

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

Final Evaluation Report

Bijoy Basant Patro
PehrOlov Pehrson

February-April 2010

Acknowledgements

We are very thankful to all staff and volunteers in the Red Cross and Red Crescent Movement who gave lots of time to the evaluation team even though the notice was so short. A special thank goes to staff and volunteers of the National Societies and the Federation Delegations who accompanied us on the field visits.

We would also like to thank those outside the Red Cross Red Crescent Movement who shared their information and knowledge during our visits to their offices.

The evaluation team met with PLHIV and members of PLHIV networks at various places. These people had come to the Red Cross Red Crescent premises upon the request of the organizers. We would like to specially thank them for the experiences they shared with us.

In many cases, school headmasters/principals were especially cooperative to give us time for discussions during the course of school and college hours and also to let students meet with the evaluation team. This was at the expense of invaluable teaching time in their institutions. Meeting the young students was interesting as well as informative. We would like to thank all the school staff for this opportunity as well.

Lastly, the Red Cross Red Crescent National Societies provided good logistical support with pleasant drivers, who patiently drove us around through the traffic in the cities as well as on the busy highways. We were also taken to places of interest, which were not entirely related to the programme but certainly helped lift our energy levels in what would otherwise have been an exhausting tour.

Many thanks finally go to the Federation support services that were invisible but arranged for our extensive travelling and comfortable stay.

Table of content

Acknowledgements	2
Table of content	3
Abbreviations	5
Executive Summary	6
Introduction	12
Context 2003-2004	12
The proposal 2004	13
The Mid-Term Evaluation 2008	14
MTE recommendations	15
Evaluation criteria	24
The actual situation	24
Programme design	26
Relevance	27
Appropriateness	30
Coverage	32
Timeliness	33
Coordination	34
Efficiency	36
Impact	37
Continuity and sustainability	39
Conclusions	41
Lessons learned and Recommendations	53
Present programme	53
Future applications	56

Annexes.....	58
Terms of Reference	58
Country sheets (based on visits and indicators).....	63
People met.....	110

Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
APN+	Asia Pacific Network of Positive People
CBHFA	Community Based Health and First Aid
CD	Country Delegation
CSW	Commercial Sex Worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HR	Human Resources
IEC	Information, Education and Communication
IFRC	International Federation Red Cross Red Crescent
INGO	International Non-Governmental Organisation
IVDU	Intravenous Drug Use(r))
MCH	Maternal and Child Health
ME&R	Monitoring Evaluation and Reporting
MoH	Ministry of Health
MoU	Memorandum of Understanding
MTE	Mid Term Evaluation
NGO	Non-Governmental Organisation
NS	National Society
PHC	Primary Health Care
PHiE	Public Health in Emergencies
PLHIV	People Living with HIV
PMER	Planning, Monitoring, Evaluating and Reporting
PMTCT	Prevention of Mother To Child Transmission
RCRC	Red Cross Red Crescent
RHU	Regional Health Unit
SARD	South Asia Regional Delegation
SARNHA	South Asia Red Cross Red Crescent Network HIV/AIDS
SIDA	Swedish International Development Agency
SRC	Swedish Red Cross
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities, Threats
ToR	Term of Reference
UN	United Nations
VIVA	Volunteer Investment and Value Audit
VNRBD	Voluntary Non Remunerated Blood Donation
WHO-SEARO	World Health Organisation South East Asia Region

Executive Summary

Background

National Societies in South Asia had since the mid-nineties been active in limited, mainly HIV-awareness raising, campaigns largely with bilateral support. With the five year funding, from Sida through the Swedish Red Cross for the period 2005-2009, it became possible to scale up the response to this emerging epidemic. At that time HIV in Asia was high on the international agenda threatening to copy the pattern of spread from Africa. A mapping of the major regional health programmes formed the background for the proposal, together with the Federation's policy expressed in the Global Programme 2002-2005. The focus should be on: fighting stigma and discrimination; prevention; treatment, care and support, in all aspects with a participatory approach and involvement of PLHIV.

The programme

In the proposal from 2004 five objectives for the National Red Cross Red Crescent Societies, in collaboration with other partners, were defined, which should lead to the overall goal “..to contribute to reduction of HIV/AIDS”:

- § Contribute to reduction in incidence of new infections among young people through youth peer education and life skills development;
- § Contribute to improving the quality of life of PLHIV and their families through care, support and anti-stigma and anti-discrimination activities with their greater involvement of PLHIV;
- § Contribute to reduction of transmission of HIV by blood transfusion through increased voluntary non-remunerated blood donations’
- § Strengthen the capacity of national societies to effectively deliver HIV interventions; and,
- § Strengthen regional approaches in the HIV/AIDS response in South Asia.

Implementation and mid-term evaluation

Implementation started in 2005 and a planned mid term evaluation was performed in 2008. This pointed at severe weaknesses and failures as: lack

of ownership, management skills and defined roles and responsibilities; absence of quantitative and qualitative data on outcome and impact of different activities; limited commitment; weak reporting systems and no strategic planning for a long term development programme; no integration with other RCRC programmes; few established partnerships with other actors and no plan for a sustained response after the end of the programme.

Recommendations from the evaluation were discussed and shared with the NSs and a follow-up plan, with a defined responsible but often without a fixed time scale, was agreed upon.

Final evaluation

Now, two years later a final evaluation, with the major intention to look for the effect on beneficiaries and to identify lessons learned, was performed by two independent evaluators. Besides studies of existing documentation, visits were made to SARD in New Delhi, national and provincial headquarters, branches and programme sites in all six countries. Individual and group interviews or discussions were held with staff and volunteers on all levels and also with youths and other target groups engaged in life skills development, as well as with PLHIV employed by Red Cross or Red Crescent, active in support groups/networks or who had benefited from the care and support/livelihood programme.

Relevance and appropriateness

The selection of target groups, mainly youths in schools, or tea estate and textile factory workers in low prevalence areas, and not intravenous drug users, commercial sex workers and their clients, where exposure/risk of HIV transmission actually takes place, meant that except for partners of migrant workers, the real risk groups were not part of the programme. Assignment of sites was often made by the respective government/MoH in line with the auxiliary role of the Red Cross Red Crescent National Societies and obviously not always based on identified needs and existing RC RC capacities.

The different country contexts made a flexible programme necessary, but with very little use of mutual support based on different NSs existing local and national experience, the sense of regionalism was lost early on. Instead

six parallel and quite different programmes developed, to a great extent with their own direction, speed and coverage.

The relevance of this part of the programme could be seriously questioned, even if appropriate and in accordance with IFRC's strategies and Sida's policy to focus on future generations and promotion of human rights in general, and sexual rights more specifically. Efforts to improve quality of life and to allow PLHIV pursue their lives with dignity, including reduction of discrimination, as well as to decrease transmission of HIV through blood transfusion are certainly relevant even if activities were less appropriate.

Management

Partly due to a slow start, where sensitisation of senior staff and recruitments of coordinators took a long time, followed by a high turnover of staff, implementation was delayed in several countries. The weakness in monitoring and reporting was early exposed, but has improved since the mid term evaluation and the use of the reporting framework introduced after joining the Global Alliance. There are few baseline studies and still no outcome or impact indicators, neither quantitative nor qualitative, which makes it impossible to follow-up and measure the programme's efficacy. Use of operational research in cooperation with local institutions was anticipated in the proposal, but never materialized, and could have made the lessons learned useful for the continuation of effective activities and for others outside the Red Cross Movement.

The support given to National Societies by RHU and CDs has for long been much of micromanagement and less of strategic thinking, again depending on shift of staff and stable counterparts to build a relationship with. Not to forget that occurring disasters have shifted focus in almost all NSs to something more urgent and well-known than HIV.

Integration and involvement

Life skills development forms the basis for building or maintaining personal and social skills, but without a real common understanding of how this could be used in connection to HIV. Life skills and HIV has recently been integrated in CBHFA and PHiE trainings, but the extensive, existing experience in the National Societies from disaster management has not

been exploited, even if there are many interests in common. The HIV/AIDS programme is still mainly seen as a medical programme and therefore very vertical located in the health department of respective National Society.

Involvement of PLHIV in the planning process was limited and this potential way to identify needs and gaps has not been used. Only a few have been actively employed or engaged by the RCRC, but where they are it shows recognition of their important experiences. Only in one country there is a comprehensive care and support package. Some PLHIV have been reached through the livelihood programme, and again for them it has meant an improved life, while cost-effectiveness of nutrition support still is questioned. The programme has probably contributed to an increased knowledge about how the HIV infection is transmitted and by that to a decreased stigmatisation of PLHIV. Advocacy for rights of PLHIV, including improved access to treatment, has been almost absent.

Advocacy and Partnership

In fact almost no planned and strategic advocacy has been used either on regional or national level. An obvious goal would have been to create a sustainable mechanism to include life skills development in the schools curriculum.

Very little cooperation and partnership with governmental structures, almost no connection with the Global Fund and its principal recipient(s), other NGO's or international organisations and no internal fundraising has led to a lack of secured continuation of a programme that has finally taken off. This can negatively influence the perception of RC RC by those who have been involved as staff or volunteers, external actors as well as those PLHIV who have been directly supported.

Volunteer management

It is repeatedly stated by external organisations and governmental structures that the strength of RCRC is its widespread network and volunteers. Still most costs are spent on central level, with very little financial and other appreciation directed to the field except for basic training. Volunteer management still leaves much to be improved, in this as in other programmes in the region, to increase attractiveness and retainment after initial training.

Other positive findings

Some positive examples have to be highlighted. The first and most important is the commitment of the volunteers, who even with small incentives and limited appreciation from higher level stay with the programme. The same can be said about many of the National Societies staff for whom HIV has been a new and learning experience. However, no studies on the impact and cost-effectiveness of staff and volunteers, except for the VIVA studies, which could have strengthened their roles, have been performed.

Students, especially those in their upper teens, have been provided with knowledge and improved skills in expressing their views, increased self-respect and respect for others, and abilities to approach their peers and other members of the community to share their knowledge. Young female students have become confident enough to speak about and discuss sexual matters and female spouses to migrant or tea estate workers to claim their right to be protected.

Awareness of the importance of VNRBD has probably increased; slight increase in blood donations by peer and peer educators is seen, but again there is limited integration and no systematic advocacy.

For the NSs the programme has certainly been a learning experience in some technical aspects on monitoring and reporting, which has improved during the last year. The present team in the RHU has assisted in making regional meetings more relevant, initiating exchange visits and some peer reviews, which are good initiatives although coming very late.

Something to learn from

Much could have been done differently and probably better, certainly with much more direct impact given this substantial financial support. Now one can hope that the National Societies will see it as a lesson in organisational development and improve human resources management accordingly to retain and integrate volunteers and staff from this programme into their core activities. It would be interesting and valuable to make an ex-post review in two years to see what has been the impact after this programme has closed.

The Swedish Red Cross and the Federation can certainly make use of lessons learned, when taking on new challenges that need a regional effort, be it other chronic diseases or the result of different social or environmental influences. Points to consider are certainly not new but have to be stressed again: improved continuity of staff; better support to strategic planning including exit strategy; facilitating cooperation with other actors and including operational research from the early stage. Sida, if funding programs like this, has to make sure that there is a strong inbuilt system for future sustainability, as five years support from inception to exit is a too short time frame for a development programme when starting almost from scratch as was the case with most of these six National Red Cross Red Crescent Societies.

Introduction

Context 2003-2004

At the time of the planning of this programme, countries in the South Asia region were at different stages of development. HIV-infection was mainly spread heterosexually with common underlying reasons as poverty and inequality, which increased vulnerability to transmission. This was further exaggerated through population movements, including human trafficking, within and between countries. Uprooting and the breaking down of previous cultural values had led to commercial sex being a major mode of sexual expression. Nearly one-third of the detected persons with HIV were between 15 and 24 years. Highly vulnerable groups, CSW and IVDU, had shown high prevalence of HIV infection and were considered to act as bridges to the general population.

National Societies had since mid-nineties carried out different, mainly awareness raising, HIV/AIDS programmes but without a collective, long term-funded and focused response. A five-year funding support from Sida through the Swedish Red Cross made it possible to plan for a massive scaling up of the Red Cross Red Crescent response.

After a regional mapping in 2003, of major RC RC health programmes, a concept paper (Annex 1 to the proposal) outlined the strategy and formed the basis for development of the proposal. The development process included collection of data on the epidemic, the responses in place and identification of appropriate intervention strategies through participation of key stakeholders. The team consisted of external consultants, representatives from SRC and the Federations Regional Health Unit. WHO-SEARO and the Asia Pacific Network of Positive People (APN+) were consulted.

A stakeholder's consultative meeting with representatives of all NSs in the region took place in March 2004. At this stage a framework for a cohesive and integrated response was identified, which again was followed by extensive discussions with major stakeholders. A SWOT analysis and consultative workshops, with NSs senior staff on country level, was used to assess institutional capacities in general and

specifically on HIV/AIDS. The result from this exercise reinforced the need for collaboration and partnership.

The Federations Strategy 2010 outlines “Health and Care in the Community” as one of the four core areas contributing to the achievement of the Millennium Development Goals. The commitment and global approach of the Federation, in increasing the RC RC response to HIV/AIDS, was further captured in the Global Programme 2002-2005. It emphasis four pillars for intervention: fighting stigma and discrimination; prevention; access to treatment, care and support; participatory approaches and involvement of PLHIV at all stages.

The NSs in the South Asia region are mandated to have an auxiliary role to the governments in addressing vulnerability at community level and have a good reputation due to its well established and wide-spread network of branches, volunteers and youth members.

A commitment for HIV/AIDS response was already given at the Secretary Generals’ Forum, in the Manila Action Plan 2001, followed by the creation of the South Asia Red Cross and Red Crescent Network on HIV/AIDS (SARNHA). Its intention was to develop strategic, long-term development plans to combat the epidemic, including capacity building through organisational development, creating a strong human resource base and tackling the stigma issues connected to HIV/AIDS by collaboration and links with PLHIV networks.

