Annual report

Southern Africa Zone: HIV and AIDS

Appeal No. MAA63003

30/04/2009

This report covers the period 01/01/08 to 31/12/08

Campaign targeting young girls and women in South Africa

In brief

Programme purpose:
In 2006, the International Federation of the Red Cross and Red Crescent Societies (IFRC) Southern Africa Zone Office (SAZO) launched an innovative and dynamic five-year (2006-2010) regional HIV and AIDS programme. The ten National Societies[1] in the zone embarked on programme consolidation and building capacities to improve the overall implementation and management of the programme, and should resources be made 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 2008 marks the period of full scale programme implementation under long-term funding commitments secured by the Southern Africa Zone Office (SAZO), whilst 2007 was more of a transition year subsequent to the end of the first phase of the programme and funding (2002-2006).

Programme(s) Summary:
The table below provides a summary and general overview of programme reach against the established indicators since its inception. Despite the slight drop in client numbers under OVC and community home-based care (CHBC) in 2008, the National Societies overall reached 24 percent of the established targets. The cumulative numbers of people reached (or number of people serviced per year) are 129,051 for CHBC and 231,813 under OVC representing almost half of the target figures. The National Societies also reached 14,148,715 people through HIV prevention activities since the beginning of the appeal.

[1] Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe Red Cross Societies in Southern Africa Zone.

Table 1: Overview of beneficiaries reached by end of 2008

Key Result	Target 2010	Baseline 2006	Achieved 2007	Achieved 2008	Cumulative Reach	Reach against 2010 Targets
Output 1: Prevention	50,000,000	4,782,711	6,549,900	7,602,529	14,152,429	28%
Output 2: CHBC	250,000	65,000	68,630	60,421	-	24%
Output 2: OVC	460,000	111,109	119,270	112,543	-	24%
Output 3: Stigma and discrimination	100% of NS staff in workplace programmes	None	32% of 1,671 staff	41% of 2,224 staff	-	-
Output 4: Capacity Building	Volunteer hours mobilized	6,963 volunteers and 774,773 hours	7,716 volunteers and 858,559 hours	8,435 volunteers and 894,110 hours	-	-

Financial Situation:
The total 2006-2010 budget for appeal (MAA63003) is CHF 384,895,997. The table below provides an overview of funding support received by year and programme component in 2007 and 2008[2]. The plan and budget did not necessarily materialize in comparable income, and the results as indicated in the figures below underscore the need for targeted fundraising efforts for specific programme areas.

Coverage in 2008 of the extensively revised budget recorded in the IFRC system (CHF 19,352,306) is at 67 percent. The budget revision was conducted during the last quarter of the year, to reflect the income and absorption capacity of SAZO and the ten National Societies.

Table 2: Overview of income vs. budget in 2007 and 2008

Output	2007		% Income vs. Budget	2008		% Income vs. Budget	Total		% Income vs. Budget
	Budget	Income		Budget	Income		Budget	Income	
Total Zone	**82,720,000**	**35,868,069**	**43%**	**86,862,354**	**27,192,614**	**31%**	**169,582,354**	**63,060,683**	**37%**
1	4,784,000	5,455,000	**114%**	12,300,675	3,897,753	**32%**	17,084,675	9,352,753	**55%**
2	40,006,000	15,060,000	**38%**	35,663,533	10,629,271	**30%**	75,669,533	25,689,271	**34%**
3	4,883,000	216,000	**4%**	2,955,354	1,116,377	**38%**	7,838,354	1,332,377	**17%**
4	22,205,000	12,865,000	**58%**	29,790,593	10,799,232	**36%**	51,995,593	23,664,232	**46%**
Secretariat	10,842,000	2,272,069	**21%**	6,152,199	749,981	**12%**	16,994,199	3,022,050	**18%**

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 inhibits 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.

Click here to go directly to the attached financial report.

[2] The figures include funds received through the IFRC as well as funds received directly by National Societies through Partner National Societies bilateral and external contributions. This information is obtained from the National Societies.

Our partners: The Southern African National Societies supported by SAZO 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 SAZO level, collaboration has been strengthened with embassies, international organizations, UN agencies, development agencies and internally with the PNS. Funding support to this appeal (MAA3003) in 2008 has been received through the IFRC Secretariat from British, Canadian, Danish, Finnish, Icelandic, Japanese, Norwegian Societies, Swedish Red Cross/SIDA and the RNE, and an in-kind donation from the New Zealand Red Cross. 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), SADC and many other local, regional, and international organizations partnered with the SAZO and National Societies over various initiatives described below.

Context

Southern Africa remains the epicentre of the HIV and AIDS pandemic, and harbours the biggest burden in Sub-Saharan Africa and the world over. Almost one third of the world's people living with HIV (PLHIV) live in this sub region. In seven countries, HIV prevalence exceeds 15 percent (Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe); about 43 percent of all children under 15 living with HIV are in Southern Africa, as are approximately 52 percent of all women above the age of 15 living with HIV. Significant differences in infection levels between men and women also remain; for instance in Swaziland, 20 percent of adult men tested HIV positive, compared to 31 percent of women according to a recent antenatal and population based surveys. There are still large numbers of people who do not know their status in the region, and despite good achievements in the roll out of ART, for every one person on treatment there are five new infections[3].

