

# Programme Update



## Southern Africa Regional HIV and AIDS Programme

Appeal No. MAA63003

31 August 2008

This report covers the period  
01/ 01/2008 to 30/06/2008



The advent of ART in a number of countries in Southern Africa, has led to the shift towards treatment adherence and monitoring, psychological support, positive prevention education, coupled with nutrition and livelihood support, and promotion of effective referral systems between the community and local health facilities.

### In brief

**Programme purpose:** Following the International Federation of the Red Cross and Red Crescent Societies (IFRC) Southern Africa zone's launch of a new, innovative and dynamic five-year(2006-2010) regional HIV and AIDS programme in November 2006, ten National Societies' (NS)<sup>1</sup> focus is on consolidating programming and building capacities in preparation for scaling-up the activities. The regional HIV and AIDS programme aims to quadruple target beneficiaries by 2010. A total of 50 million people will be reached with prevention messages and peer education activities, 250,000 people will benefit from an expanded prevention, care, treatment and support programme and 460,000 orphans and vulnerable children (OVC) will be provided with a holistic package of educational, material and psycho-social support.

**Programme summary:** In the first six months, almost six million people in Southern Africa have been reached, mainly through prevention communication activities. In 2008, programming had a slow start as the first two months were primarily dedicated to finalizing the annual operational plans, conducting ground work and preparations for baselines in at least five countries, and developing a multi-country proposal for major donors in an attempt to bridge the funding gap.

<sup>1</sup> Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe Red Cross Societies in Southern Africa zone

Several consultative meetings and training workshops were coordinated and facilitated by the IFRC Zone HIV and AIDS Unit in collaboration with other technical departments and consultants. These include the Global Alliance on HIV review, regional OVC working group, Southern Africa Regional AIDS Working Group (SARAWO), Southern Africa Planning Monitoring Evaluation and Reporting (SAPMER), and finance development meetings, as well as other external coordination meetings hosted by other agencies.

**Financial situation:** The total 2006-2010 budget is CHF 384,895,997. Coverage to date of the 2008 budget (CHF 40,000,000) is at 30 percent. However this budget will be revised and scaled down to CHF 19,000,000 to reflect the income to the Global Alliance and absorption capacity of National Societies. The budgets for 2009 and 2010 will also be likely revised after further consultation with key stakeholders.

To date, multiple year funding and technical support from the Royal Netherlands Embassy (RNE), bilateral and multilateral support from Partner National Societies (PNS), local authorities, United Nations (UN) agencies, faith-based organisation, non-governmental organisations and private companies has been instrumental in achieving the results described in this report.

It is important to note however that the uncertainty of sustained external funding sources inhibits long-term planning and programming. The trend from both bilateral and multilateral donors has been that of 'cherry picking' with the availability and magnitude of funding changing from year-to-year. Therefore, the need remains of increasing dialogue with existing and potential donors through innovative fundraising strategies.

[Click here to go directly to the attached financial report.](#)

**No. of people reached:** Since its inception the programme has reached a total of 12,475,730 people with various prevention messages. During the reporting period alone, nearly six million people were reached with prevention messages, 125,521 orphans and vulnerable children (OVC) and 52,391 home-based care (HBC) clients provided with care, support and treatment assisted by a total of 8,467 volunteers across the ten NS.

**Table1: A regional overview of the beneficiaries reached in the first six months of 2008**

Country	Preventing further infections	Care, Treatment and Support	Reducing Stigma and Discrimination	Total
Angola	2,898	140	44	3,082
Botswana	83,906	579	45	84,530
Lesotho	290,969	16,499	32	306,975
Malawi	172,501	16,837	107	189,445
Mozambique	92,184	6,481	75	98,740
Namibia	51,045	27,049	-	78,094
South Africa	4,928,359	28,220	48	4,956,627
Swaziland	39,069	2,991	25	42,085
Zambia	7,440	6,696	-	14,136
Zimbabwe	257,459	72,420	162	330,041
<b>Total</b>	<b>5,925,830</b>	<b>177,912</b>	<b>538</b>	<b>6,104,280</b>

*Source: Southern Africa Red Cross Societies, HIV and AIDS departments/PMER Units*

**Our partners:** The southern African National Societies made great strides in establishing local partnerships and using locally available resources in widening their funding base, at the same increasing service delivery to the vulnerable people. At the IFRC Zone office level, collaboration has been strengthened with embassies, international organisations, UN agencies, developmental agencies and internally with the PNS and the International Committee of Red Cross (ICRC). Funding support to this appeal ([MAA3003](#)) in 2008 has been received through the IFRC Secretariat from British, Canadian, Danish, Finnish, Icelandic, Japanese, Netherlands,

Norwegian and Swedish Red Cross, RNE and an in-kind donation from the New Zealand Red Cross. The Ministries of Health, National AIDS Councils, UNICEF, UNAIDS, WHO, European Union (EU), MSF, Regional OVC Inter Agency Task Force (RIATT), Regional Psycho-Social Support Initiative (REPSSI), Voluntary Services Overseas- Regional Office for Southern Africa (VSO), SADC and many other local organisation provided technical support at both zone and national levels.

