Annual report

International Federation
of Red Cross and Red Crescent Societies

Southern Africa Regional HIV and AIDS Programme

Appeal No. MAA63003

19 May, 2011

This report covers the period 01/01/2010 to 31/12/2010.

Support Group members in Nkerenkuru District, Namibia

In brief

Programme outcome: In line with Strategy 2020, strategic aim 2, to enable healthy and safe living, National Societies (NS) in the southern Africa region have continued to implement HIV interventions that aim at alleviating the suffering of people living with HIV (PLHIV) and orphans and vulnerable children (OVC). The Global Alliance on HIV (2006-2010), and its seven principles,[1] has been rolled out in all ten National Societies in the Southern Africa region.

The regional HIV programme is directly driven by the UNGASS Declaration of 2006 where governments committed to scale-up interventions towards universal access to HIV prevention, treatment, care and support by 2015. In line with the Millennium Development Goals the International Federation of the Red Cross and Red Crescent Societies (IFRC) Southern Africa Regional Representation Office (SARRO) launched an innovative and dynamic five-year (2006-2010) regional HIV and AIDS programme. The ten National Societies in the region[2] embarked on the programme to scale-up and build capacities to improve the overall implementation and management of their HIV/AIDS interventions.

Specifically, the aim of the programme was to quadruple the number of people reached by 2010 by targeting 50 million people with prevention messages and peer education activities, 250,000

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

people with an expanded prevention, care, treatment and support programme, and 460,000 OVC with a holistic package of educational, material and psycho-social support. Table 1 below shows the target and actual beneficiaries per result area.

Table 1: Overview of beneficiaries reached to date by end of December 2010

Key Result Area	Target 2010	Baseline 2006	Achieved Jan-Dec 2007	Achieved Jan-Dec 2008	Achieved Jan-Dec 2009	Achieved Jan–Dec 2010	Cumulative Reach – 2006 - 2010	Reach against 2010 Targets
Prevention	50,000,000	4,782,711	6,549,900	7,602,529	2,726,394	4,198,266	25,859,800	52%
PLHIV Supported	250,000	65,000	68,630	60,421	82,521	59,468	*336,040	*134%
OVC supported	460,000	111,109	119,270	112,543	106,196	81,264	*530,382	*115%
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	35% of 2050 staff	*38% of 8,165 staff	-
Capacity building	Volunteer hrs mobilized/ mth	6,963 volunteers and 774,773 hrs/mth	7,716 volunteers and 858,559 hrs/mth	8,435 volunteers and 894,110 hours/mth	7,977 volunteers and 845,562 hrs/ mth	7,729 volunteers and 819,274 hrs/mth	*31,857 volunteers and 3,376,842 hrs/mth	-

Note: The cumulative reach is calculated by adding up the number of people who received support in each year of implementation even if they are the same people, as there is a cost attached to each service. Data marked with * therefore reflect this double counting

The IFRC-SARRO and the NS have embarked on a transition plan and onward development of a four-year HIV plan beyond 2010 which is also in line with the principles of the Global Alliance on HIV. The plan addresses prevention targeted at key populations, adherence to treatment, economic empowerment, OVC support, reducing stigma and discrimination. The plan also promotes activities to reduce sexual and gender based violence in the communities. Each NS has developed clear targets, objectives and budgets. With the aim of integration, in 2011 the plans will be implemented and reported on within the broader area of health.

Financial situation: Multiple year funding has been provided by the Royal Netherlands Embassy (RNE) and the Swedish Red Cross/SIDA with bilateral and multilateral support coming from Partner National Societies (PNS), local authorities, UN agencies, faith-based organisations, non-governmental organisations, and private companies.

The year 2010 was the last year of implementation under the long-term funding commitments secured by the IFRC-SARRO. Funding for the programme dwindled during the year and with the non-disbursement of funding by RNE, the situation became even more critical for NS, with some OVC going without services, including educational support. The RNE funding was meant for activities in OVC, gender-based violence (GBV), planning, monitoring evaluation and reporting (PMER) as well as staff remuneration.

The original 2010 budget was CHF 7,970,470 of which CHF 6,389,669 (80 per cent) was covered, including opening balance. Overall 2010 expenditure amounted to CHF 5,391,927, corresponding to 84 per cent of the available funding, and 68 per cent of the original budget figure.

Click here to go directly to the financial report.

No. of people we have reached: During 2010, a total of 5,180,168 people were reached with

interventions aimed at prevention of further infections; care, treatment and support and reducing stigma and discrimination (see tables 1,2,3,4,5 and 6). The total cumulative number of people reached by the programme exceeds 25 million.

Our partners:
Partnership has been strengthened at Regional level. During the reporting period, the regional office has worked with various partners mainly at technical and financial levels. Collaboration has been ongoing with embassies, international organizations, UN agencies, development agencies and internally with Participating National Societies.

Funding support to this appeal (MAA63003) in 2010 has been received through the IFRC from Finnish, Japanese, Icelandic, Norwegian, Swedish Red Cross Societies. Additional funding has come from SIDA and the Lars Amundsen Foundation.

Partnership in support of the programme also came from the Ministries of Health, National AIDS Councils (primarily with funding from the GFATM), UNFPA, UNICEF, UNAIDS, WHO, WFP, European Union (EU), the 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-(VSO), SAfAIDS, RAANGO, NAPSAR, SAT, EST, the Southern Africa Technical Support Facility, Engender Health, SONKE Justice Network, UK AIDS Consortium, OXFAM, RFSU (Swedish Association of Sexuality Education), Soul City, SADC PF and many other local, regional, and international organizations.

The IFRC SARRO and National Societies want to thank partners and contributors for their response to this appeal.

Context

An estimated 22.5 million people living with HIV resided in sub-Saharan Africa in 2009 (UNAIDS Report), representing 68 per cent of the global HIV burden. About 34 per cent of all people living with HIV resided in the 10 countries of southern Africa in 2009. With an estimated 5.6 million HIV-positive people, living in South Africa alone making the country to have the world's largest HIV epidemic. Swaziland has the highest adult HIV prevalence in the world: an estimated 25.9 per cent of people in the country were living with HIV in 2009.

The vulnerability of women and girls to HIV remains particularly high in sub-Saharan Africa; about 76 per cent of all HIV-positive women in the world live in this region. In nearly all countries in sub-Saharan Africa, the majority of people living with HIV are women, especially girls and women aged 15-24. In South Africa, HIV prevalence among women aged 20-24 is approximately 21 per cent, compared to about 7 per cent among men in the same age range. In Lesotho, nearly 8 per cent of young women aged 15-19 are living with HIV, compared to about 3 per cent of their male counterparts. The most recent prevalence data show that 13 women in sub-Saharan Africa become infected with HIV for every 10 men.

Despite the gloomy picture painted above there is some ray of hope being registered in the region. The number of people in sub Saharan Africa newly infected with HIV fell from 2.2 million people in 2001 to 1.8 million in 2009 in accordance with the 2010 UNAIDS report. In 22 countries of sub-Saharan Africa, the HIV incidence rate declined by more than 25 per cent between 2001 and 2009. This is a good sign that efforts of prevention work and the increase access to life saving drugs is finally bearing results. Among the five countries in sub-Saharan Africa with the largest HIV epidemics, four - Ethiopia, South Africa, Zambia and Zimbabwe - reduced new HIV infections by more than 25 per cent between 2001 and 2009, while Nigeria's HIV epidemic stabilized. UNAIDS 2010 report indicated that southern Africa continues to have more than 70 per cent of the disease in sub Saharan Africa and 35 per cent of the total worldwide burden of the HIV disease. The battle

is still yet to be won in southern Africa. HIV prevalence in West and Central Africa remained relatively low in 2009, at or under 2 per cent in 12 countries.

