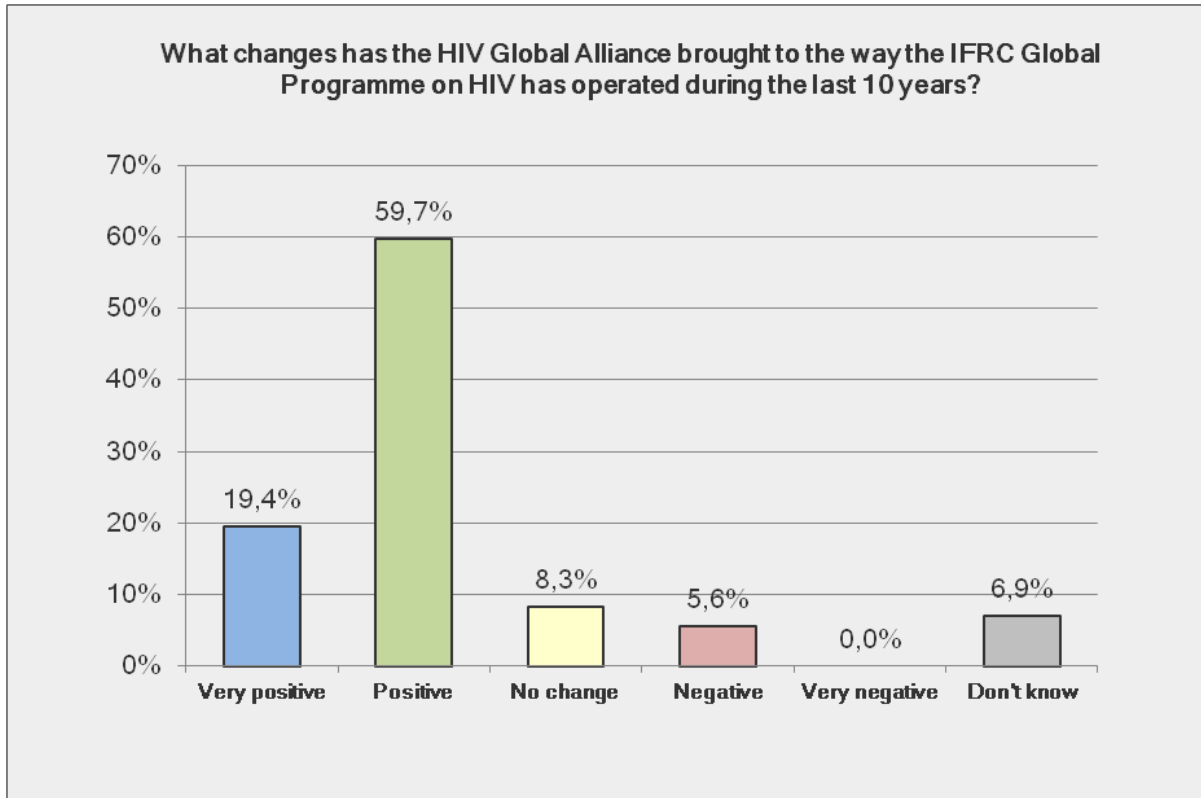


2. How successful was the IFRC HIV Global Alliance in achieving its stated objectives? (n.72)



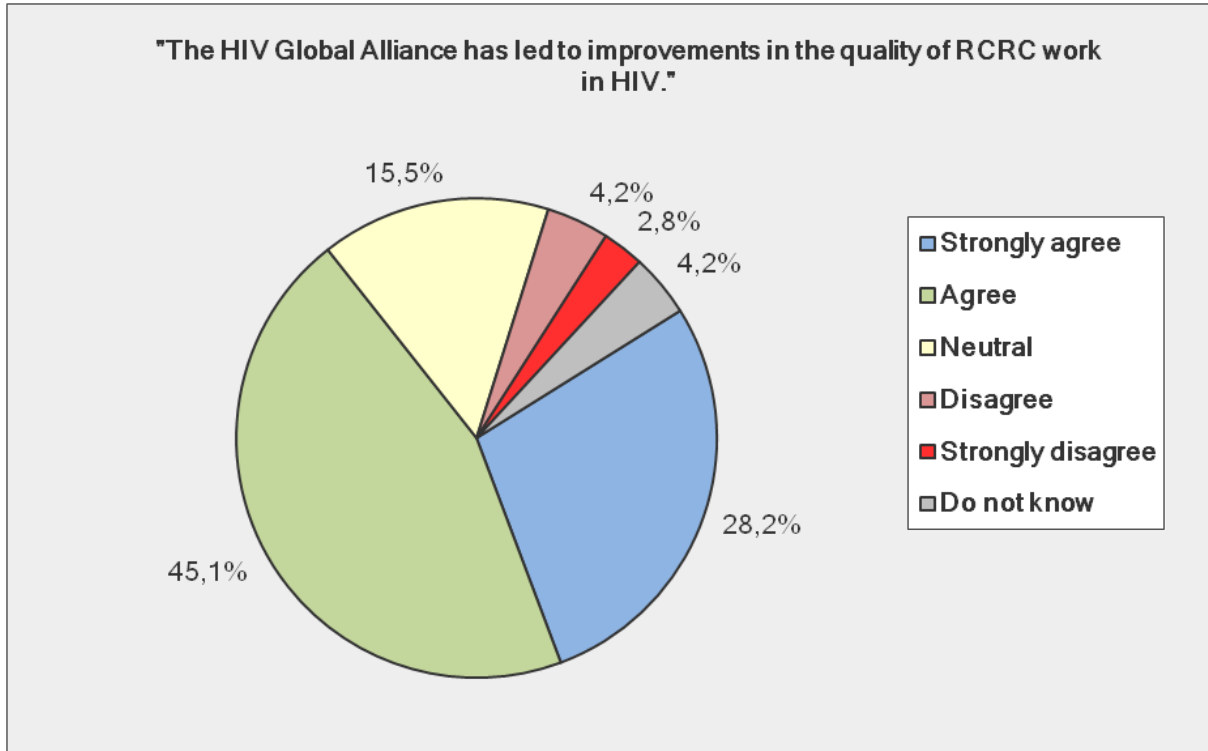


3. What changes has the HIV Global Alliance brought to the way the IFRC Global Programme on HIV has operated during the last 10 years? (n.72)

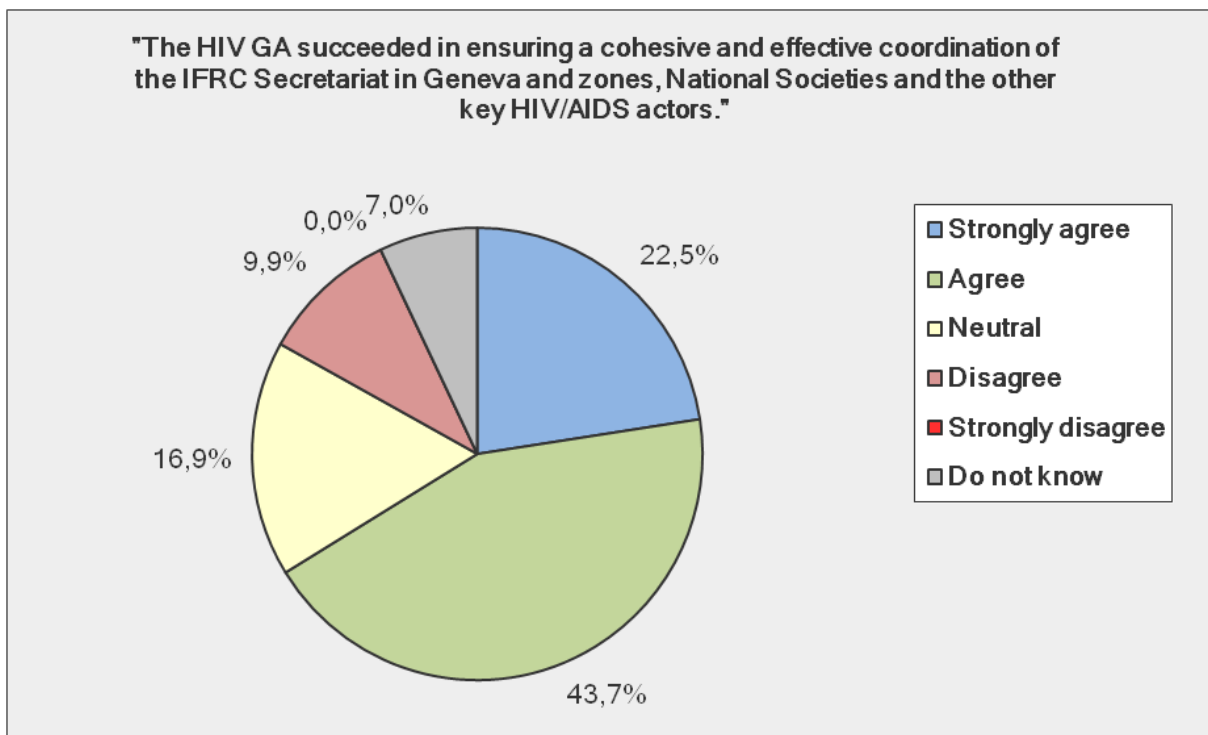


4. "The HIV Global Alliance has led to improvements in the quality of RCRC work in HIV." (n.71)