## Context

The dimensions of the HIV and AIDS pandemic remain staggering. In 2007 alone, 33 million people were living with HIV, 2.7 million people became infected with the virus, and two million people died of AIDS related illnesses. Southern Africa also remains the epicentre of the HIV and AIDS pandemic, and harbours the highest burden in Sub-Saharan Africa and the world over. Almost one third of the world's people living with HIV (PLHIV) live in this sub region. In seven countries, HIV prevalence exceeds 15 per cent (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe); about 43 per cent of all children under 15 living with HIV are in Southern Africa, as are approximately 52 per cent of all women above the age of 15 living with HIV. Significant differences in infection levels between men and women also remain; for instance in Swaziland, 20 per cent of adult men tested HIV positive, compared to 31 per cent of women according to a recent antenatal and population based surveys.

The annual total number of AIDS related deaths has declined in the past two years from 2.2 million in 2005 to 2.0 million in 2007, partly as a result of the substantial increase in access to HIV treatment in recent years. Most epidemics in the sub region appear to have stabilized with some favourable evidence in behaviour change: Zimbabwe provides a glimmer of hope where HIV prevalence in pregnant women attending antenatal clinics fell from 26 per cent in 2002 to 18 per cent in 2006. In Botswana, a drop in HIV prevalence among pregnant 15–19-year-olds (from 25 percent in 2001 to 18 percent in 2006) suggests that the rate of new infections could be slowing. HIV data from antenatal clinics in South Africa suggest that the country's epidemic might be stabilizing, but there is no evidence yet of major changes in HIV-related behaviour. The estimated 5.7 million South Africans living with HIV in 2007 make this the largest HIV epidemic in the world. Meanwhile, the 26 per cent HIV prevalence found in adults in Swaziland in 2006 is the highest prevalence ever documented in a national population-based survey anywhere in the world<sup>2</sup>.

While national governments have made significant strides towards implementing their strategies and commitments, notable gaps remain. The IFRC regional programme covering ten countries was initiated to address some of these gaps through strategies that aim to:

- Prevent further infections through targeted community-based peer education and information, education, and communication (IEC) activities, and promote uptake of services including voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT);
- Scale-up HBC and support for OVC through a holistic approach to address needs in education, food and nutrition, psychosocial support, social inclusion, and income generating activities;
- Address stigma and discrimination through targeted communication and advocacy activities;
- Build the NS capacity to plan, implement, track performance and manage the programme through IFRC zone office;
  - providing technical and policy guidance in order to foster compliance to globally accepted HIV and AIDS intervention standards.
  - assisting in building financial management capacity through, rolling-out and maintaining the Navision accounting software and training key staff on fundamentals of financial management;

---

<sup>2</sup> All epidemiological data is extracted from UNAIDS 2008 Report

- training on the implementation of a monitoring, evaluation, and reporting system specifically designed for the programme but in line with the national and other global indicators and tools on HIV and AIDS programming;
- facilitating knowledge management, information dissemination, and documenting lessons learnt, and
- ensuring compliance to donor and other regulations, policies, procedures and standards.

## Progress towards outcomes

In February 2008, the first Global Alliance on HIV review meeting was conducted in Johannesburg and attracted participants from all over the world. The main purpose was to review progress since the launch of the Global Alliance on HIV in Southern Africa. A country-based review was also conducted in Malawi, which attracted participants from the local authorities such as Ministry of Health and the National AIDS Commission (NAC), local and international organizations based in Malawi and UN agencies. The meeting included presentations and discussions on Malawi Red Cross HIV and AIDS programme activities, lessons learned from the implementation of the global alliance concept, stakeholder management, challenges and the gaps in funding. The findings have been documented and shared with other zones and partner organizations

The regional OVC working group meeting was also held (27-29 May) during the reporting period, bringing together the national OVC officers from Botswana, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Zambia and Zimbabwe, along with donor representatives from the Swedish Red Cross. Key issues covered during the three days participatory meeting included: the use of the monitoring and evaluation (M&E) tools, continuous roll-out of the OVC training module and hero work training, child protection and South African Red Cross Society psychosocial support programme, and lessons learnt from comprehensive OVC support intervention in Malawi.

A month later, the SARAWO meeting was held from June 30 to July 1, attended by the HIV and AIDS coordinators, PNS representatives, IFRC zone HIV and AIDS staff members and the HIV and AIDS programme Africa focal person from the IFRC Secretariat. One of the notable outcomes of the meeting was the adoption of access to paediatric ART (Antiretroviral Therapy) as an advocacy theme for the next twelve months. More practical advocacy tools will be developed around this subject in the second half of the year in close collaboration with the IFRC zone communication unit.

Eight National Societies have recruited national PMER officers, which is a critical step towards strengthening performance measurement, tracking and accountability at country level. Following the initial training that was held in December 2007, the Zone PMER units expanded its technical assistance and coaching to the National Societies PMER officers and their counterparts. During the reporting period, the PMER officers also gathered in Johannesburg for a one week workshop (June 30 - July 4), to provide an induction platform and orientation to new PMER officers on their roles and responsibilities, to share other NS challenges in implementation of the PMER system, to endorse and adopt the PMER tools including the revised reporting tools/formats, and to develop a plan of action for 2008-2010.