There is marked improvement in the access to treatment the report stated. In 2009, nearly 37 per cent of adults and children in sub-Saharan Africa who were medically eligible for antiretroviral therapy received it, compared to just 2 per cent seven years earlier. Treatment scale-up is saving lives: between 2004 and 2009, AIDS-related deaths decreased by 20 per cent in sub-Saharan Africa. In Botswana, where treatment coverage exceeds 90 per cent, the estimated annual number of AIDS-related deaths fell from 18 000 in 2002 to 9100 in 2009—a decrease of about 50 per cent. In rural Malawi, the provision of antiretroviral therapy has been linked to a 10 per cent drop in adult mortality between 2004 and 2008.

In southern Africa, the number of children under 15 who became newly infected with HIV fell from 190 000 in 2004 to 130 000 in 2009—a 32 per cent reduction. In 2009, 54 per cent of pregnant women living with HIV in sub-Saharan Africa received antiretroviral drugs to prevent transmission of HIV to their children—up from 15 per cent in 2005. In Botswana, Namibia, South Africa and Swaziland, coverage of antiretroviral for preventing mother-to-child transmission of HIV reached more than 80 per cent. Between 2004 and 2009, AIDS-related deaths among children in southern Africa declined by 26 per cent, from 120 000 to 90 000.

The dominant mode of transmission of HIV continues to be heterosexual sex in sub Saharan Africa. The vast majority of people in sub-Saharan Africa continue to be infected with HIV through unprotected heterosexual intercourse and onward transmission of HIV to infants. According to the 2010 UNAIDS report, urban data in Zambia suggests that 60 per cent of people newly infected through heterosexual transmission acquired HIV within marriage or cohabitation, compared to 50 to 65 per cent in Swaziland and 35 to 62 per cent in Lesotho. Research in 12 countries in eastern and southern Africa found a high HIV prevalence among discordant couples (where one partner is living with HIV), ranging from 36 to 85 per cent.

Evidence has shown that key populations play a key role in the region's HIV epidemics. Recent studies have shown high levels of HIV infection among men who have sex with men. In Cape Town, South Africa, and Mombasa, Kenya, more than 40 per cent of the adult population of men who have sex with men is living with HIV. In addition, studies conducted in Botswana, Malawi, and Namibia found that 34 per cent of men who have sex with men were married to women, and a total of 54 per cent reported having sex with both men and women in the previous six months. The studies emphasize the need to target key populations in combating HIV in communities.

Table 2: Overview of people reached with various activities during 2010

Country	Preventing further infections	Care, Treatment and Support	Reducing Stigma and Discrimination	Total 2010
Angola	38,022	4,072	-	**42,094**
Botswana	95,462	432	-	**95,894**
Lesotho	23,475	12,860	393	**36,728**
Malawi	959,433	11,812	520,471	**1,491,716**
Mozambique	368,231	10,909	*326*	**379,466**
Namibia	260,000	11,076	1,577	**272,653**
South Africa	1,497,083	41,535	1,403	**1,540,021**
Swaziland	452,468	3,218	312,000	**767,686**
Zimbabwe	504,092	44,818	5,000	**553,910**
Total	**4,198,266**	**140,732**	**841,170**	**5,180,168**

Source: National Society 2010 Annual Reports

Progress towards outcomes

Prevention of further infection

Outcomes

- Reduced vulnerability to acquiring or transmitting HIV by conducting in and out-of-school youth peer education and community mobilization;
- Increased knowledge and change in attitudes and behaviour through information, education, and communication (IEC) for general population and targeted vulnerable groups.
- Increased use of voluntary counselling and testing (VCT);
- Increased use of prevention of mother-to-child transmission (PMTCT);
- Increased skills for personal protection, including condom use.

Achievements

To fulfil its mandate of providing technical support, capacity building, coordination and resource mobilization to the membership, IFRC-SARRO focused on strengthening NS' capacities in refining key prevention strategies in order to address the key drivers of the HIV epidemic. The 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 themselves 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 youth.

At the beginning of the year, IFRC-SARRO finalized the training package distributed to all the NS. Each NS received a total of 150 peer educator packs comprising of 60 boxes of the trainers' pack, and 1,000 playing cards. The Portuguese and English versions of the training package are available on a CD Rom for easy adaptation and reprinting.

IFRC-SARRO facilitated training of trainers (ToT) on the training package in 2009 and as a result NS' capacities were built up and in 2010 NS in the region were taking the lead in the roll out of the training package at national and district level. This is one good example of the *cascading model* the IFRC-SARRO is taking on together with the membership.

By end of the year, all the NS were trained. In the last quarter of the year through south to south support promoted by the IFRC, trainers from South Africa and Swaziland supported Namibia to train peer educator trainers. Mozambique Red Cross Society[3] (CVM) supported Angola Red Cross (ARCS) to train trainers. In Namibia a total of 22 staff from the regions and districts were trained over a period of 7 days. In Angola a total 15 staff from the provinces were trained on the training package. Malawi Red Cross Society (MRCS) supported Zambia Red Cross Society (ZRCS) to train 22 peer educators. Zambia Red Cross had not trained peer educators before but with support from its sister NS (Malawi), the NS has managed to set the systems for implementing the peer education programme in Lusaka and Kazungula where plans are under way to roll out to other communities. Mozambique Red Cross was supported by SARRO to train peer educators in Inhambane and a total of 23 peer educators were trained on the prevention training package.

During the training in Mozambique, a technical review of the training methodology was made and the facilitators were advised on the appropriate methods of training which ensured provision of useful and accurate information to the participants. The peer-to-peer support is making a difference. This is the best model that defines IFRC's regionality approach. The model is cost effective and efficient. It also enables capacity building for the NS and promotes learning and exchange of experiences.

[3] In Portuguese: Cruz Vermelha de Moçambique

There has been an increase in the number of peer educators in the NS from 1,725 in 2009 to 3,630 in December 2010. South African Red Cross (SARCS) is leading with a total of 1,241 peer educators trained and reaching huge numbers of youths in and out-of-school. Table 4 below shows the number of people reached through prevention activities.

Table 3: Overview of the total number of people reached with prevention activities in 2010

Country	Total	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 (PP)	Peer educators (PED)
Angola	38,022	7,180	25,750	1,201	378	3,513	-
Botswana	95,462	94,320	2555	2000	555	45	57
Lesotho	23,475	720	5,127	40,249	1046	-	200
Malawi	959,433	238,000	700,000	18,000	1,833	1,600	690
Mozambique	368,231	98,026	268,508	169	207	1,321	303
Namibia	260,000	32,146	12,927	1,316	35	1,577	81
South Africa	1,497,083	280,735	1,128,568	32,180	9,012	46,588	1,241
Swaziland	452,468	131,533	314,909	3,826	533	667	151
Zimbabwe	504,092	442,959	55,940	2,899	383	1,911	907
Total Region	**4,198,266**	**958,902**	**2,514,284**	**101,840**	**13,982**	**57,222**	**3,630**

Source: National Society 2010 Annual Reports

As a result of the 2009 capacity building efforts through the prevention workshop organised for NS and their multilateral and bilateral partners, technical support visits to monitor implementation and coaching, emphasis was put on introducing the new HIV prevention guidelines and streamlining of strategies focussing on:

- Strengthening NS' understanding of the key drivers of HIV and the differences in the epidemic 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 systematically address 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 the NS to key partner organisations such as National Association of People living with HIV or SWEAT (Sex Worker, Education, Advocacy and Training).

