

# Annual report



International Federation  
of Red Cross and Red Crescent Societies

## Southern Africa: Regional HIV and AIDS Programme

Appeal No. MAA63003

30 April 2010

This report covers the period  
01/01/2009 to 31/12/2009



Psychosocial support activities with OVC in Swaziland

### In brief

**Programme purpose:** In 2000, the 5<sup>th</sup> Pan African Conference issued the [Ouagadougou Declaration](#) committing African National Societies (NS) to massively scale-up their responses to the HIV pandemic through advocacy, prevention, care, and mitigation of impacts. The Declaration also emphasised food security aspects and building the capacity of NS to enhance effective implementation. Four years later, the 6<sup>th</sup> Pan African Conference in 2004 issued the [Algiers Plan of Action](#) that renewed the Ouagadougou commitments and further called for support to government efforts on increased access to anti retroviral therapy (ART) for people living with HIV (PLHIV) through promoting adherence to treatment based on a home based care approach, reducing stigma and discrimination, and psychosocial support. Enabling strategies that were emphasised included social mobilisation, strategic partnerships, and stronger resource mobilization.

The initiative of African NS catalysed the adoption of HIV action as a Global Agenda priority by the 15<sup>th</sup> General Assembly of the International Federation in 2005 in Seoul. Its successor 16<sup>th</sup> General Assembly in 2007 in Geneva endorsed the HIV Global Alliance, launched in 2006, as the mechanism for doubling our HIV efforts worldwide by the end of 2010, retaining the emphasis on Africa.

Based on the UNGASS Declaration of 2006 where governments committed to scale-up towards universal access to HIV prevention, treatment, care and support by 2010 and in line with the Millennium Development Goals, 2, 3,4,5,6, the International Federation of the Red Cross and Red Crescent Societies (IFRC) Southern Africa Regional Office (SARO) launched an innovative and dynamic five-year (2006-2010) regional HIV and AIDS programme. The ten NS<sup>1</sup> in the Region embarked on programme consolidation and building capacities to improve the overall implementation and management of the programme, and should resources be made

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

available to eventually scale-up. The regional HIV and AIDS programme aims to quadruple people reached by 2010 by targeting 50 million people with prevention messages and peer education activities, 250,000 people with an expanded prevention, care, treatment and support programme and 460,000 orphans and vulnerable children (OVC) with a holistic package of educational, material and psycho-social support.

The year 2009 marked the third year of full programme implementation under long-term funding commitments secured by the Southern Africa Regional Office (SARO), despite the fact that we could not access funding from RNE since August 2009.

**Programme(s) summary:**

Three years into the implementation of the Global Alliance on HIV in southern Africa, the IFRC (SARO) and the NS have started reflecting on the future of the programme beyond 2010 taking into consideration various factors impacting on the funding level, the current programme reach, and the collective capacity to meet the established targets. This programme update provides an overview of achievements in 2009, whilst some data presented provides information on cumulative reach since the inception of the programme against the 2010 targets.

**Table 1: Overview of beneficiaries reached by end of 2009**

Key Result/Output	Target 2010	Baseline 2006	Achieved Jan-Dec 2007	Achieved Jan-Dec 2008	Achieved Jan-Dec 2009	Cumulative Reach	Reach against 2010 Tars
1: Prevention	50,000,000	4,782,711	6,549,900	7,602,529	2,726,394	16,878,823	34 %
2: PLHIV supported	250,000	65,000	68,630	60,421	82,521	*211,572	*85%
2: OVC supported	460,000	111,109	119,270	112,543	106,196	*338,009	*73%
3: Stigma and discrimination	100% of NS staff in workplace programmes	None	32% of 1,671 staff	41% of 2,224 staff	41% of 2,220 staff	*39% of 6115 staff	-
4: Capacity Building	Volunteer hours mobilized/month	6,963 volunteers and 774,773 hours/month	7,716 volunteers and 858,559 hours/month	8,435 volunteers and 894,110 hours/month	7,977 volunteers and 845,562 hours/month	*24,128 Volunteers and 30,900,816 hours/annum	-

*Note: The cumulative reach is calculated by adding up the number of people who received support in a particular year since in each year there is a cost attached to the particular service. The data in \* refers to person years of support for each service area.*

There is an important decrease of more than 50 percent on prevention outreach mostly attributed to South Africa Red Cross, which did not use to the same extent mass media communication strategies as in 2008, but also to the lack of funding for prevention in most NS of the region. This is extremely worrying as it will result in more new infections, which mean greater future treatment needs, with large cost implications, in particular for households, communities and nations.

The slight drop in client numbers under OVC reflects efforts undertaken by NS to provide quality, comprehensive, holistic support for OVC rather than expanding the number of orphans and vulnerable children to be reach. As for CHBC or PLHIV supported there has been a marked increase of 37 percent in the number of CHBC clients between December 2008 (60,421) and 2009 (82,521), as South Africa more than doubled the number of clients in 2009 which is consistent with the scale of the epidemic in that country.

The cumulative numbers of people reached (or number of people serviced per year from 2007-2009 are 211,572 (85 percent) for PLHIV supported and 338,009 (73 percent) under OVC representing almost three quarters of the appeal 2006- 2010 target figures. The NS also reached 16,878,823 (34 percent) people through HIV prevention activities which represents 34 percent of the overall target.

**Financial situation:**

To date, multiple year funding has been provided by the Royal Netherlands Embassy (RNE) and the Swedish Red Cross/SIDA. 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 and the withholding of funds for the second half of 2009 by the RNE have inhibited long-term planning, programming, and scale up. The funding trend from both bilateral and multilateral donors has been characterised by earmarked donations and the availability and magnitude of funding changing from year to year. Therefore, there is a need to increase dialogue with existing and potential donors to ensure long-term and flexible funding support in order to balance coverage in all programme components.

The total 2006-2010 budget for the appeal (MAA63003) remains CHF 384,895,997. The revised total 2009 budget was CHF 12,553,680 (USD 12,139,409 or EUR 8,437,329), of which 75 per cent has been covered with funding received through IFRC. Overall expenditure was 60 percent of the total funding. The low rate of expenditure against income is due to the outstanding pledge of the Netherlands Government, which represent 39 percent of the total funding.

**Table 2:** Summary of financial resources collectively raised towards the Global Alliance programme

Funding Channel	Year	Amount received in CHF
Through IFRC	2007	16,699,321
Through National Societies	2007	20,893,186
<b>Sub total</b>		<b>37,592,,507</b>
Through IFRC	2008	13,100,371
Through National Societies	2008	16,466,097
<b>Sub total</b>		<b>29,566,468</b>
Through IFRC	2009	9,363,164
Through National Societies	2009	7,575,210
<b>Sub total</b>		<b>16,938,374</b>
<b>Total received towards Appeal</b>	<b>2007-2009</b>	<b>84,097,349</b>

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

**Our partners:** The Southern African NS supported by SARO strengthened partnerships with local, regional, and multilateral organizations in an effort to: advocate for greater support to the programme and beneficiaries, learn from experiences and best practices, widen the funding base, and increase quality of service delivery. At SARO level, collaboration has been ongoing with embassies, international organizations, UN agencies, development agencies and internally with the PNS. Funding support to this appeal (**MAA63003**) has been received through the IFRC Secretariat from British, Finnish, Japanese, Norwegian, Finnish, Swedish Red Cross and Swedish Red Cross/SIDA, Lars Amundsen Foundation, and Netherlands Government. The Ministries of Health, National AIDS Councils (primarily with funding from the GFATM), UNFPA, UNICEF, UNAIDS, WHO, WFP, European Union (EU), Regional Inter Agency Task team on Children and HIV and AIDS in Southern and Eastern Africa (RIATT), Regional Psycho-Social Support Initiative (REPSSI), Voluntary Services Overseas- Regional Office for Southern Africa (VSO), SaFAIDS, UNAIDS, the Southern Africa Technical Support Facility, Engender Health, SONKE Justice Network, RFSU (Swedish Association of Sexuality Education), SWEAT ( Sex worker, Education, Advocacy and Training), Soul City, SADC and many other local, regional, and international organization partnered with the SARO and NS over various initiatives described in this programme update.

## Context

It has been widely assumed for many years that poverty and underdevelopment were driving factors behind the transmission of HIV, but empirical evidence does not appear to bear this out. Viewed globally, the highest prevalence of HIV is found in the poorer countries of the world, with more than two thirds of people living with HIV residing in sub Saharan Africa.

However, within sub Saharan Africa, the highest rates of HIV prevalence are found in the relatively more wealthy countries, such as Swaziland, Botswana and South Africa, and in general, the countries with higher GDP per capita have higher levels of HIV prevalence. Most of the other commonly understood poverty measures such as literacy rates, educational enrolment, under-five mortality or nutritional outcomes seem to show an **inverse** relationship at country level between poverty and HIV – the poorer countries (or countries with worse development indicators) have **lower** rates of HIV prevalence. At household level, strong evidence from population-based surveys (DHS+) has shown that HIV prevalence is **lower** among the poorer members of African society, and higher among those who are better off, and those living in urban areas.

The above analysis suggests that behavioural factors not directly related to poverty are more important drivers of HIV infection in Africa, and has clearly shown that economic status in itself is *not* a strong predictor of HIV status. The primary implication is that prevention must therefore cut across **all socioeconomic strata** of society – especially those living in urban areas.

According to a report released in June 2009 by UNAIDS and the World Bank, entitled '*The Global Economic Crisis and HIV Prevention and Treatment Programmes: Vulnerabilities and Impact,*' the global economic crisis was expected to significantly disrupt HIV and AIDS prevention and treatment programmes over the course of 2009 and beyond. The report specifically warned of the consequences of funding cuts including: unplanned interruptions and curtailed access to treatment, increased risk of HIV transmission, higher future financial costs, an increased burden on health systems and a reversal of economic and social development gains.

One of the most important recommendations that the report makes is to strengthen programme efficiency and cost effectiveness with countries having to closely scrutinise their HIV and AIDS programmes and identify where efficiency gains and/or savings could be made. Furthermore, the report recommends that countries focus on evidence based, result driven programmes, instead of spending money on ineffective and inefficient interventions. The UNAIDS and the World Bank report also highlights the importance of not neglecting complementary inputs and interventions; referring to maintaining funding for other critical areas such as salaries, drugs to treat opportunistic infections, STIs and TB, and well implemented, legal and social programmes that reduce stigma and discrimination and represent good value for money.