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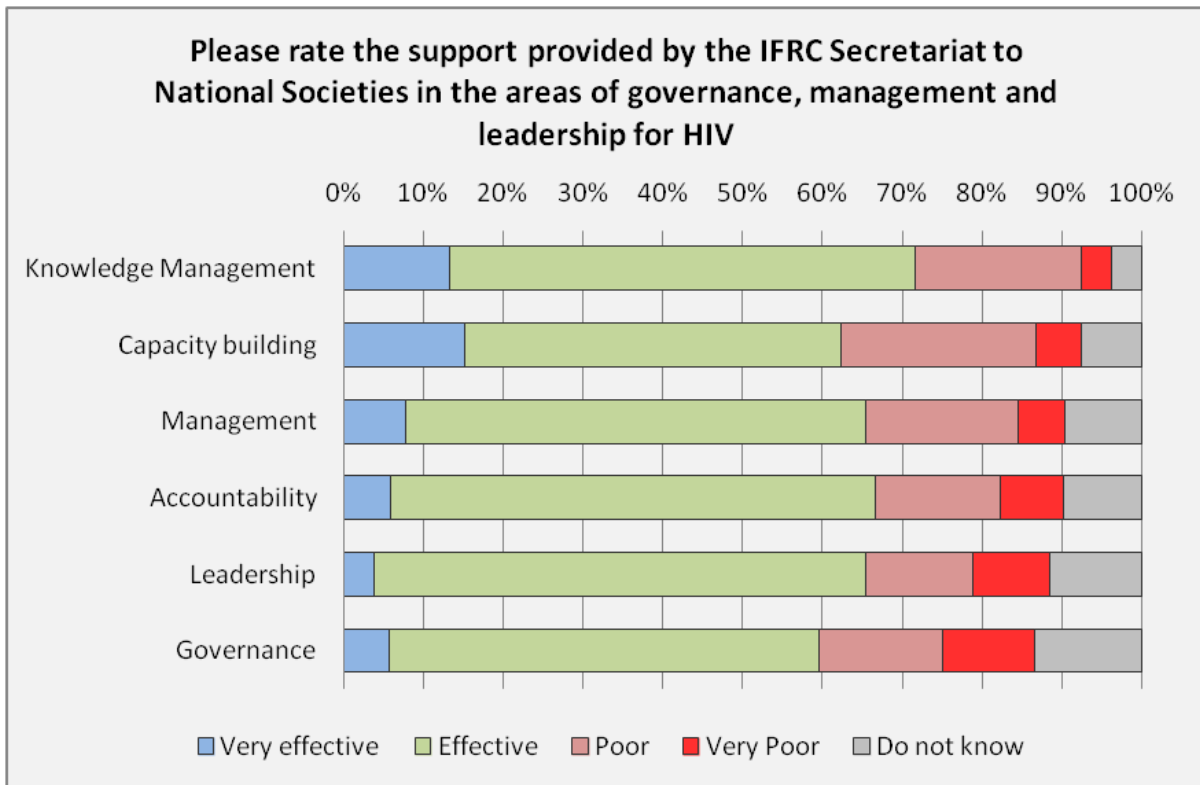


5. "The HIV GA succeeded in ensuring a cohesive and effective coordination of the IFRC Secretariat in Geneva and zones, National Societies and the other key HIV/AIDS actors." (n.71)

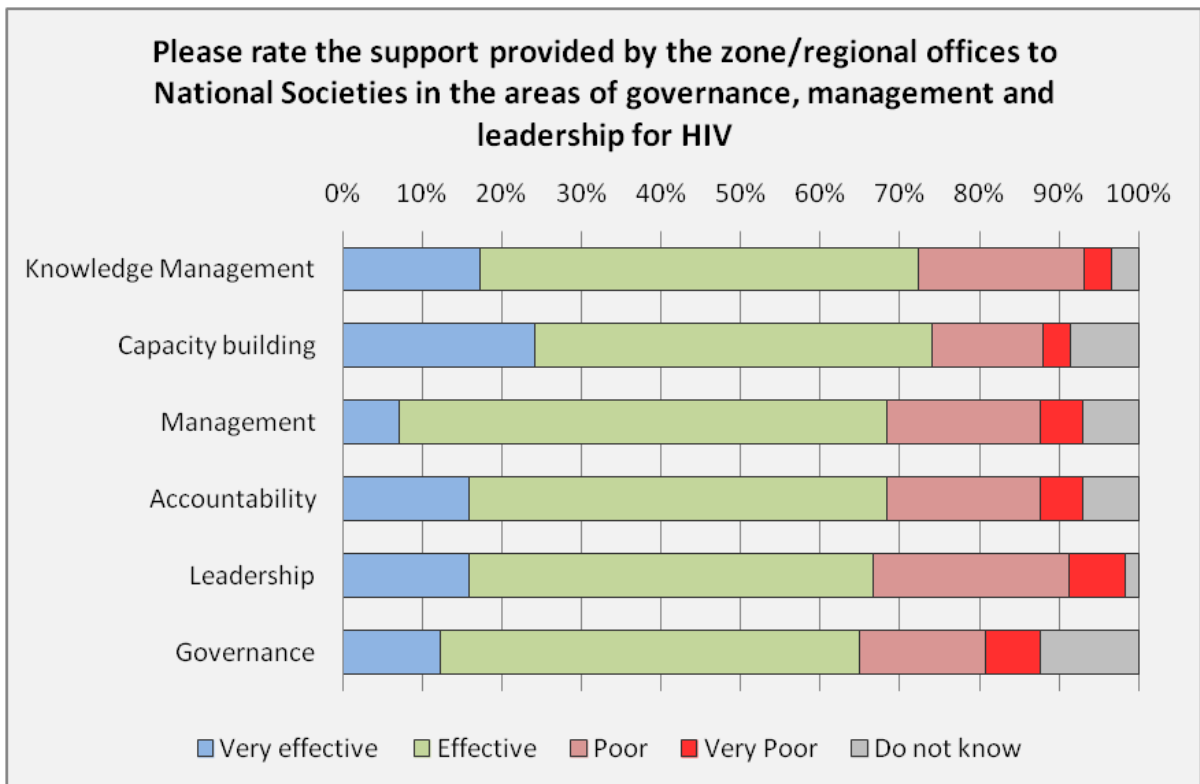


6. Please rate the support provided by the IFRC Secretariat to National Societies in the areas of governance, management and leadership for HIV response. (n.46)

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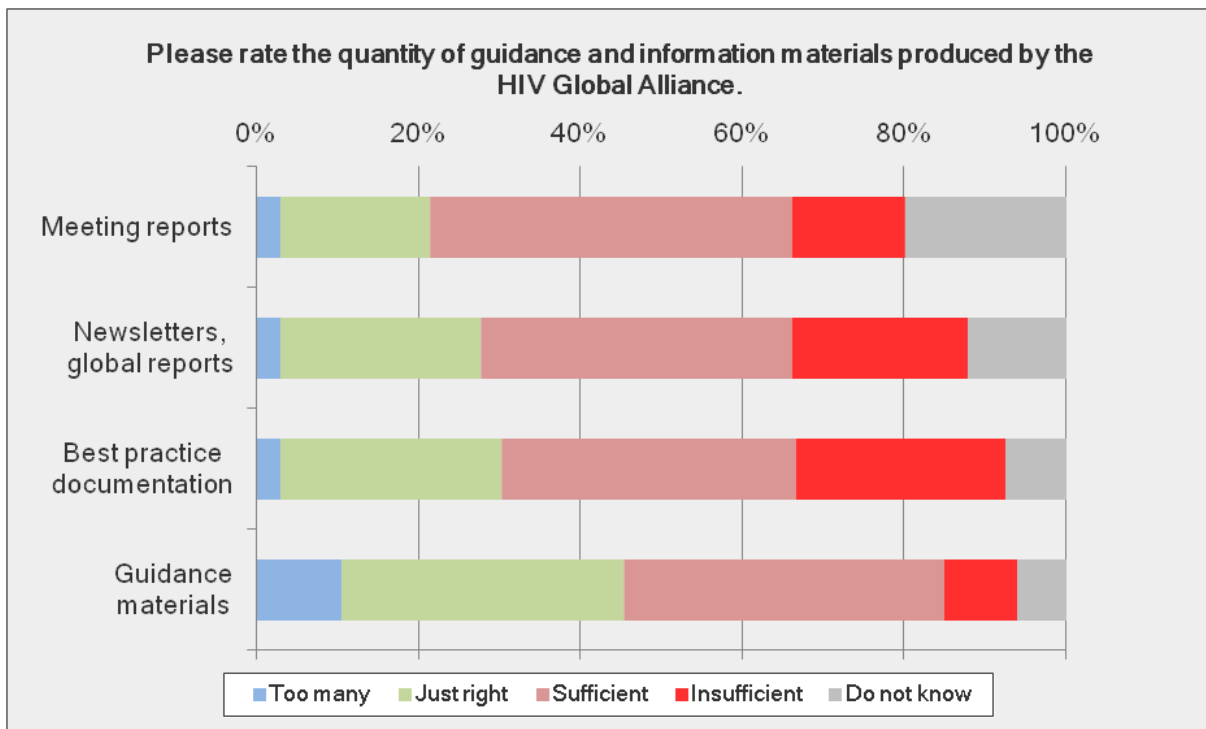
7. Please rate the support provided by by the zone/regional offices to National Societies in the areas of governance, management and leadership for HIV response. (n.49)



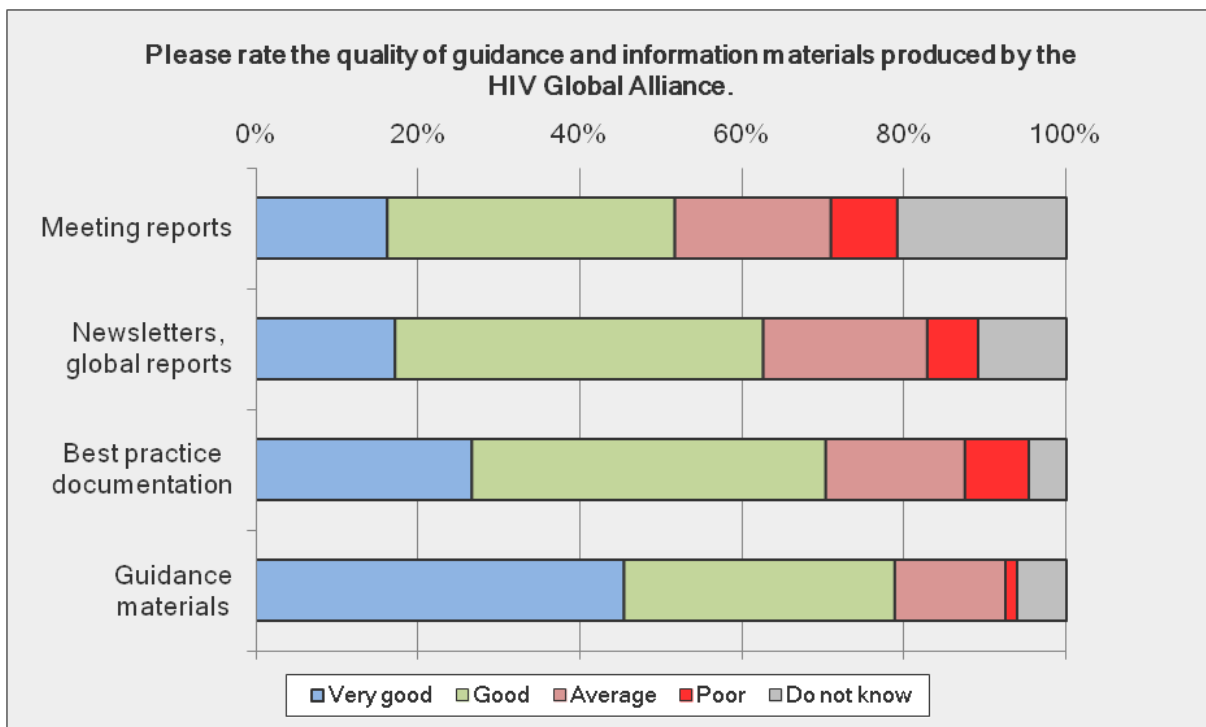
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8. Please rate the quantity of guidance and information materials produced by the HIV Global Alliance. (n.66)