SRC, with more than 25 years experience from the region in partnership with most NSs, is seen as a Federation partner, strongly instrumental in developing regional systems and networks, promoting capacity building and organisational development as an integrated part of all programmes

The proposal 2004

The overall goal of the five year programme was stated as: “Contribute to reduction of the burden of HIV/AIDS through strengthened local responses; community based prevention, care and antistigma activities; implemented through the National Red Cross and Red Crescent Societies in collaboration with other partners in South Asia”.

In order to achieve this, five objectives were selected:

- § Contribute to reduction in incidence of new infections among young people through youth peer education and life skills development;
- § Contribute to improving the quality of life of PLHIV and their families through care, support and anti-stigma and anti-discrimination activities with their greater involvement of PLHIV;
- § Contribute to reduction of transmission of HIV by blood transfusion through increased voluntary non-remunerated blood donations’
- § Strengthen the capacity of national societies to effectively deliver HIV interventions;
- § Strengthen regional approaches in the HIV/AIDS response in South Asia.

The Mid-Term Evaluation 2008

In March 2008 a planned Mid-Term Evaluation (MTE) was performed by an independent international public health consultant, together with a SRC Health Adviser, who at this time also was a Regional Health Delegate, and a Regional Senior HIV Programme Officer. In its outline it was stressed that emphasis of the programme “is placed on strengthening organisational capacity to carry out sustainable HIV responses, including information systems and human resource development”.

Specifically the objectives were to:

- § Assess progress and achievements as per indicators given in the proposal;
- § Identify and understand the obstacles, constraints and challenges in implementing; and,
- § Identify measures to improve the programme.

Some of the general findings can be summarised as:

- § Lack of ownership within RHU as the present team had not been involved in the design of the programme;
- § Lack of skills within RHU to support management; lack of boldness, creative strategies and approaches which adversely affected the achievement of desired results;
- § Lack of shared understanding on the role of different players;

- § The logframe included a list of activities and some quantitative output indicators but there was a lack of both quantitative and qualitative measurable data on outcome and impact;
- § Country visits by the RHU team did not produce any good plans. No link existed between the programmes objectives, NSs strategic plans and NSs annual or periodic plans, which were just a list of activities;
- § Commitment of the respective leadership was seen to be of importance for enhancing capacity of the branches, for diversification of partnerships and scaling up the response;
- § No evidence that the actions of NSs conformed to the planning and implementation modality of a long term development issue;
- § Lack of conceptual clarity on PMER and especially the skills and experience in planning, monitoring and reporting required for a development programme;
- § Lack of engagement with the civil society and no advocacy role in promoting HIV response shown by NSs;
- § No systematic integration of HIV prevention into public health and other NSs core programmes;
- § No instances of NSs allocating money for HIV response.

MTE recommendations

Objective 1:

- § perform studies on the impact of peer education on attitudes and behaviour and on cost-effectiveness of the peer education programme;
- § develop sustainable mechanisms for continuity of life skills and HIV education in schools using a cost-effective and sustainable model;
- § expand school education in a wider scale, targeting both in and outside school youths; and,
- § integrate life skills and HIV in all health messages rather than implementing it as a vertical programme.

Objective 2:

- § identify context specific needs and gaps, e.g. mitigate the constraints from accessing ART, followed by a care and support package;

- § perform a small study on the value of meal and the hygiene kits distribution, and if this is found to have a positive impact, explore the possibility of corporate support;
- § develop and strengthen collaboration for advocating the rights of PLHIV and supporting their networks;
- § develop and implement a policy for participation of PLHIV at all levels within NSs

Objective 3:

- § increase the community awareness on VNRBD and safe blood;
- § make use of peer educators and peers as recurrent donors; and,
- § increase advocacy and influence policy, utilising RHU and WHO's credibility

Objective 4:

- § shift focus by the IFRC country delegations from day-to-day management issues to technical assistance and coordination;
- § develop a model for the involvement of volunteers and integration in all core programmes of the NS; and,
- § create a long term human resource development plan focusing on retention of knowledge gained on all levels after this programme comes to an end.

Objective 5:

- § work consistently with senior leadership to increase and sustain their commitment;
- § provide support based on respective NS' identified needs, instead of a common package, maintaining and updating resources available in each NS;
- § facilitate cross-learning by using technical skills available;
- § examine expenses closer and explore the possibility to rationalise;
- § ensure that an indicative budget is presented well before the programme year as release of funds should depend on proper reporting; and,
- § undertake an in-depth analysis of costs of some interventions – youth peer education, VCT operations, meal distribution and community child care, to generate better value for money.

Findings and recommendations were distributed and further discussed during the Regional Health Directors meeting in October 2008.

Follow-up plans with identification of responsible for implementation, but often without a specific time-frame, was agreed upon after consultations with all National Societies and country offices.

According to the initial proposal a final evaluation was planned at the end of the programme period.

Methodology

This evaluation should be seen as a final summative one, performed by two external and independent evaluators. In the programme proposal it was scheduled as an impact evaluation with an aim to draw conclusions, identify best practices lessons and develop models, which can be applicable elsewhere within the RCRC Movement.

According to the ToR (see annex) and requests from Sida and SRC, the evaluation needed to, as far as possible, focus on the lessons learned and the effect of the programme on the beneficiaries at different levels. The evaluation needed not to give a detailed analysis of figures or perform an analysis of cost-effectiveness. We have therefore focused on a general overview, from the perspective at the end of the programme's timeframe, as a review was performed in 2006 followed by the extensive and detailed MTE in 2008, both covering the first half of the programme.

The evaluation was accomplished with participation of those involved by the programme on all different levels. Design and methodology to be used was shared with the RHU before inception. Data collection was done in a transparent manner in the presence of representative(s) from the respective NS (though this was not always the case in Bangladesh).

Given the short period of time and the logistics, not only with six different countries to be visited, but also the long distances to travel within the countries or states, this meant that a considerable proportion of the time had to be spent on travelling.

Validity

As there has been a high turnover of staff during the five year period only a few of those in the Federation, who were responsible for implementation during the first period of the programme, were available to meet or speak to. On the other hand, in Nepal Red Cross, staff who had been involved at different levels since the beginning of the programme was accessible. In Pakistan, none of the staff neither in the country delegation nor in the health unit of the Red Crescent's headquarters was any longer present, while on the provincial level all

were still on hand. Generally, it can be said that the relative loss of institutional memory did not adversely affect the evaluation, but it could have added to the richness of this report.

Though the evaluation visits covered a number of holidays and weekends, people were in most cases able to make themselves available, which was highly appreciated. Due to professional engagements, end of missions or for personal reasons, the evaluation team could not meet some individuals who could otherwise provide worthwhile information or insight to the programme and its conduct.

Another constraining factor is the languages. Although one of us is Indian and has a fairly good understanding and can speak most of the languages used, questions and answers had to be translated to the other team member. This not only meant a loss of time, but a lot of nuances in the communication were missed out. It also implies the risk of the translator innocently changing or re-interpreting the questions and the answers provided.

Findings presented from different countries are largely based on one short visit to a district or province where the present programme has been implemented. Focusing on primary beneficiaries meant that less time was spent in RC RC headquarters and with external stakeholders. The choice of the programme sites was the NS' in consensus with SARD, mainly with the accessibility and logistics in mind, though this principle was with the agreement of the evaluation team. We actually do not know if and to what extent, the chosen district is representative of the programme in the country. In the district and sub-district again, certain villages and schools were selected where as many peer educators and peers as possible could be reached for participation (limited by examination period in India). These were probably the most active and committed ones, which can also be true for the PLHIV we were exposed to.

From our impressions, it is of course not possible to give firm opinions on other parts of the programme. Although, we have tried to get as many opinions as possible one has to be aware of a risk of bias even if we tried to triangulate or, when conflicting views remain, ensure that more than one perspective/statement is provided. An instance of this is how in Bangladesh, there were huge misgivings

between the country delegation and the NS. Views had to be accommodated even though the delegation team was not available to present its case.

Documentation

The following documents formed the basis of our work and the conduct of the evaluation.

1. Evaluation Policy of the International Federation of Red Cross and Red Crescent Societies (IFRC). January 2010, draft version.
2. Guidelines for Monitoring and Evaluation Routines at the Swedish Red Cross. September 2006.
3. Red Cross and Red Crescent Societies Regional HIV/AIDS Programme in South Asia (2005-2009). Submitted August 2004. Initial proposal with annexes and log-frame.
4. The role of the regional HIV and AIDS programme in the Red Cross Red Crescent HIV and AIDS response in South Asia. Review of the South Asia regional HIV and AIDS programme 2006. March 2007.
5. Red Cross and Red Crescent Societies HIV and AIDS Programme in South Asia Mid-term Evaluation Report. March 2008.
6. Red Cross Red Crescent HIV Programme South Asia with a special focus on Stigma and Discrimination and Sexual and Reproductive Health 2010-2014. Proposal.
7. Investing for future generations. Sweden's International Response to HIV/AIDS. March 1999.
8. Global Red Cross and Red Crescent HIV and AIDS Alliance. Overview and basic guidance. November 2006.
9. The Global Alliance on HIV and AIDS. Rising to the challenge 2006-10. December 2006, revised April 2007
10. Monitoring and Evaluation in a nutshell. IFRC February 2007.
11. HIV Prevention. Principles and guidelines for programming. IFRC 2009
12. AIDS, Health and Human Rights. An explanatory manual. IFRC 1995.
13. Standards for HIV peer education programmes. IFRC 2009
14. Training manual: Life Skills/HIV& AIDS/Peer Education
15. Handbook for Counsellors. Indian Red Cross Society 2004.
16. My Future Choice. HIV/AIDS and Life Skills. Andhra Pradesh State AIDS Control Society.

Other documents that were provided and proved helpful were as follows:

- § Annual country and South Asia Regional Office reports for 2008 and 2009 (where available).
- § Programme Updates 2009 for the South Asia Regional Office and respective countries.
- § Annual Plans for 2009-10 and for 2010-11
- § Reports from Regional Health Managers meeting. Maldives, October 2008 and Sri Lanka, July 2009.
- § Report from HIV Coordinators meeting. Nepal, January 2009.
- § VIVA – The volunteer investment and value audit and reports from Nepal, Pakistan and Sri Lanka.
- § We prevent, We Care. Fighting the HIV epidemic in South Asia. A DVD brought out by the regional delegation in 2009, containing a audio-visual of the regional programme.
- § IEC material from different countries.

Documentation on involvement of target groups, PLHIV and others in the planning process; Human Resource Management; MoUs with other partners; existing policies; documentation of performed activities; reports from different meetings, advocacy and lobbying activities was sought and, to some extent, provided on state and district levels in Afghanistan, and India and quite extensively in Nepal, Pakistan and Sri Lanka. However, despite requests nothing was provided from Bangladesh.

Questionnaire

A questionnaire related to the programme was sent out before the team began its visits. We are fully aware that this was with a short notice. Until now inputs have been provided by Afghanistan Red Crescent, India Red Cross, Nepal Red Cross, Pakistan Red Crescent and the Regional Health Unit (for data see annex).

Interviews and discussions

During the visits to respective countries we were accompanied by staff from RHU (in Afghanistan, Nepal, Pakistan and Sri Lanka); from CD (in Bangladesh and India) and from the NS's headquarters

(Afghanistan, India, Nepal, Pakistan and Sri Lanka). (For details on people met, see annex.)

Semi structured group discussions and interviews, together with some individual, were carried out and the information from these interviews form considerable substance of the report. The interviews were done with target groups – Peer Educators and peers, students (at different levels) and some out-of-school youths as also with teachers, headmasters or principals, commercial sex workers, prisoners and community members.

The evaluation team met a number of people living with HIV. A few of the PLHIV were also employed by RCRC. Some PLHIV volunteered as peer educators, others were beneficiaries of the livelihood support provided by RC RC or of other programme activities. Besides these, in Nepal, Pakistan and Sri Lanka, we had discussions with representatives from network groups representing PLHIV.

Outside the Red Cross Movement, the evaluation team met with representatives from the respective government's health services, the UN system and other organizations working in partnership or related to HIV. Staff from the RCRC met during the course of this evaluation included: senior management from NS' Health Department and HIV programme; staff at different levels of the programme from headquarters to sub-branches; staff from IFRC CDs. RHU and others in SARD, responsible for or connected to this programme; as well as staff at SRC and Sida.

The frankness with which the opinions were shared was highly appreciated and in the report we have consciously avoided to use names and quotes to maintain confidentiality and as we were not everywhere and always able to explain in detail how the information given should be used.

Observations and visits

Observations of documented activities performed by RC RC volunteers and staff, role plays and condom use demonstration were possible in Bangladesh, India and Nepal.

Blood banks were visited in Bangladesh, India and Pakistan.

In Nepal visits were made to homes of PLHIV supported by livelihood programme and also to one family referred for PMTCT.

In India (Andhra Pradesh) a state prison and in Bangladesh a brothel was visited and discussions held with prisoners and CSW. In Pakistan two textile factories and in Sri Lanka one tea estate was visited in combination with interviews of peer educators and community members there.

In India, Nepal, Pakistan and Sri Lanka, the Youth Friendly Information Services were visited.

Review and revision

In all countries a verbal discussion was held before leaving the country with NSs representatives, either in the headquarters or at local level depending on the logistic schedule. A draft version of our findings was later mailed to the NSs for comments, which were then included if found relevant. A preliminary verbal debriefing was held by the evaluators (one on telephone from Delhi) at SRC with the health advisor and the desk responsible. The first draft of the full report was then shared with NSs, CDs, SARD, SRC and Sida for comments and advice for final directions. These comments and advices were considered before this final version was completed. When no comments were received, in spite of reminders, we have regarded the findings and conclusions as accepted.

Evaluation criteria

The actual situation

South Asia has a low prevalence of HIV in the general population and except for a few locations of concentrated epidemics or “hot-spots” in India and Nepal, the spread of HIV to the general population is not considered as a big problem at present. The focus of surveillance is now as in other low prevalence countries on identified high risk groups such as intravenous drug users, commercial sex workers, men who have sex with men and what is here seen as a bridging population – migrant workers and their spouses.