While national governments have made significant strides towards implementing their strategies and commitments (UNGASS, MDGs, etc) notable gaps remain. The HIV and AIDS regional programme covering ten countries was initiated to address some of these gaps through strategies that aim to complement national government priorities and contribute to the MDG goals:

- Prevent further infections through targeted community-based peer education and information, education, and communication (IEC) activities, and promote uptake of services including voluntary counselling and testing (VCT) and prevention of mother-to-child transmission (PMTCT);
- Scale-up HBC and support OVC through a holistic approach to address needs in education, food and nutrition, psychosocial support, social inclusion, and income generating activities;
- Address stigma and discrimination through targeted communication and advocacy activities and by tackling gender inequalities and gender-based violence through community mobilisation, girls' empowerment initiatives and by engaging men and boys.
- Build the National Societies' capacity to plan, implement, track performance and manage the programme through SAZO technical assistance on globally accepted HIV and AIDS intervention standards; and information sharing and south-south learning.

In 2008, the humanitarian, social, and economic situation worsened in Zimbabwe with chronic food insecurity, the cholera outbreaks in rural and urban areas further exacerbating the vulnerability of PLHIV. The local currency plunged at an all time low against major currencies further exacerbated by hyperinflation impacting negatively on all major operations and programmes. The worldwide economic crisis is also expected to have an impact on donors' reserves and their commitment in the short-term and in the coming years.

[3] All epidemiological data is extracted from UNAIDS 2008 Report

Progress towards outcomes

In 2008 a total of 7,776,550 people were reached through various HIV activities conducted by the ten National Societies.

Table 3: The table below provides an overview of people reached in 2008

Country	Preventing further infections	Care, Treatment and Support	Reducing Stigma and Discrimination	Total
Angola	3,301	812	44	4,157
Botswana	93,687	246	52	93,985
Lesotho	384,037	16,627	101	400,765
Malawi	231,133	17,350	106	248,589
Mozambique	143,911	12,445	53	156,409
Namibia	219,238	12,048	-	231,286
South Africa	5,149,717	31,101	443	5,181,261
Swaziland	905,554	3,343	88	908,985
Zambia	7,440	6,023	8	13,471
Zimbabwe	464,511	72,969	162	537,642
Total	**7,602,529**	**172,964**	**1,057**	**7,776,550**

Outcome 1: 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.

Progress

In a region noted as the epicentre of the HIV epidemic, sustained prevention education and outreach is warranted. With the advent of ART, it is even more critical to maintain relevant prevention education and sustain some of the notable gains made in slowing down and reducing the rate of new infections.

Table 4: Provides an overview of the total number of people reached with prevention activities in 2008

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	3,301	-	3,001	98	-	202
Botswana	93,687	32,856	60,442	233	23	133
Lesotho	384,037	12,005	350,000	13,947	1,241	6,844
Malawi	231,133	16,351	208,800	2,456	616	2,910
Mozambique	143,911	101,342	30,456	3,021	891	8,201
Namibia	219,238	84,886	5,272	125,079	581	3,420
South Africa	5,149,717	116,382	4,957,004	11,208	4,589	60,534
Swaziland	905,554	153,000	750,000	1,598	834	122
Zambia	7,440	6,797	420	198	25	-
Zimbabwe	464,511	141,202	281,938	9,411	618	31,342
Total	**7,602,529**	**664,821**	**6,647,333**	**167,249**	**9,418**	**113,708**

Source: National Societies' Programme Updates

It should be noted that Angola Red Cross focuses on the distribution of IEC material until a solid Prevention Strategy is developed. As illustrated above, all National Societies reported an increase in the number of people reached through peer education and general awareness raising activities. Almost all National Societies are producing some form of IEC material ranging from booklets, posters, T-shirts, caps and drama, radio, and TV production. For instance, South African Red Cross targeted young girls and women in seven of the nine provinces as part of its awareness raising programme on gender-based violence, self empowerment, and sexual and reproductive health.

The SAZO closely supported the National Societies to address any quality related issues on the IEC materials produced to ensure technical soundness and sensitivity to age, culture, gender, and vis-a-vis key drivers of the epidemic in the region (multiple concurrent partnerships, migration, intergenerational sex, etc). Guidelines have been provided to support the National Societies in producing relevant materials.

All ten National Societies were involved in various prevention activities in 2008. However, the use of various peer education approaches, training packages and standards underscores the urgent need for standardizing the training approaches and materials.

A regional workshop was held in October 2008 bringing together national HIV coordinators and volunteers to review the sexual reproductive health, life skills, peer education training manual, and the minimum standards. The participants were also trained as trainers. The workshop brought together a total of 33 people including Partner National Society staff. The training package will be finalized, printed, and disseminated in early 2009.

A total of 9,418 women were referred to the prevention of mother-to-child transmission (PMTCT) services in 2008. Through partnership with UNICEF, Swaziland, Malawi, and Lesotho have rolled out information and communication campaigns to promote uptake of PMTCT services. The partnership with UNICEF was conceptualized to enhance knowledge of the Red Cross volunteers and community peer educators on PMTCT issues, increase dialogue and engagement of community leaders and men, and increase national sensitization through targeted PMTCT social campaigns on radio, printed materials, and community theatre.

The services uptake campaigns in each country were preceded by a study to explore the drivers of the epidemic and challenges related to PMTCT and active involvement of men. Lesotho, Swaziland, and Malawi should further expand these campaigns to maintain the momentum and capitalize on the gains made to date. The materials developed and used by the three National Societies in the PMTCT social mobilization have been collected and will be further analysed with the intention of rolling the activity to other National Societies in 2009.