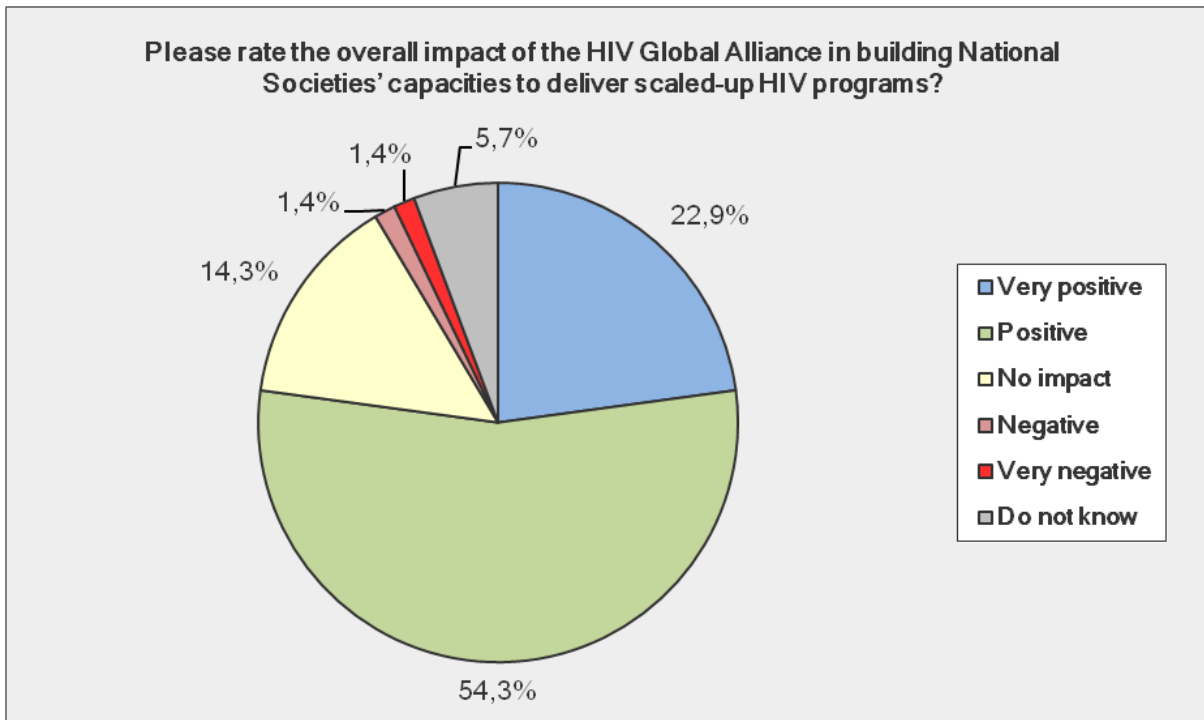
9. Please rate the quality of guidance and information materials produced by the HIV Global Alliance. (n.66)



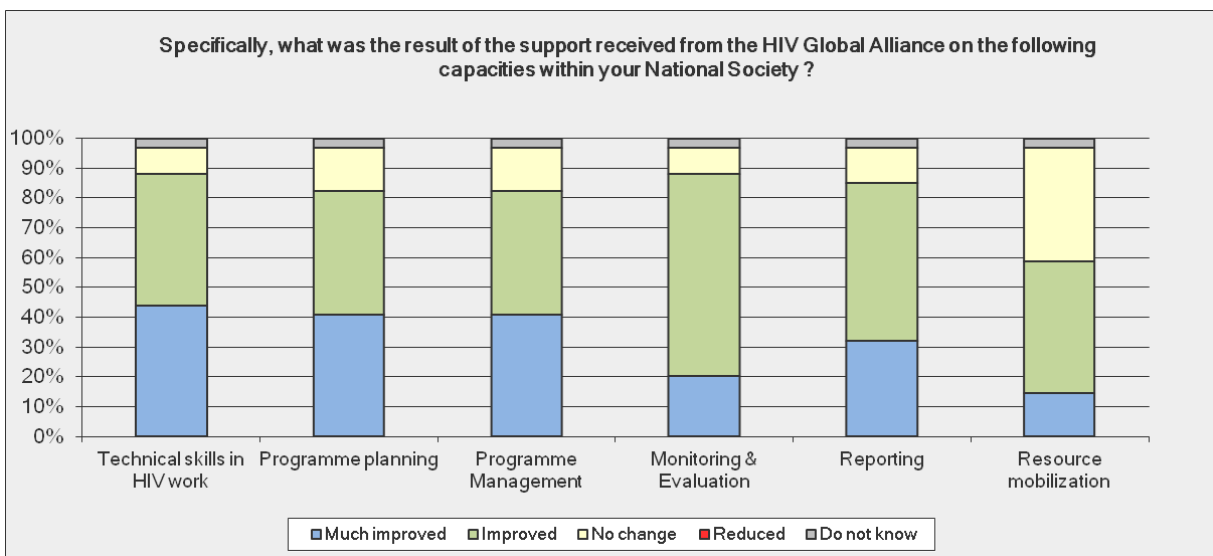
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10. Please rate the overall impact of the HIV Global Alliance in building National Societies' capacities to deliver scaled-up HIV programs. (n.70)



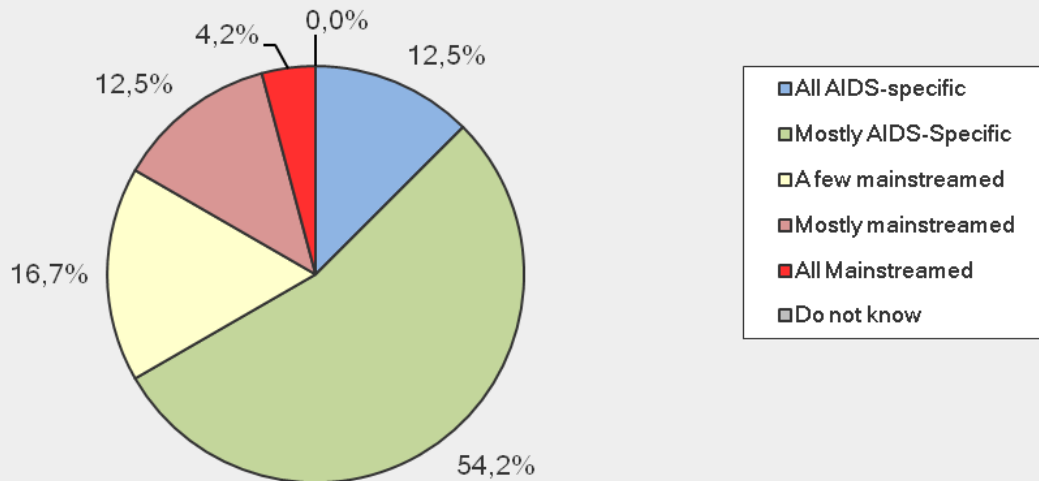
11. Specifically, what was the result of the support received from the HIV Global Alliance on the following capacities within your National Society ? (n.34)



12. Were the Global Alliance HIV/AIDS activities at the global and regional level implemented through AIDS-specific interventions or were they integrated (mainstreamed) into other National Society programs? (n. 24)

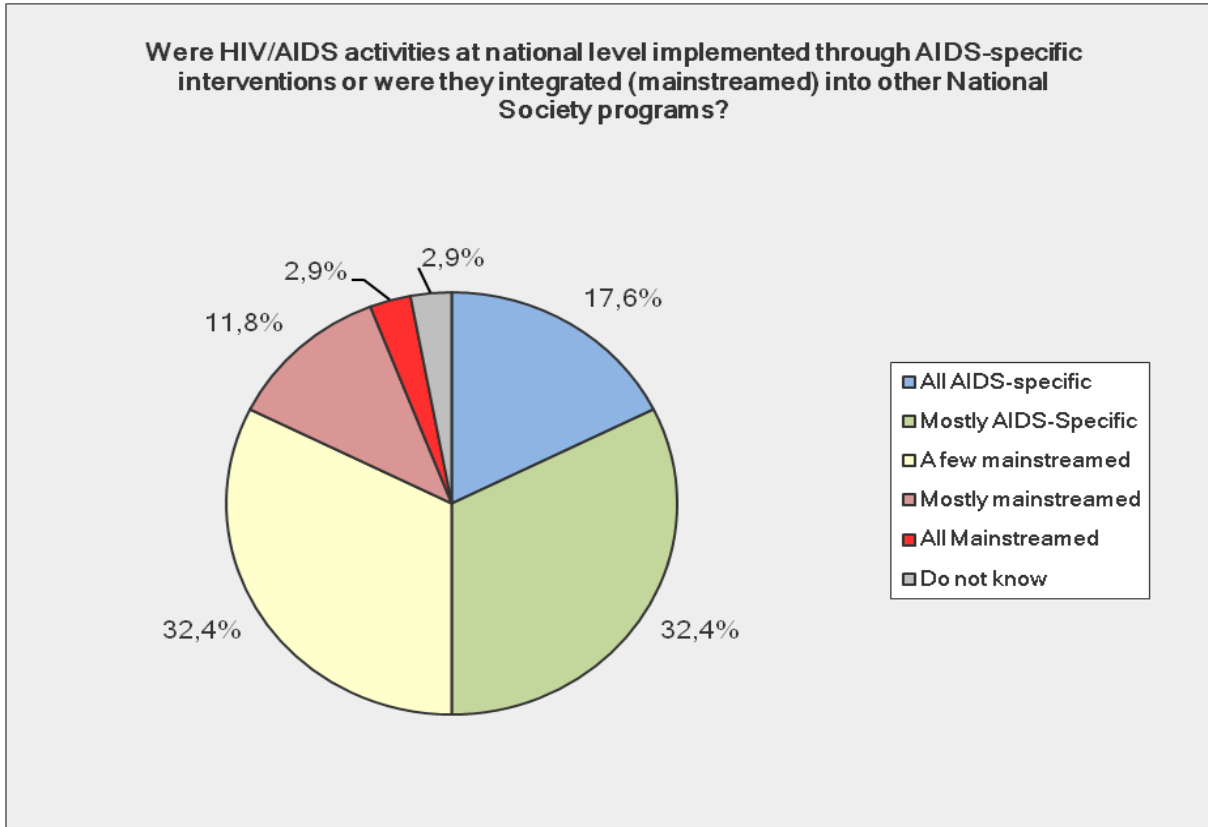


Were the Global Alliance HIV/AIDS activities at the global and regional level implemented through AIDS-specific interventions or were they integrated (mainstreamed) into other National Society programs?