Through sound and coordinated technical support of IFRC-SARRO by way of training workshops, monitoring visits to the NS, coaching, e-communication and provision of financial resources the following was achieved in some selected NS:

Botswana

After receiving training from the IFRC-SARRO on the prevention training package there has been an increase in the number of local training workshops for peer education programmes at district level. This is a result of the linkages with the Zambezi River Basin Initiative (ZRBI), through which funding support for training volunteers in all Botswana Red Cross Society (BRCS) was channelled. A total of 57 peer educators were trained and supported to conduct peer education activities in Kasane, Moshupa, Tonota and Kanye Districts. The peer educators carried out HIV and AIDS education through outreach activities to in and out-of-school youths and in workplaces and clinics.

During the reporting period, the BRCS has increased its activities in peer education targeting correctional services. A total of 90 correctional services inmates were trained as peer educators to reach fellow inmates. The BRCS will work with correctional services clinic and staff members to strengthen this new intervention. The BRCS has been motivated to start HIV prevention activities in

correctional services as a direct response to guidance from the IFRC SARRO on targeting key population groups. The NS is slowly identifying its niche in the prevention activities and is becoming a source of good practices within the country. Positive prevention is one of the activities that the NS is implementing among the PLHIV who are on treatment. Botswana is one of the countries that have rolled out treatment to many of the people who need treatment and the need to strengthen adherence is becoming increasingly important.

Lesotho

Through the IFRC, with funding from the Icelandic Red Cross, Lesotho Red Cross Society (LRCS) trained 107 peer educators increasing their capacity to conduct peer education activities in the community. The training sessions were conducted in five districts for a minimum of five days per session. The knowledge of the participants was increased and the people reached by the trained peer educators had an increase in knowledge about HIV transmission and prevention methods. It is yet to be measured on the impact of the behaviours of the targeted populations.

In June 2010, LRCS in partnership with MSF trained 37 support group members from the Kena CHBC project area on prevention of mother to child transmission (PMTCT). The training targeted mothers-in-law and daughters-in-law as culturally, mothers-in-law are influential on issues relating to the reproductive health and breastfeeding behaviours of their daughters-in-law. It was critical for them to understand PMTCT concepts in order to influence and advise their sons and partners accordingly. Topics covered during the training included basics on HIV and AIDS, VCT, PMTCT, care of a pregnant mother, nutrition, breastfeeding, formula feeding and positive living.

Namibia

Prevention remains a key strategic area in fighting HIV and AIDS in Namibia. During the reporting period the Namibia Red Cross Society (NRCS) reached 12,927 (7,804 females and 5123 males) through the distribution of IEC material on HIV prevention. An even greater number, 32,146 people were reached through prevention messages disseminated by youth peer educators. The NRCS also reached 1,316 people through voluntary counselling and testing (VCT) services provided at the NRCS VCT centre (New Start Centre). This achievement was a result of the introduction of a mobile testing and outreach service on the outskirts of the border town of Katima Mulilo.

Zimbabwe

Whilst the Zimbabwe Red Cross Society (ZimCross) increased the number of peer education activities carried out during this period as compared to 2009, there has been a significant drop in the number of beneficiaries reached. The ZimCross is facing challenges with funding as many partners have reduced activities. The good work that has been done by the NS over the past many years risks to be washed under the drain. It is important partners come to the table again and sustain the good work which well appreciated by the government. The ZimCross has developed a new plan for 2011 to 2014 looking at a comprehensive approach to health and care interventions including HIV, TB, malaria and primary health.

South Africa

SARCS is championing the youth peer education programme in the region. The NS has trained the highest number of peer educations and the peer educators are reaching their fellow youths in schools and out of school. SARCS is in the process of documenting the good practice on peer education. With support from the Finnish Red Cross the peer education activities have continued to increase in value and efficiency. More materials were printed to support peer education activities and refresher trainings were conducted in the provinces.

SARCS runs a Young Women Development (YWD) project under the youth development programme whose main objective is to empower women in society. Under the project various activities were carried out throughout the country focussing on income generation, hygiene and self image, gender-based violence (GBV), leadership, life-skills, self-development, gender mainstreaming and learning and sharing challenges affecting women.

In partnership with the Ministry of Health (MoH), SARCS adapted and printed materials on HIV prevention, treatment, care and support, which were distributed to the public on World TB Day.

SARCS also conducted community outreach interventions through door-to-door campaigns using facilitators and care givers.

Malawi

MRCS continued strengthening the activities started in the first half of the year. For the first time in many years, the NS has received more funds for prevention than any other component of the HIV programme. MRCS introduced new innovative ways to address prevention of HIV infection. The introduction of the Young Men as Equal Partners (YMEP) project in Chiradzulu, Mwanza and Nkhatabay Districts has transformed the face of MRCS prevention strategies. A training of trainers' workshop for 21 local professionals in the three districts was conducted by trainers from RFSU was instrumental in establishing the project in MRCS. The participants were drawn from the ministries of health and education. MRCS also conducted an YMEP baseline survey in Chiradzulu, Mwanza and Nkhatabay Districts. The results will provide a frame of reference for measuring impact of the YMEP project.

In order to build a solid foundation for the YMEP project, 60 peer educators were trained on the YMEP concept in Chiradzulu, Mwanza and Nkhatabay Districts by a Regional YMEP Coordinator from Tanzania. An additional 60 teachers from Mwanza, Chiradzulu and Nkhatabay were trained on sexuality and gender for HIV and AIDS prevention. They are supporting the programme as matrons and patrons.

MRCS has also intensified prevention strategies targeting the most at risk persons (MARPS) especially commercial sex workers. A total of 90 commercial sex workers were trained on peer education in Mwanza, Ntchisi, Nkhotakota, Dowa, Kasungu and Nkhatabay Districts. The commercial sex workers are providing peer education at public places such as bars. During the period under review, a total of 18 planning and coordination meetings were convened with 97 commercial sex workers. The meetings have motivated the commercial sex workers to do more though they are challenged by lack of transport to assist them to move to around to educate their peers.

During the review period, MRCS also trained 425 post test club members in Mwanza, Nkhatabay, Kasungu, Nkhotakota and Dowa Districts. The post test clubs reached a record 119,600 youth with HIV testing and counselling (HTC) information. One outcome of this intervention was the counselling and testing of 1,466 youth. During the reporting period, 430 peer educators from MRCS reached 17,360 peers through peer education.

MRCS has also increased culturally acceptable IEC activities targeting the MARPS and the general population. A total of 374,580 people were reached through community mobilization activities including 41 open days in 14 districts, 33 community dialogue meetings in six districts and two HIV and GBV awareness trophies, one each in Chiradzulu and Mwanza Districts. With support from the district hospitals, the National Society distributed 21,362 condoms during the reporting period.