## Progress towards objectives/outcomes

### General analysis of Outcomes/Expected Results and Challenges

**Table 3:** Overview of people reached with various activities in 2009

Country	Preventing further infections			Care, Treatment and Support			Reducing Stigma and Discrimination			Total 2009
	Jun	Dec	2009	Jun	Dec	2009	June	Dec	2009	2009
Angola	27,432	38,022	38,022	1,283	4,072	4,072	44	12	44	42,138
Botswana	5,678	12,206	12,206	231	235	235	7	8	8	12,449
Lesotho	21,960	41,348	41,348	14,627	12,335	14,627	50	0	50	56,025
Malawi	177,487	566,538	566,538	10,728	13,198	13,198	106	0	106	579,842
Mozambique	89,024	149,347	149,347	11,033	9,896	12,009	24	53	53	161,409
Namibia	158,225	201,882	201,882	9,858	10,271	10,456	-	-	-	212,338
South Africa	364,850	622,952	622,952	35,139	53,362	53,362	400	17	400	676,714
Swaziland	89,461	337,021	337,021	3,264	3,439	4,192	88	-	88	341,301
Zambia	1,335	1,335	1,335	1,975	-	1,975	8	-	8	3,318
Zimbabwe	333,953	755,743	755,743	74,591	74,591	74,591	162	-	162	830,496
<b>Total</b>	<b>1,269,403</b>	<b>2,726,394</b>	<b>2,726,394</b>	<b>162,729</b>	<b>181,399</b>	<b>188,717</b>	<b>889</b>	<b>90</b>	<b>919</b>	<b>2,916,030</b>

Source: National Society Programme Updates

In 2009 a total 2,916,030 people were reached with the various HIV activities. The number of people reached with prevention in 2009 has decreased by more than 50 percent compared to 2008, while the number of orphans and vulnerable children (OVC) and CHBC clients remained fairly constant, except in South Africa where there is a notable increase in the number of CHBC clients reached corresponding to the effort of the NS to reach out more beneficiaries as the country has the highest concentration of PLHIV worldwide.

## Outcome(s)/Expected result(s)

### Prevention of further HIV infection

#### Key Strategies:

- Working at community level to reduce vulnerability to acquiring or transmitting HIV by conducting in and out of school youth 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 4:** Overview of the total number of people reached with prevention activities in 2009

Country	Total Output 1	People reached by peer education	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
Angola	38,022	7,180	25,750	1,201	378	3,513
Botswana	12,206	10,241	1,651	68	36	210
Lesotho	41,348	1,711	17,764	16,637	3,447	1,789
Malawi	566,538	124,126	425,376	11,220	3,066	2,750
Mozambique	149,347	37,391	104,034	4,450	578	2,894
Namibia	201,882	45,500	63,200	89,361	581	3,240
South Africa	622,952	201,907	336,653	16,914	3,647	63,831
Swaziland	337,021	111,911	210,231	7,831	6,926	122
Zambia	1,335	524	-	698	-	113
Zimbabwe	755,743	550,055	155,940	13,544	3,571	32,633
<b>Total Region</b>	<b>2,726,394</b>	<b>1,090,546</b>	<b>1,340,599</b>	<b>161,924</b>	<b>22,230</b>	<b>111,095</b>

Source: National Society Programme Updates

As illustrated in the table above, there is a marked decrease of more than 50 percent in the number of people reached through prevention activities compared to 2008. The high figures reported in 2008 were primarily due to the mass media initiatives from the South African Red Cross.

The lack of funding for prevention is a constant amongst most NS and certainly impedes the further development of NS efforts in this area in a region with the highest number of HIV infection and where sustained and targeted prevention, education and outreach are seen critical to sustain the positive gains made so far in some countries. To be noted is the doubling of women referred to PMTCT services, which is most likely to have a positive impact in slowing down and reducing the number of new infections amongst children as well as a near doubling of people reach under the peer education strategy, a positive outcome of SARO efforts to better structure peer education within the region over the last two years.

**Peer education and IEC:** Focus during the reporting period has been on building NS capacities in fine tuning key prevention strategies in order for NS to address the key drivers of the epidemic in their respective countries. As such, peer education sexual and reproductive health and life skills training package was completed and pretested in South Africa and Zimbabwe. It is a practical tool focussing on life skills development and includes case studies, games, and other activities designed to engage youth in peer discussions on how they can protect from HIV, sexually transmitted infections and unwanted pregnancies, with

a particular emphasis on risk situations (multiple concurrent partners, intergenerational sex, alcohol and substance abuse, gender-based violence). The language used is simple and appealing to the audience (youth) in resource limited setting.

Several workshops to roll out the training package were facilitated and funded through SARO and took place in Botswana, Zimbabwe, Lesotho, South Africa, Swaziland, Malawi, Mozambique, and Zambia. In total more than 200 trainers were trained in eight NS with a fair gender balance and with in-country Provincial/Branch representation. At the same time, SARO disseminated to NS the recently produced IFRC's standards for HIV peer education programmes and HIV prevention guidelines for programming as well as a guide to interactive drama for sexual and reproductive health with young people produced by the International HIV and AIDS Alliance.

Following the Southern Africa HIV Working group (SARAWO) group meeting, a prevention workshop was organised for both NS and their multi, bilateral partners. Emphasis was put on introducing the new IFRC's HIV prevention guidelines and on:

- ✘ Building NS understanding of the HIV epidemic key drivers as well as on the fact that there are different HIV epidemics between and within countries so that they can refine existing prevention strategies and interventions;
- ✘ Meaningful community involvement in HIV prevention programme planning, implementation and evaluation;
- ✘ The need to address systematically in all prevention interventions, multiple concurrent partnership through IEC, in and out of school youth peer education, VCT, PMTCT and condom use;
- ✘ Understanding better the role of male circumcision in HIV prevention;
- ✘ Use of the 2008-2009 baseline survey findings in planning, monitoring and evaluating prevention interventions;
- ✘ Linking up NS to key partner organisations like National Association of People living with HIV or SWEAT (Sex worker, Education, Advocacy and Training).

**Below are some notable highlights in prevention activities from NS:**

- ✘ The Zimbabwe RC developed a Prevention Strategy launched in May 2009 to guide prevention interventions. A total of 13,544 people were referred by peer educators and care facilitators for VCT and PMTCT and 9,904 PLHIV were supported on positive prevention. A total of 291 peer educators were trained in sexual and reproductive health and life skills and they managed to reach 294,877 people through prevention activities.
- ✘ The national HIV prevalence rate in the 15 – 49 age groups has declined from 15.6 percent in 2008 to 13.7 percent in 2009 according to the National AIDS Council. This reduction has been attributed to behavioural change and effective prevention programmes to which the ZRCS is a major contributor.
- ✘ The major problems facing Malawi HIV prevention efforts according to the Malawi HIV Prevention strategy 2009 - 2013 are low risk perception and low health seeking behaviour. This is the tragic situation in which Malawi find itself.
- ✘ Malawi Red Cross has consequently doubled its efforts to increase access to quality HIV prevention services.
- ✘ The NS has scaled up high impact peer education and culturally sensitive information education and communication interventions. The number of youth peer educators increased to 494 from 347 in 2008. The capacities of project officers and volunteers were enhanced by conducting a Sexual and Reproductive Health and Rights and Life Skills TOT with support from SARO. The involvement of 120 OVC as peer educators has also added value to the quality of peer education as has the involvement of 551 cultural leaders in HIV prevention. The number of youth accessing peer education services increased from 16,351 in 2008 to 124,126 in 2009. In order to replicate the peer education in older groups, MRCS in 2009 introduced the stepping stones approach in the three districts of Chiradzulu, Mwanza and Ntchisi to target the older generation over 24 years particularly people in stable sexual relationships where most infections occur but according to the Extended National HIV and AIDS Framework 2010 to 2012 condom use is only three percent.
- ✘ The NS conducted 48 prevention campaigns reaching 425,376 people, and provided culturally sensitive information, education and communication. The awareness campaigns have directly led to an increased number of people and pregnant women accessing quality HIV testing and counselling and Prevention of Mother to Child (PMTCT) services. A total of 11,220 people were tested and 3,066 pregnant women accessed PMTCT services.
- ✘ During the reporting period MRCS conducted Prevention of Mother to Child Transmission training for 78 volunteers and 90 PLHIV and Chiefs in Chiradzulu district.
- ✘ In the last quarter of 2009 the NS has been mobilizing sex workers in the five districts of Mwanza, Ntchisi, Dowa, Kasungu and Nkhatabay. Malawi Red Cross is further seeking to organize teams of sex workers

peer educators in order to reach them with information and life skills for personal protection. The mobilization of sex workers has been very successful in Ntchisi district where sex workers were trained on personal protection and use of condoms.

- ✘ Angola Red Cross in 2009, made further efforts to reach out to the population most at risk of HIV infection, mainly commercial sex workers, truck drivers and people in the military.
- ✘ Lesotho Red Cross has established networks with clinics, VCT centres and hospitals for referrals. Through these networks some of the Care Facilitators were trained by the government through the Know Your Status Campaign. This has contributed significantly to an increase of VCT uptake in existing CHBC project sites since people do not have to walk long distances to the VCT centres but get VCT services within their own villages.
- ✘ VCT has shown to be an effective strategy to facilitate behaviour change for HIV prevention. It offers an entry point for early treatment, care and support for those infected with HIV and prevention of mother to child transmission. It plays an important role in reducing stigma and discrimination. From all the CHBC project sites 16,637 people were advised and referred to VCT services and are now fully aware of their HIV sero status.
- ✘ Baphalali Swaziland Red Cross through support from Government and the Swiss Red Cross have made great strides in prevention in and out of the Baphalali clinics in Sigombeni and Mahwalala through scaling-up of provision of VCT and PMTCT services. They also introduced the health worker provider initiated HIV testing as a complementary strategy, which has proved to be efficient - all documented as a good practice by the government and WHO. Equally through a Finnish Red Cross/EU grant, the National Society displayed excellence in drama performance which have been also documented as best practices.

## Challenges

- ✘ It is becoming evident that NS HIV responses are not sufficiently aligned to the in country epidemics. For example, there is an almost exclusive focus on youth programmes despite evidence that incidence increases among older groups. HIV prevention interventions are conducted by NS in rural areas at great costs while there is compelling evidence that HIV is concentrated in the cities of the high burden countries. For example in South Africa, more than 50 percent or 3,053,000 of the PLHIV are located in five cities (Gauteng 1,550,000, Durban 730,000, Cape Town 513,000, Port Elizabeth 155,000 and East London, 105,000).
- ✘ HIV prevention activities are also largely underfunded both by governments and within the Red Cross integrated HIV prevention, care, treatment and support programme, while it is recognised that seven out of ten countries in southern Africa are key to the achievement of the global millennium development goal of halting and beginning reversing the spread of HIV by 2015 - namely Botswana, Lesotho, Mozambique, South Africa, Swaziland, Zambia, and Zimbabwe.
- ✘ For instance in 2009, the total NS HIV budget for prevention was CHF 8,075,863 from which only 19 percent was covered (CHF1,505,000) - all inclusive IFRC, PNS and local stakeholders.
- ✘ Funding is required to roll out the youth peer education sexual, reproductive health and life skills manual and general to increase more prevention activities.
- ✘ To remedy this situation, the zone teamed up with Finnish Red Cross as associate partner to an EC multi country application on sexual and reproductive health for Mozambique, South Africa, and Swaziland.
- ✘ The SARO team also managed to re channel funds received from NS of Iceland, Japan and Sweden for the zone office costs to support the NS of Angola, Lesotho and Malawi in rolling out the peer education programme.
- ✘ To date, there is little integration between the various programmes of the NS. HIV related prevention messages can and should be easily incorporated in water and sanitation, First Aid, tuberculosis (TB), malaria, food security, disaster response and management activities of the NS – thus further capitalising and maximising on use of financial and human resources.