Awareness of HIV and its prevention varies – and is probably highest in India and Sri Lanka. India as it has the second highest number of infected people in the world and Sri Lanka because it has a well developed governmental health system.

Conflicts or violent disturbances pan across the region and huge resources are going into these conflicts, especially in Afghanistan and Pakistan. Sri Lanka and Nepal have recently emerged out of a phase of conflict and the deteriorating security situation in Pakistan is cause for concern.

South Asia has its own social and cultural identity and across the region, work on HIV/AIDS is affected by strong influences of patriarchal and conservative societies. South Asia’s people are deeply religious and the influence of religion on the day-to-day lives of South Asians is very obvious. Schools and teachers are very influential. Parents, and often elders in an extended family, have a say in the personal choices of the individual till a very late stage in their lives.

Health issues in the region are also influenced by its rapid economic growth and increasing urbanization. Large-scale migration is a feature common to all countries – employment opportunities beckon unemployed youth, mainly men, to leave their villages in preference for a life in the big cities.

This migration is also complemented in movement of population across states and countries, from Bangladesh and Nepal to India and from all countries in the region to the Gulf Countries.

Despite some countries rapid progress on the economic front, poverty is widespread with socioeconomic inequality.

South Asia still has a high degree of illiteracy and ignorance in many, mainly rural and remote areas, but also in urban and peri-urban settlements – except for the case of Sri Lanka.

Sex trafficking of women and girls from Nepal to India and within India, from remote areas to main cities, poses a serious challenge to public authorities in India. Particularly, in the area of health, sexually transmitted infections, notably HIV/AIDS are a strong concern.

Prostitution, both female and (to lesser extent) male is common, even if illegal in every country in the region. In many cases, it is the first and only sexual encounter for young men prior to their marriage.

Female virginity is seen as a desirable virtue, not only in physical terms but also as an expectation of emotional, spiritual and mental innocence. Pre- and extramarital sex is considered as a moral sin/illegitimate and in some countries illegal. Male homosexual acts are illegal in most countries.

Changing gender roles, especially among young people in urban areas is also catalyzed by the infotainment media, during later years often depicting female role models as sexually active, both on and off screen.

Condoms are not always easily accessible, especially for young and unmarried people, and where accessible, they are not necessarily considered a preference to avoid unwanted pregnancies or sexually transmitted infections.

The consumption of alcohol and narcotic drugs, including by intravenous injections, is increasing. Drug consumption is illegal in every country in the region and treatment options are rare.

In Pakistan, a high number of injections for different illnesses, sometimes with reuse of needles and syringes, is seen as an important cause of transmission of infections, hitherto mainly hepatitis B and C.

A scarcity of blood due to poor recruitment of voluntary non-remunerated blood donation, and gaps in the screening system to exclude blood from people with risky behaviour is also a factor in the spread of blood borne infections.

Programme design

The programme proposal says that it “was developed through an extensive consultation process with identification of gaps and unmet needs through a participatory process to identify locally appropriate intervention strategies by involvement of key stakeholders”. Discussions and consultative workshops were mainly held with high level stakeholders, senior staff members from NSs and country health delegates from IFRC. External stakeholders were met at regional and country level. During the in-depth planning in the countries, representatives from the (at that time) selected branches were present. Involvement of the potential beneficiaries was negligible, be it young people, PLHIV or potential blood donors.

Even if the leading role of SARD was initially demanded by the regional NSs at SARNHA meetings, there is still a wide spread feeling that development of the programme was a top-down process.

The selection of the sites for the programme as also the selection of the target groups varied across all countries because the programme design did not outline that – rightly so, given the huge diversity of needs that NSs were expected to cover. At times, the districts reached by the programme were not of the NS’ choice, but suggested by the government.

Yet, because this was the first regional project on HIV/AIDS, NS were cautious in what and how much they could do and also avoided being confrontational with public and private authorities. It is for this reason that most NSs avoided targeting injecting drug users, commercial sex workers and homosexual men. The proximity of the NS

to the government authorities also meant that they avoided advocating for and on subjects they considered controversial. Least this is considered as a weakness, it must be said that often, this proximity to the government has been a strength of the NSs.

Overall programme goal “is to contribute to reduction of the burden of HIV/AIDS through strengthened local responses, community based prevention, care and anti-stigma activities, implemented through the National Red Cross and Red Crescent Societies, in collaboration with other partners in South Asia”.

The programme proposal does not give a clear explanation to why three areas and not others were selected as objectives:

- § health education and life skills development among young people;
- § care and support for PLHIV;
- § voluntary non-remunerated blood donation.

except for the fact that a high proportion of those currently HIV-infected in these countries was people below 30 years of age and that the RC RC societies have a large number of young volunteers; that replacement and commercial donations are common and that some of the RC RC societies are already to varied extent involved in blood donations and blood banks. Obviously there were extensive discussions on VNRBD as an objective, but as some of the NSs saw it as a core activity, it was finally included.

Given these three chosen objectives, there was an identified and very relevant need to develop the capacity of the NSs to manage an HIV programme, which to many of them was new. Due to this it was also necessary to strengthen the regional support system through SARD and CDs. These two needs were then included as objectives 4 and 5.

Relevance

From an external point of view, it is clear that a preventive programme to have most impact should have focused on the groups/populations where exposure to infection and risk of transmission actually takes place. This was certainly not the case here for reasons given above under programme design.

The financial donor, Sida, has a HIV/AIDS policy focusing on protection of future generations by improved sexual and reproductive health and rights with emphasis on gender equality, mainly through investments in prevention activities. It includes activities in care and support to allow people, infected and affected by HIV/AIDS, to pursue their lives with dignity while promoting respect for human rights. The present programme with its first objective on reduction of new infections among young people through life skills development and the second on supporting PLHIV, can thus be seen as relevant to the donor.

It is also clear that the RC movement here has a role to play based on the fundamental principles of humanity, impartiality and voluntary service. The Federations Strategy 2010 “To improve the lives of vulnerable people by mobilizing the power of humanity” identifies Health and Care in the Community as a core area. In the Global Programme 2002-2005, “Reducing household vulnerability to HIV/AIDS and other infectious diseases”, objectives, strategies and priority actions are identified as: prevention; access to treatment; care and support and fighting stigma and discrimination. This should be implemented through operational partnership, by participatory approaches and methods with involvement of PLHIV at all stages which is also part of Sida’s policy.

The current programmes objectives are thus in line and justifiable in regards to the principles and operational policy of the RC RC although operational partnership has been limited to governmental medical and educational structures besides some outreach activities. Involvement of PLHIV in the planning process has been very limited or absent even if they to some extent later have been engaged in the performance of some activities. However, during discussion with PLHIV organisations in some of the countries, it did appear that the NSs were eliciting participation, but did not seem very comfortable when not heading such participation.

Formal MoU with governmental HIV/AIDS programmes and other organisations have mainly been used in Nepal and Pakistan. In India it was not considered necessary by the NS, due to its auxiliary role to the government. However, it would have helped the state branch in Andhra Pradesh to advocate for itself and create the lines of what they

would do in partnership, and more importantly, in the context of India, what they would not do.

Over time target groups other than youths and PLHIV have been identified by the local communities, volunteers and staff participating in the programme, which has led to new outreach activities. Some interesting and important activities have then been added to the original programme. Examples are the support given to a state prison in Andhra Pradesh (India), the new target groups like three-wheeler drivers, market helpers and beach boys (Sri Lanka), barbers and *madrassa* teachers (Afghanistan and Pakistan).

There has been a gradual understanding and appreciation by NS, CD and RHU of the need for improved skills in ME&R. This is a reason why more specific trainings and workshops have been conducted on this topic. The launching of Global Alliance on HIV and AIDS “Rising to the challenge 2006-10”, during the last year of the programme, with its aim to double the outreach and focusing on vulnerable groups, has also led to necessary changes, seen as improvements, in the reporting system. It was not clear if this improvement is confined to more mainstreamed activities and better narrative reports generated by the health teams in the NSs or whether this also pertains to the understanding and the quality of financial reports.

No examples are given on a strategic advocacy plan to achieve a certain objective, i.e. on stigma and discrimination or access to treatment, by targeting an identified group. This could as well have been used to decrease the total dependency on international funding by the programme in Tambaram hospital and Dharmapuri day care centre in Tamil Nadu to avoid the present situation when there is no funding for continuation of the activities. Interestingly, in neighbouring Andhra Pradesh there have been fund raising activities in Rajamudhary to continue the nutrition support in the prison. This is an example worth highlighting, but these do not figure in the advocacy objectives of the Indian Red Cross Society.

It should also have been relevant to perform some of the by MTE requested simple operational research to justify the same activities. As an example: weight monitoring when given nutritional support, degree of disclosure and coping skills after counselling, sustained behaviour

in hygiene and food habits after the imparting of relevant information. If found positive this could have increased the acceptance of the activities in Tambaram hospital, if negative led to switched focus instead of continued questioning of its cost-effectiveness and where future funding should come from. Very little cooperation has been established with e.g. universities who have the capacity to perform these types of studies.

Appropriateness

The diversity of the cultural, socio-economic and epidemiological situations between and within the different countries, as well as the different existing capacities of the NSs, should make it necessary to develop plans for activities on all or some of the objectives, that could be revised annually based on experience gained. This does not seem to have been the case initially, instead a “one size fits all” influenced work-plans and log-frames, which have often been severely delayed if developed at all. In some cases these have been accomplished more to satisfy the donor and RHU, by that decreasing the local ownership of the programme.

After assessment of capacities on implementation level, one should expect training in management including ME&R to cover identified gaps, before starting to train trainers, peer educators, etc. Only then proper supervision could be ensured, also increasing the possibility of retention of those trained. In parallel to this, as HIV-programming was new to most National Societies, sensitization of staff should have been carried out, first at the senior level followed by all staff at the headquarters and then spread to branches and sub-branches. After this stage, a workplace policy on HIV could eventually be introduced and lead to an acceptance of PLHIV as integrated participants in the program and not just as invited guests at certain occasions or only involved in unskilled work.

Activities were very seldom introduced in this order, Nepal being an exception where a strategic plan development workshop was organised already in 2005. Instead implementation often started with training of trainers followed by peer educators, leaving aside the important aspects of sensitization, monitoring and reporting.

Involvement of government's educational representation, school headmasters/mistresses and teachers or other structures depending on target groups (management in factories, association/ trade union leaders etc) to increase the acceptance is crucial and was in general performed in an accurate way.

After creating the ground, implementation could be introduced in a small scale, as a pilot programme, which could later be amended with experience gained, before a fast scaling up after basic quality was secured. If not so, there is a common risk for too high quality expectations both by the staff, volunteers and other beneficiaries at the expense of quantity which then limits the coverage of the programme. This later schedule was indeed followed in India with a very limited coverage, but with high quality, as a result.

Life skills development is central in this programme and should be viewed as the basis which can be applied for HIV prevention as well as for many other diseases and situations in daily life. Sometimes we had the impression that in the implementation of this programme, HIV came first and that life skills and HIV were seen as two different, quite unrelated topics during the trainings. Obviously HIV-infection is presented as a medical condition and even young students have knowledge about CD4-cell counts and the name of medicines to be used. This is hardly necessary and also draws attention from the HIV-infections' social and psychological effects on the individual, family and community. It reduces the question about stigma and discrimination to a technical issue that can be solved through information on how the infection is spread or not.

As most donor-driven programmes this is no exception in being to a large extent vertical within NSs with its own staff and reporting lines. Though late, integration has now begun with other programmes as CBHFA, PHiE, PHC, MCH and even in certain parts of Disaster Management. Trained peer educators and peers have then sometimes been involved in other activities performed by the respective RC RC National Society.

Analogies with Disaster Management, where the National Societies have many achievements to count on, has however not been fully explored. The HIV/AIDS programme has two broad components, where

youth peer education, stigma and discrimination correspond to preparedness, whereas care and livelihood support correspond to response. Integration could have been encouraged further and earlier as a way to continuously involve volunteers to keep them active and engaged and thereby increasing the sustainability. HR management of staff and volunteers is in general absent or has not been given enough importance.

Coverage

The degree of coverage varies and depends on which perspective is used and which activity observed. From a national, state or even a provincial perspective the programme has had a very limited coverage except for some occasional public awareness raising campaigns in connection with World AIDS Day, Condom Day, Blood Donors Day, Red Cross Day or other rallies.

PLHIV, who have disclosed their status and some of them employed by RC RC, were actively involved in public Red Cross activities in India, Nepal and Sri Lanka, particularly in connection with the above mentioned awareness raising activities.

At the school and college levels, the coverage in life skills development is dependent on the number of trained teachers and peer educators in respective school and form. In Indian schools it is limited, while in Nepal the coverage is much higher. In textile factories in Pakistan, in tea estates in Sri Lanka and in target communities in Nepal the coverage can be quite high.

The goals set by following Global Alliance policies are certainly not met and it can definitely be questioned if these quantitative indicators are at all realistic even if aspects of quality are excluded.

Those included in the livelihood programme in Nepal resided in the district of activities. In Sri Lanka, applications for participation were accepted from all over the country and then assessed by a committee. In the hospital in Tamil Nadu, all patients with HIV were provided with supplementary food support. It was unclear how the children were selected to the day care centre in Dharmapuri, except from the fact that they should be HIV orphans according to the WHO definition.

We did not see any indications that people were excluded from any activities because of ethnicity, religion, social class, gender or age. On the contrary some expressed that they through the programme had made friends with people confessing to another religion and been able to discuss different issues with people of higher age, opposite sex and belonging to a different caste or social class.

For reasons elaborated on earlier, Red Cross Red Crescent have not been working with the groups most at risk in this region caused by an expressed or implicit unwillingness/impossibility to confront the government or questioning existing legislation.

Timeliness

This programme was planned when HIV in Asia was high on the global agenda. Many saw an emerging infection, copying the spread in Africa, but here in Asia with much greater potential impact when it comes to number due to the high population in many countries. It was also during a time when much focus was on introduction of antiretroviral treatment in countries and contexts with limited resources. Prevention, which always has been the cornerstone in Sida-supported programmes, was lagging behind when most international donors supported the fast scaling up of treatment programmes. Stigma and discrimination was seen as an obstacle for testing and thereby indirectly for access to life-saving therapy. Even if late in relation to the spread of the epidemic, the current programme was launched at a time when it could expect support both from international organizations and by national governments.