Through partnership with the Ministry of Health and Social Services (MoHSS), the Namibian Red Cross continued to aggressively promote access to VCT. A National HIV VCT testing day was organized in collaboration with MoHSS on 8 May 2008 with over 34,232 people tested at the event. Namibia Red Cross further recorded the referral and testing of 125,072 people favourably enhanced with the community counsellors' programme and the deployment of 523 counsellors in VCT centres nationwide. This partnership funded by PEPFAR/CDC with the MoHSS may come to an abrupt end as early as the first quarter of 2009 - leaving the National Society in potential financial crisis. The community counsellors engaged by Namibia Red Cross may have to be absorbed into government structures through the MoHSS as a result of new labour legislation gazetted in 2008.

Challenges:

- The National Societies should target other key vulnerable populations for their peer education activities. Peer education activities and messages need to reflect gender, age, culture sensitivity, hence the need for establishing minimum standards for peer education and focus on the epidemic key drivers.
- According to the latest available data for funding received directly through the IFRC Secretariat, the funding for prevention activities reached only 32 per cent[4] of the budget for this output. There is an urgent need to refocus fundraising efforts towards prevention activities in order to ensure a greater impact and more cost effective HIV response.

Outcome 2: Expanding Care Treatment and Support

Key strategies:

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

[4] This figure includes funding directly received by National Societies from bilateral and external sources.

Progress

Table 5: Overview of OVC reached with services provided in 2008

Country	OVC receiving RCRC services	OVC receiving food assistance	OVC receiving educational support (books, uniforms, school fees)	OVC receiving material support (blankets, clothes, mosquito nets)	OVC receiving psychosocial support	OVC reached by RCRC kids or youth clubs
Angola	512	-	-	512	-	-
Botswana	101	-	53	101	-	50
Lesotho	12,500	10,500	1,280	10,500	8,900	3,888
Malawi	13,200	5,520	581	5,520	13,200	4,200
Mozambique	6,565	1,890	2,009	1,005	3,590	642
Namibia	5,442	177	2,929	2,150	166	-
South Africa	16,101	5,373	935	3,535	6,185	14,192
Swaziland	1,804	390	867	456	125	-
Zambia	2,000	-	2,000	-	-	-
Zimbabwe	54,318	49,171	10,288	13,663	188	38,463
Region	**112,543**	**73,021**	**20,942**	**36,930**	**32,354**	**61,435**

Source: National Societies' Programme Updates

The Red Cross regional approach on OVC programming is anchored into the regional OVC working group made of the eight National Society OVC officers. In 2006, the OVC working group supported by SAZO developed the regional Red Cross OVC Strategy; now adopted by all National Societies. The group has been supported by the SAZO technical officer in monitoring its implementation.

In 2008, under the coordination and leadership of SAZO, the OVC working group met twice: in Johannesburg in May and Swaziland in October. In Johannesburg the group discussed the newly developed Zonal and National Society planning, monitoring, evaluation and reporting (PMER) system aimed at improving data collection. In Swaziland, the group drafted the OVC operational plans and budgets for 2009.

In an effort to enhance quality of programming and comprehensive support to OVC, in July 2008 an MoU was signed with REPSSI leading to the development of a joint work plan. This includes a joint REPSSI/IFRC training manual on memory work, which was published in 2008. The joint work plan also includes collaborating with REPSSI on developing supplementary guidelines on mainstreaming psychosocial support into home-based care (HBC), joint development of a manual on "grannies clubs" (working with grandparents/guardians of OVC), and joint approaches on advocating for access to paediatric ART. All National Society OVC officers have been trained on psychosocial support, on hero and memory work and have rolled out the training to their volunteers.

South African Red Cross youth soccer club

The regional OVC Strategy also advocates for holistic support for OVC – educational, material, psychological, social and health. Rather than expanding on the number of children reached, most of the National Societies are concentrating on gradual inclusion of all elements under holistic support to their OVC caseloads. While the Angola and Zambia Red Cross Societies only managed to provide basic material support to 512 OVC and educational support to 2,000 OVC respectively, National Societies such as Lesotho and Malawi are good examples where several of their projects now include most aspects – e.g. kids clubs, recreational activities, educational support through school fees, uniforms and educational materials, psychosocial support through hero work, established local child care committees and grannies/guardians clubs. Lesotho Red Cross has made considerable progress in the implementation of holistic support for OVC. This approach is gradually being rolled out to all the project sites. Elements of support include kids clubs (youth clubs), nutrition support through a large horticultural project, which provides food for HBC clients and OVC. Any profits are directed towards supporting OVC in education, "grannies clubs" for grandmothers/guardians caring for OVC, and psychosocial support through memory and hero work. Through support from Norwegian Red Cross, water and sanitation activities are being integrated into OVC projects.

SAZO also developed a basic training module for OVC programming with input from National Society OVC officers; and has now been rolled out in most countries in the zone. The SAZO OVC team facilitated the first trainings and topics included beneficiary selection criteria, children's rights, and child participation, working with the community, working with guardians, and working with children under fives, confidentiality and psychosocial support. To date 1,086 people have been trained from Lesotho, Malawi, Namibia, South Africa, Swaziland, and Zambia.