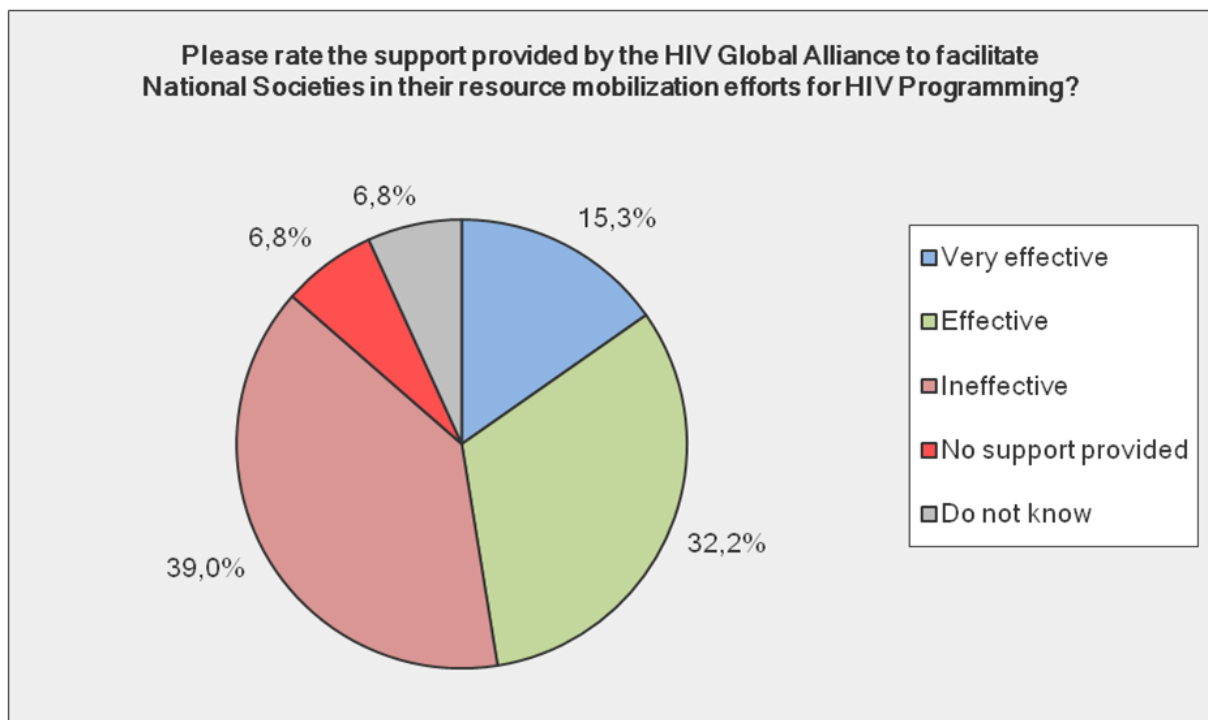


13. Were HIV/AIDS activities at national level implemented through AIDS-specific interventions or were they integrated (mainstreamed) into other National Society programs? (n. 34)

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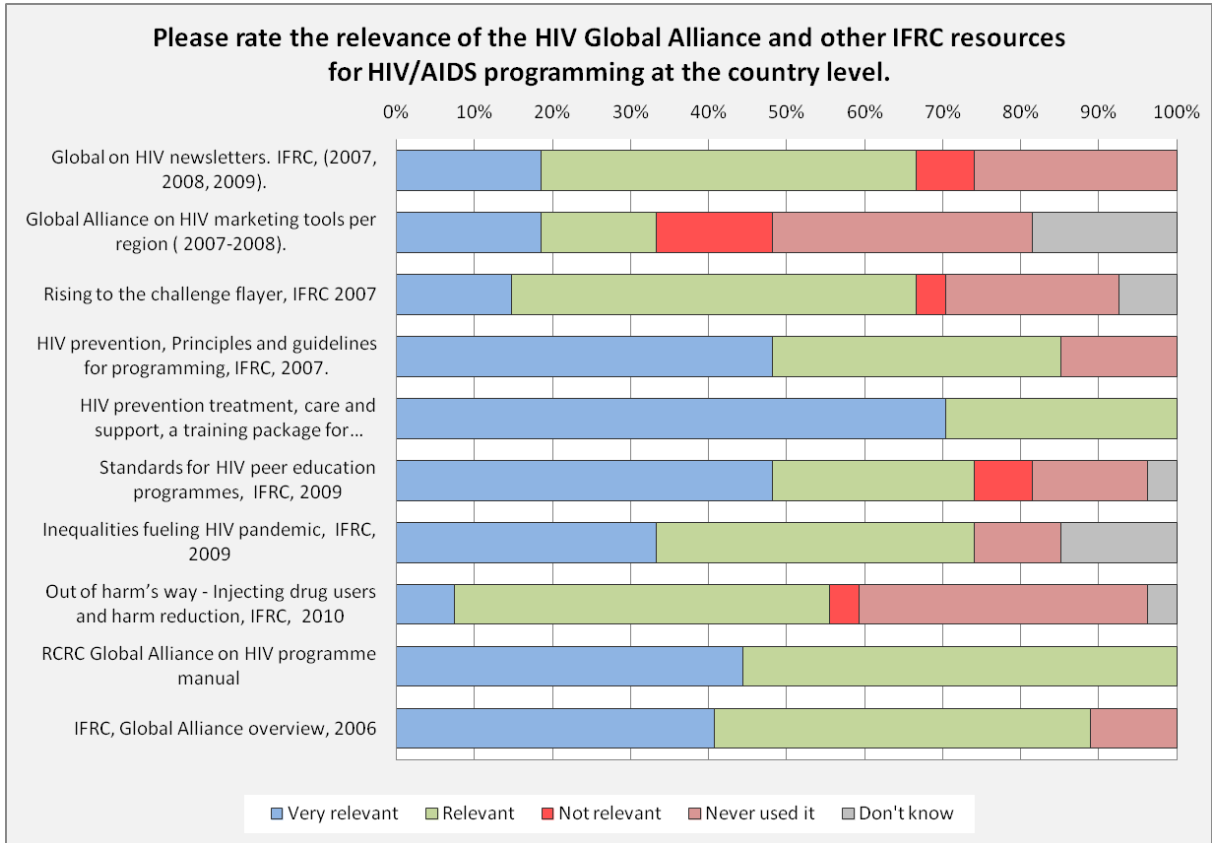


14. Please rate the support provided by the HIV Global Alliance to facilitate National Societies in their resource mobilization efforts for HIV Programming? (n. 59)

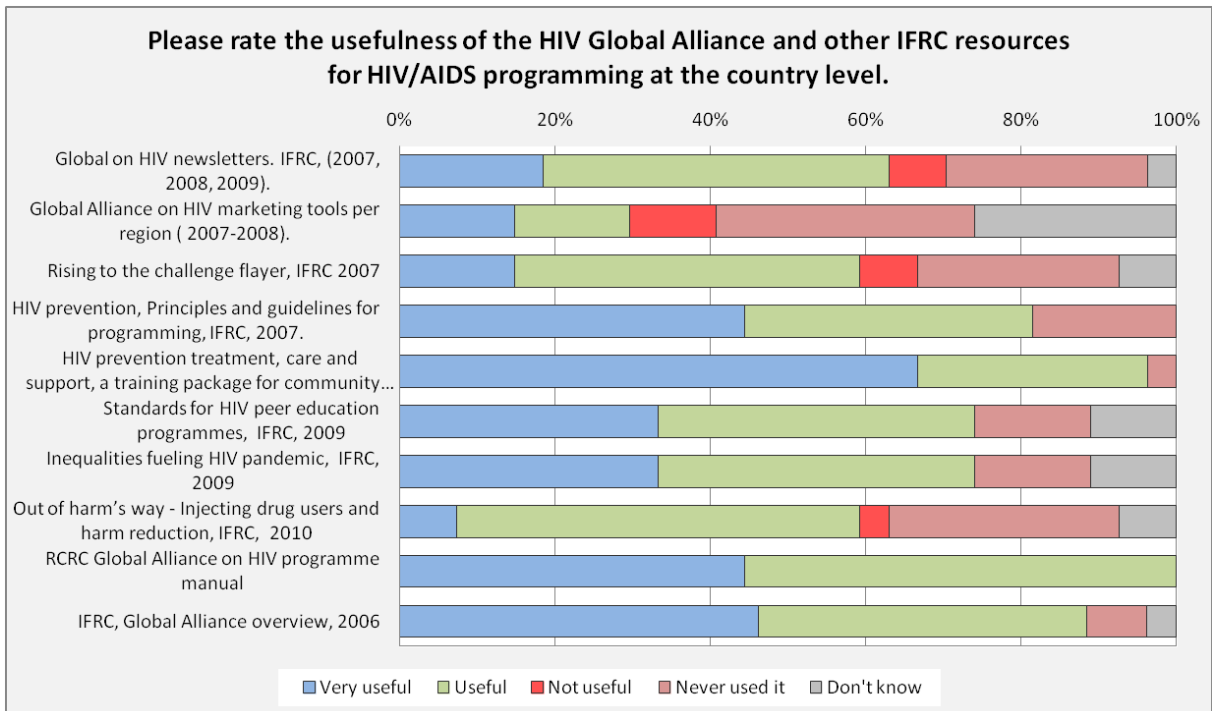


15. Please rate the relevance of the HIV Global Alliance and other IFRC resources for HIV/AIDS programming at the country level. (n. 27)