The epidemic in Asia has not developed as foreseen by many doomsday prophets. It has rather stayed as contained pockets of epidemics except in India and Nepal, where it has a wider spread in some communities, even if estimated figures on the number of infected also here have been reduced.

The programme took some time to reach its implementation phase due to a long process of acceptance at different levels in a strongly hierarchical RC RC system followed by delay in recruitment of new staff. In Pakistan it took until 2008 before a HIV coordinator was in place. As the programme in most countries is targeting school youths

it had to be accepted by school authorities and adapted to the school calendar.

One has also to remember that Sri Lanka together with the states of Andhra Pradesh and Tamil Nadu in India were hit by the tsunami in 2004, Pakistan by the earthquake in 2005, Bangladesh by the cyclone SIDR in 2007 and India by floods in 2008. This changed for a long period of time the priorities of the NSs.

After a slow start, exaggerated by limited commitment, low competence and high turnover of staff, as highlighted in the mid-term evaluation, we are now in a situation where the programme is up and running, though still on a small scale. According to the Global Alliance goals, this programme should have scaled up massively before external financial support dried up. Neither exit strategy nor planning of alternative fundraising has been performed and now, big international donors, including Sida, are turning away from AIDS in Asia. The future of the programme is at present wrapped in obscurity.

Coordination

Even if the need for partnerships and coordination was strongly emphasized in the proposal, this has been limited, on the national level, to information to and acceptance by governmental authorities. In countries where the NSs have established some sort of HIV steering committee, this has mainly been used for information sharing and not for common planning of coordinated activities.

An attempt to coordinate HIV activities, at least within the RCRC family is the India Consortium consisting of the India Red Cross, representatives of partner national societies and the IFRC. There are different views on whether it has been successful or not. The most obvious outcomes have been some common IEC material and reporting formats. An extraordinary example of lack of coordination is the Hong Kong branch of the Chinese Red Cross beginning activities in Andhra Pradesh without naturally including the ongoing projects in the same state even though funding for their continuation is highly uncertain.

Before this programme there was a HIV network, SARNHA, in the region. It was obviously not very well functioning and was finally dissolved in October 2008 to avoid duplication after a common

agreement. Some NSs would have liked to see it continue as it was owned and run by the NSs themselves, even if the manager in fact was employed and paid by the Federation.

Coordination among the six countries was supposed to be facilitated by the RHU in Delhi and CD representatives. This should have been performed through “sharing existing manuals and guidelines and producing new common relevant material, monitoring visits and creating a supportive regional network”. Obviously the unit in Delhi was too small to be able to fulfil these intentions and instead of having a strategic perspective they became involved in micromanagement of the programme.

Contributing to this was a high turnover of the staff, first when those being involved in the proposal left before implementation. They were succeeded by a weak RHU team also not owning the programme. Finally this whole team was shifted, during a sensitive stage 2007-2008, when activities were about to be scaled up. Not until after that has there been a stable and qualified team which has lately resulted in important improvements in management.

Much time was spent on developing a common youth peer education resources pack, which was later not found suitable or acceptable in the existing contexts, why the NSs rather used already existing locally developed material. There are many more examples when excellent local material, produced by the government structures or by national and international organizations, either has not been used or instead have been replaced by less adapted RCRC material.

As a way to coordinate activities between the NSs in the region, biannual meetings for health managers and HIV coordinators have been held to share information, experience and training on issues identified by the RHU, sometimes with invited external facilitators. In the early years of the programme these were not seen as very relevant and useful. During the last two years the meetings (now held annually) have been more used as a forum for practical workshops and/or discussions on common issues. A clear agenda is by now set by the NSs and notes on decisions, how and when they should be followed up are taken and agreed upon. National Society participants expressed their appreciation for these changes.

Coordination with international NGO's has been negligible. The only attempt was a common planned proposal, centred on migration, to the Global Fund by Bangladesh Red Crescent, India and Nepal Red Cross together with CARE and Save the Children. This was however stopped by the Indian Red Cross as this NS wanted to play the role of primary rather than secondary recipient. The RHU or CDs has not showed any further attempts to establish and support such co-operations, which could have increased the sustainability of the programme.

Efficiency

Due to the perceived absence of experience, much resources – human, technical and financial – have been allocated to IFRC at regional and national headquarters levels. A substantial amount of the programme budget has been used for salaries to international and national staff in country delegations, whose role was unclear and undefined, which led to duplications and micromanagement. An improved ownership, better learning and probably also continuity had been possible if more responsibilities earlier on had been transferred to NSs. This model was used in Nepal, without creating a heavy structure with many employed staff as was the case of India. The importance of increased NS responsibility was highlighted in the mid-term evaluation and now again raised during discussions in Bangladesh and Pakistan. Of course this would have to be balanced to the well recognized lack of accountability in many of the countries by creating a transparent system of financial transfers matching performed activities.

Much resource within SARD was spent on developing a youth pack which was not found accurate to the local needs and where better alternatives already existed. As said before there is an abundance of good material developed by well recognized organizations that could have been used to save time and money. Similarly, a HIV project management manual was developed and shared at a SARNHA meeting with the NSs 2005, but was not used subsequently.

A substantial amount of resources have been spent on trainings which of course is necessary given the strong focus on peer education, information and awareness rising in the programme.

The high administrative and personnel expenses highlighted by the MTE, especially concerning India, have been reduced. Also the cost-effectiveness of various programme activities in general (youth peer education) and more specifically (support to a hospital and a day care centre in Tamil Nadu) was questioned and an in-depth analysis by RHU and NS asked for. This has however still not been performed.

There is a skewed balance between money spent at the national headquarters level and the small financial resources available at the local level, making it difficult to retain volunteers and perform more in-depth and thereby time-consuming activities directly targeting the beneficiaries. Even if volunteers should not be remunerated, as requested in Bangladesh and perceived as a promise at some stage, there is a need to add some more incentives. This can be done in the form of local training and education, grants for further studies, creating more and better equipped youth centres, participation in exchange visits, organising youth camps etc.

In an attempt to value the contribution of volunteers, VIVA studies were performed in four of the countries during 2009, showing quite different results mainly depending on the stage of the implementation of the programme. Interestingly enough the results of the studies were never mentioned or appreciated by the NSs during our discussions on headquarter level.

On the other hand, it was repeatedly stated by government and international organizations' representatives that they saw the strength of RC RC in their huge network of committed volunteers. This is why it is even more surprising that such meagre financial resources are spent on them and their meetings and contacts in different forms with the beneficiaries. This is obviously not only true for this programme, but a cross-cutting issue in all NSs in the region.

Impact

The programme proposal and its logframe do not contain any impact indicators and there has never been any coordinated effort to measure neither the outcome nor the impact of performed activities. It has obviously not been requested by IFRC/Geneva or the donor either.

Except for some very basic studies, on knowledge and attitudes before and immediately after training sessions, the only other impact study comes from Sri Lanka where education and awareness building led to increased condom use and reduced alcohol consumption among tea estate workers.

It is impossible with certainty to say if the youth peer education has contributed to reduce the incidence of new infections. The education has however at least provided a number of young people with tools to protect themselves. There are some testimonies of how it has been used by women in Nepal, whose partners had been migrant workers in India or in the Gulf countries. After their return the women refused sex without condom until a negative HIV status was confirmed. Other statements indicating impact came from trained students and others, who had referred persons, including pregnant women, suspected for HIV infection to testing, thereby protecting future partners and the expected baby from infection.

For those HIV-infected who have been involved in different RC RC activities this has often improved their quality of life, being seen as someone who can contribute with her or his experience for the benefit of others. The most obvious example was shown by the prisoners in the state prison in Andhra Pradesh, who got access to treatment and treatment literacy training and who were prepared to contribute to spread information after their release.

Some have also been empowered by participating in different organizations or networks for PLHIV and/or by getting the benefit of livelihood and other support in the form of nutrition, covered school expenses or provision of possibility to grow vegetables, breed goats and chicken or starting a small business.

Indirectly many more have benefited from the reduction of stigma and discrimination in families, communities and health care settings where the RC RC awareness-raising activities at least has contributed to imparting knowledge and changing attitudes.

Again, even if not documented and thereby not proven, there are indications that the number of VNRBD has increased in areas where

campaigns have been performed, indirectly reducing the risk of HIV transmission through blood donations.

The NSs have definitely been strengthened through this programme which has led to improvements not only in how to deliver HIV interventions but also to better planning and reporting systems in general.

Added to these positive impacts should be the harmful effect observed in Bangladesh where the programme, due to a perceived promise of salaries to volunteers and as the result of the heavy criticism by the MTE, came to a total standstill, thereby leaving the trained volunteers, their peers and PLHIV without any of the foreseen support. In contrast, an almost similarly critical view on the (lack of) performance by the Pakistan Red Crescent became a turning point and led to a vitalized programme.

The India Red Cross was by the mid-term evaluation grouped together with Nepal and considered to be “best in class”. Again this created two different reactions – the Nepal Red Cross expanded their activities further while the India Red Cross was satisfied with this and just consolidated their activities.

Some activities have been started rather late in the programme cycle and when continuation cannot be guaranteed, this can cause discontent, both among the volunteers involved and the beneficiaries.

Another negative impact is the delay in looking for alternative funding when financial support from a long-term project, perhaps expected or hoped to continue, eventually comes to an end (more on that below).

Continuity and sustainability

This five year long intervention had as an important objective to strengthen the technical and coordination capacity of NSs, implement a human resources development plan and coordinate activities with national programmes and other key players. If this had been performed in an intended and proper way it could have contributed to a

sustainable programme even after funding from Sida through the SRC ceased. This has however not been the case and almost all NSs have not until now, when the programme in fact already is finished, realized this fact. Creating partnerships has been regrettably absent from the agenda and there are therefore no other organizations that can take over part of or full responsibility for the activities.

Alternative funding has not been looked for, neither from external donors nor as part of the core funding within the NS. This is even more peculiar as the RC RC recognition is so often stressed by both governmental, INGO and NGO representatives, which would make it possible to tap into GFATM money, at least where MoH or an organization belonging to the UN family is the primary recipient. As a unique example, Sri Lanka RC has recently applied for grants from Round 9 as a secondary recipient.

It would also be possible to raise money locally given the fact that some of these countries can be seen as emerging economies. At least this should be tried in India and Andhra Pradesh with its growing IT business. Funding should also be possible in Pakistan and Sri Lanka where the programme in fact takes over some corporate social responsibilities from the factories, giving their management credit for what is done, but without getting anything in return.

Even if there has been a new proposal developed for funding through the Federation “Red Cross Red Crescent HIV Programme South Asia with a special focus on Stigma and Discrimination and Sexual Reproductive Health 2010-2014” this is hardly anything visionary and attractive to potential external donors. The proposed activities and the budget is more or less the same as the current programme, while having much less wide objectives.

The sad fact is that there nowhere is an exit or phasing out plan which in worst case scenario can lead to an abrupt end of activities including livelihood support to PLHIV. Another consequence can be that many of the trained volunteers and staff can be lost as there is no human resource management plan in place and many of them have not been integrated into other programmes. All this taken together can negatively influence the perception of RC RC and taint the strong branding in the eyes of both the general public and actors in HIV and different other aspects of international assistance.

Conclusions

Proposal, previous experience and sense of ownership

Most National Societies in South Asia have been, and are still very focused on disasters, both from internal (Red Cross Movement) and external (general public and stakeholders') point of view. Long-term planning and working in a development area (outside the realms of disaster management) such as the current programme was new to the National Societies. Except Nepal Red Cross Society, who were doing a HIV/AIDS programme since long before, the NSs did not recognize the similarities in preparedness and response between a rapid (as a flood or a cyclone) and a slow developing disaster (as a famine or HIV). Therefore, they did not make use of previous experience when planning the programme and its implementation on the lines of preparedness (or prevention) and response (as care and support).

One size does not fit all – different NSs were at relatively different stages of development in the beginning – both in general terms and in experience of HIV/AIDS programming. A high degree of flexibility was therefore necessary to avoid a common framework from becoming a limitation. In the light of their experiences, it would be difficult to expect all to deliver uniformly in all aspects of the programme across all objectives. But this flexibility also made it more look like six parallel national programmes instead of one regional programme, where experience from the region was used to coach those who did not have that experience.

The proposal seemed rather top-down in its approach. Though it was well-written and based on a thorough analysis of the situation in the region, it missed a transparent discussion with NSs on the choice of the three objectives in comparison with other alternatives. It was taken as a fact, that being based on the Global AIDS Programme of the Federation, they were binding to all NSs. This led to an initial lack of ownership and gave an impression of a programme imposed on the NSs and not necessarily in line with their priorities, capacities and (later) identified or realized needs. It may be argued that there were commitments from the leaderships, yet, this may not suffice in view of

the existing low managerial capacities, particularly in ME&R, at all levels and across all NSs.

Adding to this lack of ownership was the fact that some of the NSs not until late in the programme cycle were aware of the size of the budget available, but was rather informed to present planned activities and then ask for funding. Planning was not performed in continuity, but had to be asked for by the RHU team. This seemed to be a communication problem that could have been easily solved through full transparency.

Indicators, only output and only quantitative

The initial logframe, contained (almost) only output indicators. For such a programme, it would be proper to also have a set of outcome and/or impact indicators. The lack of such indicators makes it difficult to analyse changes over time. Outcome indicators could have made it possible for qualitative estimation of learning (knowledge) in the community or identified target groups, as an example changes in attitudes towards PLHIV, and thereby giving an estimation of the performance by peer educators. But even if changes in attitudes and behaviour had been shown, this does not mean that it would have any effect on transmission, which does not take place in the groups mainly reached by this programme. The quantitative output indicators later expressed though the launching of the Global Alliance are far from being realistic. In general, there has been and continue to be a lack of qualitative indicators of the outputs as well as impacts of the inputs and resources used – be it human, technical and financial.