Constraints or challenges

- It is becoming evident that NS' HIV responses are now changing shape. For instance MRCS is beginning to address specific target groups such as young men and commercial sex workers. There is need for many NS to increase their prevention interventions that target the most at risk populations.
- HIV prevention activities are still largely underfunded in many NS. In order to achieve a reduction in HIV infection in many countries there is need for significant funding directed at prevention interventions.
- The NS will require more peer educators' training packs in order for them to reach many young people at community level. Whilst this is important, most NS do not have funding to print more packs.
- Development of relevant and culturally sensitive IEC materials is still a challenge in most NS. There is need to strengthen the capacity of the NS in this area. Strong partnerships are required with organizations who are experts in the development of IEC materials.

Expanding care, treatment and support

Outcomes

- Increased assistance to OVC;
- Provision of home-based treatment, psychosocial support and HBC for PLHIV;
- Community support groups and networks are strengthened;
- Livelihoods and food security for the most vulnerable are promoted.

Achievements

After many years of capacity building in OVC programming by IFRC-SARRO through the establishment and maintenance of the OVC working group, training workshops, coaching monitoring visits and development of technical documents, most NS in the region have continued focus on quality rather than quantity in provision of services to OVC. During the reporting period the number of OVC supported decreased mainly due to the reduction in funding support by some donors and the closure of 8 project areas by ZRCS, which resulted in a reduction of OVC numbers in Zimbabwe from 55,031 to 28,791.

The regional OVC working group coordinated by IFRC-SARRO is a technical working group that meets quarterly. The main purpose of the working group is to coordinate NS, share experiences and lessons, develop strategies and policies. The working group met once during the reporting period to discuss amongst other issues the sustainability of support of OVC programming. There was renewed emphasis on the need for greater community (and branch) involvement in the programme and the need to build up the capacity and resilience of families and guardians to cope with the children in their care. There was consensus that it is not possible to “discharge” children from the programme unless there were support systems in place to care for the children. Children have different needs and one of the aims of the programme is to empower them through education, psychological and social support, life skills and child participation to build their confidence and self esteem. During the meeting there was also a one day refresher workshop on the updated version of the Hero Book Manual facilitated by REPSSI.

During the working group meeting IFRC-SARRO engaged the NS on the issue of school fees which was discussed at length. Education is vital for OVC if they are to have a brighter future, but school fees and other educational support are expensive. LRCS is lobbying the Ministry of Education to support the educational costs of OVC in the programme. The BEAM (Basic Educational Assistance Model) has been re-introduced in Zimbabwe and ZimCross aims to advocate at national and community level for OVC education costs to be covered by BEAM.

The Child Protection Strategy developed by the IFRC together with the OVC working group, was endorsed by SAPRCS in January 2010 and a plan for the dissemination, orientation and implementation has been developed. The strong partnership with REPSSI continued and plans have been mooted for production of a manual on children as carers targeting child headed households, children taking care of sick parents and elderly grandparents taking care of OVC. The NS will provide case studies for the manual.

The IFRC-SARRO provided funding to the NS for OVC activities using the Children of the World (COW) funds which is channelled through the Swedish Red Cross. The funding made a huge difference at a time when other funding sources are decreasing and enabled support of almost 5,000 children in Botswana, Malawi, Mozambique, Namibia, Swaziland and Zimbabwe from June 2009 to March 2010. The funding covered a variety of activities including educational and material support, training, and support for kids and grannies clubs and life skills camps.

Through concerted support from IFRC-SARRO, the NS in the region managed to implement the following vital activities:

Lesotho

Through the IFRC supported partnerships with the Ministry of Finance, which is the principal recipient of Global Fund for AIDS, TB and Malaria in Lesotho LRCS received support for food

security activities from the GFATM during the period. The food security activities focussed on the establishment of key-hole gardens and community gardens. With support from Norwegian Red Cross, LRCS expanded the water and sanitation component of the OVC programme benefitting 780 OVC households.

South Africa

As a beneficiary of the IFRC partnership with REPSSI, SARCS experienced an increase in the number of OVC provided with psychosocial support through the implementation of a specific psychosocial support programme supported by REPSSI. SARCS has mainstreamed psychosocial support into all programmes.

Malawi

With guidance from IFRC-SARRO, MRCS made a decision not to increase the number of children provided with educational support due to financial constraints. MRCS will also advocate for educational support through the government sponsored bursary which is dispersed at community level. During the reporting period, MRCS provided start-up tools for 40 OVC who were trained in various vocational skills in 2009 and two OVC from the children's corners in Chiradzulu participated in the children's parliament in the district. The NS increased the number of guardian clubs from 11 to 12.

Namibia

As a result of strong collaboration, NRCS continued to receive some assistance for educational support through a scheme administered by government. IFRC-SARRO has always encouraged NRCS to work together with the government.

Swaziland

Grannies or guardians clubs continued to play a major role in the OVC projects. Activities carried out in the clubs include psychosocial support through memory work or livelihoods projects. During the reporting period Baphalali Swaziland Red Cross Society (BSRCS) established a club for the guardians of children who are on ART. The NS also disseminated the child protection strategy (CPS) to staff and 90 per cent of the staff and 56 care facilitators were trained on the CPS. The HR department has included the CPS as part of the staff Code of Conduct.

One of the RC supported grannies making a grass mat through under the IGAS project.

Zimbabwe

With financial support from IFRC-SARRO, ZimCross established the grannies/guardians clubs in a systematic way by initially carrying out a rapid needs assessment and then a baseline survey to establish the needs and baseline indicators for use as a basis for measuring impact of the clubs. A total of 63 clubs have now been established whose objectives are to strengthen and empower families and communities to effectively implement OVC activities. All the clubs are now involved in livelihood projects including bee keeping, poultry and goat keeping and nutrition gardens. Club members are also trained on basic HIV and AIDS, ART, parenting, health and hygiene. Psychosocial support is provided through memory work.

Table 4: Overview of OVC reached with services during 2010

Country	OVC receiving RC services	OVC receiving food assistance	OVC receiving educational support	OVC receiving material support	OVC receiving psychosocial support	OVC reached by RC kids or youth clubs
Angola	1,499	590	590	512	712	0
Botswana	191	63	0	50	191	50
Lesotho	10,500	20,225	743	9,200	8,115	3,888
Malawi	9,661	1750	396	8,700	1,400	2,560
Mozambique	6,145	1,900	6,145	6,145	6,145	500
Namibia	4,250	237	207	829	863	275
South Africa	19,201	1,250	2,371	908	12,640	5,925
Swaziland	1026	209	436	0	30	50
Zimbabwe	28,791	1,491	1,565	843	5,063	3,298
TOTAL	**81,264**	**27,715**	**12,453**	**27,187**	**35,163**	**16,546**

Source: National Society 2010 Annual Reports

Providing community home- based care (CHBC) services

The activities under this component of the programme have not changed since the first programme update in June 2010. This component did not receive additional funding from partners. As a result the activities that took place in the first half of the year are the ones reported.

IFRC-SARRO continued to support NS in developing technical documents on the implementation of CHBC. The CBHC programme takes a holistic approach by looking at the entire household as the unit for support focusing on empowering all the members of the family and not the individual alone. For instance, food cannot be provided to a child who may be an OVC and leave out the caregivers.