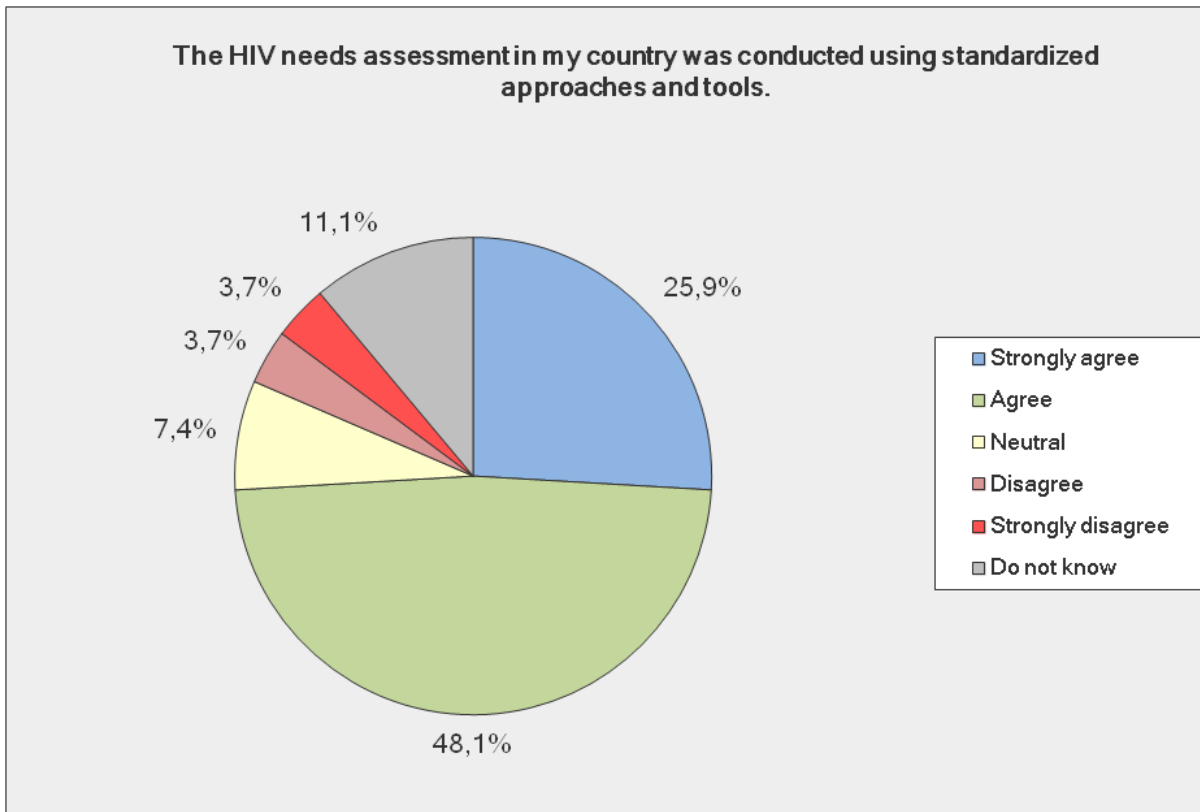
The Red Cross Red Crescent Global Alliance on HIV



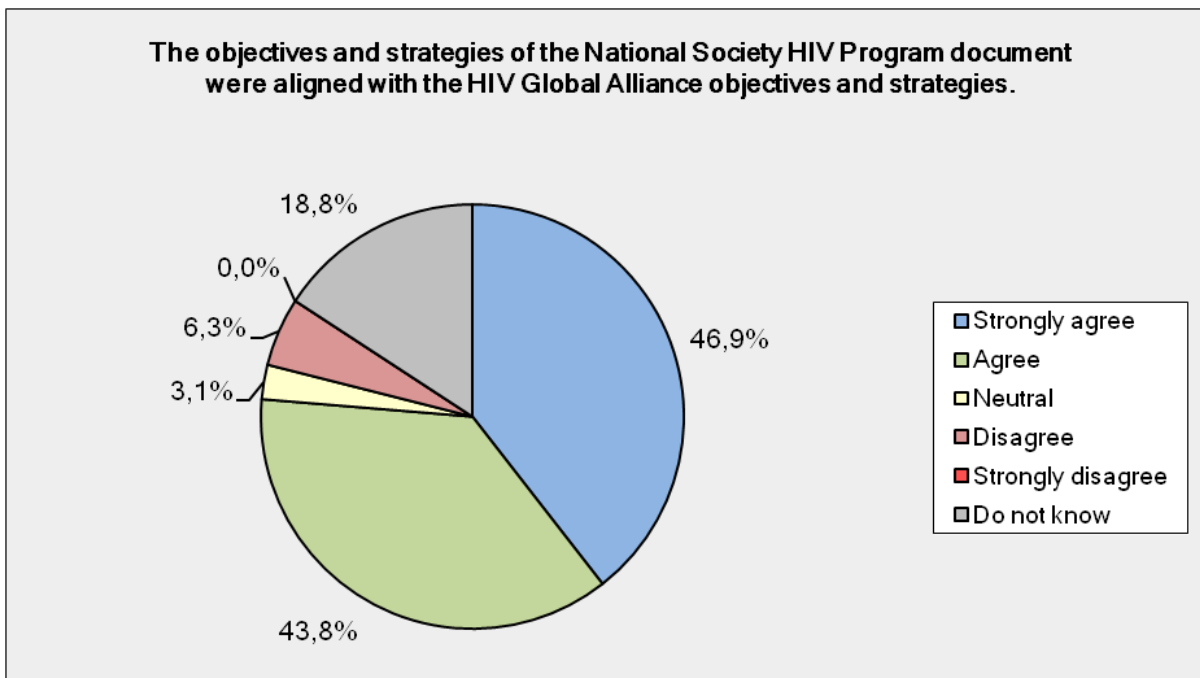
16. Please rate the usefulness of the HIV Global Alliance and other IFRC resources for HIV/AIDS programming at the country level. (n. 27)



17. The HIV needs assessment in my country was conducted using standardized approaches and tools. (n. 27)

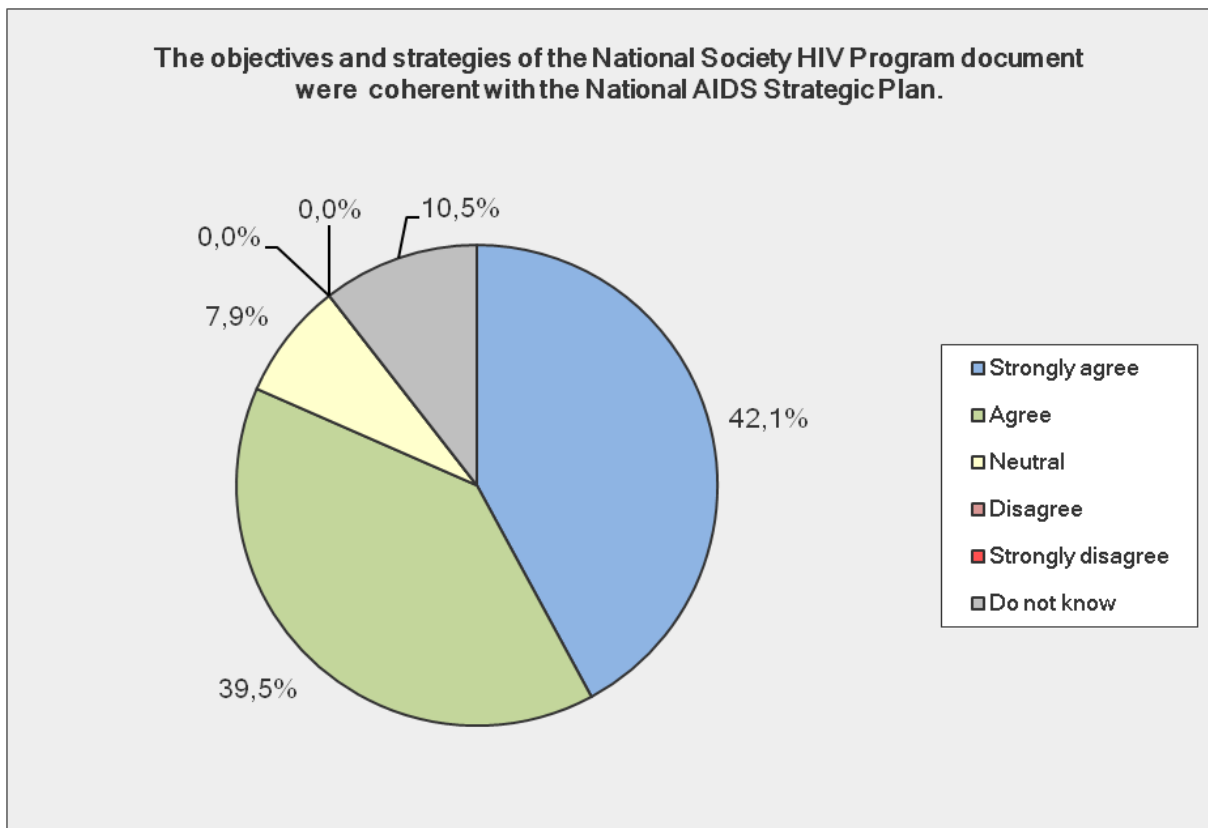


18. The objectives and strategies of the National Society HIV Program document were aligned with the HIV Global Alliance objectives and strategies. (n. 32)





19. The objectives and strategies of the National Society HIV Program document were coherent with the National AIDS Strategic Plan. (n. 38)

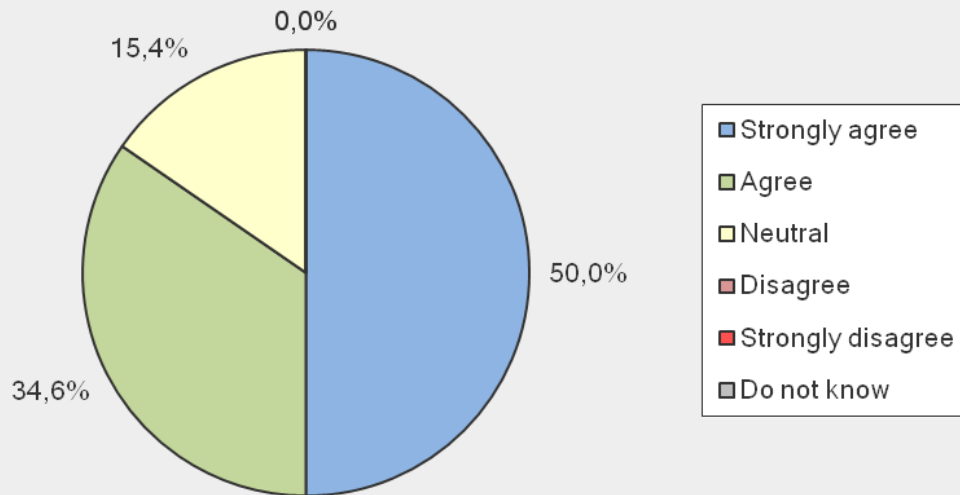


20. "All the HIV activities implemented by the National Society and partners were included in the National Society HIV Program document."(n. 26)