This is not a comment on the proposal alone, since it could in most cases be applied to the annual plans as well. However, Nepal Red Cross Society has come up with its own set of qualitative and quantitative outcome indicators, which could have been used by other NSs and where SARD should have played a leading and coordinating role.

Beneficiaries

The definition of beneficiaries was unclear and not well understood. Perhaps, the proposal should have defined beneficiaries for all actors

in the programme – the regional delegation (SARD), the country delegations, the NSs' headquarters, the branches and, if necessary, at the community level as well. Sometimes the beneficiaries were seen as the whole community and sometimes as more specific target groups. In other aspects of the programme, the beneficiaries were the NSs. At the regional level, the beneficiaries were the country delegations and through them, the NSs headquarters.

In one way, the proposal can be read as if the NSs are the main beneficiaries, e.g. when it comes to organizational development to be able to deal with a new developmental programme. From the NSs perspective, the beneficiaries are their defined target groups, be it their staff, trainers and facilitators, peer educators or volunteers. From the point of view of the peer educators and the district branches, the beneficiaries are obviously their peers.

A common understanding of who is a beneficiary was reached during the Monitoring and Evaluation workshop in January 2009. Besides, not until then was there a clear split in reporting of those reached directly by targeted interventions and indirectly through mainly awareness raising activities.

Baseline studies

For a programme of this scale, and because it was the first important regional programme on HIV/AIDS, a set of baseline studies specific to different target groups alongside objectives was to be expected. However, no real such studies were performed except for some KAB studies. This has made it impossible to follow the development of the programme over time through operational research. Proper baseline studies with follow up would have made it possible also to share the results with a greater audience outside the Red Cross Movement.

Although it can be argued that the NSs and the SARD does not have a competence to perform such studies, this can be refuted by claiming that there are probably a number of universities or organisations outside the RC RC that are willing to assist in its planning and performance. A few examples exist – an impact study of Condom Day in Nepal and some baseline studies In Afghanistan and Sri Lanka. Though just a beginning, a good example comes from Matale in Sri

Lanka, where the local Red Cross branch accomplished a baseline study in collaboration with the local university.

Implementation and observed results

There is a positive perception of RC RC NSs, in the communities across all countries in the region, as they have an impressive network of volunteers and members unlike any other organization. As the RC RC presence came closer to the community, the sense of belonging and bonding between the volunteers and the community was also seen as getting stronger. Numerous examples of this were shown in almost all visiting sites.

The work performed by the staff and volunteers in the districts and the communities is a huge body. Their high level of engagement and close identification with the community and the pride they took in their work and achievements showed the ownership at this level. The volunteers are very committed and have been eager to learn and to disseminate what they have learned about HIV/AIDS.

There has thus been an increase in knowledge about HIV/AIDS within the communities, accompanied by a corresponding reduction in the discrimination, which in most cases seem to have been based on previous fear of transmission. Discrimination is now said (and in some cases also demonstrated) to have totally disappeared in some communities and been reduced in others. The underlying stigma has also decreased in many communities. In others, the reduction of stigma may be questionable – some of the programme communities still spoke of pre- and extramarital sex, involvement with CSWs or using IV drugs in disapproving and condemnable tones.

The high commitment was seen not only at the primary level, but also among trainers and supervisors at the regional and state/provincial level. There have, of course, been interruptions due to high turnover of staff. RC RC staff salaries are much lower as compared to international and national NGO's. As local NGOs valued RC RC staff and volunteers for their capacities and commitment, some NS staff and volunteers left when these other organisations were recruiting new employees.

The training of trainers, peer educators, supervisory staff and others to raise their capacity and to transform theoretical knowledge into activities was an impressive effort. This outcome should have been closely monitored and evaluated, and, if found to be of good quality, this evaluation should be the basis of scaling up rapidly. By doing so falling into the trap of increasing quality to perfection, on the expense of reaching out to more beneficiaries but while still maintaining a basic level of quality, could have been avoided.

An example of this is India – where the programme was small on scale but high on quality. This perhaps makes sense for a country of the size of India where the Red Cross programme is small in quantitative terms and has been explained, justifiably so, as a drop in the ocean. But, it is true that even while the programme impresses with its quality, there has been no documentation on the process or of the programme itself. This could have provided very good lessons for other National Societies as well as for organisations outside the Red Cross Red Crescent Movement and could also have been an opportunity to make contacts and collaborations with academia.

The programme has a strong focus on girls and women. This has led to their empowerment and those involved have obviously gained a stronger and more respected voice both within their families and in their communities. This is shown everywhere but is perhaps strongest in Nepal.

Life skills is the tool, HIV is its application

Life skills' training is a cornerstone in the school activities of this programme. If practiced correctly, this can be a good training in tolerance, self-respect and respect for others, rights and responsibilities/duties of the individual and the society, power balance and equity in relations.

Some interesting linkages have been made between life skills, faith and gender issues, especially considering the fact that the people in general are very religious and that there is a strong patriarchal influence in this part of the world. Building on supporting quotations and connecting these with HIV and sexual and reproductive health, non-discrimination and other issues is certainly a good practice.

In general, there was however very little work done in the area of life-skills, except for what was observed in Andhra Pradesh, India. This appeared to be a serious shortcoming of the programme. It was not very clear if there was a common understanding of what is meant by life skills, even if this was supposed to conform to the social and cultural contexts of the communities each NS works among. Thus, with the diversity of South Asia, the understanding of lifeskills changes from country to country and within each country as well. The IFRC material on peer education, including life skills, was neither seen as appropriate in relation to the cultural context nor to the background knowledge of the people to be trained which led to a lack of a common template on life skills. This gave rise to an over-emphasis on the medical and technical aspects of HIV/AIDS, which can narrow the scope and be quite detrimental to the impact of the programme.

Information and knowledge around life skills must be seen as the tool that can be applied in different fields, among them sexuality and reproduction, including sexual health and HIV, keeping in mind the age and environment of the beneficiaries. It is also important to introduce life skills gradually as young teens may not really be expected to apply this part of life skills trainings in the same manner as young people in their early 20s.

From the high levels of reluctance in the initial years of the programme, a positive fact is that there has been an increased acceptance by schools, teachers and parents on training and teaching sexual and reproductive health even if negative views persist. Involvement of religious leaders, where it has been done, is crucial in contexts where religion plays a vital role in daily social life. However, the National Societies have to maintain a delicate balance in multi-ethnic communities, which so far, they have been doing with due caution.

Support to and involving PLHIV, fighting stigma and discrimination

The limited numbers notwithstanding, for many of PLHIV reached by this programme, it has sometimes been the difference between life and death. The provision of livelihood support has provided a sense of economic security to the infected people as well as to the affected families. In other cases, it has raised the limited purchasing power of

the family. The livelihood support has encouraged acceptance and helped PLHIV find a space in their families in cases where they were discriminated or even thrown out. Used in a right way it was also enabling PLHIV to find solutions and helped beneficiaries avoid the trap of falling into the victimised mindset that would further amplify their dependence.

The Nepal Red Cross Society showed how it has helped to develop a positive-people's networking in the districts where the programme is implemented, but the process or lessons on this were unfortunately not documented.

In the NSs, a few HIV-positive persons have been involved in trainings and workshops, but this linkage with networks of PLHIV has not been exploited enough in developing plans and strategies.

Except in the regional delegation and in the Nepal Red Cross Society, workplace policies on HIV/AIDS were not seen as a priority. Employment of PLHIV has been limited and has come relatively late in the programme. Nepal Red Cross Society made a conscious decision to employ PLHIV as the National Society staff in all the three district branches where the programme was implemented. The Pakistan Red Crescent Society has employed a PLHIV in one of its branches since 2008, while India Red Cross has PLHIV working in hospital settings.

The scale and duration of involvement of PLHIV within the programme has thus varied from country to country. When PLHIV have been involved this also shows that their view is valued. By their willingness to disclose and their active participation, especially when on treatment, they probably are the best promoters for early testing and detection. Arranging interactions with PLHIV is also the best "vaccine against discrimination" through exposing "positive living with HIV" to the general public.

Volunteer and staff management

Neither any structured system for staff development except for initial formal training sessions, nor any hands-on training or follow-up has been an essential aspect of the programme. This may have to do with the fact that staff development remains part of NS' HR policy.

However, there is scope within the HR policies for enhancing capacities of technical and programme staff and all that it required was a system, especially because the technical managers at the country level were working closely with their regional counterparts.

The annual (and earlier, bi-annual) presentations at the meetings/workshops of HIV programme coordinators have been mainly narrative and not much of a learning experience. The presence of branch staff and volunteers (peers) from the region's NSs should have been exploited to get more of critical thinking and inputs from the field. This was a good feature of the only peer review undertaken (Afghanistan, Nepal and Sri Lanka on the programme in Pakistan). Unfortunately, Nepal's programme peer review by Afghanistan could not take place due to security concerns. There have been many opportunities to make better use of a regional approach and peer review or benchmarking could have been one of them.

Exchange visits both within and between countries were a good idea. But these were introduced too late towards the end of the programme cycle. The goals should be identified in advance to facilitate a mutual learning process. Visits can be good incentives and stimulate staff development if used in a way where field volunteers and not only higher ranked staff become involved.

Monitoring and reporting

Early on it was obvious that there was a weakness in monitoring and evaluation of the implementation of this programme. This flaw was evident as NSs had much to show in the period of the programme following the PME&R workshop in January 2009. It does seem that this workshop did help the teams at the NS level as well as the CD to improve the quality of their reporting. NSs mentioned how the reporting formats had changed from time-to-time until a final format emerged in the run-up to the Global Alliance, which too was introduced at the same workshop. SRC and Sida both expressed satisfaction with the received reports.

Feedback from SARD and Country Delegations, on the still often extensive reporting has seldom been in the shape of constructive criticism. Rather, it comes as questions (often financial) and very

general remarks. There were some critical inputs in the initial years, but during the last year especially, when the programme had reached a peak, staff at the NS opined that there were no critical inputs at all. It was interesting to note that several of the NSs were looking forward to criticism as constructive advices and not as threats.

There should have been a better follow up by RHU, CDs and SRC of the recommendations from the mid-term evaluation. In fact most of the recommendations have not been followed and the remaining only partially accomplished. RHU did react by changing to a role more as a facilitator. The different NSs responded to the MTE conclusions in different ways – it jerked up the Pakistan Red Crescent Society into action, while there was no reaction from Bangladesh Red Crescent Society, where certain relevant portions contained in the MTE eluded the notice of the National Society as well as of the Federation. It was clear from this evaluation that Bangladesh Red Crescent, which had suffered from high turnover of staff, in combination with shift of priorities towards the cyclone, needed closer monitoring, support and supervision which however never became a reality.

Integration with other activities

The implementation has to some extent been built on the impressive existing network of RC RC volunteers. However, this could have been exploited furthermore by linking HIV to other RC RC work in South Asia. It is well accepted that HIV/AIDS is a slowly developing emergency. In this light, efforts should have been made to link aspects on HIV-related trainings and trained peer educators to disaster preparedness and response, CBHFA and PHiE. This would transform the volunteers into real multi-purpose trained volunteers and not as is often the case now – volunteers just working on HIV/AIDS and having totally different skills compared to others.

This is not to say that the integration has not happened. It has only been done a little late in the day and to a limited extent. At the level of the NSs, HIV programming is now included in the national plans, to an increasing degree as an integrated component in other programmes. The necessity for integration is more obvious on branch or subbranch level, due to shortage of staff that has to be more multipurpose, than

on headquarter level where the programme still is strictly vertical even within the health department,

The RCRC NSs in South Asia have a reputation for their excellence in the area of disaster management, which for good reason, is the flagship of all NSs. Their work in disaster preparedness offers examples across the globe. The same can be said of the work of the National Societies in the area of disaster response and relief. There is also good expertise in linking the preparedness for disasters with response. However, this culture of managing programmes on disaster management has not influenced either health programming, or, for that matter, programming on HIV/AIDS. There is a need to look at the preventive component (including stigma and discrimination) of the programme as preparedness, and the care and support component as response. Imbibing the culture of disaster management in health management could help the National Societies' health programming in general, and HIV/AIDS programming in particular.

However, HIV/AIDS is, across all National Societies and at all levels, still seen as a deadly disease rather than a condition one can live with. The programme has taken the message that HIV/AIDS is treatable, but the degree to which this message has been disseminated varies from country to country. When it comes to prevention it is not really clear what should be the main message. The disseminated information is very much focussed on condom use, and, to a smaller extent on fidelity. But nowhere did we hear anything on safer sex techniques other than use of condoms.

In general it can seriously be questioned if this programme should have been seen as a health programme from the beginning. In fact, the only health component is the care part under Objective 2. Much more can be seen as promotion and strengthening of humanitarian values – life skills training, fighting stigma and discrimination, voluntarism in blood donations – and organisational development.

SARD could have done much more to make it a horizontal programme instead of placing it in the lap of the respective health department within the NSs and by that having a basically non-medical programme managed by medical doctors.

Partnership

The RC NSs have, in general, good cooperation with their respective governments. Given their history of service, the NSs are well respected and this is also why they often experience few obstacles in having their plans and implementations accepted as compared to other organizations.

Partnerships with Ministries of Health and other organizations in the respective countries have been rather limited, but could have increased the strength as well as complemented an exit strategy and improved the possibility of others taking over as and when the programme began phasing out. There were few MoUs drawn up with partners, but Nepal and Pakistan put emphasis on a documented MoU as being especially important in view of the high turnover of staff causing loss of institutional memory.

In spite of the positive recognition of the Red Cross/Red Crescent Societies there has been a total lack of advocacy with clear goals, both on national and regional level. Visible activities have been restricted to observing certain days as World AIDS Day, Condom Day, Blood Donors Day etc. Different NGO's with rather limited activities have been much more vocal and influential. Here again the SARD could have been actively assisting in finding ways to give voice to vulnerable groups in general and to PLHIV particularly. Preferably this should be done in partnerships with their own organisations and with other local or international NGO's.