Promoting adherence for clients on ART and TB treatment is a critical activity that must be strengthened and expanded. The roll-out of ART by governments was encouraging and has been expanded. However, governments have limited structures and mechanisms to monitor and promote adherence at community level. The Red Cross has the structure and organisational capacity and readiness but lacks funding support.

The establishment of support groups has facilitated the care of clients who are being discharged from the CBHC. The support groups are providing positive prevention for PLHIV. Some support groups, for example, the widows group in Mozambique have embarked on income-generating projects as a way of strengthening livelihoods. LRCS is ensuring that support group members engage in livelihood activities including food security through keyhole gardens or backyard gardens where they are able to grow vegetables.

Table 5: Overview of PLHIV supported through CHBC related activities in 2010

Country	Number of HBC Projects	Number of PLHIV supported through CHBC	No. of care facilitators/ Volunteers	No. of PLHIV in Support groups
Angola	7	2,573	287	50
Botswana	1	241	46	95
Lesotho	5	2,360	184	639
Malawi	12	2,151	1086	1,600
Mozambique	29	4,764	651	595
Namibia	7	6,826	683	1,577
South Africa	24	22,334	437	2913
Swaziland	8	2,192	365	1319
Zimbabwe	19	16,027	1,130	3,365
Total	**112**	**59,468**	**4,869**	**11,964**

Source: National Society 2010 Annual Reports

The number of clients has decreased slightly from 60,750 in June 2009 to 59,468 in 2010. Equally the number of care facilitators decreased from 7,955 in June 2009 to 4,869 in 2010. Some of the reasons for the decrease are :-

- Reduced funding to the regional HIV and AIDS programme.
- Many clients have become mobile hence they have been discharged from the programme and joined other forms of support such as psychosocial support through the support groups.
- Some NS have reduced the number of project areas and hence the number of clients and care facilitators has been reduced significantly. Zimbabwe Red Cross is one NS due to funding constraints has reduced its operations to merely19 project areas from 27 areas.
- This also in line with the SARRO's approach to proper programming and having focussed programmes and with the emphasis on quality and not quantity. NS are beginning to implement this philosophy.

IFRC-SARRO has continued to provide guidance on admission and discharge criteria especially with the change among clients who are on antiretroviral treatment (ART). There is less and less focus on traditional nursing care by NS as a result of the roll out of ART in many countries in the region. UNAIDS reports indicate that there is an increase in the number of people accessing treatment in low income countries. At the end of the 2009, 5.2 million people were on treatment world-wide and 60 per cent of these are in high HIV prevalence countries the majority of which are in southern Africa. Approximately three million people are receiving ART in southern Africa and South Africa alone accounts for 30 per cent of the people on treatment. The majority of people on treatment are healthy and mobile. They no longer require intensive care at home and they have fewer opportunistic infections. This has transformed the way CHBC is implemented in many countries hence the need for a new approach in CHBC.

During the reporting period, IFRC-SARRO developed new CHBC minimum standards and were rolled out across all NS. The main purpose of the standards is to ensure that the NS are provided with guidance on the management of clients in the era of ART and to guide on the admission and discharge of clients from the programme.

IFRC-SARRO organized and conducted a CHBC minimum standards workshop in Namibia, Windhoek in February 2010 for five countries namely Malawi, Namibia, Zimbabwe, Botswana and Zambia. The workshop was attended by 40 participants including field officers working at project sites who were trained on the CHBC minimum standards.

The workshop was also an opportunity for the five NS to review the CHBC minimum standards manual before finalization. The second workshop was held in Maputo in April 2010 for the Portuguese speaking countries, attended by 35 participants from Mozambique and Angola Red Cross.

The CHBC minimum standards manual is almost ready for publication pending translation into Portuguese and will be shared with other regions within Africa and beyond. Through the support provided by the IFRC in the form of capacity building, monitoring and coaching the capacity of the NS programming was strengthened and increased. As a result the following achievements were realised:

Zimbabwe

Despite a backlog in care facilitator allowances disbursements, care facilitators continued to hold monthly meetings in all provinces with their supervisors and update their reports and share information related to programming. A total of 12 officers from ZimCross participated in a CHBC minimum standards workshop held in Namibia to review the content, structure and feasibility of the standards.

With support from UNICEF, ZimCross received CHBC kits during the reporting period. Funds were also received for the Health and Care programme through the IFRC, to support the HIV and AIDS programme in the procurement of hygiene kits for the OVC and production of IEC materials for cholera, malaria and HIV and AIDS.

ZimCross also worked with other stakeholders to develop the national CHBC guidelines, which have been defined as “an integrated system of HIV care designed to meet the health needs of individuals, families and communities in their local setting”. Some of the components include Provider Initiated Testing and Counselling (PITC) and Behaviour Change (BC), which had been mainstreamed into CHBC making it more appealing and resilient.

In the last quarter of the NS conducted an end of programme evaluation of the HIV programme. The partners supported with funding the evaluation, however the report was not well written by the consultants and the results therefore were not conclusive. At the end of the year the existing partners of the NS were considering the form of partnership with the NS and the way forward. The Japanese Red Cross had indicated that they would not continue supporting the NS.

Malawi

The number of vulnerable people on the programme (OVC and PLHIV) keeps on declining but the interventions are becoming more holistic than before. After a rapid assessment conducted in 2009, the CHBC targets for 2010 were drastically reduced in accordance with the resource base.

The capacity of the PLHIV support group to be self sustaining was enhanced through the training of 100 members from four support groups from Zomba, Karonga and Lilongwe Districts. The support group members were trained on positive development and mushroom production. The National Society also purchased and distributed CHBC kits to care facilitators in Zomba, Balaka, Mchinji, and Karonga Districts.

MRCS has continued to work closely with MANET+, a national network for people living with HIV in Malawi. The NS is implementing some good practices including the goat-passing on project. A family with an OVC is provided with two goats (male and female), when the off springs are brought forth, they are passed on to the first family on the list and then the chain follows. The project is doing well and many families are benefiting from the passing on of goats to the other.

Mozambique

With the guidance of the IFRC-SARRO and the government, CVM has changed the approach of its CHBC programme to reflect the change in programming from the traditional nursing care to home visits. CVM is focusing more on home visits where services include psycho-social support, adherence monitoring and HIV awareness with minimal nursing care in line with new government guidelines. During the reporting period, the NS provided support to 4,527 CHBC clients from Tete, Manica, Gaza, Ressano Gacia and Maputo.

The staff who were trained on the training package on HIV prevention, treatment, care and support in 2009, continued training and disseminating messages to care facilitators on issues such as adherence, treatment literacy, and ensuring that those on treatment are supported. More funding is required to train more volunteers on the training package and also to reprint the documents.

Many partners funding was coming to an end in 2010 and this was the trend among all NS in the region. The NS is looking at ways to fundraise in order to maintain a minimum level of funding to implement activities related to care and support.

South Africa

Due to the ending of the Netherlands Embassy funding, the NS was engaged in the restructuring of the HIV programme. The RNE funding was covering nearly all the provinces that SARCS was operating in. The challenge for the NS would be to maintain the activities that were being supported by the RNE funding. The NS has good programmes and dedicated facilitators and care givers including staff.

Swaziland

During the reporting period, the BSRCS provided support to 2,192 home-based care clients, who benefited from basic nursing care services, treatment adherence counselling, and livelihoods support (integrated food security and IGAs). During the period under review, 93 new clients (39 males and 54 females) were enrolled into the CHBC programme, whilst 11 deaths were reported and 28 clients were discharged from the programme.