The National Societies and the IFRC Zone office also invested time on preparing a multi-country proposal to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), following the release of the Round 8 call for proposals. The effort and the process were unprecedented. The proposal was submitted on July 1, 2008 with the anticipation that all endorsements from Country Coordinating Mechanisms (CCMs) would be received within the 30 days grace period given to the IFRC by the GFATM. Lessons were drawn from the process, primarily that of actively engaging national level stakeholders (Ministry of Health, National AIDS Commission, Country Coordinating Mechanisms, UN and other actors) early in the proposal development process in order to guarantee their buy-in into the regional approach and endorsement of the proposal.

## Outcome 1: Prevention of Further HIV Infection

### Key Strategies:

- Working at community level to reduce vulnerability to acquiring or transmitting HIV by conducting peer education and community mobilization;
- Information, education, and communication (IEC) for general population and targeted vulnerable groups so as to increase knowledge, influence attitudes and change behaviour;
- Promoting voluntary counselling and testing (VCT);
- Promoting the prevention of mother-to-child transmission (PMTCT);
- Promoting skills for personal protection, including condom use.

### Achievements

**Table 2: An overview of people reached through prevention activities:**

Country	People reached by peer education programme	People reached by IEC programmes	People who were referred to VCT services	Pregnant women who were referred to PMTCT services	PLHIV supported on positive prevention	Total
Angola	0	2,701	57	0	140	2,898
Botswana	23,609	60,000	150	20	127	83,906
Lesotho	37,305	250,000	1,969	983	712	290,969
Malawi	12,263	156,600	1,456	0	2,182	172,501
Mozambique	74,892	16,137	1,155	0	0	92,184
Namibia	50,776	0	269	0	0	51,045
South Africa	80,002	4,834,971	6,415	300	6,671	4,928,359
Swaziland	12,640	25,280	193	834	122	39,069
Zambia	6,797	420	198	25	0	7,440
Zimbabwe	39,863	199,315	120	0	18,161	257,459
<b>Total</b>	<b>338,147</b>	<b>5,545,424</b>	<b>11,982</b>	<b>2,162</b>	<b>28,115</b>	<b>5,925,830</b>

As illustrated in *Table 2* above, the programme managed to reach over five million people during the reporting period, mainly in South Africa with its aggressive peer education and information, education, and communication (IEC) campaigns. In South Africa alone, an estimated 4.8 million people were reached during the reporting period through television interviews, weekly radio programmes and talk shows (IGAGASI FM in Kwa Zulu Natal Province) as well as community outreach programmes and distribution of printed IEC materials during special events such as the World Red Cross Day.

Through partnership with UNICEF, Swaziland, Malawi, and Lesotho have rolled out information and communication campaigns to promote PMTCT. The partnership with UNICEF was conceptualized to enhance knowledge of the Red Cross volunteers and community peer educators on PMTCT issues, increase dialogue and engagement of community leaders, and increase national sensitization through targeted PMTCT social campaigns on radio, printed materials and community theatre. All three National Societies implemented a qualitative research including focus group discussions to establish a baseline and identify concrete issues relating to the drivers of the epidemic and challenges of PMTCT social mobilization. Evidence generated from the processes led to the adoption of three social communication efforts namely; support to on-going radio programmes on PMTCT, printing of communication materials used by volunteers and other service providers during community mobilisation activities; and development of generic templates and prototype materials for community engagement.

In Lesotho, over 250,000 people were reached through radio dramas and television programmes contributing to the relatively higher number of pregnant women referred to PMTCT services as illustrated above. Malawi Red Cross is pioneering a PMTCT project in conjunction with UNICEF targeted at men and traditional leaders. A curriculum has been developed and it will be used to train men and traditional leaders on PMTCT to further bridge the gap in PMTCT uptake. The curriculum will also be potentially adapted and implemented by other countries in the region.

Voluntary Counselling and testing (VCT) is an entry point for early access to prevention, treatment, care and support services. There is a risk that the important progress achieved in recent years might lull the community into complacency, especially as the disability and death associated with HIV becomes less visible. There is a need to continue developing and disseminating education materials that emphasize prevention and promote uptake of essential services such as VCT.

In Namibia, more people are being tested for HIV due to the increase in coverage of the community counselling programme implemented by the Red Cross. Namibia Red Cross has been mandated by the government to roll out community counselling and testing in all regions of the country. The National Society receives funding and support from the government through the global fund mechanism. Due to this effort by the Red Cross, Namibia as a country has reported over 80 per cent coverage on VCT, a record high throughout the world, according to the UNAIDS 2007 report. Over 500 community counsellors have been trained and deployed to health centres countrywide.

In South Africa, referral to VCT services is mainly concentrated in the Mokopane branch in Limpopo Province. A total of 6,415 people were referred to VCT from a target of 82,000 people for the year. To ensure that SARCS reaches its target, lay counsellors and volunteers are equipped with IEC materials and the National Society has adopted an aggressive outreach strategy where branches are carrying out awareness raising sessions.