Fundraising to ensure sustainability

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

Only Sri Lanka Red Cross Society is part of the Country Coordinating Mechanism (CCM) and except for Nepal Red Cross Society (to a very limited extent), no other NS has yet tapped into funding from GFATM. Else, it should have been easy for the NSs to approach the governments for funding in view of their strong auxiliary

relationships, certainly when governmental bodies are the primary recipients.

Phasing out and exit strategy

A question that arose often in our discussions was regarding the duration of the programme. In general it can be said that a five-year perspective is too short a programme-cycle for a development program like this one, based as it is, on training of staff and volunteers with no previous knowledge or experience of HIV. The high turn-over of staff is also an issue that bears over the duration of the project.

Though an exit strategy is mentioned in the proposal, it was often observed that the programme was coming to an abrupt ending without a systematic phasing out of activities, handing over to the government or other organisations. There have been efforts to integrate aspects of HIV into other trainings such as CBHFA, PHC, PHiE and DM. But, what is missing is inclusion into the core activities in a more strategic way that could have secured continuation beyond the duration of the present programme.

Lessons learned and Recommendations

These recommendations can be divided in two parts – recommendations for the consolidation and possible development of the current programme and recommendations for future similar regional programmes. As the probability to start new regional programmes focusing on HIV are highly unlikely the latter has to be discussed in terms of other conditions with a wide effect on the society.

Lessons can be learned from planning and reporting in India and Nepal; management of volunteers, partnerships with PLHIV and VNRBD again in Nepal; working with factories and companies in Sri Lanka and lately in Pakistan; involving religious representatives in Afghanistan and Pakistan; experience from life skills training in India and Nepal; importance of strong support to a weak structure in Bangladesh.

Present programme

Volunteers and integration

As has been said before, the strength of the RC RC societies, in this as in other regions, is the widespread network and its volunteers. This is why measures to consider are about how to retain and make use of these resources with their knowledge and experience.

Trained staff and volunteers have to be managed by including them in other permanent programmes, be it CBHFA, PHiE or disaster management. To integrate HIV preparedness and prevention based on life skills in these programmes, where it has not already been performed, is a natural task for the National Societies.

When doing this also showing stronger appreciation of voluntary work, based on the findings from VIVA studies, by involving volunteers in decision making groups, including them in exchange visits and rewarding them with further education and training opportunities.

Blood donor recruitment and blood safety

Another obvious integration, of what has been part of the programme, is of blood safety and VNRBD. Where donor recruitment is already a core activity it can certainly be strengthened through newly formed groups, Club 25 in Afghanistan, India and Nepal and 'You and Me' in Sri Lanka. Where NSs are engaged in blood collection and running blood banks, counselling not only on HIV, but also on hepatitis and other STI's should be included in the routine process together with use of the best techniques to exclude donors with high risk behaviour and detect blood born diseases. Continued advocacy for VNRBD and assisting in recruitment of blood donors in general, and in particular among those already reached through the programme, should be included in core activities. Advocacy for VNRBD should also be part of new national projects on blood safety by the MoH, such as the one to start in Pakistan with support of the German Government and where Pakistan Red Crescent Society is viewed as an important partner.

Youth and Life skills

As most of the RC RC societies have a strong base among young people, and as experience now has been gained in life skills development, this should become an integrated module when recruiting and training volunteers in general. This will prepare them to face challenges in their own lives as well as supporting others in different situations. It will familiarize them with tools to reduce stigma in their own and others minds, tackle the 'us versus them' thinking, avoid discrimination and base all activities on humanitarian values.

At the country level, the Red Cross Red Crescent National Society, together with other partners, should advocate for inclusion of life skills training in the curricula of schools. There is now experience available within the region on how to perform this, but it is necessary to structure and document for it to become useful and successful in this advocacy.

When targeting a young audience, the focus should be switched from HIV to STI's in general. Changing sexual habits is a global phenomenon, which will result in many more young people exposing themselves or being exposed to the risk of unwanted pregnancies and

STI's, including HIV. These risks contain increasing resistance to available drugs (gonorrhoea), sexual impact of lifelong infections (herpes), risk for malignancies (papillomavirus) and complications (Chlamydia and syphilis), not to forget the wide psychological and social effects in a still traditional, religious and patriarchal society.

Vulnerable groups and Advocacy

Where already initiated, NSs should at least continue activities targeting vulnerable groups: CSW in Nepal and Sri Lanka; migrant workers and their spouses in Nepal, Pakistan and Sri Lanka; prisoners in India and Sri Lanka. Working on prevention with clear messages on safer sex techniques (not only condom use), and testing as a tool for early detection and access to treatment, should now be possible for NSs after experience gained from this programme.

It is high time the NSs become more active in advocacy, in partnership with other organizations and with already established networks of PLHIV – this should be seen as a duty given the strong recognition the RC RC NSs enjoy within the society and also their good relations with their respective governments. NSs should not only advocate for the above mentioned groups but also for intravenous drug users and men who have sex with men (homo-, bisexual and transgender) to increasing availability of early testing, access to treatment and counselling in positive living for those found to be HIV infected.

Partnership and research

It is recommended that NSs maintain partnerships with PLHIV networks and work towards creating new partnerships with other local NGOs to combine livelihood programmes with income generating programmes in larger scale. This should be performed by using the strengths and capacities within the beneficiaries own family or group instead of regarding PLHIV as victims, producing demands which can seldom be met. The support should be based on baseline studies with continued operational research, preferably in cooperation with local universities. Similar arrangement can be used to study the outcome of the India programmes activities in the prison in Rajamudhary, the hospital in Tambaram, and day care centre in Dharmapuri.

Local fundraising and sustainability

Given the strong branding, and the highly appreciated work done by RC RC staff and volunteers during national disasters such as earthquakes, floods and cyclones, this should be better exploited. Some of these countries are emerging economies with high increase in their Gross National Income, an increasing number of very profitable companies and a rapidly growing rich and middle-class population.

To continue some or all the above mentioned activities and to create sustainability, it is of utmost importance for the NSs to begin local fundraising, both from individuals and from corporate houses to reduce dependency on foreign donors and their specific interests.

This relationship could also be used to consolidate partnerships, including financial sponsorship, with the factories in Pakistan and tea estates in Sri Lanka. Here the RC RC support should be seen as taking on a corporate social responsibility initiative that also improves the image of the company and which should be paid back in one way or another.

Creating innovative collaborations, as with Honda and private practitioners in Pakistan, can also become a source of income as could First Aid Training courses in nursing colleges, training schools for the police, ambulance providers, etc. These courses can then include information and build awareness on HIV/STI and encourage participants to become regular blood donors.

Future applications

Turning to the other part of recommendations there will probably in the future be more situations where a regional response is necessary and meaningful. In the Asian region, effects caused by climate change; population growth; strong and rapid urbanization; economic growth and recessions; an aging population are just some of the possibilities. Besides social (up-rooting and loss of connectedness) and psychological effects (different kinds of stress reactions), other health impacts as wider spread of some contagious diseases, non-infectious diseases coming with age (cardio-vascular and metabolic as diabetes)

and mental (as dementia and stroke) are areas of work that the National Societies must be prepared to seize.

Lessons learned from the current programme is the need for an early involvement of NSs staff (not only those on the higher levels of hierarchy, but also those implementing programmes) to sensitize and increase ownership. There is a need for honest and realistic estimation of the capacities on different levels, when it comes to management, fundraising, monitoring and evaluation.

All new programmes should be carefully reviewed on where they belong to, and not necessarily included under the umbrella of the health departments. It is also important to approach local institutions to perform adequate baseline studies and follow-ups, starting with small pilot programmes to learn and adjust from before scaling up. Clear roles and responsibilities with strong supportive mechanisms built on local and regional resources are necessary. A competent regional network that can give technical support and managerial advice is a prerequisite to the implementation of a regional programme. Exchange visits and benchmarking should be encouraged early on both within and between countries.

It is necessary to have an advocacy plan with clear goals and objectives: whom to target and why, how and when. Again, if this expertise does not exist within the National Society, there is a need to make use of external professional sources or to undertake extensive in-house training.

Lastly, an important task is to follow up what impact remains of the current programme after a period of two or three years, both when it comes to the staff and volunteers involved and the different beneficiaries reached. Connection could be established with local universities to perform this ex-post evaluation– this is an opportunity waiting to be tapped yet neglected in almost all programmes that can become a valuable lesson learned to be applied globally.

Annexes

Terms of Reference

For external consultant responsible for final evaluation of the National Societies implementing “Red Cross Red Crescent HIV Programme of South Asia (2005-2009)”

BACKGROUND:

AIDS will kill more people in this decade than all the wars and disasters in the past 50 years. Since the HIV pandemic began, 33 million are now living with HIV globally. South Asia homes about quarter of the world’s population and is among the most disadvantaged regions in the world. While overall HIV prevalence in South Asia is still recorded low, but with some of the highest deprivation levels in the world, political instability, growing conflict, human trafficking, population movement and porous borders, the HIV epidemic has the potential to advance at an alarming rate.

The International Federation of Red Cross & Red Crescent Societies (IFRC), a membership organization of 186 National Red Cross & Red Crescent Societies (NS) around the world, is committed massively to scale up its global efforts to respond to the epidemic of HIV & AIDS, working through worldwide volunteer networks and in close partnership with international, national and civil society partners.

“The Red Cross Red Crescent HIV/ Programme of South Asia (2005-2009)” was developed in 2004 by SARD in collaboration with 6 NS and Swedish Red Cross. The regional HIV/AIDS programme focuses on scaling up of Red Cross/Red Crescent (RCRC) HIV and AIDS responses in six South Asian countries - Afghanistan, Bangladesh, India, Nepal, Pakistan and Sri Lanka - in collaboration with key partners. A monitoring and evaluation framework (both programmatic and financial) is a significant part of the programme, with an emphasis on monitoring progress towards set targets and feedback of information on emerging needs. Focus is given to sustainable capacity building and emphasis placed on strengthening organisational capacity to carry out sustainable HIV responses, including information systems and human resource development. The Regional Health Unit (RHU),

South Asia Regional Delegation (SARD), IFRC is providing technical and managerial support to these 6 NS in the region.

The overall goal of “The Red Cross Red Crescent HIV/ Programme of South Asia (2005 – 2009)” is to contribute to reduction of the burden of HIV and AIDS through strengthened local responses, community based prevention, care and anti-stigma activities implemented through NS, in collaboration with other partners in South Asia.

In 2008, a midterm evaluation was conducted and certain recommendations were given. At this stage some countries had come further in their programming while others were not at the same level. There recommendations were followed up and there has been and change of momentum in the program.

The Global Alliance (GA) was launched in the region in December 2008 and four of the six countries are part of the alliance. A unified reporting system has been put in place and even the countries not yet part of the GA report in the same framework and logframe. The two remaining countries have showed interest in joining and one NS has already sent a letter of intent to Geneva.

PURPOSE OF THE EVALUATION:

The Final evaluation of NS for The Red Cross Red Crescent HIV/ Programme of South Asia (2005-2009) will be carried out to draw conclusions, identify best practices lessons and develop models which can then be applicable elsewhere in the RC/RC movement

OBJECTIVES OF THE EVALUATION:

- § To identify progress and achievements as per indicators given in proposal.
- § To assess the program design, relevance and appropriateness
- § To assess the effectiveness and sustainability of the programme
- § To To identify and understand the obstacles, constraints and challenges.
- § To identify best practices, lessons learned and identify models which can be applicable in the RC/RC movement.

SCOPE:

The external consultant will work closely with Regional Health Team throughout the evaluation. The evaluation of the programme goals would be based upon 5 objectives, expected results and Indicators of Regional HIV/AIDS Program in South Asia given in proposal document. The emphasis will be put on

1. Capacity of NS – In terms of number of trained manpower working for the program, Human resources policy, needs etc.
2. Review of Reports – Reports of various events, trainings, meetings, existence of reporting system, feedback system from NS to field staff. The reports should also be reviewed in terms of completeness & quality (as determined by external consultant along with RHU, CD & NS) mid term evaluation.
3. Mid term evaluation report; and the follow up of the findings and recommendations.

METHODOLOGY:

The final evaluation will be based on wide and open consultation with the active involvement of NS, CD and RHT at all levels. External consultant will decide the methodology, instruments for data collection. The basic format of evaluation methodology prepared by external consultant for the respective country will be sent to NS in advance so that the respective NS may have enough time to prepare and present the data. The evaluator will also review the documents, presentations by respective NS during country visit. Each country will have visits by the team with the schedule mutually agreed upon by NS, CD & RHT. The regional health team and country teams will facilitate the evaluation process.

Reference Team:

In addition, inputs and advices will be sought from the following:

WHO Technical and/or Medical Officer of respective country

Swedish Red Cross

SIDA

Representative of respective country PLHIV

MoH or equal

The consultant will adhere to code of conduct and rules & regulations of IFRC.

EXPECTED OUTPUTS/OUTCOMES:

The External Consultant will be responsible for the development of evaluation reports with recommendations. The final output will be an evaluation report.

REPORT: The report will have the following Basic Minimum Components:

- § Table of Contents
- § Abbreviations
- § Executive Summary
- § Introduction
- § Background with all references
- § Methodology
- § Terms of References
- § Overview of National Societies: based on indicators
- § Findings in details
- § Best practices
- § Conclusions and lessons learnt
- § Recommendations and justifications
- § Annexes

TIME LINE:

The final evaluation activity will take 40-45 days (February – March, 2010).

Planning and Orientation: 2-5 days

Visits to NS and Fields: 5 x 6 = 30 days

The visits will include:

1 day – Presentations, meetings and interviews with NS/field staff involved in program by evaluation team

2nd day – Meetings with external stakeholders/partners, Federation, PNS

3rd to 5th day - Field visit

1 day for travelling in region

Reporting schedule:

- § The evaluation report first draft should be submitted within 7 days of the last field visit.
- § The evaluation report finalization meeting will be conducted in 3 days of submission of first draft.
- § The final evaluation report should be submitted within 3 days of report finalization meeting.