## Expanding Care Treatment and Support

### Key strategies:

- Assisting orphans and other children made vulnerable by HIV and AIDS (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.

### Achievement

#### Supporting orphans and vulnerable children

**Table 5:** Overview of OVC reached with services provided in 2009 (reach in 2009 denoted in red font)

NS	OVC receiving RCRC services		OVC receiving food assistance		OVC receiving educational support		OVC receiving material support		OVC receiving psychosocial support		OVC reached by RCRC kids or youth clubs	
	JUNE	DEC	JUNE	DEC	JUNE	DEC	JUNE	DEC	JUNE	DEC	JUNE	DEC
ANG	590	1,499	590	590	413	-	512	-	580	712	-	-
	<b>1,499</b>		<b>590</b>		<b>413</b>		<b>512</b>		<b>712</b>		<b>-</b>	
BRCS	100	100	100	-	62	62	53	100	100	100	48	50
	<b>100</b>		<b>100</b>		<b>62</b>		<b>100</b>		<b>100</b>		<b>50</b>	
LESO	10,500	10,500	10,500	4,840	1,870	1,226	10,500	10,500	8,900	10,500	3,888	1,198
	<b>10,500</b>		<b>10,500</b>		<b>1,870</b>		<b>10,500</b>		<b>10,500</b>		<b>3,888</b>	
MRCS	8,041	10,304	3,275	3,275	428	428	2,356	5,211	8,041	1,236	2,718	3,007
	<b>10,304</b>		<b>3,275</b>		<b>428</b>		<b>5,211</b>		<b>8,041</b>		<b>3,007</b>	
CVM	6,545	4,431	1,900	700	1,942	3,252	588	3,165	388	4,315	335	-
	<b>6,545</b>		<b>1,900</b>		<b>3,252</b>		<b>3,165</b>		<b>4,315</b>		<b>335</b>	
NRCS	3,136	3,551	117	1,368	2,780	3,551	2,150	968	166	-	-	73
	<b>3,736</b>		<b>1,368</b>		<b>3,551</b>		<b>2,150</b>		<b>166</b>		<b>73</b>	
SARCS	15,072	16,117	2,350	6,529	1,299	1,299	3,389	6,764	4,222	10,496	3,467	5,760
	<b>16,117</b>		<b>6,529</b>		<b>1,299</b>		<b>6,764</b>		<b>10,496</b>		<b>5,760</b>	
BSRCS	1,804	1,051	390	409	643	632	7	11	154	90	100	100
	<b>1,804</b>		<b>409</b>		<b>643</b>		<b>11</b>		<b>154</b>		<b>100</b>	
ZRCS	560	-	-	-	-	-	-	-	-	-	-	-
	<b>560</b>		<b>-</b>		<b>-</b>		<b>-</b>		<b>-</b>		<b>-</b>	
ZimRCS	55,031	55,031	22,768	23,337	5,115	10,288	5,136	9,061	11,295	41,396	10,150	38,533
	<b>55,031</b>		<b>23,337</b>		<b>10,288</b>		<b>9,061</b>		<b>41,396</b>		<b>38,533</b>	
TOTAL	101,979	102,584	40,575	40,558	14,552	20,738	24,700	35,780	33,846	68,845	20,706	48,721
	<b>106,196</b>		<b>48,008</b>		<b>21,806</b>		<b>37,474</b>		<b>75,880</b>		<b>51,746</b>	

During the reporting period, eight NS continued to implement holistic support for OVC (educational, material, psychological, social and access to health) with varying degrees of success. Rather than expanding the numbers of children they reach, most of the NS are now concentrating on gradually including all the elements of holistic support and increasing quality rather than quantity. To be noted is the doubling of children receiving psychosocial support in comparison to 2008, a positive outcome of efforts undertaken by the OVC working group, NS and of our partnership with REPSSI. Thus the numbers of children supported throughout the year remained fairly constant. However, with the cuts in funding, some NS are already planning to reduce the number of children they support

Many of the programmes also include elements of support for the guardians of the children, most of whom are grandparents who are often frail and elderly and in need of assistance. Support to the guardians includes “grannies” clubs, psychosocial support – particularly through memory work, and small self support projects such as the goat rearing in Malawi. Zimbabwe Red Cross Society undertook an assessment of the situation of guardians of OVC in the first half of the year and the guardian/grannies clubs have now started.

The regional OVC working group met twice during the year. In April they took part in training on mainstreaming psychosocial support into paediatric ART (Anti Retroviral Therapy), provided by REPSSI. The second working group meeting was held in Malawi in October and topics discussed included integration of HIV with Health and Social Services (HSS), key messages for the access to paediatric ART campaign, indicators for psychosocial support, sustainability of OVC support in the face of diminishing donor funds, and the rapid HIV assessment held in each country in terms of future OVC support. In the face of diminishing funds greater emphasis will be put on increasing community and branch involvement in supporting children and in building the capacity and resilience of families.

Two members of the OVC working group were sponsored by the region to attend the First International Conference on Family Based Care for Children in Africa, held in Nairobi. The two working group members improved their knowledge on family based care through sharing information and experiences and the importance of strengthening family support and the role of the family in the children’s lives. They also learned more about the need to support older carers of OVC and the need for community structures like child care committees. They shared all that they learned with the other OVC working group members at their last meeting



OVC in Swaziland

on drafting a Child Protection Strategy and Guidelines for Implementation. The Strategy aims to promote awareness amongst Red Cross management, staff and volunteers of the need to protect children from abuse and exploitation by enabling them to recognise and respond appropriately to signs of child abuse or exploitation. The Strategy was endorsed by SARAWO at their annual meeting and finally endorsed by SAPRCS in January 2010. The OVC working group will be working on an implementation plan at its next meeting in April 2010.

The NS through the psychosocial support that they provide, help children build resilience in order to increase their ability to cope in a crisis, to face the difficulties in their lives and to “bounce back”. Some NS are collaborating directly with REPSSI on mainstreaming psychosocial support into their HIV and AIDS and other programmes. The zone also collaborated with REPSSI during this period on developing supplementary guidelines on mainstreaming psychosocial support into home based care.

The regional office, together with the OVC working group, has been working for some time

**Zimbabwe Red Cross Society** held a life skills camp for 54 children between 12 and 17 years from Zimbabwe and 2 children each from South Africa, Malawi and Botswana and one child from Lesotho. The children had the opportunity to learn to cope with their own difficulties and the challenges they face in life through experiential learning. They were trained on skills such as problem solving, decision making, and effective communication. The children also received psychosocial support to meet their emotional, social, mental and spiritual needs. During the camp, the children planned for the Children’s Conference which was held after the camp was finished. This is the first time there has been a Red Cross children’s conference and it was a great success. The activities at the conference were by the children and for the children. The contributions of the children through their songs, poems, dancing and presentations were very inspiring. This was true child participation at its best!

**Below are some notable highlights from NS on OVC support:**

- ⌘ Lesotho Red Cross with the support of SARO and a consultant produced a good practice on their care and support of children on paediatric ART. Through support from the Global Fund, OVC and their guardians were assisted in making keyhole gardens – 303 gardens have been constructed in six communities in Berea and Maseru, seeds have been distributed to 800 OVC households for growing beetroot, spinach, carrots and rape, garden tools were provided to 400 OVC households and 371 children received food parcels.

- ✘ Malawi Red Cross is addressing the issue of out of school youth, and children who have reached the age of 18. It is supporting 8 young people in tertiary education and 40 in vocational education for out of school youth. Vocational skills include carpentry, tailoring, bricklaying and tin smithery. 7 students are studying agriculture and natural resources for a diploma course and one is on a diploma course on environmental health.
- ✘ Namibia Red Cross started an after class project in Kunene region where children attend sessions on a variety of topics including academic and practical subjects. NRCS also produced a document on writing a will and another on information on available grants and community services

### Providing HBC:

The table below provides an overview of the reach or PLHIV supported under the CHBC component.

**Table 6:** Overview of PLHIV supported through CHBC related activities in 2009

Country	Number of HBC Projects			Number of PLHIV supported through CHBC			No. of care facilitators/ Volunteers			No. of PLHIV in Support groups		
	JUN	DEC	2009	JUN	DEC	2009	JUN	DEC	2009	JUN	DEC	2009
Angola	-	7	7	693	2,573	2,573	287	287	287	-	-	-
Botswana	1	2	2	131	135	135	113	113	113	95	95	95
Lesotho	7	5	7	4,127	1,835	4,127	322	172	322	2,487	1,028	2,487
Malawi	13	12	13	2,687	2,894	2,894	1,024	506	1,024	1,049	1,202	1,202
Mozambique	29	29	29	4,488	5,464	5,464	758	758	758	204	595	595
Namibia	7	7	7	6,122	6,720	6,720	2,765	2,765	2,765	3,240	3,240	3,240
South Africa	24	24	24	20,067	37,245	37,245	793	793	793	3,791	3,791	3,791
Swaziland	5	8	8	1,460	2,388	2,388	420	420	420	1,425	1,447	1,447
Zambia	2	0	2	1,415	-	1,415	20	-	20	-	-	-
Zimbabwe	27	27	27	19,560	19,560	19,560	1,453	1,475	1,475	8,094	8,094	8,094
<b>Total</b>	<b>115</b>	<b>121</b>	<b>126</b>	<b>60,750</b>	<b>78,815</b>	<b>82,521</b>	<b>7,955</b>	<b>7,289</b>	<b>7,977</b>	<b>20,385</b>	<b>19,492</b>	<b>20,951</b>

Source: National Society programme updates

There has been a marked increase of 36 percent in the number of PLHIV supported from 60,421 in 2008 to 82,521 in December 2009. The increase could be attributed to the wider utilization by NS of PMER tools which were rolled out in 2008 in some NS. South Africa more than doubled the number of clients from 2008 which is consistent with the scale of the epidemic. Another reason is that South Africa RC remains the only NS in the region with unearmarked funding which has enabled the NS to scale up and implement its HIV activities comprehensively and holistically. Angola is another country which has recorded a significant increase in the number of clients when compared to number of people reached in 2008.