Table 6: Overview of clients supported through CHBC related activities

Country	Number of HBC Projects	Number of HBC Clients	Number of care facilitators/Volunteers	Number of people in Support groups
Angola	2	300	246	17
Botswana	2	145	93	95
Lesotho	7	4,127	371	1,545
Malawi	15	4,150	1,241	1,474
Mozambique	33	5,880	720	930
Namibia	7	6,606	1,988	3,240
South Africa	20	15,000	1,323	14,324
Swaziland	3	1,539	558	447
Zambia[5]	8	4,023	420	100
Zimbabwe	27	18,651	1,475	14,413
Total	**124**	**60,421**	**8,435**	**36,585**

Source: National Societies' Programme Updates

National Societies steadily made progress on cascading training to the care facilitators, except Angola and Mozambique who have planned to train trainers as soon as the Portuguese version of the training package is printed in early 2009. For instance, Namibia Red Cross rolled-out care facilitators training in all the regions and initial training has been conducted in each programme site. A total of 200 care facilitators/volunteers have been trained in 2008, far below the planned 2,500 trainees. Swaziland and Zimbabwe Red Cross have trained all their care facilitators, with Malawi and South Africa who have trained 70 and 60 percent of their current care facilitators respectively. Zambia Red Cross has not trained care facilitators but engages with the government and civil society in the adaptation of the WHO/IFRC/SAFAIDS training package. Zambia Red Cross has also supported the Ministry of Health on training of trainers in early 2008. Botswana trained care facilitators in one programme site to support clients on treatment. About 40 percent of care facilitators in Lesotho Red Cross have been trained on the training package.

In the project sites anecdotal evidence has shown that, PLHIV on treatment who are not monitored by care facilitators are more likely to default than those followed up by care facilitators with the adequate knowledge and trained on the training package. A project officer in Grootfontein in Namibia noted that : '*clients that we follow up with our care facilitators do adhere to treatment, but those who are not referred to us by the district hospital for follow up do default on treatment all the time'* – further highlighting the need for training of the care facilitators. With the advent of ART and tuberculosis (TB) treatment, bedridden clients will be increasingly mobile. The need for home-based nursing care will become less and less critical. It is however important to monitor these clients and sustain adherence to ART and TB treatment in order to avoid a public health disaster.

As shown above, a number of countries have not trained all their care facilitators on the prevention, care treatment and support package which is designed to impart information, knowledge and skills on treatment literacy, preparedness, nutrition, counselling, palliative care and care for carers. This is a vital component for the quality provision of care and support for PLHIV. Many clients being seen by the care facilitators and volunteers are also on ART and TB treatment, in need of support on treatment literacy and adherence. As such, the IFRC and WHO have assisted eight countries (Ministries of Health) to adapt the generic Prevention, Care, Treatment and Support training package. There is now a need for an urgent and critical focus on the training of all care facilitators in the region on adherence and treatment literacy as well as the remaining components of the new WHO/Federation/SAFAIDS training package.

Following the advent of ART and potential continued decrease in funding for HBC activities, the number of clients has decreased from the recorded figures in previous years and is expected to decrease further in 2009. For instance, in Namibia, 1,925 clients have been discharged from the programme due to improved status or death. Zambia Red Cross closed six programme sites out of eight due to inadequate funding to maintain HBC activities. Mozambique Red Cross closed operations in six districts that were funded by the German Red Cross.

[5] Zambia Red Cross scaled down its activities in September by reducing activities from eight to two districts. The number of clients reduced as well as the care facilitators from 420 to 120.

Lesotho Red Cross closed two programme sites because funding from the National AIDS Commission was discontinued. In addition, Lesotho Red Cross will close two more programme sites in June 2009 funded by German Red Cross. Namibia Red Cross will also have no funding for five programme sites (one funded by German/Swedish RC, four funded by the Global fund and one with no particular donor). The lack of funding to maintain HBC activities in most of the countries, has seriously affected the quality of service rendered to the clients. Morale of the care facilitators is low, which could lead to potential burn out and attrition. However, through commitment and sacrifice of the volunteers, a total of 60,421 clients were reached in 2008.

Challenges

- Progress towards provision of holistic support was varied according to the capacity of each National Society. The inputs provided by SAZO are translated into results at different speed and scale depending of the organisational context of each of the National Society as well as the amount of resources available in each country.
- Transforming an ad hoc support into a holistic support to OVC cannot be achieved in one year, hence there is still work to be done in the current implementation phase.
- OVC support is not over-funded, but just the contrary. With the exception of the three years RNE commitment, other sources of funding are mostly characterized by short-term and/or insufficient injection of funds ranging from three months to one year. This presents a problem in terms of enrolling OVC into a long-term programme, in particular when it comes to education.
- National Societies also need to develop strict criteria for the discharge of clients who are well enough to graduate from the CHBC services and promote their enrolment in support groups for PLHIV.
- There is a need for National Societies to establish a better balance between long-term programming and emergency operations, so as to maintain quality service on both. For instance in Zimbabwe, with the outbreak of cholera, the care facilitators were also engaged in providing services in the cholera treatment centres and clients - which may have increased the care facilitator/client ratio. On the other hand, very few of the Zimbabwe Red Cross HBC clients were affected by the cholera outbreak as care facilitators were already engaged in health and hygiene education at household level.
- There is a need to strengthen community leadership and Red Cross branch structures involvement at the project site level to enhance understanding, acceptance, participation, ownership, and future sustainability.
- Many bilateral funded projects have no exit strategies. This is posing an administrative, ethical, legal, but most importantly a humanitarian crisis. National Societies will be encouraged to ensure that exit strategies are developed and agreed upon with donors from the initiation of specific projects; ensuring that long-term funding is secured and mechanisms for sustainability are built-into the proposals, budgets, and implementation plans.
- Many National Societies increased the geographic scope of their programmes in 2007/2008 without necessarily improving on the quality and depth of services provided. Human and related structures were put in place to support this expansion. The expansion however, exceeded the available resources and National Societies are left with the legal and financial implications. It is critical that all National Societies revisit the geographic scope, scale, and depth of their programmes not only to ensure quality but to also avoid future financial deficits.