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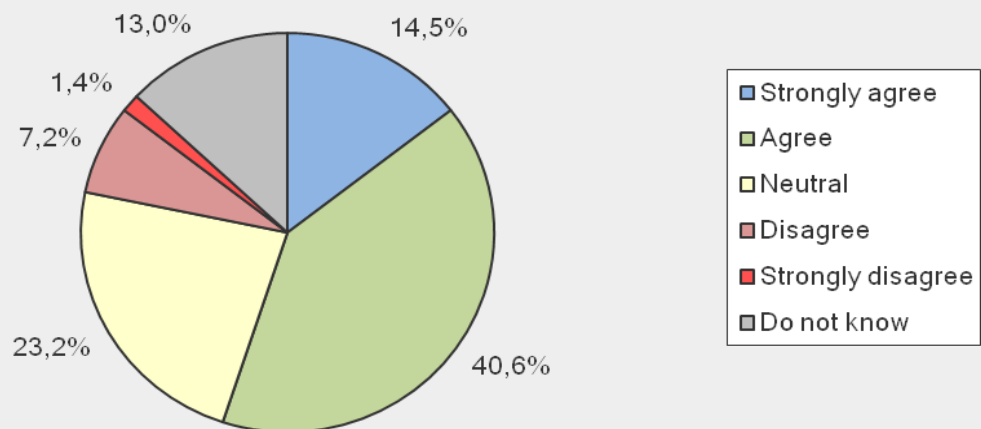


"All the HIV/AIDS activities implemented by the National Society and partners were included in the National Society HIV Program document."



21. "The division of labor in HIV programming among IFRC entities (i.e., Secretariat in Geneva and zones, ONS, PNS, partners) has led to increased efficiency and reduced duplication and transaction costs". (n. 69)

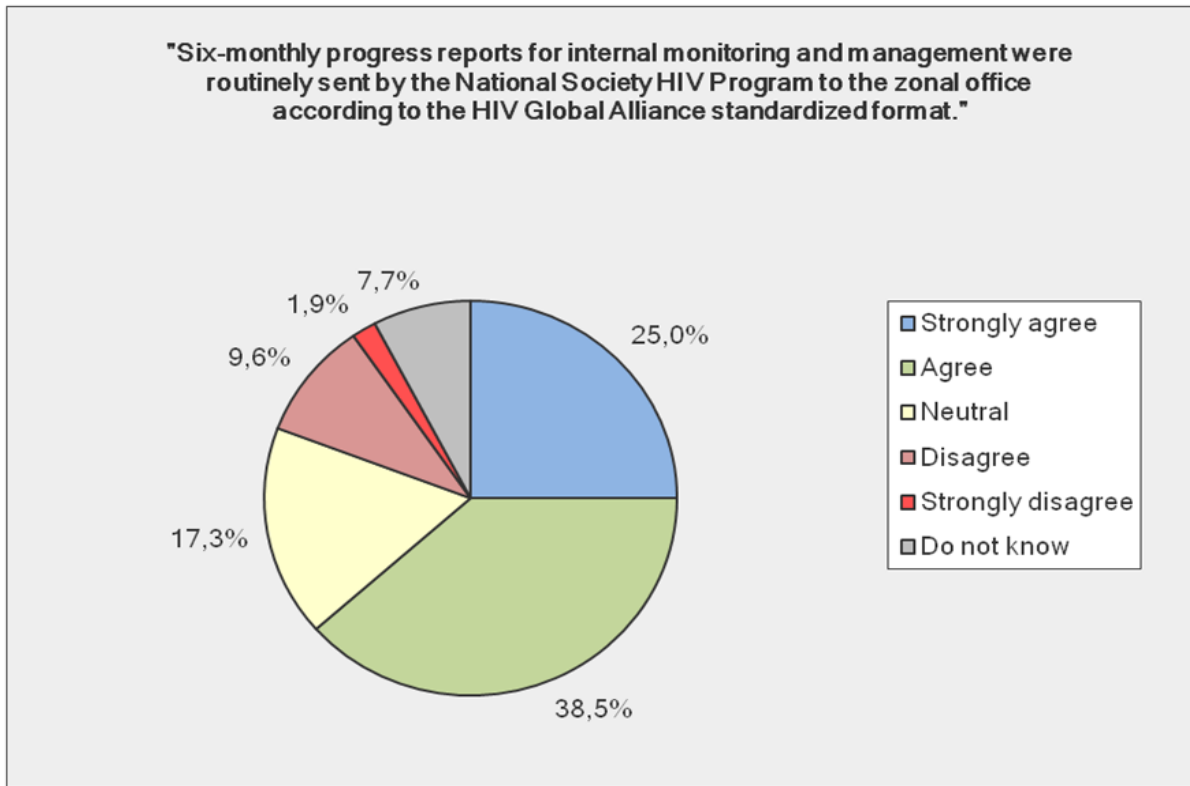
"The division of labor in HIV programming among IFRC entities (i.e., Secretariat in Geneva and zones, ONS, PNS, partners) has led to increased efficiency and reduced duplication and transaction costs".



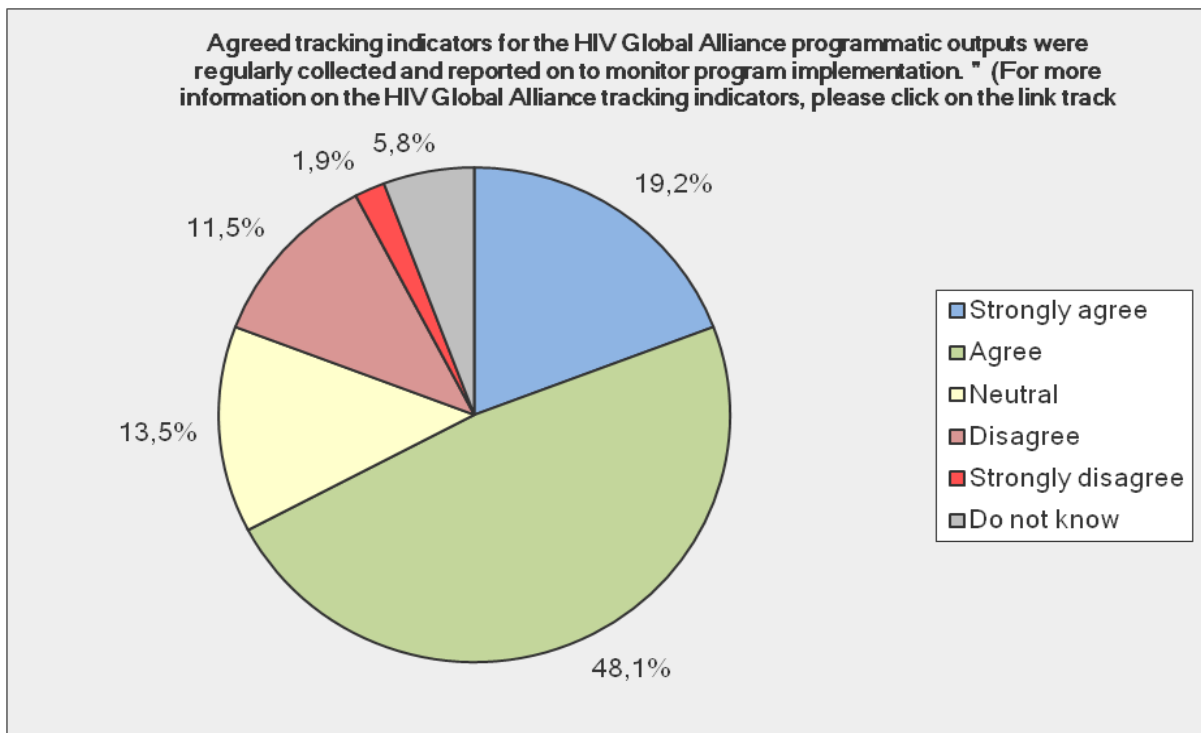
The Red Cross Red Crescent Global Alliance on HIV



22. "Six-monthly progress reports for internal monitoring and management were routinely sent by the National Society HIV Program to the zonal office according to the HIV Global Alliance standardized format." (n. 52)

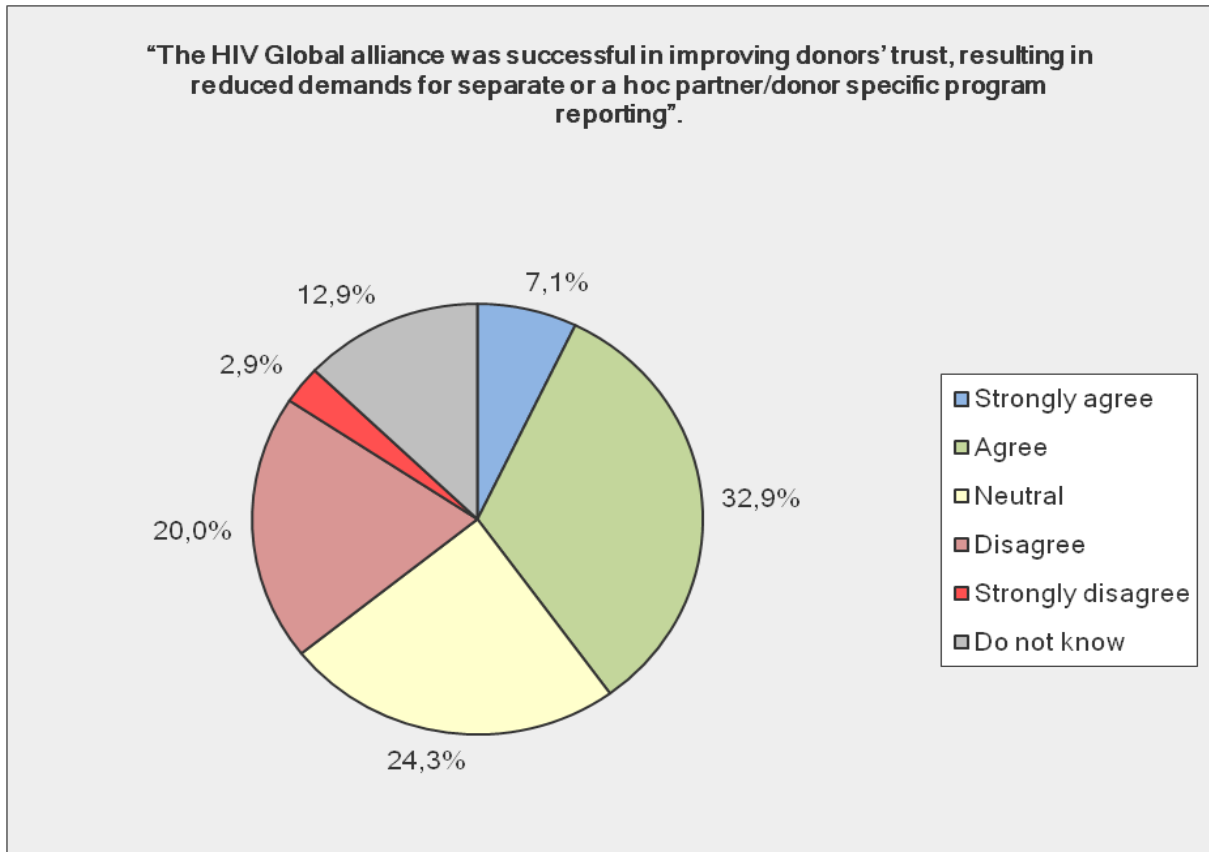


23. "Agreed tracking indicators for the HIV Global Alliance programmatic outputs were regularly collected and reported on to monitor program implementation." (n. 52)