Data from Malawi has shown an increase in the discharge of clients from the CHBC programme. Consequently MRCS increased its number of support groups from 24 to 28 in 2009, a sign that more people are getting better and leading normal healthy lives. This scenario emphasizes the need for the SARO together with NS to strengthen and invest more resources into the management of support groups. There is need to strengthen this component of programming and build the capacity of NS staff and volunteers in management of support groups to avert the loss of members as shown by the 40 percent decline between 2008 and 2009. A practical solution foreseen by SARAWO is to make Community based income generating activities more relevant to the economic needs of PLHIV and restructure the contents of the positive living programme.

The number of care facilitators has decreased compared to 2008. With the advent of ART, the ratio client/care facilitator has changed from 1 to 7 to 1 to 10 between 2008 and 2009 as the workload of care facilitator per client decreased. Also some projects were closed down in Lesotho, Mozambique, Zambia and Malawi. However the workload of care facilitators in supporting OVC remains relatively high.

In order to address the recommendations of the 2008 SARAWO meeting and in tandem with the WHO/UNAIDS approach on task shifting, the Zone embarked on a rapid assessment in Lesotho, Malawi, Mozambique, Namibia, South Africa and Swaziland to review the following:

- ✘ Assess the coverage of Antiretroviral treatment (ART) among clients/OVC in at least two selected programme sites per National Society;
- ✘ Assess how clients and OVC on treatment are faring in terms of well-being (physical, psychological, mobility, health and ability to perform daily chores);
- ✘ Assess the number of clients/OVC who still require care and support in the home;

- ✘ Identify and document the needs of clients/OVC on ART and compare with other chronically ill patients not on treatment;
- ✘ Establish the current inadequacies and refine the roles, responsibilities, and required skills of care facilitators in view of the roll out of ART; and assist in the formulation of CHBC minimum standards.

The team conducted visits in two districts in each country along with national level interviews with the National Society staff, health officials, National AIDS commissions and networks of people living with HIV (PLHIV). District level interviews were conducted with health facilities, community based organizations and district health offices and administrators. At project site level interviews were held with project officers, supervisors, HBC clients, family members, and community leaders to solicit their opinions along with focus group discussions with care facilitators and support group members. Observations were conducted among clients and transect walks (a methodology used to observe existing resources and challenges communities experience through observations) in the community revealed a number of issues.

The findings of the community care facilitators' task shifting study were presented and discussed at the 2009 SARAWO meeting. The following key issues were agreed upon for consideration;

- ✘ NS and their partners should view CHBC not business as usual because of the advent of ART in communities.
- ✘ Equipping care facilitators with new skills on adherence monitoring, treatment literacy and nutrition information for them to be able to advise clients and provide comprehensive services to the communities.
- ✘ Strengthening of support groups by developing guidelines
- ✘ Developing an adherence for all campaign
- ✘ Ensuring that the weaning criteria for adult clients and OVC are in place
- ✘ Strengthening of income generating activities for PLHIV, OVC.

SARO also brought on board a short-term consultant to support the development of the CHBC minimum standards, in order to guide the NS on level of quality of services expected of them. In addition, the standards guide volunteers on the minimum tasks taking into consideration the task shifting induced by the advent of ART in many countries.

As part of the process, country visits were conducted to South Africa and Swaziland to assess the current level of workload, specific tasks of volunteers and the prevailing situation with the HBC clients, CHBC minimum standards were presented for review and discussions at the SARAWO meeting in September 2009. Coordinators provided critical feedback, centred around;

- ✘ Refining the enrolment and discharge criteria of CHBC clients;
- ✘ Care facilitators training and content;
- ✘ Volunteer working hours in the context of mobile clients;
- ✘ Defining the grading of clients (bedridden, home bound and mobile);
- ✘ Clear definition of the roles and responsibilities of care facilitators in the context of ART roll out;
- ✘ Ensure OVC standards are in line with the recommendations of the OVC strategy;
- ✘ Ensure that care facilitators are multi-skilled in child counselling, PSS, communication with children;
- ✘ The need to strengthen family involvement and training family members;
- ✘ Strengthening of support groups.

Since then the CHBC minimum standards have been revised several times by national and field staff from South Africa, Lesotho and Swaziland Red Cross who met in Mbabane. The workshop was held to provide an opportunity for the field staff to review the document. At the same time the document was tested and used as a training of trainers' tool.

The evaluation of the workshop indicated that participants gained knowledge and skills after the training. The participants indicated that the document will greatly improve the way CHBC projects operate and it would provide more information, knowledge and skills to the care facilitators who work in HIV prevention, care, treatment and support. In addition the participants appreciated the integrated nature of the standards which include malaria, TB and other general health issues. In view of the integration of HIV under the broader HSS umbrella, participants indicated that the document would be an ideal tool to be used in conjunction with the CBHFA methodology.

Two more workshops are planned to take place in Namibia for five countries (Namibia, Zambia, Zimbabwe, Botswana and Malawi) and Mozambique (Angola and Mozambique) in 2010.

**Below are some highlights on CBHC activities:**

- ✘ While many NS have not developed exit strategies for CHBC projects, Lesotho Red Cross jointly with German Red Cross developed an exit strategy for Berea and Leribe projects. The two projects were funded through the European Union and the funding came to an end in June 2009. The National Society was able to put in place mechanisms to handover the beneficiaries and the volunteers to the local district health facilities. Notably;
  - the branches have assumed responsibility for monitoring the activities of the volunteers;
  - the volunteers were supported with income generating activities from which their incentives will be derived, and
  - the community structures were sensitized on their role in the ongoing implementation of the project after the funding of the project comes to an end.

As a result of the excellent work, a good practice DVD of the two projects was compiled and funded by SARO in partnership with the Lesotho and German RC Societies to highlight the experiences and lessons learnt.

- ✘ Mozambique Red Cross with support from the IFRC, introduced in January the training package on HIV prevention, treatment, care and support for NS national staff and then in July with support of VSO, SAFAIDS and WHO under the guidance and approval of MoH the package was launched to all stakeholders working in HIV. This training package brought a new dynamic to the quality of implementation of HIV prevention, treatment, care and support interventions. Volunteers have gained confidence to adequately support through home visits, household members' trainings. As a result of involvement of volunteers supporting and caring for patients in the training and with the expansion of ART services, the number of deaths and bedridden clients in need of intensive care has decreased.

The National Society is working to strengthen IGAs by implementing mainly activities in the area of farming and cattle breeding carried out by beneficiaries and these are: planting of fruit trees, cultivation of cereals and legumes, breeding of small animals such as ducks, goats, pigs and chickens, distribution of oxen for ploughing, cultivation of vegetables in PLHIV gardens and/or near their houses, installing of mills, construction of dams, wells, and improved barns, tanks for fish breeding, installation of small-scale irrigation systems and construction of adequate livestock facilities.

Another activity of utmost importance was the training and consolidation of self-support groups especially for PLHIV. This initiative is showing positive effects, but it is necessary that when creating these groups it is stressed that they have to manage their own self-support group while at the same time improving income generation activity on the short, medium or long term for the sustainability of the group and also for the economic empowerment of the group members.

- ✘ Malawi Red Cross supported 2,894 CHBC Clients in 2009 through 506 CHBC care facilitators (a reduction from 556 care facilitators after the temporary closure of Nkhotakota project). There has been a reduction of approximately 30 percent of CHBC clients assisted from 4,150 in 2008 to 2,894 in 2009. On analysis, 909 clients were discharged from the CHBC projects for various reasons. Most of the clients were referred to support groups and others became better and autonomous hence didn't require further support from the care facilitators.

There is an emerging phenomenon with regard to the numbers of clients being newly enrolled and discharged. There are more clients who are being discharged than the ones being enrolled, except in South Africa. This is a good trend in the sense that eventually there will be no new cases in the programme and it is a way of exiting from CHBC.

In Malawi, the mortality rate within CHBC projects reduced to 2.6 percent in 2009 from as high as 10 percent in 2007. The percentage of CHBC clients on ART remained high at 57 percent (1,610 HBC clients are on ART).

The scaling-up of ART in Malawi has resulted in the reduction of the number of people who are bedridden. Many of the clients who were previously very ill and bedridden are now mobile and leading normal lives. However, there is greater involvement of PLHIV in MRCS and the number of support groups increased from 24 in 2008 to 28 in 2009 with 1,202 members. MRCS has developed strong links with the national

network of PLHIV focusing on capacity building for the support groups and ensuring that they are registered as community based organisations.

## Challenges

- ✘ The lack of funding to train care facilitators on treatment literacy in all the countries remains a stumbling block from ensuring quality service provision. Defaulting is beginning to be seen in many communities especially where Red Cross volunteers are not operational.
- ✘ Support groups in many project sites are not active and are not trained. Income Generating Activities (IGAs) are also not working effectively where they are operational. SARO is currently finalising user friendly guidelines on IGA expected to help NS greatly improve on the management of IGAs. In 2010 support group guidelines will be developed to help NS in the implementation of their activities related to support groups.
- ✘ The lack of minimum standards in care treatment and support has affected the provision of quality care for CHBC clients. The development and dissemination of the minimum standards is expected to help NS refine their CHBC interventions.
- ✘ The greatest challenge for 2010 will be to find ways to continue to support the children when external donor funding is diminishing. The OVC working group is looking at ways to face this challenge including greater involvement of communities and branches in the programme and building the capacity and resilience of families. It is likely that with decreased funding, support for children's education will have to be cut and yet education is vital for the future of these vulnerable children.
- ✘ It is critical that NS determine their exit and hand over strategies in line with the end of the funding cycle.
- ✘ The volatile economic situation in Zimbabwe continues to impact on programme implementation. For instance the government policy on school fees has continuously been shifting since the introduction of the multi currency economy resulting in large discrepancies in the school fees structure from one location to the other, rendering the planning and budgeting process futile. The NS is looking into other payment methods such as "block granting" in lieu of cash payment for school fees.

## 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 sexual gender-based violence (SGBV);
- Peer education, community mobilization, and population-based information, education and communication.

### Achievements

#### Promoting support groups:

Support groups are an effective sure way to support clients who are being discharged from the CHBC programme. At the September SARAWO meeting and from the recommendations of the rapid assessment on task shifting of care facilitators, it was agreed that there is need to develop support group guidelines to orient staff and volunteers on the management of support groups. In collaboration with networks of people living with HIV in the region, guidelines will be developed in 2010. The main emphasis will be on the implementation of quality activities within the support groups and ensuring that the staff and volunteers have necessary skills to manage the support groups. The need to empower the members of support groups will be mainstreamed into the guidelines to augment the relevance and efficiency of CBIGA projects. Some NS will be used as models for replication in other NS.