Output 3: Reducing Stigma and Discrimination

Key strategies

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

In 2008, a total of 36,585 clients from the CHBC programme were enrolled into self support group of PLHIV throughout the zone. The support groups are very important platform for sharing information on positive living and prevention, ART literacy and adherence and psychosocial support. With enough resources, the support groups are integrated with income generating activities in order to improve the nutrition and/or economic income of PLHIV. The National Societies are partnering with National PLHIV networks to implement this very crucial strategy.

National Societies made steady progress in 2008 in implementing HIV and AIDS Workplace Policies mostly disseminating existing policies to staff and volunteers at branch levels. A total of 18 applications were made to the Massambo Funds (IFRC Secretariat initiative) designed to support staff and volunteers in need of access to treatment and other services (assistance with transport, nutrition, clinical monitoring visits and laboratory exams), an encouraging acceptance of the impact of HIV on Movement staff and volunteers.

Table 7: The table below provides an overview of the overall National Society staff involved in workplace programmes in 2008:

Country	Full time staff	Staff participating in workplace programme		
		Male	Female	Total
Angola	147	28	16	44
Botswana	72	0	0	7*
Lesotho	74	20	30	50
Malawi	106	71	35	106
Mozambique	302	19	34	53
Namibia	678	0	0	0
South Africa	400	44	356	400
Swaziland	90	0	0	88*
Zambia	170	0	0	8*
Zimbabwe	185	0	0	162*
Total	**2,224**	**182**	**471**	**918**

*Breakdown by gender not available.
Source: National Societies' Programme Updates

In regard to gender inequalities and gender-based violence (GBV) and as a preamble to community interventions, most National Societies implemented awareness raising and training activities on women's rights, sexual and reproductive health (SRH) and GBV for all staff and volunteers. The activities were implemented in partnership with other in-country stakeholders for example the Ministry of Women and Children in Malawi, or UNFPA in Lesotho.

Malawi Red Cross made great strides in addressing GBV. With funding support from the Canadian Red Cross and RNE, all staff at headquarters, district levels and 780 volunteers were trained in prevention of GBV and rehabilitation of victims of abuse in ten projects areas. In order to mobilize support and have greater impact, Malawi Red Cross worked with the SAZO technical staff, Partner National Societies, the Ministry of Women and Child Development Affairs, UNICEF, Plan International, Malawi Police Service, and the Judiciary to support the roll out of Community Victim Support Units country-wide. This is a community structure to enhance community safety and justice for women and children. To further support the National Society's initiative on addressing GBV, the SAZO decided to complement GBV funding for Malawi Red Cross by re-allocated additional resources.

Gender and GBV were integrated into the in and out-of-school life skills training on SRH for young people, culminating into a training of trainers workshop held in October, involving two youth leaders per National Society, facilitated and funded through the SAZO team and budget. The outcome of the workshop was the development of a training package on SRH, life skills for trainers of peer educators together with an activity kit for youth peer educators in English and Portuguese.

SAZO entered into a collaborative relationship with organisations experienced in addressing GBV involving men and boys (Engender Health, Sonke Justice Network, and RFSU). At the end of 2008, the SAZO, requested technical assistance from the Secretariat towards the implementation of the GBV component within its regional HIV programme. A joint study (SAZO and Secretariat) was commissioned to: a) assess the current level of the IFRC's facilities to respond to GBV-related issues in the Southern Africa Zone and, b) to prepare a regional GBV/HIV strategy to enable Red Cross Societies to improve their effectiveness in fighting both HIV and GBV.

Challenges

- There is an urgent need for SAZO to provide a clear framework to National Societies on how to integrate GBV in the HIV programme in the last two years of the programme. The framework should outline concrete interventions, that contribute to reducing the number of GBV incidences in the communities as well as ensuring the provision and timely response to the needs of GBV survivors. Such interventions are complex and require the active sectoral interventions (health, social services, police, judiciary, other support services, etc); hence the need to enhance National Society in such collaborative efforts.

Output 4: Strengthening National Society Capacity

Key strategies:

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

Progress

The 2009 operational planning exercise started as early as August 2008 and as of the end of December, all National Societies have had the second draft approved by SAZO. There has been a tremendous improvement in the National Societies' capacity to develop these plans. Critical to the success of the planning exercise is the active involvement of all partners, bilateral and external included, as part of the framework of the Global Alliance. The regular use of these plans for planning, fundraising, forecasting, and reporting is crucial to the continued success of the programme.

The National Societies programme coordinators and finance managers participated in a finance workshop in early 2008. The platform served as an opportunity to strengthen the common understanding of the Global Alliance principles, programme components, financial management, reporting tools and the working relationships between the programme and finance staff. SAZO conducted the 2007 annual financial audit of the programme with success and will continue with the process in subsequent years.