#### **Constraints or Challenges:**

- Large amounts of funds were committed and received for specific outputs and activities, mainly to provide support to OVC and for activities aimed at tackling gender inequalities, stigma and discrimination. Long-term success in the HIV response however, demands sustained reductions in the rate of new HIV infections ensuring that effective prevention interventions focus on populations and risk behaviours that are truly driving the local epidemics -yet HIV prevention is consistently under-prioritized and under funded as the epidemic evolves. The IFRC and National Societies will increase their efforts to refocus funding towards prevention activities in the last two years of programme implementation.
- National Societies also faced high mobility and attrition of youth peer educators. In Zimbabwe for instance, the political, social, and economic situation has left only few volunteers to cover wider areas with a very high peer educator to client ratio. This is underscoring the need for National Societies and donors to ensure allocation of funds towards volunteer management costs.

### **Outcome 2: Expanding Care, Treatment and Support**

#### **Key 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.

## Achievements

**Table 3: An overview of people reached through care, treatment and support activities**

Country	OVC Clients receiving RCRC services	HBC or treatment clients receiving RCRC services	OVC reached by RCRC support groups	PLHIV reached by RCRC support groups	School age OVC supported by RCRC to attend school	Total
Angola	0	140	0	0	0	140
Botswana	484	95	35	112	0	579
Lesotho	12,500	3,999	84	1,012	1,253	16,499
Malawi	13,200	3,637	3,200	1,474	562	16,837
Mozambique	3,436	3,045	0	645	556	6,481
Namibia	21,737	5,312	0	650	247	27,049
South Africa	16,101	12,119	3,073	8,828	2,635	28,220
Swaziland	1,804	1,187	830	447	940	2,991
Zambia	2,000	4,696	880	3,980	2,000	6,696
Zimbabwe	54,259	18,161	1,346	2,560	4,843	72,420
<b>Total</b>	<b>125,521</b>	<b>52,391</b>	<b>9,448</b>	<b>19,708</b>	<b>13,036</b>	<b>177,912</b>

During the reporting period, there has been a drop in community home based care (CHBC) clients by 12 per cent and OVC by 19 per cent compared to the first six months of 2007. The reduction has been as a result of a combination of factors such as; National Societies CHBC programmes weaning clients who are on ART due to their improved health status (1,185 in Namibia, 1,000 in Malawi, and an estimated 3,000 in South Africa), limited funding leading to scaling-down of activities in some countries; and consolidation and integration of care, support and treatment activities with other programming areas such as disaster management and food security.

Following the large injection of funding in the 2007, many National Societies had established new HBC and OVC projects that proved difficult to sustain, thus underscoring the need for long-term and committed funding for CHBC activities. CHBC is the main entry point for community level support and intervention hence is required to be firm in its structure and operations.

The training package<sup>3</sup> on prevention, care, treatment and support for community-based volunteers has proved to be very useful. The governments of Lesotho, Malawi, Namibia, Mozambique, Zimbabwe, Botswana and Zambia have taken steps of either adopting or adapting the training package. The other countries are in the process of discussing modalities of adoption and roll-out of the training package. All National Societies have trained trainers except Angola and Mozambique due to the unfinished printing of the Portuguese version of the training package. Some National Societies are now training volunteers, but require further funding support to complete the process.

The IFRC Zone office in collaboration with the Geneva Secretariat and the British Red Cross has commenced the development of minimum standards in order to ensure quality programming and standardisation. The standards will be rolled out at a regional youth forum to be organized during the second half of the year, along with a sexual and reproductive health and life skills training manual.

<sup>3</sup> The prevention care, treatment and support training package for community-based volunteers was developed jointly by the IFRC, Southern Africa HIV and AIDS Information Dissemination Services and WHO. The training package covers eight modules (Basic facts about HIV and AIDS, Treatment Literacy, Treatment preparedness, Adherence, Community based counselling, Nutrition, Palliative care and Care for carers).

Documentation of good practices has continued with Swaziland Red Cross in collaboration with WHO, Ministry of Health and other local partners on publishing a new good practice in Sigombeni in relation to the rolling out of ART, PMTCT, VCT and community support in a rural setting. The good practice on male involvement in Zambia is also at printing stage and will be shared with all stakeholders before the end of the year.

Findings from the initial desk review under the psychosocial research project led by the South African Red Cross (SARCS) were also discussed at the OVC working group meeting held in May. SARCS was given a unique mandate to develop a comprehensive model of psychosocial support for CHBC to be rolled-out to other southern African countries. The project is funded by the EU and the Finnish Red Cross and is focused on volunteers working with community HBC clients and OVC.

SARCS and Lesotho Red Cross in collaboration with the IFRC Zone office and REPSSI are expected to hold participatory consultations with children in South Africa, in preparation for a continental children's conference to be held in Tanzania from 27 September to 2 October; under the organizing umbrella of RIATT, of which the IFRC is a member.