Malawi is leading the way in this approach. CHBC clients in Malawi who are getting better are being discharged to support groups. The support group members meet twice in a week to discuss coping mechanisms; and engage in income generating activities in order to empower themselves economically. Funding will be required to roll out both the support group and CBIGA (Community based income generating activities) guidelines in 2010 and beyond. Strengthening support groups and CBIGAs is the best way forward to sustainability for CHBC and OVC support in the region.

In Botswana 176 PLHIV were reached through the support group in Kasane. There is also a support group in Dukwi camp which has about 45 members of the support group who were engaged in livelihood projects in this last half of the year. They were trained on leather work and fabric printing and the group has started producing

and making sales. The group showcased their work at the commemoration of the World AIDS Day in the refugee camp in December 2009.

In Lesotho a workshop was held in Mafeteng for 60 members of support groups of PLHIV in July 2009. It included IGA establishment, expectations, roles and responsibilities of members of the support groups and memory work. In order for clients to take their medication properly, Lesotho Red Cross is also ensuring that they engage in livelihood activities including food security through keyhole gardens or backyard gardens where they are able to grow vegetables. So far 1774 clients received livelihood support. Many of the beneficiaries are members of support groups.

#### **HIV workplace policy and programmes:**

The NS made steady progress in implementing HIV and AIDS Workplace Policies mostly by disseminating existing policies to staff and volunteers at branch levels. Despite a lack of financial commitment for long term support of the workplace initiatives, the 18 Masambo Fund applications previously made by the Mozambique Red Cross were approved and funds disbursed for the first time in the region an encouraging demonstration of the relevance of the Fund when a NS manages to break the silence surrounding HIV infection amongst staff and volunteers.

A total of 37 new applications to the Fund for staff and volunteers were made by Malawi, Zimbabwe, Swaziland and Mozambique Red Cross during the reporting period - an encouraging sign of openness within NS.

**Table 7:** Overview of the overall National Society staff involved in workplace programmes in 2009:

Country	Full time staff			Staff participating in workplace programme		
	JUN	DEC	2009	JUN	DEC	2009
Angola	154	154	154	44	12	44
Botswana	72	72	72	7	8	8
Lesotho	74	38	74	50	-	50
Malawi	106	85	106	106	-	106
Mozambique	291	291	291	24	53	53
Namibia	678	678	678	-	-	-
South Africa	400	400	400	400	17	400
Swaziland	90	90	90	88	-	88
Zambia	170	170	170	8	-	8
Zimbabwe	185	170	185	162	-	162
<b>Total</b>	<b>2,220</b>	<b>2,148</b>	<b>2,220</b>	<b>889</b>	<b>90</b>	<b>919</b>

#### **Reducing gender inequalities and tackling sexual and gender based violence (GBV):**

In January 2009, a joint study IFRC (SARO and Geneva Secretariat) was commissioned to;

- ✘ assess the current level of the IFRC's capacities to respond to gender-based violence (GBV)-related issues in the southern Africa region; and
- ✘ to prepare a regional strategy on GBV to enable NS to improve their effectiveness in fighting both HIV and GBV.

The assessment which essentially took place in Malawi and South Africa revealed that, despite some commendable efforts put in place to better integrate GBV issues in the Global Alliance on HIV framework since its inception in 2006, understanding of GBV has remained limited within the region.

Similarly, the programming and implementation capacity on the side of NS was delayed and resulted in very few initiatives. The assessment confirmed the importance of integrating GBV into the regional HIV programme in order to achieve its overall objectives.

In collaboration with external stakeholders, Geneva Secretariat, SARO and the NS finalised a strategy to prevent and respond to GBV in the southern Africa following a consultation and training on GBV after the Global Alliance on HIV annual review meeting held in April 2009. Based on the inevitable link between GBV and HIV infection rates, the purpose of this strategy is to:

- a) Provide a clear framework for the integration of interventions against GBV into HIV programmes currently implemented by NS across southern Africa;
- b) Outline concrete interventions to mainstream GBV issues in all IFRC's programmes.

Based on the framework and the concrete interventions, the strategy is intended to outline IFRC's contribution to:

- a) Reduce the number of GBV acts in the communities where Red Cross NS in southern Africa are operating;
- b) Contribute to a reduction of HIV infection rates; and
- c) Ensure the provision of adequate and timely response to the needs of GBV survivors.

A number of priority areas have been identified to strengthen the work of NS in the region:

- ✘ *Capacity building of staff and volunteers*, to enhance understanding of GBV across the region and strengthen NS capacity to address it fully and more comprehensively in their programming.
- ✘ *Partnering with men*, to ensure active engagement of men and boys as equal partners in the fight against GBV through the promotion of positive attitudinal and behavioural changes as a means to address the social and cultural factors that perpetuate GBV.
- ✘ *Advocacy and communication* at all levels to convey a clear message that GBV is a violation of human rights and against the Red Cross's Fundamental Principles and humanitarian values. Furthermore, advocacy and communication will contribute to increase the visibility of IFRC and NS and their role as key players in preventing and responding to GBV at different levels and across sectors.
- ✘ *Partnership and coordination*, to encourage information sharing and more collaborative efforts on GBV and to capitalize on the NS strengths in community mobilization and provision of services at the community level.
- ✘ *GBV Integration and Mainstreaming*, to ensure that GBV issues and concerns are taken into account throughout the project cycle from analysis and planning, to implementation, monitoring and evaluation of programmes.

This strategy also outlines a series of key actions that should guide activities by NS under each priority area.

- ✘ Botswana, Malawi, Zambia and Zimbabwe submitted GBV plans of action for the second half of the year as a follow up to the GBV strategy design workshop but these plans have not been fully funded yet as earmarked funding to implement this strategy from the RNE has been withheld since July 2009.
- ✘ Due to limited resources, effort has been placed on capacity building of staff and volunteers as well as on advocacy and communication at all levels to convey a clear message that GBV is a violation of human rights and against the Red Cross's Fundamental Principles and Humanitarian Values. South African, Malawi and Botswana Red Cross were involved in the 16 days of activism against GBV in December 2009.
- ✘ SARO in the context of the rolling-out the sexual and reproductive health and life skills for youth peer education contributed to the training of more than 200 trainers with a module on GBV and substance abuse.

**The following are some notable NS highlights:**

- ✘ In Lesotho, weak social support may represent a significant barrier to treatment adherence for many HIV infected patients. Support groups may help build support networks favourable to adherence. Currently there are 1,028 PLHIV who are participating in 46 support groups. A workshop was held in Mafeteng for 60 members of support groups of PLHIV in July 2009. It included IGA establishment, expectations, roles and responsibilities of members of the support groups and memory work.
- ✘ Baphalali Swaziland Red Cross has established 32 networks of PLHIV with 25 support groups with a membership of 1,447 people. In the fourth quarter, the NS also



Choir festival – South African Red Cross in 2009

trained 35 staff members and 45 volunteers on GBV. The training was facilitated by facilitators from Swaziland Action Against Abuse (SWAGAA), Royal Swaziland Police (RSP), Save the children, and Red Cross.

- ✘ Zimbabwe Red Cross through the HIV and AIDS prevention programme spearheaded the training and support of 102 Ambassadors of Hope who have been sensitising communities on reducing stigma while working with PLHIV to accept their status. GBV, anti stigma and discrimination topics are included in the peer education training manual and a total of 49 peer educators were trained also in GBV as change agents.
- ✘ Namibia Red Cross trained 60 volunteers on gender based violence in Oshikoto and Kunene regions. A total of 30 staff members and volunteer were trained as Ambassadors of Hope, the trained volunteers will then take lead in promoting positive living in their communities. In Caprivi region, the Tusano programme facilitates/encourages clients testing positive at the centre to join support groups. Support group members come together for group counselling (20 weeks' sessions) once per week.
- ✘ The South African Red Cross held its annual Choir festival as a psychosocial support initiative for staff and volunteers of the programme. The 2009 Choir Festival was held from 4-8 December at the Metropolitan University in Port Elizabeth. A total of 630 caregivers and staff participated in the festival including South Africa Red Cross governing board members, project officers and provincial staff members. The event is not only an opportunity for volunteers to get together, share experiences, display their talents, raise awareness on HIV, TB and other related illnesses. It also enables interaction with governance and management of the NS - a critical and necessary link especially for a NS of such size and scope.

## Challenges

- ✘ With the development of the regional GBV strategy, NS as noted above are ready to engage further and implement their actions plans. GBV interventions however require active sectorial collaboration (health, social services, police, judiciary, other support services...) and sustained funding. The uncertainty of funding makes it difficult for NS to further engage in such initiatives.
- ✘ Implementation of the GBV strategy continues to be a challenge in many NS. Efforts will be applied in 2010 to assist NS implement their planned activities in tackling GBV at community level should the funding be released by the RNE.
- ✘ Support groups continue to have challenges in implementation due to lack of guidelines. In 2010 the guidelines will be developed to address this challenge. Many support groups lack funding to start community based income generating activities. With the increased number of clients being discharged to support groups, there is need to strengthen both support groups and CBIGAs to ensure coherent support to the clients in support groups.
- ✘ Funding for training trainers on support groups and CBIGA is a challenge. NS staff and project officers are not trained on how to run support groups as a result the knowledge and skills are not cascaded down to the care facilitators and supervisors who are to the management of support groups. More funding is required for this component in order to sustain the ongoing activities in care treatment and support.
- ✘ There is minimal linkage with networks of PLHIV. NS and the regional office will strengthen relationships with the regional network of people living with HIV and national networks.
- ✘ While the interest and need among NS to apply to the Masambo Fund has been heightened and more applications are being submitted, there is a challenge of availability of funding for new candidates at Geneva level. This situation might affect the motivation of NS to encourage more volunteers to apply to the Fund. Aggressive fundraising efforts should be applied in order to mobilize more funds for the Masambo fund at Geneva level.

**Success stories in addressing stigma and discrimination:**  
**Examples from Malawi Red Cross Society (MRCS)**

MRCS has been leading in the implementation of varied approaches to address stigma and discrimination:

**Increased of PLHIV support groups from 24 in 2008 to 28 in 2009:** Since 2003, MRCS has been working with Malawi Network of People Living with HIV (MANET+) in order to establish, train and support networks of PLHIV. MRCS is supporting 28 PLHIV support groups with 1,202 members from 24 support groups with 1,474 members in 2008. In 2009, MRCS supported the PLHIV support groups by organizing training and supplies. Eight support groups were trained in positive living in three districts (Chiradzulu 5, Balaka 1, and Karonga 2). Topics covered include positive prevention including PMTCT and ART adherence, usage and cultivation of herbs for immunity boosting. The support groups were also supported to set up herbal/medicinal herbs gardens using herbs like ginger, garlic, aloe Vera etc.