After further consultation with the donors, the Zimbabwe Red Cross started trading in USD, which induced some slight logistical challenge at provincial level without foreign currency accounts. The overall dollarization of the economy where all goods and services are traded in hard currencies such as USD and ZAR, implies that funds in local currency would devalue. The National Society will further analyze the loss and may potentially request a write off from major donors.

Funding received through the IFRC, with the exception of long-term commitments from Swedish Red Cross/SIDA and RNE are short-term, many with less than six months operating timeframe. Other than stretching the operational capacity of the National Societies and SAZO, quality and comprehensive programming area compromised.

In addition to the training on the monitoring tools held in early July 2008 for newly recruited PMER officers and programme coordinators; the SAZO PMER unit was engaged in rolling out the programme baselines in five countries namely Botswana, Malawi, Namibia, South Africa, and Zimbabwe. The PMER senior officer provided technical assistance to each National Society in the development of the terms of reference for the baselines, samples and tools, budgets, training data collectors and supervisors, review of the analysis and draft reports. It is anticipated that the data/results from the baselines will be used to strengthen and refine future programming and the direction of the National Societies' HIV and AIDS programme, and support their outreach and fundraising efforts.

A total of 8,435 volunteers throughout the zone were active during the year. The notable increase in number of volunteers was recorded in Angola, Malawi, South Africa, and Zimbabwe mainly due to emergency operations, new initiatives, and better recording system of active volunteers. All National Societies reported challenges in maintaining the volunteer pool and a sustainable balance of volunteer/client ratio. The payment of volunteer allowances, while required in some countries (labour law require payment of volunteers who work above a certain number of hours), and warranted in others in order to remain competitive, is an expensive practice and may eventually prove to be unsustainable. It is critical that the assessment carried out in 2007 in collaboration with the organizational development unit on the future of the volunteer recruitment and management practices is revisited and recommendations acted upon.

Most National Societies were affected with staff turnover or have proceeded with staff reshuffling and restructuring. Six of the senior managers at the National Societies such as Secretary Generals and Programme coordinators are either new to the Movement or are relatively new in their posts. While such change is commendable and is expected to improve programme implementation and oversight, the transition period however have a short-term negative impact on quality and progress of programming.

The annual SARAWO (Southern Africa Regional HIV and AIDS Working group) meeting was from 30 June to 1 July in Johannesburg. Key issues were raised at the meeting including the role of the Red Cross in advocacy around access to paediatric ART. A commitment was made by the group to further pursue the topic and identify the potential opportunities.

Following the submission of a proposal in response to the Round 8 call for proposals from the GFATM, the SAZO later retracted the proposal from consideration after five countries failed to obtain the necessary endorsements from their local Country Coordinating Mechanism (CCM). After extensive consultation with various stakeholders on the resubmission of a regional proposal covering all ten countries to the GFATM Round 9 call for proposals, the SAZO team decided to support instead individual countries and National Societies in the submission of country specific proposals through their local mechanisms. To that end, the SAZO team negotiated and established a partnership with the Technical Support Facility of Southern Africa. The decision to focus on country proposals is in recognition of a key shift in donor trends: resources are being disbursed at country level rather than at international and regional levels. Donors are seeking to build capacity of local organizations and are increasingly looking for better government and civil society partnerships - underscoring the need for increased resource mobilization and outreach capacity of National Societies.

Challenges

- While all the National Societies work closely with their district or provincial established structures (e.g. the District AIDS Commission or Provincial AIDS Commission) and other stakeholders, there is little coordination and participation at national level structures and discussions. Many of the National Societies do not have an established relationship with their CCM and other local stakeholders - a situation that has to urgently change if the National Societies are to assert themselves as one of the key stakeholders in the fight against HIV and AIDS. The active involvement of the senior management of the National Societies is important to ensure visibility and credibility.
- All requests concerning operations, financial management of the programme, operational plans and budgets, are landing on the desk of the health and care and/or the HIV coordinators. Only three NS have an HIV coordinator (Malawi, Mozambique, and Namibia), the remaining maintain a health and care coordinator with some National Societies who have hired thematic staff focusing on OVC, prevention, and/or HBC. While the latter structure may be an ideal opportunity for ensuring programme integration and coordination (between HIV and other health and care activities), it often leaves little time for effective programme management (planning, monitoring, technical support, reporting, resource mobilization, etc). At this scale of programming and with the desire of National Societies to expand in other priority health areas (community-based health and First Aid), malaria and tuberculosis, measles and polio, health in emergencies, water and sanitation, etc); it will eventually lead to the crucial question of how quality and coordinated programme management can be sustained**.**
- As described above, many National Societies are currently faced with multiple funding sources that have ended or will be ending in 2009, and the challenge will be sustainability of the programme. In 2008 and during the various visits of SAZO team, it was noted that many bilateral and external funding was suspended or ended with no pre-defined and coordinated exit strategy. The SAZO team will hence coordinate the development of strict guidelines on exit strategies, in collaboration with the National Societies and donors.
- There is a need to revisit the established Global Alliance principles to ensure common understanding and better shape and refocus the fundraising, planning, implementation, and reporting modalities. New initiatives, bilateral funding, or routine programme implementation need to be better coordinated and planned. While there are some notable successful models of integration especially at the community level, there is much more to be done in terms of integration between HIV and other key programme areas including food security, water and sanitation, CBHFA, etc. Exit strategies are not well articulated leaving National Societies with a humanitarian and financial dilemma.
- National Societies operating capacity is stretched to the limit with the multiple and differing reporting requirements. There is a need to assess the operationalization of the "seven ones"[6] in the region and the programme - and the upcoming Global Alliance Review meeting in early 2009 will offer the opportunity for open discussion between donors, the IFRC, and National Societies.
- The IFRC Secretariat's decentralization process had an impact on the programme particularly at SAZO level, as it led to gaps in human resources capacity. The reallocation of responsibilities to cover the gaps consequently derailed the programme implementation and monitoring.