### **Constraints or Challenges:**

- The large injection of resources during the last quarter of 2007 provided important support however, over-stretched the operational capacity of the National Society as they were pressed to use and report on the funds within a short operating timeframe. This also contributed to the lag in implementation under other programme components.
- With the advent of ART in many countries, the focus of the community HBC component will need to shift towards treatment adherence monitoring, psychological support, positive prevention education, coupled with nutrition and livelihood support, and effective referral system between the community and health centres. To implement this, would require re-training of existing volunteers which requires substantial funding support.
- As noted above, the reduced funding for HBC activities impacted negatively on the capacity of NS to sustain their client base. There is an urgent need to strengthen targeted fundraising, and NS also need to promote programme integration to ensure continued support to PLHIV, for instance the integrated approach brought a temporary relief as the Malawi Red Cross was able to support CHBC interventions with OVC funding; the Zimbabwe Red Cross is also doubling its effort to make sure initiatives established to address the food insecurity also reach its CHBC clients.
- ART has certainly helped to contain and minimize some of the epidemic's most severe ramifications however, does not make either HIV or its harmful consequences completely disappear. Therefore continuous efforts in providing a holistic support to OVC and HBC clients and their families is still critical for achieving long-term health and well-being of the entire community; which requires consistent and long-term substantial funding support, currently not available.

### **Outcome 3: Reducing Stigma and Discrimination**

#### **Key strategies**

- Promoting community support groups and networks of PLHIV as well as partnerships with PLHIV organizations;
- Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent National Societies;
- Tackling gender inequalities and SGBV;
- Peer education, community mobilization, and population-based information, education and communication.

## Achievements

**Table 4: An overview of people reached through stigma and discrimination and advocacy activities:**

Country	Total	HIV positive RCRC staff and volunteers who received ART in last 12 months			NS staff participating in workplace HIV education		
		Total	Male	Female	Total	Male	Female
Angola	44	0	0	0	44	28	16
Botswana	45	45	25	20	0	0	0
Lesotho	32	32	11	21	0	0	0
Malawi	107	0	0	0	107	91	16
Mozambique	75	0	0	0	75	47	28
Namibia	0	0	0	0	0	0	0
South Africa	48	30	5	25	18	5	13
Swaziland	25	0	0	0	25		
Zambia	0	0	0	0	0	0	0
Zimbabwe	162	0	0	0	162	0	0
<b>Region</b>	<b>538</b>	<b>107</b>	<b>41</b>	<b>66</b>	<b>431</b>	<b>171</b>	<b>73</b>

Nine National Societies have established their workplace programme, which needs to be complemented by a robust Human Resources Policy and implementation plan. With only 19 per cent of NS staff (431) participating in or oriented to the workplace programme, there is an urgent need to accelerate the approval of these workplace policies/programmes by the management; and intensify the roll out to at least 75 per cent of each National Society workforce.

Representatives from the National Societies at the SARAWO meeting also welcomed the draft Southern Africa Zone HIV and AIDS advocacy strategy, which will be finalized and shared with other stakeholders during the next reporting period.

Engagement of PLHIV in the development, implementation, and monitoring of activities is not only a question of promoting their rights and ensuring fairness, but requires an effectiveness initiatives to fight stigma and discrimination. The perspectives and insights of PLHIV are invaluable assets and National Societies are taking steps to ensure their engagement at all level of programme planning and implementation. Namibian Red Cross has spearheaded the involvement of staff living with HIV in education and advocacy efforts at all levels as well as programme planning and implementation.

The IFRC Zone office in collaboration with Geneva Secretariat is also in the process of developing and disseminating practical tools and guidelines. For instance, Malawi Red Cross is partnering with UNICEF, the Ministry of Women and Children Development, Malawi Police Service, the Judiciary, and Ministry of Education to pilot the establishment of victims support unit at community level.

### Constraints or Challenges:

- Limited common understanding and practical tools for the implementation of the strategies on reducing stigma and discrimination, addressing gender inequalities, and sexual and gender-based violence has contributed to a lag in progress on the implementation of this programme component.
- Local partnerships with community leaders, local authorities, faith-based organisations and community-based organisations needs further strengthening in order to enhance National Society should seek more partnerships locally to develop relevance and culture sensitive programme activities on anti-stigma and discrimination.

- Simply developing a Workplace Policy is insufficient and National Societies need a robust implementation plan and Human Resources Policy to support its operationalization. Stigma is a powerful constraint to combating the epidemic at the workplace; therefore National Societies need to establish a strong and contextually appropriate education and communication activities at the workplace.

#### Outcome 4: Strengthening Red Cross national society and zone office capacity

##### Key strategies:

- 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.

##### Achievements

*Finance Development:* A finance development training workshop was held for National Society finance and HIV and AIDS programme staff from 7 to 11 of April in Johannesburg. While the training focussed on specific budgeting, accounting and reporting issues, it also provided premise for strengthening working relationships between programme and finance staff at National Society level. The participants also had an orientation on the Navision accounting software adopted by all National Society. As a result, there has been some marked improvement in the quality and consistency of financial reports from the National Society although there is a need to continue supporting the financial management capacity at provincial and district levels.

*Human Resources Development:* In order to strengthen the capacity of National Societies, the IFRC zone office organized an orientation workshop for new NS staff in April 2008 (HIV and AIDS coordinators, prevention officers, HBC officers, OVC officers, PMER officers and a programme coordinator). In total, 23 new staff attended the induction workshop. Apart from briefing on the overall HIV programming, the participants were also briefed on other programmes and support services at the IFRC Zone office. An orientation visit was also organised to SARCS HBC project in Soweto, Johannesburg, and the participants took home the lessons learnt.