Five PLHIV support groups in Chiradzulu received treadle pumps. Again, in Chiradzulu Support groups were also trained in making energy serving/conservation stoves as income generating activity. Another notable achievement was that Chiradzulu PLHIV support groups through Icelandic Red Cross sold Red Ribbons to people of Iceland. A total of MK 460,000 was realised was used to support PLHIV outreach activity and for herbal gardens.

**Increased number people reached (96,500) with anti-stigma campaigns (336) by PLHIV themselves:** Though membership has decreased, the number of support groups has increased and the most encouraging is that a few members conducted 336 outreaches in communities reaching an estimated 96,500 people with anti-stigma messages.

**Increased number of PLHIV (60 percent) attaining semi autonomy:** In collaboration with MANET+, the NS has successfully facilitated the registration of support groups as autonomous registered Community Based Organizations (CBO) independent enough to seek technical and financial support from other partners through the national decentralization process where funding for CBOs can be obtained at district level. Over the years 60 percent of the PLHIV support groups have accessed funding at the local level from National AIDS Commission, Action AID and other partners.

**MRCS has scaled up interventions that addresses gender inequalities**

MRCS has also scaled up interventions that address GBV and child abuse. Information has been provided through 160 anti GBV campaigns reaching 640,000 people. There was Greater Involvement of Partners and chiefs in prevention of GBV campaigns. There is also improved girl empowerment through the introduction of the girl unit concept in Chiradzulu and Mwanza. The project aims to empower the girls to be self assertive, improve their self esteem, make effective decisions and address many of the problems facing them. There are 24 girl groups with a membership of 362. A total of 42 trained girl leaders are supporting the girl groups.

**Greater involvement of partners and chiefs in prevention of gender based violence campaigns:** All campaigns were attended by district commissioners, officials from Ministry of Gender, child and community development, police and NGOs. The proposal to Swedish Red Cross for the piloting of a Young Men as Equal Partners (YMEP) project in partnership with the Swedish Reproductive Health Association (RFSU) has been successful and implementation is expected to start in 2010. The initiative proposes to increase adoption of gender sensitive safer sexual practices amongst males aged 10-24 years.

IFRC (SARO) together with MRCS and in the context of the Movement wide "Our world, Your move" campaign, produced a DVD on GBV in Dzaleka refugee camp, titled "Let's talk about it" - featuring the real life story of refugee women affected by GBV and the

## National Society Capacity Building

### Key strategies:

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

### Achievements

#### Planning/Rapid Assessment:

At the June 2009 Southern Africa Partnership of Red Cross Societies (SAPRCS) meeting, the SARO presented the possible scenarios on the future of the programme in 2010 and beyond- each with implications for the beneficiaries, volunteers and staff members, the NS and the Movement in general. The following scenarios were presented and discussed at length:

- ✘ **The review and scale-down of current appeal MAA63003 and integration under Health and Care:** revision of the geographical scope of the programme, the scaling down/handing over of beneficiary case loads, and adjustment of the collective resource mobilization intentions after 2010. The platforms

developed over the past ten years (human resources, volunteers and systems) would be useful when integrating HIV with other health and care activities and resource mobilisation.

- ✘ **The maintenance of current operation levels under appeal MAA63003 and integration under Health and Care:** revision of the geographical scope of the programme, and the scaling down of *appeal* and beneficiary *targets*. Aggressive and sustained fundraising by all is needed, with all NS in Southern Africa at the forefront in order to maintain the current levels of programming; and
- ✘ **The extension of the current appeal MAA63003:** this course of action would allow all partners to continue with the shared ambition of scaling up HIV interventions beyond 2010; also demanding significantly improved resource mobilization capacities by all partners.

Following the meeting, all NS requested a rapid assessment to be conducted in each country allowing each NS to determine for itself the most relevant scenario. While HIV remains a priority for all, the NS agreed that the current appeal targets are ambitious and that it is not an option to continue at the current scale and scope - hence they opted to drop the proposed third scenario.

The HIV and AIDS SARO team assisted the NS to conduct the rapid assessment in all ten countries and the following are the key decisions taken:

The NS predominantly opted for a combination of proposed scenario 1 and 2: “**Scaling-down and handing over beneficiaries in some project sites, while maintaining in others with the aim of providing integrated and comprehensive services**”.

- ✘ Scale down CHBC beneficiary size by establishing and applying client discharge criteria in some project sites while maintaining them in others.
- ✘ With the changing architecture of CHBC, scale down some components of CHBC like the basic nursing care, material distribution, food distribution and maintain PSS, support groups, livelihood promotion, adherence monitoring.
- ✘ Establish graduation criteria for OVC. Aim for comprehensive service in fewer project sites
- ✘ Review geographic scope and potential reduction of project sites
- ✘ Strengthen/expand prevention activities
- ✘ Use established structures (human, volunteers, branches, equipment etc...) to integrate other key Health and Care activities.
- ✘ Potential review of human resources structure in line with size and scope of future interventions.

The findings from the rapid assessment formed the key parameters for the midterm review and the discussion points for planning and strategizing beyond 2010.

Following the rapid assessment, NS embarked on the operational planning exercise for 2010. By the end of the year, eight NS had submitted their second draft operational plan. The exercise in 2010 is further complicated by the need for NS to include their transition plans as the appeal is coming to an end in 2010. It has however become evident that NS need further guidance and support in ensuring key transition activities are planned and budgeted for.

### **Monitoring and Reporting:**

The senior PMER officer also undertook a critical monitoring visit to Malawi. The main objective of the mission was to review the planning, monitoring, evaluation and reporting (PMER) tools developed and used for HIV and AIDS programme, to assess effectiveness in performance tracking and measurement. Specifically the review was carried out to determine whether the performance tracking and reporting tools were:

- ✘ User friendly for effective data collection;
- ✘ A means for measuring and quantifying programme achievements;
- ✘ Consistent with the Global Alliance on HIV reporting framework;
- ✘ Ensuring collation and quantifying of data in line with the Global Alliance on HIV performance tracking indicators;
- ✘ Accurately tracking programme performance and measuring results;
- ✘ Generating reports for programme management and accountability to beneficiaries and partners.

The review was carried out in Malawi from 26 to 31 October 2009. The methodology included two field visits, key informant interviews with HBC clients, care facilitators, peer educators, coaches/supervisors and district staff at selected project sites. Meetings were also held with key technical stakeholders, including HIV and AIDS coordinator, OVC officer, prevention officer, PMER manager and programme director.

## **Results of the HIV and AIDS Programme rapid assessment (July – October 2009)**

The mapping exercise further revealed:

**HIV flagship intervention:** HIV remains the single largest, consistent and long term programme for the NS. Other programmes coverage remains low, short term, and in some instances ad hoc with little or no overlap with HIV activities/sites. Other interventions have in the past used the platform and structures established by the HIV programme to deliver services.

**Geographic spread vs. depth and quality:** The NS are geographically spread, heavily impacting on the NS ability to provide the full spectrum and comprehensive prevention/stigma and discrimination, and care and support services. With the geographic spread, NS are not always able to effectively manage staff and volunteers. Although in many instances the NS remain the only entity providing life saving interventions in those areas, it is important that NS closely review the geographic spread, and establish: a) existing and future community/individual needs, b) financial sustainability of interventions, c) sustainability of volunteer and staff management practices.

**Volunteer management practices:** Some NS are managing several layers of volunteers impacting on the effective management of the very structure required to deliver services. For instance Namibia Red Cross followed the South African Red Cross model and manages three layers of volunteers: coaches/supervisors, care facilitators, and care providers. The care providers are at the front line and provide direct service to the clients. They do not receive any allowance and are expected to be trained by the care facilitators. The 2009 Global Alliance Review in Namibia noted that the quality of service at the care providers' level is compromised and needs to be revisited. The review also noted the need to revisit the incentive package and skills building practices.

Volunteers are not always integrated across interventions within the HIV programme and among HIV and other programmes. The volunteer/client ratio is not always necessarily justifiable and sustainable: although the recommended ratio is 10/1, in some instances volunteers are supporting less than five clients at any one time. However most of them are supporting large numbers of OVC. It is critical that NS address volunteer recruitment, training, and management practices with the aim of standardizing across all programmes.

**Entry and exit strategies:** The mapping exercise highlighted the need for better coordination (among programmes) and better definition of programme/project/activity/ site/and beneficiary selection criteria. Overall the rapid assessment exercise also highlighted the need for improved coordination and definition of exit /withdrawal strategies from project sites with internal and external stakeholders and among programmes. The client/beneficiary (CHBC clients and OVC) weaning/graduation criteria and process is also not always well defined at the onset or nonexistent in some instances.

**Working beyond the Movement silo:** during the mapping exercise and with the difficulty NS had identifying the stakeholders operating in the same sites where they are operating, it became evident that NS are not always aware of and coordinating with other partners- a critical area that needs to be urgently addressed if NS are to remain assertive in the increasingly competitive scenario of HIV programming and funding.

The mapping also gave emphasis to the following key challenges: a) NS accessing Global Fund have found the funds to be earmarked and limited to direct programme activities with little contribution towards the operations and management cost of the NS. The geographic spread of NS makes coverage of NS core costs even more difficult, not to mention the financial management and reporting; b) other bilateral support from PNS has been earmarked, with strict and differing reporting requirements, with no predefined exit strategies

**Data collection, data management, and data flow:** in many instances key staff did not have the relevant information on beneficiaries and volunteers readily available. Only three NS had 90 percent of the mapping completed by the time the IFRC facilitators left the country. It is important to note that data management is not the sole responsibility of the PMER officer but all management staff. Managers at all levels (provincial/branch project officers, national level managers including finance staff) need to ensure that they have this critical information on beneficiaries and volunteers readily available and regularly updated-a prerequisite for any effective project/programme management.

The review concluded that the national PMER system used by the MRCS is successful in achieving its objectives, and facilitates important aspects of the NS response to HIV in terms of performance tracking, measurement and accountability. Some basic changes in the data collection tools and system would facilitate more effective long-term assessment of the HIV and AIDS programme. As the number of programme areas and beneficiaries continues to expand, the current manual paper-based system may also be overwhelming- there is an urgent need to identify and implement a feasible electronic data system that would maintain and improve data quality and the efficiency of data recording and reporting; and further enhance effective programme management.

The review also noted the need for continued training for existing and new volunteers and provision of on-going support to improve data quality. Whilst the current PMER tools were reported to be easy to use and effective, the proposed integration of HIV and AIDS with Health and Care should aim to use a minimum number of tools so as not to over burden the volunteers.

The discussion on integrating HIV with other Health activities also justifies the need for cost sharing PMER related expenses across programmes to ensure that the PMER system has adequate funding that guarantees sustainability.