Due to the decrease in funding support to the programme, the maintenance of care facilitators that receive monthly incentives is becoming a great challenge. There were 155 care facilitators from five divisions who were trained on the PMER system designed for the HIV and AIDS programme in December 2009, however due to lack of incentives these care facilitators are unable to report.

The NS has developed a discharge plan in order to cut down on the costs. With financial support from the Japanese Red Cross received through the IFRC-SARRO, the exercise completed in December 2010. Feedback from care facilitators has revealed the difficulties in discharging CHBC clients particularly those on ART since they need regular follow up to ensure adherence to treatment. Strong linkages should be developed in the community and innovative strategies should be developed on how to support clients who are being discharged from the CHBC programme by strengthening family and community support.

Namibia

During the period under review; prevention, care treatment and support interventions were implemented in seven regions namely Caprivi, Kavango, Otjozondjupa, Oshikoto, Ohangwena, Kunene and Khomas through the CHBC programme. The Regional office has continued to provide funding and technical support to the NRCS in various ways and as a result the NS has been able to reach beneficiaries who need support.

Constraints or challenges

- The NS had challenges in implementation of the programme due to lack of adequate financial resources, thus most of the components of the programme were not implemented as planned. The major problem was the non-availability of RNE funding, which affected the provision of support to OVC. As a result, it has negatively affected the reputation of the Red Cross at community, district, national and regional level due the fact that a large number of OVC have been denied educational, nutritional and material support due to non-disbursement of funds.
- Volunteers who were supporting the children have also left the programme joining other organizations. Some NS staff members have been retrenched, whilst some NS accrued debt in unpaid salaries and benefits.
- 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, the availability and magnitude of funding is changing from year-to-year. 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 lack of funding support has forced ZRCS to close eight project sites resulting in a discharge of 25,000 OVC from the programme.
- Due to the decreased funding support coupled with the roll out of ART, some CHBC sites have closed in Malawi, Mozambique, Zambia and Zimbabwe. On a positive note, some NS have started discharging clients who have fully recovered. LRCS and MRCS are discharging clients to support groups, where they meet regularly to discuss coping mechanisms; and engage in IGAs that are economically empowering.

Reducing stigma and discrimination

Outcomes

- Community support groups and networks of PLHIV as well as partnerships with PLHIV organizations are strengthened;
- Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent NS;
- Reduced gender inequalities and sexual gender-based violence;
- Increased awareness against stigma and discrimination through peer education, community mobilization, and population-based information, education and communication.

Achievements

Promoting support groups

In order to strengthen support groups in NS, regional guidelines have been developed in conjunction with the Regional Network of African People Living with HIV in Southern Africa (NAP+SAR). The guidelines will be used throughout SADC with a strong endorsement from the SADC HIV and AIDS Unit. The NS will be oriented and trained jointly with the national networks of people living with HIV in the ten countries. It is expected that support groups will be well managed and maintained after the training of group members and facilitators.

Together with the network of people living with HIV, the NS will strengthen income generating activities (IGAs) approaches. It is important to note that the main focus among many organizations is increasingly becoming economic support through microcredit facilities, cash transfers and income generating activities.

MRCS has taken the lead in piloting this approach as they have started discharging CHBC clients to support groups. The support group members meet twice a week to discuss coping mechanisms; and engage in income generating activities in order to empower themselves economically. MRCS trained 100 members of support groups from Lilongwe, Karonga and Zomba Districts on positive development and mushroom production.

With funding support through the EU/Finnish Red Cross, BSRCS trained members of support groups in IGAs management and positive living. This project was implemented in partnership with Swaziland National Network for People living with HIV and AIDS (SWANNEPA) a national network for people living with HIV.

SARCS continued to strengthen the young women in development programme. The programme is reaching many young girls with life skills and positive messages. The young girls in schools meet to discuss the challenges they encounter in life such as sexual abuse, pregnancy and drug and alcohol abuse.

HIV workplace policy and programmes

SARRO has continued to promote work place programmes among the NS emphasizing that 'charity begins at home` and that we have to walk the talk. During the reporting period, NS made steady progress in implementing HIV and AIDS Workplace Policies mostly by disseminating existing policies to staff and volunteers at branch levels. SARCS with support from the Finnish Red Cross reviewed the policy to include wellness in the psychosocial support programme. This will go a long way in helping staff and volunteers deal with their HIV status. Though funding maybe a major impediment to the implementation of workplace programmes, NS can still implement their workplace programmes with no or less funding. What is required is the will and involvement of management in the process and it should be driven by human resources departments.

BRCS has an equipped gymnasium at the headquarters for staff to promote wellness. Educational sessions on HIV and general wellbeing are being implemented for staff. Condoms are being placed in toilets for use by staff.

Table 6: Staff on workplace programmes in 2010

Country	Full time staff	Staff participating in workplace programme
Angola	154	44
Botswana	72	9
Lesotho	74	30
Malawi	106	85
Mozambique	291	50
Namibia	678	46
South Africa	400	236
Swaziland	90	85
Zimbabwe	185	142
Total	2,050	727

Reducing gender inequalities and tackling sexual and gender based violence

IFRC-SARRO developed a gender base violence (GBV) strategy, which is now in its roll out stage. With availability of funding, the NS would have increased their GBV interventions at community level, however due to lack of funding there has been a lag in the introduction of new activities.

The major challenge to implement this strategy has been the non-disbursement of funds by RNE since June 2009. In accordance with the contractual agreement, RNE was supposed to fund OVC, GBV and part of NS capacity building. The NS activities have been severely affected as a result of the withholding of the funds. However, some NS such has MRCS have continued to strengthen the community victim support units by working with other partners.

Some NS made significant improvements in sensitizing staff members and volunteers on the availability of the Masambo Fund and on how to apply for it. Swaziland, Malawi, Mozambique and Zimbabwe have submitted applications on behalf of volunteers and staff members in need of the support. Out of 90 applications, 47 per cent of them have been funded from Malawi and Mozambique Red Cross Societies.

Through technical and financial support provided by the IFRC-SARRO and bilateral partners the NS achieved the following:

Swaziland

BSRCS embarked on a campaign aimed to raise awareness on SGBV of people at community level and amongst the staff. The NS mounted two billboards with GBV messages along the Mbabane-Manzini corridor where they are estimated that to reach more than 300,000 people per day. The NS advocates for gender equality even in its recruitment and currently has 53 females and 44 males on its staff compliment. Out of the 68 people working on the HIV and AIDS programme, 33 are males and 35 females. BSCRS successfully managed to integrate care facilitators into the government structure and they will now be part of the Rural Health Motivators.

Namibia

NRCS established a total of 238 support groups. In Caprivi region alone, the NS ran a post-test club which encouraged clients who test positive to join support groups. Support group members come together for group counselling once per week. Group counselling activities were introduced after it was discovered that time for counselling at VCT centres was too short for a counsellor to cover all topics for a client to understand and accept his or her HIV status and change behaviour. Group counselling sessions help clients gain more information on HIV and AIDS and have a better understanding of their status.