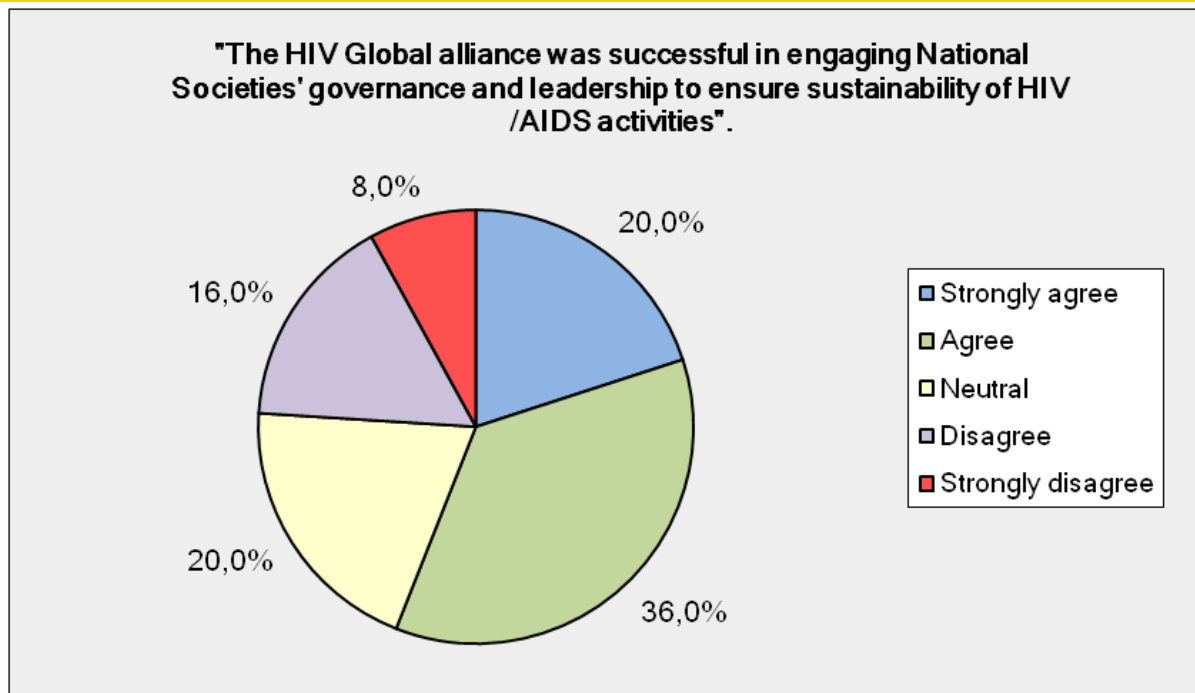


24. "The HIV Global alliance was successful in improving donors' trust, resulting in reduced demands for separate or a hoc partner/donor specific program reporting". (n. 70)



25. "The HIV Global alliance was successful in engaging National Societies' governance and leadership to ensure sustainability of HIV /AIDS activities". (n. 52)

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26. Do you feel any aspects of the HIV Global Alliance strategic and/or operational approaches should be retained for future HIV/AIDS programming? If yes, please describe them. (n. 33)

- 1. The Programming approach (10 respondents)**
"The HIV GA programming approach is very good and should be retained in the future not just for HIV but also for other programmes in the Red Cross. The Federation should continue helping countries prepare good National Strategic Plans and implementation plans, inclusive of voluntarism."
- 2. A standardized Monitoring and Evaluation System (8 respondents)**
"The coordination mechanisms, the definition of indicators, the monitoring system are all positive elements of the HIV GA that should be maintained. NS working on the subject of HIV/AIDS should use standardized indicators and reporting mechanisms for programme management, monitoring performance, exchanging experiences and for resource mobilization."
- 3. Capacity building and regular coordination meetings (6 respondents)**
"The operational approaches to NS capacity building, in an integrated and coordinated fashion, to facilitate the mobilization of local resources and their effective management should continue. Coordination and information exchange meetings, and country visits to other NS to share lessons learned should be expanded."
- 4. The four HIV/AIDS outputs (5 respondents)**
"The four outputs of the HIV GA are topical providing that they are aligned with countries National Strategic Plan (country needs). However, there is a need of a clear definition of role and responsibility between IFRC and National societies."
- 5. The "Seven ones" (4 respondents)**
"The standardized approach (initially called the "Seven Ones") should be retained."

27. Do you feel any aspects of the HIV Global Alliance strategic and/or operational approaches should NOT be retained for future HIV/AIDS programming? If yes, please describe them. (n. 30)

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1. None (15 respondents)

"They should all be retained"

2. A complicated, separate HIV reporting system (6 respondents)

"The development of a separate reporting system involves double work for NS. Better to integrate HIV reporting into the general health reporting system. All partners should agree to accept common reports."

3. Global target setting (3 respondents)

"Target setting should remain with the NSs so that the objectives and the level of scaling up are commensurate with their capacities."

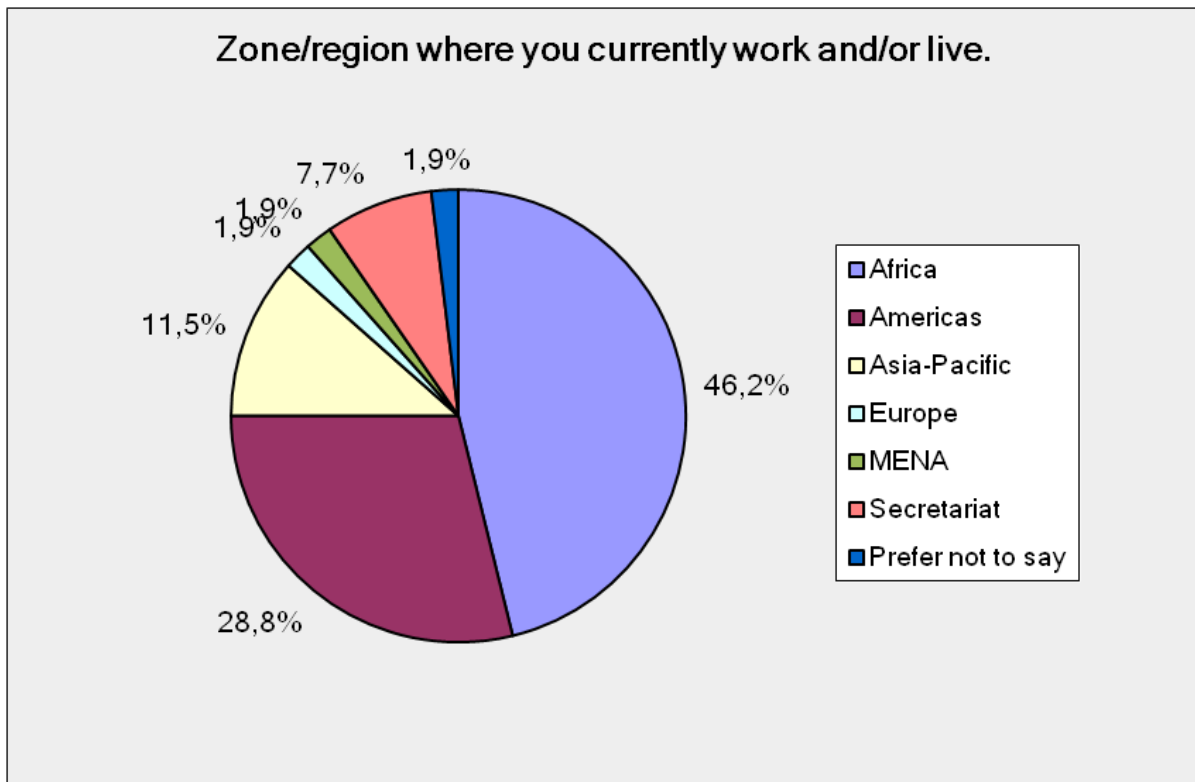
4. Aiming for large scale programmes where NS have no ability/willingness to sustain (3 respondents)

"Serious research and capacity assessment should be an absolute requirement before engaging in such a venturesome initiative. Sustainability of programmes is always a problem. Since big funding ended many NSs have had to drastically reduce their HIV programmes and get rid of very effective staff members. Maybe it is better to start small and build up gradually rather than come in with huge amounts of funding at the beginning."