Namibia Red Cross trained 25 staff members and volunteers in advanced project cycle management and report writing. The NS also held a volunteer management workshop for two days at the NS headquarters with all volunteer managers across the country. The workshop focused on the volunteer management cycle including recruitment and retention as these are the critical topics for the NS.

#### **Baseline studies:**

With SARO technical support and funding, two additional NS embarked on an integrated HIV, health and food security baseline survey in the first half of 2009. Data collection, analysis, and reporting have since been finalized.

#### **Global Alliance on HIV Review:**

The review meeting was held in Johannesburg in April 2009 followed by a three day consultative meeting on the finalisation of the regional GBV strategy described above. The Global Alliance review meeting addressed key areas such as the overall reach vs. the established targets, the resource mobilization capacity of NS vs. the downward funding trend and competitive environment; and the specific challenges with programme implementations, best practices and lessons learnt were shared among participants. Some of the key decisions are noted below.<sup>2</sup>

- ✘ *Output 4* is consistently inflated as all management cost of the HIV programme including PMER, capacity building of staff; volunteer management, salaries, and office operations/management are currently all reflected under *Output 4*. This usually discourages existing and potential new donors. The IFRC Southern Africa will be looking at streamlining the structure of *Output 4* by distributing some management costs directly under the various programme outputs in subsequent operational plan guidelines.
- ✘ It was noted that the ten percent contribution towards NS core cost comes from the Ouagadougou declaration of 2000. There is a need however for consistent application of the allocation and disbursement practices not only for funds coming through the IFRC but also funds received bilaterally from other PNS. It was noted that senior management (finance and organisational development units included) in close consultation with other donors and NS management need to develop and disseminate a guideline on: identifying/isolating budgeting of core cost; allocation of core cost across different programmes and funding sources; and expensing and/or invoicing for core cost.
- ✘ It was also observed that salary of support staff (human resources, logistics, and administration) should not be regarded as an HIV and AIDS programme, as is primarily the case in current operational plans. The NS should ensure equitable distribution of such costs across all funding sources and programmes. It is important that senior management of the Societies are also involved in this planning process and have a good understanding and appreciation of the funding situation and distribution of the support cost.

The annual Global Alliance on HIV review meeting follows the country specific review held in Namibia in February 2009. The review revealed some notable successes and challenges with the programme implementation in Namibia.

#### **Evaluation/Mid Term Review:**

Following the country specific midterm review of Zimbabwe Red Cross' integrated HIV and AIDS programme and ART for PLHIV in early 2009; the SARO HIV team developed the regional midterm review terms of reference in consultation with its stakeholders (management, donors, NS). The midterm review unlike traditional quantitative assessments will focus on seven core areas including:

- ✘ A financial cost analysis to determine if the programme has been cost effective in pursuing its goal and objectives.
- ✘ A review of programme PMER systems to see whether it contributed in building NS capacities to plan, implement, track performance and manage the programme.
- ✘ A critical review of the volunteer recruitment, management and retention systems established,
- ✘ Review the progress made by partners in using Global Alliance principles and see whether it benefited NS in terms of mobilization of capacity and resources.
- ✘ Review the relevance, effectiveness and comprehensiveness of the regional integrated strategy with partners.

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<sup>2</sup> The full Global Alliance Review meeting report is available upon request from the IFRC Southern Africa HIV and AIDS team

- ✘ Review the extent to which NS have benefitted from regional programming and technical support as well as of the tools developed to support the implementation of the various strategies.
- ✘ Review measures put in place by the zone, PNS and NS to ensure sustainability of the programme beyond 2011.

The focus on the above areas is intended to further support NS and the IFRC refine the operational, management, resource mobilization efforts of programming in 2011 and beyond. By the end of 2009 and after an extensive competitive process, a team of consultants was put in place to immediately start the process in early 2010.

**Financial management and finance development:**

Nine out of ten NS in the region received intensive training on Navision operating systems and only seven out of ten are fully utilising the system. The final phase of reports development has been completed and piloted in the Namibia Red Cross before a full roll-out.

In 2008 six NS getting had Unqualified Audits and five of them having been audited using Navision. There were marked improvement in South Africa Red Cross, whilst Lesotho Red Cross recruited a new head of finance; it is anticipated that there will be positive audit results for the 2009 financial year.

None of the NS has so far met the requirements to and convert to a Cash Transfer System with the exception of the Mozambique Red Cross, which manages a Cash Transfer system already. However, with the improved internal financial controls in 2010, more than one NS could achieve a Cash Transfer.

Nine out of ten NS in the region have some form of core costs budgets in place. However, this has not translated into a finance resource mobilization plan to cover part or all of the core costs from own incomes on a sustainable basis. Four NS (Namibia, Mozambique, South Africa and Swaziland) achieved a core cost assessment methodology with a view to developing a sustainability plan. The Swaziland Red Cross undertaken a detailed analysis of the core cost as part of the Recovery Plan of the Society

Mozambique Red Cross was supported on systems customisation. This exercise revealed problems with the IT support system in the NS. An IT consultant was to install anti-viruses on 50 computers, install a sperm web to scan all emails coming and going out of the NS and to set-up access control on directors' folders including those of the SG. The Spanish/Danish RC supported IT project in Angola Red Cross, which started in December 2008 and extended to the end of February 2009 which facilitated completion of some outstanding activities such as the installation of the server. Malawi Red Cross was also supported with a customised Navision system which has helped the Society to produced unqualified audit for 2008 year end.

Namibia Red Cross is going through some serious financial difficulties as a result of an administrative support budget, which was withdrawn by the Ministry of Health. Zambia Red Cross continued its efforts to clear its financial situation as the NS is under high pressure to solve urgent pressing need of cash while continuing to implement the activities. The practice of account inter-borrowing has reached its extreme limits as well as the working advance system which blocks itself if 75 percent of returns are not booked and validated. The SARO office has made unprecedented efforts to assist the NS in clearing its working advance.

**Volunteer management:** A total of 8,115 volunteers were active during 2009 with an estimated 860,190 hours mobilised contributed to the success of the programme. During the rapid assessment, all NS have highlighted the need to closely look at their volunteer management practices (recruitment, training, retention, monitoring, support etc..) with the aim of standardizing these practices across all programmes. The OD team at the regional level has a critical role to play in this area in collaboration with all programmes and NS management.

**Human resources management:** Staff turnover continued at all levels in 2009. At the regional level, three local staff resigned and/or contract was not renewed; putting more responsibilities on existing staff at SARO. The staff turnover within NS was exacerbated in 2009 with Angola, Botswana, Namibia, Lesotho, Mozambique, South Africa, Swaziland, Zimbabwe, and Zambia losing their programme coordinators, finance officers, and/or PMER officers at provincial or national levels. The turnover will inevitably have an impact on quality and progress of implementation.

**Branch capacity development and ownership:** During the rapid assessment, it became even more evident that despite the investment the HIV programme has made to build the NS capacity in various areas, there is a disconnect between NS headquarters structures and branch capacity. It is critical that branch structures are actively supported and engaged in the programme planning, implementation, monitoring including financial and human resources (staff and volunteers) management. The NS branches at community level are the foundation for community ownership and sustainability of the interventions, and clear roles and responsibilities should be established with national and branch structures and staff. It is important that the IFRC Organizational Development Unit in collaboration with programmes provides technical support in this area. The current model applied under the [Zambezi River Basin Initiative](#) where branch capacity development has been prioritized prior to the roll out of the programme activities should be well documented and lessons learnt should be applied in the programme beyond 2010.

**SARAWO 2009:** The 2009 SARAWO meeting was held in Johannesburg from September 28th, 2009 to September 29th, 2009. The participants reviewed the achievements since the last meeting held in June 2008 and further agreed on some key action points for follow up. Some highlights are noted below:

- ✘ The final submission of feedback and inputs to the regional advocacy strategy and IGA guidelines;
- ✘ The submission of feedback and inputs to the CHBC minimum standards;
- ✘ The submission of final feedback and input to the Child Protection Strategy and endorsement of the Strategy by SARWO. It will be presented to SARPCS for endorsement at their first meeting in 2010;
- ✘ The finalization of each NS transition plan taking into consideration the discussions and decisions made during the rapid assessment exercise; and
- ✘ Agreement on a region wide advocacy campaign on access to paediatric ART

**Resource mobilization:** In recognition of a key shift in donor trends the IFRC has teamed-up with the UNAIDS based Southern Africa Technical Support Facility to deploy technical consultants to NS pursuing local funding opportunities. Botswana and Mozambique Red Cross benefitted from this support and submitted applications to their local AIDS Council or Ministry of Health. Mozambique Red Cross was successful in its submission and has been awarded USD 1 million towards community based TB interventions.

A consultant to assist Mozambique Red Cross to develop a CHBC proposal submission to the Ministry of Health was deployed towards the end of the year.

During 2009, the HIV team held extensive discussions with one of the major donors to the programme, the Royal Netherlands Embassy in an effort to facilitate the final commitment from the Embassy for 2009 and 2010. By December 30, 2009, except for South Africa RC, no funds have been released to the IFRC since mid 2009 putting the SARO and its partners in a critical cash flow situation.

### Challenges

- ✘ The uncertainty of additional funding and the delay of one of the major donors in disbursing funds for 2009 and 2010 has had negative implications for planning and implementation of the programme activities including transition plans. There is a need to urgently map out the future of the programme and structure beyond 2010 and establish concrete plans for diversifying the donor base particularly at local level tapping into Government and corporate sources.
- ✘ As of April 16, 2010 and the posting of this annual report, no funds have been released to the IFRC since mid 2009 from the RNE. Should any funds be disbursed in the later part of 2010, the operational capacities of the IFRC and the NS will undoubtedly be stretched as they rush to spend the funds by December 31, 2010 as stipulated in the contractual agreement between the RNE and the IFRC.
- ✘ The IFRC has embarked on a continent wide restructuring in mid 2009. New IFRC SARO management was announced and expected to take office in early 2010. The restructuring coupled with the reduction in funding has had some impact on the existing team structure. With any restructuring, business operations can be affected and this will have an impact on day to day management and implementation at SARO level.

## Working in partnership

The NS continue to partner with local, regional and international partners in the implementation of their HIV and AIDS and related Health interventions. For instance, in Namibia, the Ministry of Health and Social Services remains the primary partner to the NS. The NS actively participates in national level technical committees on both HIV and TB.

Malawi Red Cross continues to work in partnership with the Ministry of Women and Child Development, UNICEF, the Police Service, Plan International, and the Judiciary on the implementation of the community Victim Support Unit for women and children and developed closer relationship with the national AIDS control programme which awarded the NS with a grant on Prevention. Many NS in the region are active members of the national bodies and task forces including: OVC task force, National Child Care Coordinating Committee, HBC task force, and early childhood development taskforce.