[6] **Seven Ones**: One set of working principles, One Plan; One set of objectives; One division of labour understanding; One funding framework; One performance tracking system; One accountability and reporting system.

Working in Partnership

- **Joint studies and collaborations:** The SAZO continued working with VSO-RAISA/WHO on a regional research into the burden of care among women, girls and the elderly. The research targeting ministries of health and civil societies is part of the SADC mandate, which should culminate into an advocacy framework on reducing the burden of care among the above mentioned vulnerable groups.
- **Mainstreaming psychosocial support:** The collaboration has continued with REPSSI, which will lead to the development of supplementary guidelines on mainstreaming psychosocial support into HBC, joint development of a manual on “grannies clubs” (working with grandparents/guardians of OVC), and joint approaches on advocating for access to paediatric ART.
- **HIV during humanitarian crisis:** In the context of the recently signed IFRC agreement as collaborating centre with UNAIDS to maximize integration of HIV prevention, care, and support into humanitarian crisis situations, the SAZO is seeking further engagement with UNAIDS inter-country team for Eastern and Southern Africa and other stakeholders to further strengthen the inter-agency working group on HIV during humanitarian crisis. SAZO will host the first meeting in early 2009.
- **Addressing GBV:** The SAZO team facilitated discussions and has actively engaged with various organizations including Engender Health (a US based PVO), RFSU, and Sonke Gender Justice (South African-based advocacy group) towards the development of the GBV strategy.
- **Adaptation and adoption of the WHO/Federation/SAFAIDS training package:** As noted above, the collaboration with WHO continued in 2008 for the adaptation of the Prevention, Care, Treatment and Support training package through consultation with Ministries of Health and local stakeholders.

Looking Ahead

Below are some highlights of key activities planned for 2009 and not an exhaustive list of all planned activities at National Society and SAZO level:

- The Global Alliance Review will be held in the first quarter of 2009 bringing together all key partners of the programme.
- The SAZO team will finalize printing of the Prevention, Care and Support Training Manual in Portuguese allowing the Angola and Mozambique Red Cross Societies to roll out the training.
- The SAZO team will continue providing technical support and actively seeking funding for the training and refresher courses for care facilitators in the region.
- Task shifting rapid assessment will be conducted in 2009. The study will focus on the paradigm shift and role of CHBC care facilitators due to the advent of ART. The results will be used to shape minimum standards for CBHC including structure and costing of the interventions.
- The Sexual and Reproductive Health training package and minimum standards will be finalized and printed in both English and Portuguese for circulation during the second quarter of the year.
- The CHBC minimum standards will be developed and key staff and volunteers from National Societies will be trained in the third quarter of 2009.
- The regional Advocacy Strategy will be finalized and disseminated in the first quarter of 2009.
- The SAZO in collaboration with external stakeholders, Geneva Secretariat, and National Societies will conduct a consultation towards the development and finalization of the regional SGBV strategy and implementation plans.
- The SAZO in collaboration with REPSSI will facilitate training for National Society OVC officers on mainstreaming psychosocial support in peadiatric ART during the first quarter of 2009.

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

Annual Report

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

All figures are in Swiss Francs (CHF)

I. Consolidated Response to Appeal

	Goal 1: Disaster Management	Goal 2: Health and Care	Goal 3: Capacity Building	Goal 4: Principles and Values	Coordination	TOTAL
A. Budget		**19,352,306**			**0**	**19,352,306**
B. Opening Balance		**2,253,031**			**-1,209**	**2,251,822**
Income						
Cash contributions						
British Red Cross		*83,000*				*83,000*
Canadian Red Cross		*111,896*			*1,209*	*113,105*
Danish Red Cross		*102,214*				*102,214*
Finnish Red Cross		*23,374*				*23,374*
Finnish Red Cross (from Finnish Government)		*132,451*				*132,451*
Icelandic Red Cross (from Icelandic Government)		*88,000*				*88,000*
Japanese Red Cross		*100,000*				*100,000*
Netherlands Government		*1,999,973*				*1,999,973*
Norwegian Red Cross		*12,340*				*12,340*
Norwegian Red Cross (from Norwegian Government)		*485,747*				*485,747*
On Line donations		*2,787*				*2,787*
Swedish Red Cross		*1,033,263*				*1,033,263*
Swedish Red Cross (from Swedish Government)		*2,205,481*				*2,205,481*
Switzerland - Private Donors		*20*				*20*
Unidentified donor		*-8*				*-8*
C1. Cash contributions		***6,380,537***			***1,209***	***6,381,746***
Outstanding pledges (Revalued)						
British Red Cross		*-30,850*				*-30,850*
Danish Red Cross		*-102,214*				*-102,214*
Netherlands Government		*4,524,436*				*4,524,436*
Swedish Red Cross (from Swedish Government)		*67,943*				*67,943*
C2. Outstanding pledges (Revalued)		***4,459,315***				***4,459,315***
Other Income						
Miscellaneous Income		*7,488*				*7,488*
C5. Other Income		***7,488***				***7,488***
C. Total Income = SUM(C1..C5)		**10,847,341**			**1,209**	**10,848,550**
D. Total Funding = B +C		**13,100,371**			**0**	**13,100,371**
Appeal Coverage		**68%**			**#DIV/0**	**68%**