5. Creating huge expectations (3 respondents)

"The hype and scale up communication messages, creating huge expectations with multi-billion projects that are unrealistic and ignoring the basic issues of limited NS capacities at governance and management levels and the lack of IFRC fundraising capacities (a lot of promises but few results)"

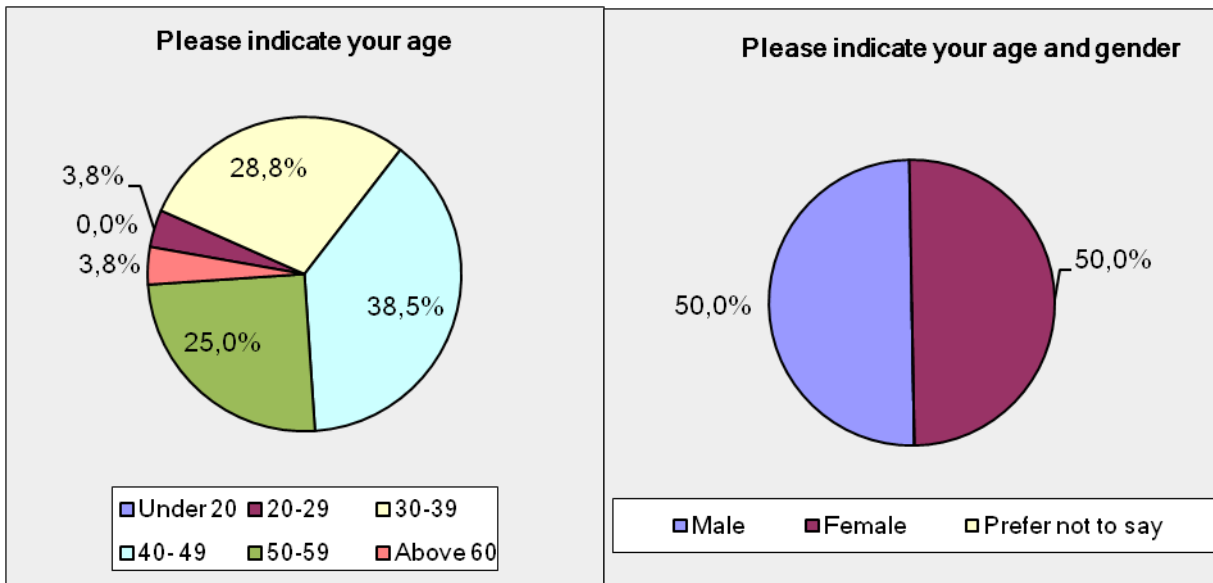
28. Zone/region where you currently work and/or live. (n. 52)



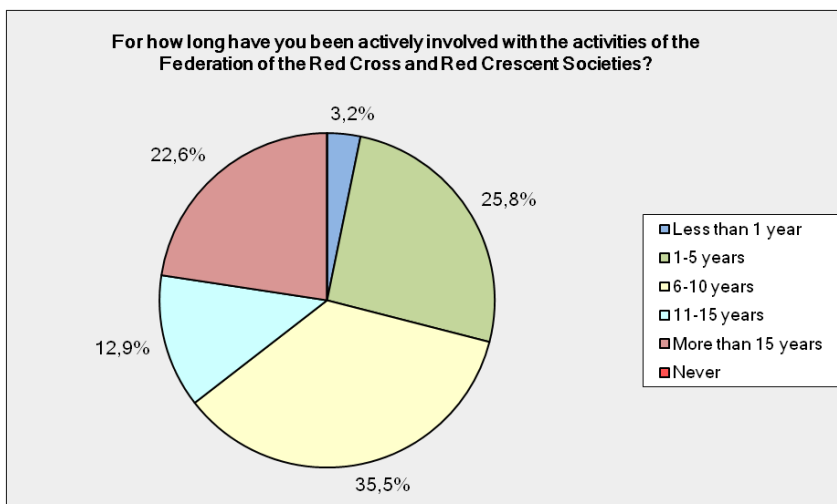
The Red Cross Red Crescent Global Alliance on HIV



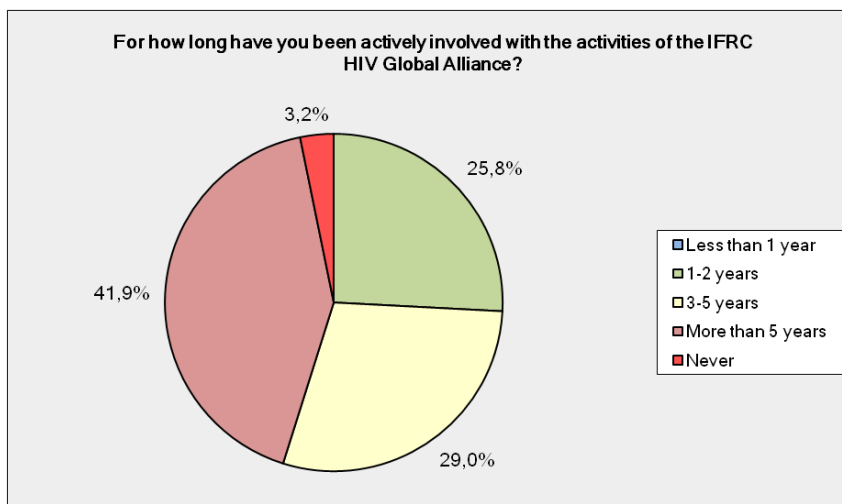
29. Please indicate your age and gender (n. 52)



30. For how long have you been actively involved with the activities of the Federation of the Red Cross and Red Crescent Societies? (n. 52)



31. For how long have you been actively involved with the activities of the IFRC HIV Global Alliance? (n. 52)





Annex H

List of people interviewed

| Name | Title | Organization |
|---------------------------|--|---|
| National Societies | | |
| Paola Romero | HIV Program Coordinator: | Cruz Roja Argentina |
| Fernand Etienne Gbagba | HIV Program Coordinator: | Croix Rouge Centrafricaine |
| Mom Chanthy | HIV Program Technical Team Leader | Croix Rouge Cambodgienne |
| Dougs Mulenda | Secrétaire Général a.i | Croix Rouge de la République Démocratique du Congo |
| Ricardo Jiménez | HIV Program Coordinator and RCRC+ focal point. | Cruz Roja Ecuatoriana |
| Matsepo Moletsane | Program Director | Lesotho Red Cross |
| Patrick Phiri | HIV Program Coordinator: | Malawi Red Cross |
| Karuna Shrestha | Head of health department | Nepal Red Cross |
| Prosper Ruberwa | Head of health department | Rwanda Red Cross |
| Prosper Byonabye | HIV Program Coordinator: | Uganda Red Cross |
| Bildard Baguma | Deputy Secretary General | Uganda Red Cross |
| Susanna Mnatsakanova | Coordinator, Harm Reduction Project | Ukrainian Red Cross |
| Serik Kozhabekov | Head of Health Department | Kazak Red Crescent and Red Cross |
| Zhibek | HIV Project Officer | Kazak Red Crescent and Red Cross |
| Somsri Tantipaibulvut | HIV Programme | Thai Red Cross |
| Praphan Phanuphak | Director | Thai Red Cross AIDS Research Centre |
| IFRC | | |
| Matthias Schmale | USG NS & Knowledge Dpt Division | IFRC Geneva |
| Stefan Seebacher | Head of the Health Department | IFRC Geneva |
| Josse Gillijns | Head of Planning and Evaluation Department | IFRC Geneva |
| Patrick Couteau | Senior Officer HIV | IFRC Geneva |
| Françoise Le Goff | Head of Administration Dpt | IFRC Geneva |
| Pierre Kremer | Head of the communication Department | IFRC Geneva |
| Lasha Gogouadze | Senior TB & Harm reduction officer, Acting Europe Health coordinator | IFRC Geneva |
| Terhi Heinäsmäki | Zone Health Coordinator, Asia Pacific | IFRC Asia Pacific Zone |
| Julie Hoare | Zone Health Coordinator, Americas | IFRC Americas |
| Carolina Cossio | Regional Health Coordinator, Andine countries & CONOSUR | IFRC Americas |
| Dawn Byng | Health Programme officer, Caribbean | IFRC Americas |
| Samuel Matoka | Regional HIV and AIDS Delegate, Southern Africa | IFRC Africa |
| George Biock | Regional HIV Coordinator, Yaoundé | IFRC Africa |
| Viviane Nzeusseu | Regional Health Coordinator, Yaoundé | IFRC Africa |
| Aissa Fall | Regional Health Manager, Dakar | IFRC Africa |
| PNS | | |

The Red Cross Red Crescent Global Alliance on HIV



| | | |
|--|--|---|
| Tiina Saarikoskii | Health Adviser | Finnish Red Cross |
| Dymphna Kenny | Health and Quality | Australian Red Cross |
| Sally Moore | American RC on HIV in the Caribbean | American Red Cross |
| Maud Amren | Health Adviser | Swedish Red Cross |
| Anne Marete Bull | Senior OD Adviser | Norwegian Red Cross |
| IFRC partners | | |
| Guillaume de Brier | UNAIDS Programme Officer | UNAIDS Rwanda |
| Patrick Brenny | UNAIDS CC | UNAIDS Malawi |
| Mamadou Lamine Sakho | UNAIDS CC | UNAIDS République Démocratique du Congo |
| Joy Backory | Former Partnership Advisor, Civil Society and Partnership Team | UNAIDS Geneva |
| Michael Byrne | Head of High Impact Africa I Department | The Global Fund to fight AIDS, TB and malaria |
| Julian Hows | Programme Officer | Global Network of People Living with HIV (GNP+) |
| Former IFRC Staff | | |
| Dr. Mukesh Kapila | Former SG Special Representative for HIV | |
| Bernard Gardiner | Former Head of the IFRC HIV team | |
| Getachew Gizaw | Former head of HIV, TB & Malaria Unit & former HIV senior | |
| Gelila Tsega | Former operations manager, GA on HIV in southern Africa | |
| Participants in the Focus Group Discussions | | |
| Tonya Nyagiro | Head of HIV, TB & Malaria Unit | IFRC Geneva |
| Patrick Couteau | Senior Officer, HIV & AIDS Global Programme | IFRC Geneva |
| Scott Chaplowe | M&E Senior Officer, Planning and Evaluation Department (PED) | IFRC Geneva |
| Lasha Gogvadze | Senior TB & Harm reduction officer, | IFRC Geneva |
| Jason Peat | Senior Officer, Malaria | IFRC Geneva |
| Panu Saaristo | Senior Officer Emergency Health | IFRC Geneva |
| Ian Steed | Senior Officer Organisational Development | IFRC Geneva |
| Shaun Hazeldine | Senior Officer Volunteering Development | IFRC Geneva |
| Gabriel Pictet | Head of Community Health and Innovation Unit | IFRC Geneva |
| Terhi Heinasmaki | Zone Health Coordinator, Asia Pacific | IFRC Asia Pacific Zone |
| Manhal Annaz | Zone Health Coordinator, MENA | IFRC MENA Zone |
| Mahesh Gunasekara | Zone Health Coordinator, Europe | IFRC Europe Zone |
| Julie Hoare | Zone Health Coordinator, Americas | IFRC Americas |

The Red Cross Red Crescent Global Alliance on HIV



| | | |
|---------------|--|-------------|
| Samuel Matoka | Regional HIV and AIDS Delegate, Southern Africa | IFRC Africa |
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