NRCS trained a total of 40 support group members as support group leaders. The training covered the following topics critical stress, stigma and discrimination, advocacy and HIV and AIDS. Another 20 support group members were trained on nutrition and micro- gardening to empower support group members to manage their own individual and group gardens. The objective was to reduce dependency and generate income for the members.

A total of five members from different support groups attended a one week proposal writing training in Windhoek. As a result of the work of support groups, cases of discrimination have generally

decreased nation-wide as more people are sensitised on issues related to the negative effects of stigma and discrimination.

Lesotho

LRCS conducted a training workshop for 15 project officers on SGBV in February 2010 facilitated by the Child and Gender Protection Unit, Ministry of Health and Social Welfare Department and Ministry of Gender. Project officers are expected to cascade the training to care facilitators who interact regularly with survivors of GBV.

During the reporting period, LRCS assisted four OVC to claim their inheritance whilst a total of 59 who could not be assisted were referred to the Child and Gender Protection Unit (CGPU) and Office of Master of the High Court for further assistance. LRCS reached 393 people through 20 advocacy meetings held with various authorities on issues of discrimination, property inheritance and children's rights.

Zimbabwe

ZimCross conducted a national IEC material development workshop leading to the production of 1,500 pamphlets and 1,000 posters on GBV, which are being distributed to target communities. In addition 19 training workshops on GBV were conducted at project site level in partnership with the Ministry of Youth, Gender and Development. Each workshop was attended by approximately 30-40 participants.

The NS continued to participate in anti-stigma campaigns at provincial level through participation in events such as World AIDS Day commemorations. The NS also reached 5,000 people with anti stigma messages through the use of Ambassadors of Hope at events such as Zimbabwe International Trade Fair (ZITF) and the Chimanimani Arts Festival.

Constraints or challenges

- With the development of the regional GBV strategy, the NS are ready to engage further and implement their action plans. GBV interventions however require active sectoral collaboration (health, social services, police, judiciary, and other support services) and sustained funding. The uncertainty of funding makes it difficult for the NS to further engage in such initiatives.
- Funding for the training of trainers on support groups and IGAs 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 manage the support groups. More funding is required for this component in order to sustain the ongoing activities in care treatment and support.
- There are weak linkages with networks of PLHIV. The NS need to strengthen relationships with the national and regional networks of people living with HIV.
- While the interest and need among the NS to apply to the Masambo Fund has been emphasised and more applications are being submitted, there is a challenge of availability of funding for new applicants at Geneva level. Aggressive fundraising efforts should be applied in order to mobilize more funds for the Masambo fund at Geneva level.

Building National Society capacity

Outcomes

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

Achievements

Planning, monitoring evaluation and reporting

IFRC-SARRO embarked on a midterm review (MTR) from January to April 2010. Four countries were visited namely Lesotho, Malawi, Mozambique and South Africa. The rest of the countries participated through postal questionnaires. The objective of the MTR was to assess progress made so far by the IFRC and the NS in southern Africa in the implementation of the Global Alliance on HIV in the region, and to make recommendations on the future direction of the programme. The MTR focused on various aspects of the programme including reviewing the cost effectiveness of some key interventions, structures, processes and systems established for the regional programme. A team of external consultants was hired to carry out the MTR with strong support and guidance from IFRC. Recommendations from the mid-term review will be factored into the planning process for the next four years.

One of the key findings from this study is that the Global Alliance on HIV concept has been understood and adopted by the NS in the form of the seven principles and programmatic framework. However, the implementation of the seven principles is of varying degrees, with Malawi and Zimbabwe Red Cross having successfully applied all the seven principles. The review noted that the two principles hardly applied are "*one division of labour understanding*" and "*one accountability and reporting system*". Basically these have been difficult to apply as NS are protective of their bilateral relationships and sources of funding and they have to report to different donors which have different requirements.

The review team also interviewed partners in the Global Alliance, where many PNS expressed their willingness to continue their bilateral funding to the NS.

Volunteer management

Strong linkages have to be created with the organisational development departments in all NS in order to address current discrepancies in volunteer management. The MTR found out that the NS do not have a standard strategy for recruiting, motivating and supporting volunteers. Efforts should be made to streamline and harmonize the volunteer management systems at NS and regional levels.

Human resources management

IFRC-SARRO experienced staff losses during the reporting period with the resignation of the operations manager and finance officer and the move to Geneva of the HIV Coordinator leaving the Regional HIV delegate and the health and care coordinator managing the programme. At the NS level, many project officers have been retrenched or have left the programme due to uncertainties in funding. The human resources management and development at NS levels should be strengthened in order to address the prevailing challenges, the major factor being the financial constraints to pay reasonable salaries and benefits.

Resource mobilization

The Norwegian Red Cross confirmed the allocation of NK1 million to the regional HIV programme to support activities in NRCS and BSRCS. The funding will go a long way in supporting HIV activities that have not been funded in the two NS due to non-availability of RNE funding.

The Japanese Red Cross confirmed funding for LRCS, MRCS and BSRCS totalling JPY 3 million for each NS. Additional funding was allocated for IFRC regional activities amounting to JPY 3 million. The Swedish Red Cross and the Icelandic Red Cross have continued to give funding to support HIV and AIDS activities at regional and country levels.

At country level the NS are increasing their efforts in fundraising. NRCS, LRCS, MRCS, BSRCS, CVM and BRCS are accessing GFTAM funding through their governments or National AIDS Commissions. Some of these NS have developed strong partnerships with UN agencies and corporates in fundraising. This is an excellent trend since opportunities for resource mobilization at global and regional levels are becoming increasingly scanty. The way forward for the NS is to

ensure that they position themselves strategically at country level as the most preferred organisations in their countries in all aspects including transparency and accountability.

Constraints or challenges

- The uncertainty of future funding support and non-disbursement of funds by one of the major donors for 2009 and 2010 has had negative implications for planning and implementation of the programme activities including the transition plans.

Working in partnership

In order to increase its market share and competitive advantage in the region, the IFRC has strengthened its linkages with relevant partners. The aim of partnerships will continue to be reviewed and evaluated looking at value addition. The IFRC has a comparative advantage among many regional organizations. It has a facet that allows it to have influence at global, regional and country level using its structures. In the coming years the IFRC will focus on its advocacy role to ensure that the organization uses its maximum potential to influence policies at global, regional and country level. During the reporting period the following activities have been implemented together with partners.

Regional Inter-Agency Task Team on Children and AIDS (RIATT)

IFRC is a member of RIATT (Regional Inter-agency Task Team on Children and AIDS). RIATT is an important networking group for southern and eastern Africa for partners to come together and discuss vital issues on policy and programming related to children and AIDS. IFRC is a member of the "Strengthening Families as Units of Care" working group which is looking at inter-generational issues between elderly caregivers and the children they care for.

Issues discussed at RIATT are passed on to the NS via the members of the regional OVC working group – for example the most recent RIATT meeting which was held in March 2010 focussed on child sensitive social protection. Some NS will be involved in conducting focus group discussions with children which will feed into the RIATT inter-generational research.

RIATT is also the forum where SADC issues relating to OVC and youth support are discussed. Most recently this included a discussion on the SADC minimum package on support for OVC which is currently being developed and which will provide policy and programme guidance to member states.