The IFRC is a member of the RIATT (Regional Inter Agency Task Team) on children and a member of the RIATT working group on "Strengthening families and communities as units of care". The working group's topic for the focus for this year is on inter-generational issues- especially older carers looking after teenage children including the difficulties that older carers often face in relation to children in their care who are on ART. A concept note was developed identifying key inter-generational issues from the perspective of both the older carers and the children, in the context of HIV and AIDS. A study is underway on what programmes are currently in place, what is working and not working, how to scale up and replicate and fill the gaps. Focus group discussions have been held with older carers, and discussions with children will follow.

Zimbabwe Red Cross also had discussions in this context, with HelpAge Zimbabwe. The study will also include reviewing existing tools and if necessary, developing new tools. It fits well with the Red Cross emphasis on supporting grandparents/guardians and the planned joint development with REPSSI, on a manual on "grannies clubs" which will be developed in 2010. In 2009, IFRC collaborated in jointly writing, with REPSSI, the manual on "Mainstreaming Psychosocial Care and Support into Home Based Care Programmes". The SARO team regularly participate in the SADC/UNAIDS partnership meetings. The HIV coordinator is the chair of the inter agency working group on HIV in emergencies which open doors for NS for closer cooperation with the UN System on HIV prevention, care and treatment in times of disasters.

## Contributing to longer-term impact

The regional HIV programme has contributed significantly to the capacity building of NS in the region. Structures at branch levels such as offices and volunteer networks have been established and strengthened. At National, provincial and district levels partnerships have been established which have contributed to the image building of the NS. Through these partnerships NS have acquired credibility for fundraising opportunities. Some NS have even gone further by being role models for governments and other NGOs as leaders in good practices.

Overall NS through their HIV interventions have contributed to National efforts to tackle the HIV pandemic and in mitigating its impact. In many countries in the region, incidences of HIV are stabilizing and in some specific age groups or population segments the infection rates are decreasing. While the Red Cross cannot attribute the decrease to its own efforts, we can judiciously say that it has contributed significantly to the reduction in some way and made a difference in the lives of many individuals, orphans and vulnerable children, families and communities.

## Looking ahead

- ✘ The programme midterm review will be conducted in the first quarter of 2010. Four countries, Lesotho, Malawi, Mozambique, and South Africa have been selected for the site visits while the remaining countries are expected to participate via postal questionnaires.
- ✘ The Swedish Red Cross will also conduct an independent review of the PMER system established under the programme as part of its annual thematic review and reporting requirement to SIDA. Zimbabwe and Namibia have been selected as the focus sites.
- ✘ During the first quarter of 2010, the Health Network meeting will also be held where the concept of integration and plans for programming and resource mobilization beyond 2010 will be discussed.
- ✘ Key funding partners to the Global HIV and AIDS Alliance in southern Africa will meet with SARO to review the findings of the midterm review, resolve the differences which affect the proper disbursement of funds and implementation of the programme and discuss the way forwards beyond 2010.

- ✘ With the end of the funding cycle 2006-2010, NS will start to implement their transitional plans to prevent disruption of services to beneficiaries and maintain volunteer motivation.
- ✘ The CHBC minimum standards will be further tested in Namibia with field practitioners from Zimbabwe, Malawi, Botswana, and Zambia and translated into Portuguese in preparation for a workshop for Angola and Mozambique to be held in 2010.
- ✘ SAPRCS will be requested to adopt and endorse the Child Protection Strategy and NS (board, management, staff and volunteers) and family members and communities will be orientated on the child protection strategy and implementation of the strategy will begin by mid 2010.
- ✘ SARAWO members will proceed with the development of the community based Income generating guidelines and the strengthening of the positive living programme for self support groups, "Positive health, dignity and prevention".

## 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.

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# International Federation of Red Cross and Red Crescent Societies

MAA63003 - Southern Africa regional HIV and AIDS

Draft Annual report 2009

Selected Parameters	
Reporting Timeframe	2009/1-2009/12
Budget Timeframe	2009/1-2009/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

## I. Consolidated Response to Appeal

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
<b>A. Budget</b>		13,114,934			0	13,114,934
<b>B. Opening Balance</b>		3,710,617			0	3,710,617
<b>Income</b>						
<u>Cash contributions</u>						
<i>British Red Cross</i>		12,600				12,600
<i>Canadian Red Cross</i>		0				0
<i>Danish Red Cross</i>		0				0
<i>Finnish Red Cross</i>		22,295				22,295
<i>Finnish Red Cross (from Finnish Government)</i>		126,338				126,338
<i>Icelandic Red Cross (from Icelandic Government)</i>		0				0
<i>Japanese Red Cross</i>		109,966				109,966
<i>Lars Amundsen Foundation</i>		300,000				300,000
<i>Netherlands Government</i>		5,073,115				5,073,115
<i>Norwegian Red Cross</i>		0				0
<i>Norwegian Red Cross (from Norwegian Government)</i>		172,391				172,391
<i>On Line donations</i>		191				191
<i>Other</i>		-150				-150
<i>South Africa - Private Donors</i>		135				135
<i>Sweden Red Cross</i>		1,179,335				1,179,335
<i>Sweden Red Cross (from Swedish Government)</i>		1,827,872				1,827,872
<i>Unidentified donor</i>		-503				-503
<b>C1. Cash contributions</b>		<b>8,823,586</b>				<b>8,823,586</b>
<u>Outstanding pledges (Revalued)</u>						
<i>Netherlands Government</i>		-1,456,277				-1,456,277
<i>Sweden Red Cross (from Swedish Government)</i>		-67,943				-67,943
<b>C2. Outstanding pledges (Revalued)</b>		<b>-1,524,220</b>				<b>-1,524,220</b>
<b>C. Total Income = SUM(C1..C5)</b>		<b>7,299,366</b>			<b>0</b>	<b>7,299,366</b>
<b>D. Total Funding = B + C</b>		<b>11,009,982</b>			<b>0</b>	<b>11,009,982</b>
<b>Appeal Coverage</b>		<b>84%</b>			<b>#DIV/0</b>	<b>84%</b>

## II. Balance of Funds

	Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination	TOTAL
<b>B. Opening Balance</b>		3,710,617			0	3,710,617
<b>C. Income</b>		7,299,366			0	7,299,366
<b>E. Expenditure</b>		-7,348,940				-7,348,940
<b>F. Closing Balance = (B + C + E)</b>		<b>3,661,043</b>			<b>0</b>	<b>3,661,043</b>

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

MAA63003 - Southern Africa regional HIV and AIDS

Draft Annual report 2009

Selected Parameters	
Reporting Timeframe	2009/1-2009/12
Budget Timeframe	2009/1-2009/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

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

Account Groups	Budget	Expenditure					TOTAL	Variance
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination		
A		B					A - B	
<b>BUDGET (C)</b>		<b>13,114,934</b>					<b>0</b>	<b>13,114,934</b>
<b>Supplies</b>								
Shelter - Relief			59,655				59,655	-59,655
Construction Materials			101,519				101,519	-101,519
Clothing & textiles	478,062		209,744				209,744	268,319
Food	465,411		277,706				277,706	187,705
Seeds,Plants			79,392				79,392	-79,392
Water & Sanitation	82,228		29,013				29,013	53,215
Medical & First Aid	287,362		95,716				95,716	191,646
Teaching Materials	389,311		697,784				697,784	-308,473
Utensils & Tools	31,362		16,724				16,724	14,638
Other Supplies & Services	170,816		58,403				58,403	112,413
<b>Total Supplies</b>	<b>1,904,552</b>		<b>1,625,656</b>				<b>1,625,656</b>	<b>278,897</b>
<b>Land, vehicles &amp; equipment</b>								
Vehicles			28,351				28,351	-28,351
Computers & Telecom			52,788				52,788	-52,788
Office/Household Furniture & Equipm.			3,960				3,960	-3,960
<b>Total Land, vehicles &amp; equipment</b>			<b>85,099</b>				<b>85,099</b>	<b>-85,099</b>
<b>Transport &amp; Storage</b>								
Storage	102,924		6,947				6,947	95,977
Distribution & Monitoring			7,691				7,691	-7,691
Transport & Vehicle Costs	217,510		243,538				243,538	-26,028
<b>Total Transport &amp; Storage</b>	<b>320,434</b>		<b>258,176</b>				<b>258,176</b>	<b>62,258</b>
<b>Personnel</b>								
International Staff	716,000		593,046				593,046	122,954
Regionally Deployed Staff			26,605				26,605	-26,605
National Staff	298,064		428,388				428,388	-130,324
National Society Staff	1,819,292		1,754,218				1,754,218	65,073
Consultants	422,277		90,011				90,011	332,266
<b>Total Personnel</b>	<b>3,255,633</b>		<b>2,892,268</b>				<b>2,892,268</b>	<b>363,365</b>
<b>Workshops &amp; Training</b>								
Workshops & Training	1,926,903		937,715				937,715	989,188
<b>Total Workshops &amp; Training</b>	<b>1,926,903</b>		<b>937,715</b>				<b>937,715</b>	<b>989,188</b>
<b>General Expenditure</b>								
Travel	100,891		298,327				298,327	-197,436
Information & Public Relation	246,554		129,507				129,507	117,047
Office Costs	359,628		230,034				230,034	129,594
Communications	145,417		103,785				103,785	41,633
Professional Fees	220,000		50,467				50,467	169,533
Financial Charges	16,180		9,373				9,373	6,808
Other General Expenses	3,899,858		134,062				134,062	3,765,796
<b>Total General Expenditure</b>	<b>4,988,528</b>		<b>955,554</b>				<b>955,554</b>	<b>4,032,973</b>
<b>Programme Support</b>								
Program Support	718,884		499,275				499,275	219,609
<b>Total Programme Support</b>	<b>718,884</b>		<b>499,275</b>				<b>499,275</b>	<b>219,609</b>
<b>Services</b>								
Shared Services			177,291				177,291	-177,291
<b>Total Services</b>			<b>177,291</b>				<b>177,291</b>	<b>-177,291</b>
<b>Operational Provisions</b>								
Operational Provisions			-82,094				-82,094	82,094
<b>Total Operational Provisions</b>			<b>-82,094</b>				<b>-82,094</b>	<b>82,094</b>

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

MAA63003 - Southern Africa regional HIV and AIDS

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Selected Parameters	
Reporting Timeframe	2009/1-2009/12
Budget Timeframe	2009/1-2009/12
Appeal	MAA63003
Budget	APPEAL

All figures are in Swiss Francs (CHF)

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

Account Groups	Budget	Expenditure					TOTAL	Variance	
		Disaster Management	Health and Social Services	National Society Development	Principles and Values	Coordination			
A							B	A - B	
BUDGET (C)		13,114,934					0	13,114,934	
TOTAL EXPENDITURE (D)		13,114,934					7,348,940	7,348,940	5,765,994
VARIANCE (C - D)		5,765,994						5,765,994	