Distribution:

The final report will be shared with Swedish RC, NS, CD/office, SARD and other stakeholders like WHO etc. All of the outputs of the consultancy belong to the IFRC. IFRC has a right to publish those outputs and make them publicly available. This does not preclude publishing the working paper in other forums, provided that the IFRC SARD is properly acknowledged.

Country sheets (based on visits and indicators)

Objective 1: <i>Contribute to reduction in incidence of new infections among young people through youth peer education and life skills development</i>						
Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No. of Peer Educators Trained in Life Skills	1,484	No Data	1,952	4,829	6,585	No Data
No. of Peer Educators Trained in HIV Prevention	1,820	No Data	1,952	33,785	6,585	No Data
How many Peer Educators were RC volunteers?	536	No Data	No Data	10 % (aprox)	633	No Data
How many of peer educators remain / are active	1,801	No Data	All	55 %	714	No Data
Estimated drop-out rate/year	198 (in 2008-09)	No Data	400	5-10 %	40 %	No Data
No of youth contacted per PE by individual sessions	10,846	No Data	10	20,500	60-70 %	No Data
No of youth contacted per PE through group sessions	119,317	No Data	10	57,500	80-90 % of total	No Data
Of these, how many were school-going	57,060	No Data	No Data	48,000	64 %	No Data
Of these, how many were out of school	50,509	No Data	No Data	30,000	36 %	No Data
Average time spent on an individual	30 min	No Data	15-30 min	30 min	30-60 min	No Data
Time is spent on HIV/STI prevention and life skills development in CBHFA training	2 days each on STI and AIDS according to CBFA guidelines - ARCS not using CBHFA approach	No Data	No Data	No Data	At least 30 mins. But in some branches, over 3 hours.	No Data
Ratio of peer educators to a supervisor	20 : 1	No Data	10 : 1	160 : 1	8 : 1	No Data
How often is monitoring performed	Monthly	No Data	Weekly	Monthly	Monthly	No Data
No of school teachers provided RC trainings on life-skills and HIV prevention?	90	No Data	40 per year	177	2,658 parents	No Data
Objective 2: <i>Contribute to improving the quality of life of PLHIV and their families through care, support and anti-stigma and anti-discrimination activities with their greater involvement of PLHIV</i>						
Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No. of PLHIV (females and males) referred for care	Nil	No Data	Referrals not formal activity	2,474 persons	19 persons	No Data
No. of PLHIV supported by the programme	Nil	No Data	Nutrition support for 8,632 & hygiene kits for 400 PLWHA/families	980 persons	1 PLHIV employed as social mobiliser	No Data
No of PLHIV estimated to need such support	Nil	No Data	No Data	1,600	15 to 20	No Data
No of anti-discrimination activities targeting health care workers	Nil	No Data	No Data	17 activities	30 sessions	No Data
No of health-care workers reached	Nil	No Data	No Data	75 health service providers trained	1,910 health workers	No Data
No of staff who have participated in discussions, seminars or workshops on stigma and discrimination	300	No Data	All staff in AP Branch	Over 90 per cent staff	All HIV/AIDS programme staff	No Data
Networks or PLHIV groups formed with RC support	Nil	No Data	None	27 support groups	2 groups in Lahore	No Data
No of PLHIV recruited as staff in the NS	Nil	No Data	1 (in field)	3 staff	1 staff	No Data
Does the NS have a workplace policy in place?	Under Progress	No Data	Under progress	Just adopted guideline	Planned for 2010	No Data

Objective 3: Contribute to reduction of transmission of HIV by blood transfusion through increased voluntary non-remunerated blood donation.						
Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
Have donors been recruited through HIV programmes in health-care settings, garment industries, schools, tea estates etc.? How many of these become regular donors – two times a year or more?	Blood donors recruited in 8 targeted schools in Kabul city. 90 of these have donated blood upon request of the national central blood bank.	No Data	Donations received through donors for programme, but not a regular occurrence as staff capacity needs to be built.	Yes, donors been recruited from the +2 (senior) schools and 225 are regular donors (80%+)	Yes. Approx. 5,000 volunteer blood donors per year of whom, 1,500 are regular donors	No Data
No of RC/RC staff and volunteers are regular blood donors/members in Club 25	6 ARCS employees and 90 volunteers donate whenever approached or requested by the central blood bank.	No Data	No Data	20% staffs & volunteers are regular donor but not Club 25 members.	17 PRCS staff and 48 volunteers. No Club 25.	No Data
How many Club 25s have been formed in the districts covered by the programme?	12 Clubs in 8 schools of Kabul city.	No Data	9 Club 25s	22 schools	None	No Data
Has there been creation and support of networks for voluntary blood donors?	VNRB donation committee is	No Data	No Data	Yes, NRCS have been	Yes, PRCS is working with	No Data
	established with ARCS health director as focal person; MoUs between ARCS and Ministry of Public Health and Ministry of Education; Club 25s recognised by Central Blood Bank			closely working with the Nepal Blood donors association (NBDAN).	other voluntary blood donation organisations. Also working with National AIDS Control Programme for safe blood with focus on VNRBD.	

Objective 4: Strengthen the capacity of National Societies to effectively deliver HIV interventions?						
Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No of trained volunteers and others trained and involved in the HIV programme retained	124,261 trained YPFs, YPF trainers, VNRBD motivators, volunteers, peers, CBFA team leaders and volunteers, ARCS staff, teachers and principals are involved in the HIV programme.	No Data	Most working with Health and DM programmes on a regular basis	5,206 (including trainer, PEs and RC members)	90 % staff 60 to 70 % volunteers	No Data
How many PLHIV are represented in the National Society's HIV/AIDS Advisory Committee/ Steering Committee/ any other committees or forums?	Nil	No Data	No formal allocations done	One person in national level advisory committee and one person in each programme district.	PLHIV represented by Association of PLHIV in the steering committee (NHQ).	No Data
How many meetings/workshops/seminars have been organised together with other key players targeting policy makers on different levels (HIV prevention, care and treatment, human rights issues, stigma and discrimination, employment, legal aspects, blood safety)?	Regularly with government AIDS Control Authorities on	No Data	Total number not available – however	9 meeting at central level and 32 meetings in	NACP organised VCCT training for	No Data
Have RCRC representatives been invited to deliver talks or conduct workshops or workshop sessions in the programmes of other organisations working on HIV/AIDS at national level?	advocacy and communication; blood safety policy; POP meetings and workshop; Finalising of Police Training curriculum meetings; WAD working group meetings have been organized with NACP.	No Data	stakeholders have participated in events such as World AIDS day forum.	the districts	PRCS staff. 15 workshops conducted in Sindh branch with various associations/ authorities.	No Data
	National AIDS Control Programme has invited ARCS HIV master trainers to facilitate life skills based youth peer education ToT to MoPH youth supported by UNICEF twice. ARCS hosted the first HIV and Reproductive health symposium in	No Data	No	At least on 20 occasions.	One PRCS staff co-facilitated a training on VCCT organised by ANCP.	No Data

	Kabul.					
Have RCRC representatives been invited to deliver talks or conduct workshops or workshop sessions in the programmes of other organisations working on HIV/AIDS at district level?	ARC'S HIV local coordinators and YPE trainers invited to conduct sessions and train schools students outside coverage areas in Kabul, Mazari, Herat and Jalalabad cities and invited local coordinator to distribute national IEC materials to people at community	No Data	No	At least on 50 occasions.	At the provincial level too, many trainings have been facilitated by PRCS staff.	No Data
What is the percentage of budget allocated to HIV programme activities relative to the total budget of the national society?	4-5 percent of the IFRC supported health budget.	No Data	No Data	5 – 6 % annually.	2005: 0.00% 2006: 0.039% 2007: 0.08% 2008: 0.73% 2009: 1.56%	No Data
Please provide (in percentage terms) the budget allocated to HIV/AIDS programmes in the National Society since 2005.	2006: 70,000 2007: 107,000 2008: 129,000 2009: 130,000	No Data	No Data	2005: 4.1% 2006: 4.6 % 2007: 5.8 % 2008: 5.75 % 2009: 5.35%	2005: 0% 2006: 0.04% 2007: 0.08% 2008: 0.68% 2009: 2.0%	No Data
How is HIV/AIDS reflected in the current national strategic plans of the National Society?	The HIV and AIDS project is reflected as one of the priority areas in the ARC'S strategic plan (2008-2012)	No Data	HIV/AIDS occurs prominently in the strategic plans and guidelines of the National Society	HIV and AIDS are prioritized issues in the 4 th and 5 th development plan of NRCS.	HIV/AIDS is a priority area in the PRCS policy document. PRCS strategy for health and HIV is being developed.	No Data
How many HIV/AIDS programme coordinators have changed during the course of this programme at the National level?	At national level, only a HIV officer left in the beginning of 2010	No Data	2	1	None	No Data
How many HIV/AIDS programme coordinators have changed during the course of this programme at the district level?	Nil		Turnover has been frequent	None	No Data	
How much of internally raised funds have been allocated to this program?	None / Nil		No formal allocations – however funds have been raised for events like World AIDS Day at various levels in the field.	150,000.00 NPR was raised by JRC members for WAD Campaign in 2007.	None.	
Has your National Society put in proposals for other	None.		Yes. A	At least 10	Put in one	

HIVAIDS programmes - and how many?			proposal was put to HKRC through the IFRC National Society also has bilateral funding programmes with other FNSs.	times (two times for PR of GFATM)	proposal with AmCross in 2009. Sindh Branch established a HIV/AIDS Prevention and care project with collaboration with other agencies funded by USAID.	
------------------------------------	--	--	---	-----------------------------------	--	--

AFGHANISTAN

In Afghanistan, the regional programme has shown a good implementation, execution and general functioning, largely due to a committed coordinator in the Afghanistan Red Crescent Society. Besides, the respect ARCS enjoys among the general public has also come handy to approach the issue of HIVAIDS, always considered a difficult thing in the context of Afghanistan.

In this respect, the Afghan Red Crescent Society has covered much ground in this area, especially with respect to raising awareness and reducing stigma and discrimination. This is despite the initial scepticism within the national society, much of which has been overcome since. Addressing stigma and discrimination, and even programming on HIV/AIDS generally, were uncharted realms, though the National Society was aware of the emphasis on reducing stigma and discrimination within the Red Cross Red Crescent Movement in South Asia.

The programme took off a year late in Afghanistan because it took the national society six months to get permission from the ethics board of the ministry of health. Some of the matters in Afghanistan were very different from other regions we visited. For example, there was no issue of what would be the right age to introduce awareness regarding HIV/AIDS. The girls in senior school were of the age of college-going young ladies in other parts of the region. This may have to do with a late-start to their education due to the situation prevailing in the country.

Objectives for National Societies:

- 1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.*

The work in this area has been impressive and strongly counters the stereotype images one may conjure with young people in Afghanistan. One of the reasons for this was the support from the Ministry of Education. Following a MoU, school authorities and teachers provided support to the Red Crescent for this programme. A number of master trainers for YPE have been trained, including the director of the National AIDS Control Programme of Afghanistan (NACP). Other civil society actors also say that ARCS has made the change in behaviour possible in Afghanistan.

However, the emphasis of the programme has been to avoid unsafe sexual contact as a factor of spreading the infection, in favour of the other means, especially blood transfusion and injecting drugs. In spite of the agreement signed with the Ministry of Education, it was not possible to speak of sex and promotion of the use of condoms for fear of introducing promiscuous behaviour. Only after a lot of lobbying were the ARCS allowed to talk about condoms with married students, and though ARCS has not really carried out any activities among married students, matters like this impinge on the performance of the programme's contribution to life skills development.

There is a lot of contradiction within the government agencies' stand on the issues in view of a society still seeped deep in its social and cultural settings. For instance, the ministry of education's stand on this issue is a little different from that of the ministry of public health that now promotes the use of condoms over media advertisement. This has not helped in the implementation of the programme by the ARCS.

National AIDS Control Programme of Afghanistan envisages a strong role for ARCS and other actors in the country recognise the ARCS HIV programme, besides its role in events like World AIDS Day. ARCS is also part of the policy committee for formulating the advocacy and communication material in Afghanistan. This gives the Red Crescent a vital role in view of its experience in developing IEC material and by virtue of this role, ARCS is charged with overseeing the content of all IEC material regarding HIV/AIDS in the country. (I)NGOs and other actors in Afghanistan are happy for a forward looking organisation to be charged with this role as also due to the ARCS' achievements in both, advocacy and the promotion of its own IEC material. NACP envisages a role for ARCS to develop further IEC as well as BCC methodologies in the future.

NACP is a very young organisation and is hugely dependent on the role of ARCS volunteers.

Afghanistan is short on school infrastructure. Schools have many students and this makes it possible for the ARCS to reach thousands of students through its collaborations. For instance, a boys school with 21,000 students is easy to reach by ARCS through its small programme staff working with a committed group of science teachers. ARCS is the only organisation working among school students in Afghanistan, especially in schools for girls. This is facilitated by a MoU signed with the government for a four-year period coinciding with the duration of the programme in Afghanistan. As the Ministry of Education was interested in the follow up of the programme, this MoU has been followed up with a special order to facilitate the Red Crescent's entry into the schools.

Schools principals and teachers understood HIV to be an important issue for the young generation. It was also realised that selecting the right person for the Master Trainer's training and to locate the right people for the youth peer educators was central to the approach. When ARCS began the programme with the schools four years ago, they empowered the master trainer, and through them, the YPE to pass the message. As part of this scheme of things, each YPE passed the message to 40 students or peers. One example cited by a principal was that earlier girls in the school used the same pin to pierce their ears – a pin was rotated among the girls, so conscious of having their ears pierced. After they learnt about HIV/AIDS, they stopped doing so.

There are 125 master trainers in all branches put together and together with the principal of the schools, they form a bridge. It is the job of the teachers and the trainers to support the 2588 Youth Peer Educators (YPE) to do their work, create an environment for the YPEs to speak on HIV/AIDS to the rest of classroom – a chance that comes when a teacher is on leave and the master trainer or the school principal come to the classroom to tell the students, “here's your friend who wants to speak to you about something serious, important and interesting.” This has delivered the desired results and youth peers have achieved a lot of positive results with the dissemination on HIV, how it spreads and how young people could protect themselves. They have, in many a case, done so in the face of great odds. As we spoke, a number of these educators would break down when narrating the opposition they faced – in the context of the situation of Afghanistan, we were left to interpret volumes of the unspoken word.