*Operational Planning:* During the first three months of the reporting period, all National Societies were preoccupied with the development and finalization of their 2008 operational plans, delaying the release of funds from the Zone and programme implementation. As a key planning and budgeting tool, the operational plan will continue to be refined and used; and the process for 2009 is expected to be easier for the National Societies.

*PMER:* As noted above, the PMER workshop was successfully held at the close of the reporting period. Some National Societies have also started planning for baselines exercises, which are critical for a programme of such complexity and scope. It is expected that at least three National Societies will conduct their baselines before the end of the calendar year. National Societies are also rolling out the PMER training to district/branch level managers, volunteer coaches, and to some volunteers assisting as enumerators. For instance in South Africa, PMER workshops were held in seven branches of Gauteng and Kwa-Zulu Natal Provinces. All project coordinators, facilitators, volunteers, peer educators and administrators (a total of 420 people) at these branches were trained on the PMER tools. Each PMER workshop was over a two-day period and was conducted by the National Society PMER officer and provincial health and care coordinators of Gauteng and Kwa-Zulu Natal Provinces.

The PMER officers from Namibia and South African Red Cross spent time at the IFRC Zone PMER unit receiving orientation on guidelines and tools, as well as an induction on all aspects of the HIV and AIDS programme.

### Constraints or Challenges:

- There is a wide difference in volunteer management practices among and between the National Societies and there is need for standardisation. Lack of adequate allocation of resources to support volunteer allowances is also a challenge for the National Societies, coupled with burn out and attrition. The Red Cross Movement relies heavily on volunteers' assistance to deliver services and there is an urgent need to develop standard guidelines for volunteer recruitment, management, and retention. By the end of the reporting period, only 8,467 volunteers were active in the region.
- The limited level of skilled personnel and high staff attrition or turnover has significantly impacted on programme implementation. Almost all National Societies have lost or changed one or two of the key positions of the programme (HIV coordinator, finance officer etc). This impacted negatively on effectiveness of programme implementation. The level of capacity and skills of NS staff also varies, with some in need of close support and capacity building.
- The IFRC Secretariat's decentralization process had an impact on the programme particularly at zone level, as it led to gaps in human resources capacity. The reallocation of responsibilities to cover the gaps consequently derailed the implementation plan and monitoring schedule.
- The political and economic situation in Zimbabwe has a negative impact on procurement and cash management at all levels due to currency losses and shortage of basic commodities required for the CHBC programme.

## Working in partnership

A Memorandum of Understanding (MOU) was signed with REPSSI to promote a joint learning, sharing and harmonization of knowledge, approaches and expertise in the enhancement of psychosocial support programming, which will contribute to the psycho social well-being of children, volunteers, youth, families and communities affected by HIV and AIDS. REPSSI is a non-profit making regional organization operating in 13 countries in east and southern Africa that aims to contribute towards the psychosocial well-being of children affected by HIV and AIDS, poverty and conflict.

The application to the call for proposal from GFATM and the processes involved made it evident of the urgent need for National Societies to strengthen collaboration with country level stakeholders including the Ministry of Health, NAC, Country Coordinating Mechanism (CCM) members, and other key partners involved in HIV and AIDS work. One of the key requirements from the GFATM was the submission of endorsements from CCM and by the end of the reporting period and the proposal submission deadline (1 July 2008), only three National Societies had obtained these endorsements. The IFRC Zone office was granted another 30 days window to submit the remaining endorsements.

Some National Societies have made great strides in establishing partnerships and using locally available resources to benefit their clients. Lesotho Red Cross (LRCS) for instance, is networking with Senkatane Prince Harry Fund, Baylor clinics, MSF (Doctors without Borders), and the Government of Lesotho and has made use of four clinics and refers its clients to access ART. Lesotho Red Cross is also benefiting from the Global Fund working through the Ministry of Finance and Planning and the NAC. Funds have been made available to LRCS for support to OVC: procurement of food packages and sanitary wear, repair of OVC houses, and for integrated CHBC activities.

Southern Africa NS made some progress in local resource mobilisation; for instance Malawi Red Cross has received financial support locally from NAC for four projects in Mwanza, Ntchisi, Nkhotakota and Nkhatabay. Malawi Red Cross has also improved its partnership with UNICEF who may support the OVC projects in Mwanza, Ntchisi and Nkhotakota for two years (2008 and 2009). Nevertheless, more needs be done in developing a robust local resource mobilization strategy.

At Zone level collaboration has been strengthened with WHO (care, treatment and support with regard to the training package roll out, adaptation and adoption, training), UNAIDS (HIV in emergencies), VSO-RAISA (training package and research), RIATT (coordination, OVC), and UNICEF (PMTCT roll-out at country level).