Regional Psychosocial Initiative (REPSSI)

IFRC has an MOU with REPSSI which is the leading organisation in SADC working with partners to promote psychosocial care and support for children affected by HIV and AIDS, poverty and conflict. IFRC has been working closely with REPSSI for many years. Collaboration has included joint manual production – for example the *memory work* manual and the manual on *mainstreaming PSS into CHBC* – and in 2010 IFRC collaborated on a manual on working with older carers and children as caregivers. The manuals produced are used by governments and SADC partners to strengthen psychosocial support interventions in the region. The NS benefit from this collaboration by attending joint trainings related to PSS – in 2009 this included training on *mainstreaming PSS into paediatric ART* and more recently the members of the OVC working group received training on the revised *hero work manual*. The OVC working group pre-tested the first hero manual with REPSSI. The NS also develop joint work plans with REPSSI for country specific PSS work.

Programmes and policy on OVC support are all discussed at a regional level through the regional OVC working group. Most recently this has resulted in the development of a regional Child Protection Strategy which has been endorsed by SAPRCS and which all the NS have pledged to implement. Through the regional working group, members are sponsored to attend relevant regional conferences – for example the First International Conference on Family Based Care for Children in Africa held in Nairobi, and bring back learning and good practice to share with the rest of the group. IFRC facilitates the sharing of good practice within the group – for example, OVC officers from four NS together with children attended the ZimCross children's camp and children's conference. The IFRC also facilitates the development of good practice documents for regional

learning – for example the LRCS good practice document on caring for children on ART. The working group members are also involved in the regional Red Cross campaign on access to paediatric ART.

Adaptation of the WHO/SAFAIDS/IFRC training package for community based volunteers

After the joint development of a generic training package on HIV prevention care treatment and support for community-based volunteers to support government efforts in the roll out of ART at community level, IFRC once again using its comparative advantage led the process of adaptation at county level working closely with WHO – AFRO. The training package has found acceptability at country level with ministries of health leading the process of adaptation by bringing together all relevant partners together. IFRC and WHO have provided technical support in the process of adaptation. The training package has contributed in various ways including development of care and support minimum standards, guidelines and HIV policies.

Regional partners such as SAFAIDS, VSO-RAISA, REPSSI, SADC and ARASA have used the training package as reference material and have promoted or advocated for its use among grass roots partners.

The following interventions were jointly implemented with WHO:

Zambia – Ministry of Health

IFRC and WHO provided technical support in the adaptation of the training package. Care Zambia funded the process by bringing together all district AIDS task force focal persons and national partners including faith based organizations. As a result the entire training package has been adapted and is now a national training package being used by MoH and all partners.

Lesotho Ministry of Health

Lesotho was the first country to lead and complete the adaptation process of the training package. The package is currently being translated into Sesotho by the University of Lesotho. The training package was instrumental in training community-based volunteers country-wide who were involved in the “Know your status” campaign.

Mozambique Ministry of Health

The MoH, CDC, UNDP and WHO country office led the process in the translation into Portuguese and adaptation of the training package. IFRC, WHO and VSO-RAISA together supported the process. A launch of the adapted training packaged was conducted and all partners in the country were oriented on the training package. The training packaged has become the main training tool national-wide.

Namibia Ministry of Health

IFRC and WHO supported Namibian government and its partners in the adaptation process of the training package which has resulted primarily in the development of CHBC minimum standards and additional training materials on HIV treatment and support. The developed and adapted materials will help the government and its partners on the implementation of treatment programmes at national, regional, district and constituency levels.

Botswana Government

With full technical support from WHO and IFRC, the government of Botswana is almost at the end of the adaptation process of the training package. The MoH brought together all partners to review the generic training package in order to suite the local situation – cultural and political. As the SADC HIV unit is based in Botswana, a representative was present at the adaptation meetings. It is planned that after the adaptation process is complete a training of trainers workshop will be held at which IFRC and WHO will be invited to facilitate.

Malawi Government:

The Malawi Government has not entirely adapted the training package, however, the MoH with support from the WHO country office; VSO-RAISA and the MRCS have succeeded in using the training package in the development of a comprehensive CHBC manual. MRCS on behalf of the

IFRC-SARRO has been called upon by national partners including networks of PLHIV to train trainers on the training package.

VSO-RAISA has used the training package to train its country coordinators in all its six countries. Furthermore, VSO has cascaded training down to its grass roots partners in South Africa, Namibia, Mozambique, Malawi and Zimbabwe. Their advocacy work has included the training to SADC parliamentarians too.

UNDP in Mozambique has used the training package to train its partners operating in flood prone areas to equip their community-based volunteers with treatment and adherence skills/knowledge. The volunteers will be able to trace people who are on ARVs during flooding and make follow ups to ensure adherence to treatment. This is in support of government efforts to sustain adherence to treatment.

Reduction of the Burden of care on women and girls:
At the mandate of SADC, three organizations namely VSO-RAISA, IFRC and WHO-AFRO, conducted consultative meetings with stakeholders in six countries namely Namibia, South Africa, Malawi, Mozambique, Zambia and Zimbabwe to find out the views of the stakeholders on the extent of the burden of care among women and girls. The research was to produce an advocacy strategy directed at SADC members to consider the challenges and plight of women and girls in view of provision of care and support. The advocacy framework was presented at the AIDS International Conference in Vienna and it attracted lots of discussion.

Regional PMTCT Multimedia campaign
In partnership with UNICEF office for east and southern Africa, a regional and country PMTCT multimedia campaign to strategically increase the involvement of men in PMTCT was crafted and finally implemented in Lesotho, Swaziland and Malawi. IFRC provided funding and technical support and in the initial stage conducted a snapshot survey of the PMTCT status quo in the region on which basis the multimedia campaign was founded. In the three countries, the initiatives provided examples to government on how to strategically increase PMTCT uptake and also how to address challenges of provision of PMTCT services in resource-limited countries.

Contributing to longer-term impact

The regional HIV and AIDS programme has contributed to the reduction in the HIV prevalence especially among the young people who are the major targets for peer education activities in all the NS in the region. Red Cross has concentrated on interventions for in and out of school youth for many years and results are being observed. In many countries the incidence among the young people is falling.

The Red Cross niche has been for many years in providing CHBC services. Many clients who were bedridden ten years ago are now up and mobile. This is due to the concerted efforts that NS through their network of volunteers are providing to the PLHIV and OVC. It is important to plan long term interventions for care and support in order to observe impact. In all project sites approximately 80-90 per cent of all clients are mobile. The other impacts that can be observed are the high adherence levels among many clients on treatment (ART/TB) in Red Cross supported projects. The volunteers (care facilitators and peer educators) are doing a commendable task to ensure that those on treatment are followed up and take their drugs at all times.

Looking ahead

The HIV and AIDS plans for NS (2011-2014) will continue to be adjusted to take into consideration current trends in HIV and AIDS programming (tailored prevention interventions targeting key populations, a shift in needs in terms of provision of nursing care services to chronically ill to

treatment literacy, adherence to treatment, positive living, psychosocial support, nutrition and economic empowerment of clients, households and communities). Efforts will be made to keep the OVC working group activities and also to ensure that support for the actions of the group is sourced.

IFRC through SARRO will continue to provide technical support to the NS as well as strengthening collaboration and coordination among PNS. Efforts will be made to help NS in fundraising ventures/initiatives both at country and regional levels.

All Federation assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and is committed to the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to:	The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:
Inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.	1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises. 2. Enable healthy and safe living. 3. Promote social inclusion and a culture of non-violence and peace.

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