II. Balance of Funds

	Goal 1: Disaster Management	Goal 2: Health and Care	Goal 3: Capacity Building	Goal 4: Principles and Values	Coordination	TOTAL
B. Opening Balance		2,253,031			-1,209	**2,251,822**
C. Income		10,847,341			1,209	**10,848,550**
E. Expenditure		-9,389,755				**-9,389,755**
F. Closing Balance = (B + C + E)		3,710,617			0	**3,710,617**

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

All figures are in Swiss Francs (CHF)

III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure						Variance
		Goal 1: Disaster Management	Goal 2: Health and Care	Goal 3: Capacity Building	Goal 4: Principles and Values	Coordination	TOTAL	
	A						B	A - B
BUDGET (C)			**19,352,306**			**0**	**19,352,306**	
Supplies								
Shelter - Relief	79,553		140				**140**	**79,413**
Construction Materials	186,584		23,430				**23,430**	**163,154**
Clothing & textiles	505,051		235,070				**235,070**	**269,981**
Food	1,255,333		967,843				**967,843**	**287,490**
Seeds,Plants	152,603		13,996				**13,996**	**138,607**
Water & Sanitation	165,028		2,782				**2,782**	**162,246**
Medical & First Aid	425,930		285,202				**285,202**	**140,729**
Teaching Materials	1,876,727		207,623				**207,623**	**1,669,104**
Utensils & Tools	1,219		39				**39**	**1,180**
Other Supplies & Services	1,303,887		37,891				**37,891**	**1,265,997**
Total Supplies	**5,951,916**		**1,774,016**				**1,774,016**	**4,177,900**
Land, vehicles & equipment								
Land & Buildings	20,982							**20,982**
Vehicles	235,188		45,864				**45,864**	**189,324**
Computers & Telecom	543,592		120,642				**120,642**	**422,950**
Office/Household Furniture & Equipm.	35,455		40,095				**40,095**	**-4,640**
Others Machinery & Equipment	2,100							**2,100**
Total Land, vehicles & equipment	**837,317**		**206,601**				**206,601**	**630,716**
Transport & Storage								
Storage	13,108		34,244				**34,244**	**-21,136**
Distribution & Monitoring	-9,697		8,142				**8,142**	**-17,839**
Transport & Vehicle Costs	391,493		338,941				**338,941**	**52,552**
Total Transport & Storage	**394,905**		**381,327**				**381,327**	**13,577**
Personnel								
International Staff	715,659		586,349				**586,349**	**129,311**
Regionally Deployed Staff	1,194		15,486				**15,486**	**-14,293**
National Staff	314,836		388,238				**388,238**	**-73,402**
National Society Staff	2,612,021		1,481,050				**1,481,050**	**1,130,971**
Consultants	91,995		132,857				**132,857**	**-40,862**
Total Personnel	**3,735,705**		**2,603,979**				**2,603,979**	**1,131,726**
Workshops & Training								
Workshops & Training	3,374,279		623,565				**623,565**	**2,750,714**
Total Workshops & Training	**3,374,279**		**623,565**				**623,565**	**2,750,714**
General Expenditure								
Travel	254,096		277,374				**277,374**	**-23,278**
Information & Public Relation	817,204		212,802				**212,802**	**604,402**
Office Costs	287,043		186,568				**186,568**	**100,475**
Communications	10,855		69,249				**69,249**	**-58,394**
Professional Fees	83,534		38,910				**38,910**	**44,624**
Financial Charges	125,093		244,190				**244,190**	**-119,097**
Other General Expenses	2,050,653		80,769				**80,769**	**1,969,884**
Total General Expenditure	**3,628,479**		**1,109,863**				**1,109,863**	**2,518,616**
Contributions & Transfers								
Cash Transfers National Societies	830							**830**
Total Contributions & Transfers	**830**							**830**
Programme Support								
Program Support	1,257,900		627,831				**627,831**	**630,069**
Total Programme Support	**1,257,900**		**627,831**				**627,831**	**630,069**
Services								
Shared Services			104,116				**104,116**	**-104,116**

International Federation of Red Cross and Red Crescent Societies

MAA63003 - Southern Africa Regional HIV And AIDS

Annual Report

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

All figures are in Swiss Francs (CHF)

III. Budget Analysis / Breakdown of Expenditure

Account Groups	Budget	Expenditure						Variance
		Goal 1: Disaster Management	Goal 2: Health and Care	Goal 3: Capacity Building	Goal 4: Principles and Values	Coordination	TOTAL	
	A						B	A - B
BUDGET (C)			**19,352,306**			**0**	**19,352,306**	
Total Services			**104,116**				**104,116**	**-104,116**
Operational Provisions								
Operational Provisions	170,977		1,958,456				**1,958,456**	**-1,787,479**
Total Operational Provisions	**170,977**		**1,958,456**				**1,958,456**	**-1,787,479**
TOTAL EXPENDITURE (D)	**19,352,306**		**9,389,755**				**9,389,755**	**9,962,551**
VARIANCE (C - D)			**9,962,551**				**9,962,551**	