## Looking ahead

Below are some highlights of activities until the end of 2008; and not an exhaustive list of planned activities by the IFRC Zone and National Societies:

- Baselines will be completed in three or four countries setting the premise for rolling-out all planned activities;
- Finalizing the National Societies 2009 operational plans through in-country support by the IFRC Zone office;
- Preparing proposals for submission to major donors including the Global Fund;
- All National Societies participating at the 7<sup>th</sup> Pan African Conference to be held in October in Johannesburg.
- IFRC Zone facilitating a thematic evaluation on OVC projects;
- Training of National Societies' OVC officers by REPSSI on mainstreaming psychosocial support into paediatric ART;
- Rolling-out of peer education and CHBC minimum standards to all NS;
- Regional training of youth peer education facilitators in reproductive health and life skills.
- To pilot the training manual developed following the youth consultative meeting held in Johannesburg in March 2007;
- All nine National Societies who have finalized HIV Workplace Policies would have developed an implementation plan and provided orientation to at least 75 per cent of their workforce;
- A programme financial audit will also be carried out in close collaboration with the IFRC Secretariat.
- Work together with WHO, VSO-RAISA and SADC to carryout a research on the '*burden of care among girls, women and elderly*'. The findings will be presented to SADC Ministers of Health in 2009. It is expected that the findings will be used to encourage governments in the region to pay more attention to needs of carers who are mainly girls, women and elderly.

### How we work

The International Federation's activities are aligned with its Global Agenda, which sets out four broad goals to meet the Federation's mission to "improve the lives of vulnerable people by mobilizing the power of humanity".

#### Global Agenda Goals:

- Reduce the numbers of deaths, injuries and impact from disasters.
- Reduce the number of deaths, illnesses and impact from diseases and public health emergencies.
- Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability.
- Reduce intolerance, discrimination and social exclusion and promote respect for diversity and human dignity.

### Contact information

For further information specifically related to this report, please contact:

- **In Operational Zone for Southern Africa:** Françoise Le Goff, Head of Zone Office, Johannesburg; Email [françoise.legoff@ifrc.org](mailto:françoise.legoff@ifrc.org); Phone: Tel: +27.11.303.9700; +27.11.303.9711; Fax: +27.11.884.3809; +27.11.884.0230
- **In Geneva:** Busi Tshili; Officer (Management Support Team), Coordination and Programmes Division; Email: [busisiwe.tshili@ifrc.org](mailto:busisiwe.tshili@ifrc.org); Phone: Tel: +41.22.730.4207; Fax: +44.22.733.0395

# International Federation of Red Cross and Red Crescent Societies

MAA63003 - Southern Africa Regional HIV And AIDS

Mid-year report 2008

Selected Parameters	
Reporting Timeframe	2008/1-2008/6
Budget Timeframe	2008/1-2008/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

## I. Consolidated Response to Appeal

	Health and Care	Disaster Management	Humanitarian Values	Organizational Development	Coordination & Implementation	TOTAL
<b>A. Budget</b>	40,000,000				0	40,000,000
<b>B. Opening Balance</b>	2,253,031				-1,209	2,251,822
<b>Income</b>						
<u>Cash contributions</u>						
British Red Cross	41,600					41,600
Canadian Red Cross	111,896				1,209	113,105
Danish Red Cross	101,720					101,720
Finnish Red Cross	27,019					27,019
Finnish Red Cross (from Finnish Government)	127,667					127,667
Icelandic Red Cross (from Icelandic Government)	-338					-338
Japanese Red Cross	100,000					100,000
Netherlands Government	-17,252					-17,252
Norwegian Red Cross	-455					-455
Norwegian Red Cross (from Norwegian Government)	-4,093					-4,093
On Line donations	373					373
Other (from Danish Red Cross)	494					494
Other (from Finnish Red Cross)	-4,490					-4,490
Other (from Icelandic Government)	338					338
Other (from Netherlands Government)	17,252					17,252
Other (from Norwegian Government)	4,093					4,093
Other (from Norwegian Red Cross)	455					455
Other (from Swedish Government)	2,239					2,239
Other (from Swedish Red Cross)	9,792					9,792
Swedish Red Cross	862,570					862,570
Swedish Red Cross (from Swedish Government)	1,726,961					1,726,961
<b>C1. Cash contributions</b>	<b>3,107,842</b>				<b>1,209</b>	<b>3,109,051</b>
<u>Outstanding pledges (Revalued)</u>						
British Red Cross	-2,200					-2,200
Danish Red Cross	-102,214					-102,214
Finnish Red Cross	11,507					11,507
Finnish Red Cross (from Finnish Government)	65,209					65,209
Netherlands Government	6,524,401					6,524,401
Norwegian Red Cross	12,340					12,340
Norwegian Red Cross (from Norwegian Government)	111,057					111,057
Swedish Red Cross (from Swedish Government)	128,025					128,025
<b>C2. Outstanding pledges (Revalued)</b>	<b>6,748,125</b>					<b>6,748,125</b>
<u>Inkind Personnel</u>						
New Zealand Red Cross	37,200					37,200
<b>C4. Inkind Personnel</b>	<b>37,200</b>					<b>37,200</b>
<b>C. Total Income = SUM(C1..C5)</b>	<b>9,893,167</b>				<b>1,209</b>	<b>9,894,376</b>
<b>D. Total Funding = B + C</b>	<b>12,146,198</b>				<b>0</b>	<b>12,146,198</b>
<b>Appeal Coverage</b>	<b>30%</b>				<b>#DIV/0</b>	<b>30%</b>

**International Federation of Red Cross and Red Crescent Societies**

MAA63003 - Southern Africa Regional HIV And AIDS

Mid-year report 2008

Selected Parameters	
Reporting Timeframe	2008/1-2008/6
Budget Timeframe	2008/1-2008/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

**II. Balance of Funds**

	Health & Care	Disaster Management	Humanitarian Values	Organizational Development	Coordination & Implementation	TOTAL
<b>B. Opening Balance</b>	2,253,031				-1,209	<b>2,251,822</b>
<b>C. Income</b>	9,893,167				1,209	<b>9,894,376</b>
<b>E. Expenditure</b>	-5,155,646					<b>-5,155,646</b>
<b>F. Closing Balance = (B + C + E)</b>	6,990,552				0	<b>6,990,552</b>

# International Federation of Red Cross and Red Crescent Societies

MAA63003 - Southern Africa Regional HIV And AIDS

Mid-year report 2008

Selected Parameters	
Reporting Timeframe	2008/1-2008/6
Budget Timeframe	2008/1-2008/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

## III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure					TOTAL	Variance
		Health & Care	Disaster Management	Humanitarian Values	Organizational Development	Coordination & Implementation		
A							B	A - B
<b>BUDGET (C)</b>		<b>40,000,000</b>				<b>0</b>	<b>40,000,000</b>	
<b>Supplies</b>								
Shelter - Relief		140					140	-140
Construction Materials		14,656					14,656	-14,656
Clothing & textiles		190,136					190,136	-190,136
Food		889,756					889,756	-889,756
Seeds,Plants		5,735					5,735	-5,735
Water & Sanitation		157					157	-157
Medical & First Aid		236,028					236,028	-236,028
Teaching Materials		20,879					20,879	-20,879
Utensils & Tools		0					0	-0
Other Supplies & Services		32,020					32,020	-32,020
<b>Total Supplies</b>		<b>1,389,506</b>					<b>1,389,506</b>	<b>-1,389,506</b>
<b>Land, vehicles &amp; equipment</b>								
Vehicles		45,864					45,864	-45,864
Computers & Telecom		120,642					120,642	-120,642
Office/Household Furniture & Equipm.		38,918					38,918	-38,918
<b>Total Land, vehicles &amp; equipment</b>		<b>205,424</b>					<b>205,424</b>	<b>-205,424</b>
<b>Transport &amp; Storage</b>								
Storage		7,343					7,343	-7,343
Distribution & Monitoring		7,085					7,085	-7,085
Transport & Vehicle Costs		94,705					94,705	-94,705
<b>Total Transport &amp; Storage</b>		<b>109,133</b>					<b>109,133</b>	<b>-109,133</b>
<b>Personnel</b>								
International Staff Payroll Benefits		335,059					335,059	-335,059
Regionally Deployed Staff		1,091					1,091	-1,091
National Staff		194,968					194,968	-194,968
National Society Staff		419,290					419,290	-419,290
Consultants		1,380					1,380	-1,380
<b>Total Personnel</b>		<b>951,788</b>					<b>951,788</b>	<b>-951,788</b>
<b>Workshops &amp; Training</b>								
Workshops & Training		208,749					208,749	-208,749
<b>Total Workshops &amp; Training</b>		<b>208,749</b>					<b>208,749</b>	<b>-208,749</b>
<b>General Expenditure</b>								
Travel		84,612					84,612	-84,612
Information & Public Relation		21,525					21,525	-21,525
Office Costs		37,647					37,647	-37,647
Communications		17,686					17,686	-17,686
Professional Fees		10,348					10,348	-10,348
Financial Charges		27,415					27,415	-27,415
Other General Expenses	37,400,000	31,831					31,831	37,368,169
<b>Total General Expenditure</b>	<b>37,400,000</b>	<b>231,063</b>					<b>231,063</b>	<b>37,168,937</b>
<b>Programme Support</b>								
Program Support	2,600,000	333,293					333,293	2,266,707
<b>Total Programme Support</b>	<b>2,600,000</b>	<b>333,293</b>					<b>333,293</b>	<b>2,266,707</b>
<b>Services</b>								
Shared Services		68,911					68,911	-68,911
<b>Total Services</b>		<b>68,911</b>					<b>68,911</b>	<b>-68,911</b>
<b>Operational Provisions</b>								
Operational Provisions		1,657,778					1,657,778	-1,657,778
<b>Total Operational Provisions</b>		<b>1,657,778</b>					<b>1,657,778</b>	<b>-1,657,778</b>

**International Federation of Red Cross and Red Crescent Societies**

MAA63003 - Southern Africa Regional HIV And AIDS

Mid-year report 2008

Selected Parameters	
Reporting Timeframe	2008/1-2008/6
Budget Timeframe	2008/1-2008/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

**III. Budget Analysis / Breakdown of Expenditure**

Account Groups	Budget	Expenditure					TOTAL	Variance
		Health & Care	Disaster Management	Humanitarian Values	Organizational Development	Coordination & Implementation		
A							B	A - B
BUDGET (C)		40,000,000				0	40,000,000	
TOTAL EXPENDITURE (D)	40,000,000	5,155,646					5,155,646	34,844,354
VARIANCE (C - D)		34,844,354					34,844,354	