Schools also organise stage plays based on HIV/AIDS that involve students to explain how HIV spreads and to avoid the stigma attached to HIV as well as the discrimination that accompanies such stigma. These plays are staged during the school assemblies and there were nine such plays in just one school. Besides this, YPEs organise regular

quiz contests on the subject of HIV/AIDS for students to participate in and the winners are awarded prizes and provided light snacks bought out of the pocket money collected by the YPEs and students themselves.

One of the YPEs is also a Video Jockey with a local TV channel and she uses the programme to share information on HIV/AIDS.

All of this illustrate how in Afghanistan, the ARCS has taken the initiative to rope in the schools as an important institutional link in its programme. This has resulted in a high level of ownership by the school managements and together with the students, they have innovated ways and means on keeping the programme going.

Parents of the YPEs are met during the monthly meetings and teachers convince them of their wards' activities. Usually, parents realise, though with some hard convincing, that with the teacher in between, it is safe to take up the matter of HIV/AIDS. However, some parents have objected to the graphic details on the training material and as a result, four participants in a ToT had to drop out. Perhaps, it would be a good idea to avoid outright provocative issues on training materials.

The work of these trained teachers, so important to take the Red Cross programmes to the vicinities of the schools does not end with HIV/AIDS, but instead, many of these teachers have also joined hands with the Red Crescent programme for H1N1.

In Afghanistan, the messages around HIV/AIDS have been neatly spun around religion and religious beliefs. A school principal says that from the point of view of Islam, there is much said on being faithful and this message is drilled with a religious import. This helps.

In a High School for Boys, where 21,000 students study under one roof in three shifts daily, the HIV/AIDS master trainer roped in the Mullah in the mosque because initially the students were very agitated and even got violent when the mention of HIV came in the classroom. The opinion was that lessons on HIV are about sex (even if it is about unsafe sex, and, is therefore un-Islamic) the teacher had to convince parents on the need to educate the young lads about HIV. As a last resort, he had to go to the mosque, where the Mullah explained to the family the importance of young people learning about HIV. In this way, some 25 Mullahs of Kabul have been involved for the purpose of this programme.

In the light of all this, it can be said that ARCS activities as part of the present programme have helped reduce new infections among young people.

2. Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

There is not much that the National Society has done for PLHIV as the NS still has not been able to access PLHIV.

However, there is a slowly growing opinion that the National Society can do some intervention in this regard, though, this intervention must be limited to IDUs. The Director of the NACP too voiced the need for the ARCS to undertake some care and support activities for PLHIV who were infected through drug needles.

There is an opinion among school teachers (who have been involved in the programme) that the Afghan Red Crescent Society can plan to provide food rations to PLHIV in need of care and support while the rest can be taken care of by the government. "We and our volunteers can stay in touch with them and provide psychological counselling," a teacher said, while saying that it would be preferable if ARCS worked with drug users.

Much work has been done to reduce the stigma attached to HIV/AIDS and the Youth Peer Educators can be the agents of change. It was commonly heard that 10 years ago, people would quarrel at the suggestion of taking a test for HIV. Now, people come for testing.

As mentioned under Objective 1, schools also organise stage plays based on HIV/AIDS that involve students to explain how HIV spreads and to avoid the stigma attached to HIV as well as the discrimination that accompanies such stigma.

The young students have taken the programme to the precincts of the homes. Mothers came to meet during the evaluation and spoke of how their children had brought about a sea-change in their attitudes towards HIV. The mothers are supportive of the young people going out to speak to others and peers about HIV. There were yet other cases where illiterate parents were happy about their children learning about HIV and listening to their children speak why PLHIV must not be discriminated.

All these are strong gains made in Afghanistan by the ARCS programme but these have not impacted PLHIV through this programme.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non remunerated blood donation.

In Afghanistan, there is a slight confusion regarding what is a Club 25. However, wherever the ARCS programme is on, young students, boys and girls, are happy to donate their blood. Many students got up individually to mention the number of times they were donating blood. Some stood up and began crying because it was a real struggle for them to donate their blood as the elders in their families still did not approve donating blood. It was obvious that the programme has reached the message of blood donation in a nation short of blood supplies and young people reached with this message were very enthusiastic to put the information they received into practice, sometimes at great odds due to resistance from their families.

On the last Blood Donors' days, 4,700 litres of blood was donated by volunteers at a blood donation camp organised by the ARCS. The schools have learnt their lessons on organising blood camps. On blood donation day, for instance, there were many donors who waited from 6 am but the blood bank team arrived only at 10 am, by which time the donors-to-be were tired and the school hours were over.

Now, school principals and teachers like to set the example by being the first to offer their blood during a blood camp. A vast majority of these teachers and principals are first time blood donors.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

HIV is integrated into CBHFA and from this process; the knowledge on HIV/AIDS has increased. Earlier the information on HIV was very limited. With 336 CBHFA team leaders, each of whom is responsible for 20 more, this is a permanent resource for the national society.

The Director, NACP, outlined that the biggest gains from the Red Crescent programme was the enhanced the capacity of civil society generally by also raising awareness around the issue of HIV/AIDS. The NACP echoes the feeling in the government that the ARCS works closely with the people and not on technical issues because the first

need in Afghanistan is to change the minds, and in doing so, ARCS is having a strong impact on society.

Schools with trained master trainers do not need to ask the national society to do further trainings as they conduct trainings for another student master trainers for the school purely as an initiative by the school managements.

The willingness to sustain the gains of the programme is the common note at most centres. Often, schools and students have only one thing to ask of the ARCS – printed training material to be able to do the trainings by themselves. Teachers have come up with their own and even novel ways of sustaining the programme by putting questions on HIV in the examination question papers and students have got the message: that HIV/AIDS is important for the exams and that way, they learn the subject.

The teachers have done strong advocacy for lessons on HIV/AIDS as part of the school curriculum and beginning the coming year, the government has mandated that schools will have lessons on HIV. This is the effect of the advocacy measures taken up through this programme.

In Afghanistan, where young people are so keen to keep spreading the word and are so ably supported by their school administrations and managements, the support they need from ARCS is very little. We even heard from some schools that they would provide a token fee for the ARCS trainer coming to their school to train the students. This may be a strong statement that the schools may find difficult to see the light of day, but it shows the importance attached to this programme in a country none thought would be able to implement a programme like this.

The Secretary General of ARCS spoke of the difficulties within the ARCS on the programme in the initial years and of his own apprehensions and scepticisms. However, he is happy to concede that all the apprehensions and scepticism have now been laid to rest and the national society is proud of the achievements of the programme.

As the programme comes to an end, the National Society is planning to retain the project staff – just a sign of how keen they are to keep this programme going on.

BANGLADESH

Objectives for National Societies:

- 1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.*

Training of Trainers (ToT) and youth peer education training was performed in Jessore, Cox's Bazaar and Selhyt (only ToT), but without any supervision or monitoring. The peer educators are supposed to teach their peers and as they are young people, the peers have to be mainly trained in life skills, on how to negotiate etc and how to apply this when it comes to prevent getting exposed to HIV. It was difficult for those we met to express what is meant by life skills and the connection between HIV and life skills.

There are output figures on the number of trainings and participants etc. but there is nothing measurable on what has been the outcome of these trainings. After the funding stopped totally in February 2009 there has been no monitoring and many of the trained volunteers have left the programme. Some awareness raising campaigns have been performed related to World AIDS Day, Red Cross Day, Independence Day, Victory Day etc.

It is not possible to tell that whatever has been done in terms of activities will contribute to the reduction of HIV/AIDS, though probably it has somewhat increased the knowledge about HIV. The impact of this knowledge on attitudes and behaviour is uncertain.

Some activities have been directed to the Bangladesh Rifles and Police, although its relevance to this programme is unclear. They can be seen as risk groups, but should perhaps not qualify under peer education, because the approach seemed to be more of a classroom approach and not participatory as in the case of youth peer education.

In Jessore, 64 young people have participated in the ToT while 300 youths have been further trained by the peer educators. Besides this, 50 teachers and community leaders have been trained. Many, though, have dropped out for lack of monitoring, supervision and support.

It must be said that the young people the evaluation team met came across as a very aware lot. They frankly said that the programme had

given them much in terms of change in their attitude. What was obvious (and they themselves said so) was that their personalities had developed very much as a result of this programme. They mentioned that before the arrival of this programme and the trainings they went through, they could not have spoken openly about the matters of sexuality young people were being confronted with. As one volunteer said, “we got a lot of information and knowledge that we did not have before. Now we know how to express and communicate it.” They have probably used the knowledge and skills they acquired in the past in an informal way.

2. Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

There is little evidence of any capacity on care and support within the national society prior to the programme. However, there was some experience in other organisations in Bangladesh that the BDRCS worked closely with. An example is Ashar Alo, with whom the National Society had an agreement for the purpose of livelihood support to 20 PLHIV. This agreement was however not honoured by the Federation, which meant that the organisation lost its financial support from the government as well as its trust in the Red Crescent.

It was obvious from the meetings that the concentration of the programme has been on HIV positive people (on whom too, there has been very little achieved as mentioned below). It has totally excluded the population affected by HIV/AIDS and this was a lost opportunity, especially because the Red Crescent in Bangladesh has a lot of credibility among the general population for its record of helping people in need. Given the stigma attached to HIV in the initial years of the programme, approaching the issue of stigma and discrimination towards people affected by HIV/AIDS should have been very do-able for BDRCS.

It is telling that the Jessore branch had no estimation of the number of People living with HIV/AIDS in the district or even in the town. Their information was restricted to the four cases they knew of some year ago. These four cases still had some connection with the Red Crescent health outreach programme.

The reduction of stigma and discrimination towards PLHIV was evident among the young RCY volunteers we met in Jessore but, there was no evidence to suggest that this sensitisation had moved any further. Stigma has probably been somewhat reduced in the society, but this cannot be attributed to the work of the Red Crescent in Jessore.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non-remunerated blood donation.

There has been some increase in blood donations through the Red Crescent, but no figures were available and it confirms to the general growth of voluntary blood donation and blood donors in Bangladesh. It must be said, however, that the awareness on voluntary blood donation has increased. However, more could be done. For instance, the MM College in Jessore has 21,000 students and over 100 RCY, a huge youth population waiting to be tapped.

All RCYs interviewed during the exercise were very aware of the advantages of non-remunerated blood donation and its significance and relevance in the context of Bangladesh. However, while many had donated blood, few had done so regularly.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

The evaluation team saw that there was generally low capacity on management, monitoring, evaluation and reporting. Even where financial reporting is performed (often with exceeding expenses during trainings) it does not get the support of the narrative. One of the main weaknesses was that the activities and their possible impact were not described in qualitative terms.

At both BDRCS headquarters level and at the levels of the district and peer educators, there were claims that a promise of funding incentives and allowances for tea and snacks to peer educators, trainers and even teachers was not kept. It was learnt that the programme was stopped in protest to this broken promise. Given the absence of anyone in the Federation Office to confirm this, it was not clear under what circumstances and conditions such a promise for allowances was made.

The Director of Health, at the national headquarters, also mentioned that the team was not regularly informed of the programme by the Federation staff in Dhaka. An example given was the Federations funding of constructions of a hospital unit and an ambulance in Jessore bypassing the headquarters. However, there was no way to get the version of the Federation delegation as the relevant people were no longer there.

The mid-term evaluation recommended regular visits by the headquarters and the RHU with training on monitoring and reporting, which however did not take place.

The development of a training manual was delayed over arguments on the cover layout and the introduction. This led to delays in the implementation of the trainings. This was resolved by using the material produced by the government. It was not clear why, in that case, there was a need to develop a specific RC training manual when one existed in the country and could be re-printed with the funds available.

It was obvious that there was no real coordination existing within the health department. There was some information on the trainings on HIVAIDS at the PHC levels and during the MCH trainings.

Only one full time staff employed in the programme, frequent changes of this HIV coordinator and a total interruption in the position during most of 2009 contributed to the low degree of activities. There was also a friction with the Federation Office on the position of the health delegate whose salary was much higher than the staff of the Bangladesh Red Crescent. There was an effort to convey that the work could have been performed by a local staff at lower costs, especially because the health delegate gave much time to the emergencies like Cyclone SIDR. However, though delegates come at higher salaries, there was another opinion that a new delegate was required to restart the programme – this reflected that there was not enough ownership of the programme.

There was also the issue of poor follow-up after the training. This meant that much of the impact of the training was lost as the participants did not get any opportunity to practice what they learnt at the training sessions.

An possibility to work with commercial sex workers in Jessore is knocking on the doors of Red Crescent. The commercial sex workers enthusiastically received the evaluators and they mentioned about their experience of working with other organisations whose programme was wound up and themselves broached upon the issue of Red Crescent service to the CSWs. They were asking for a regular supply of condoms which the Red Crescent could provide for without much difficulty. It was evident that there was a clear vacuum that the Red Crescent was welcome to step into. The CSWs were an organised group who knew about the Red Crescent and there was also some capacity built by the other organisations.

The issue of partnership was taken seriously neither in the BDRCS headquarters nor in the field. Throughout, there was no effective partnership the Red Crescent entered into with other organisations. Initially there was some level of cooperation with the Ashar Alo organisation, but after this was lost no networking has been established with any organisation of PLHIV. This in spite of the good reputation of the BDRCS has in the country and within the government as well. In fact, the BDRCS has the government's blessings to act freely on its own premise by an order of 1972. There was also good cooperation with the National AIDS Committee at the national level, but this was not capitalised upon.

In Jessore, the District Secretary was also the secretary of the district HIV/AIDS steering committee. But this did not seem to impact the programme in any positive way. In Jessore, again, the only partnership with a local NGO, Saviour, did not have any written agreement or MoU. This is in spite the fact that the Secretary of the district branch was also the Executive Director of Saviour.

An initial effort to come up with a workplace policy on HIV was made with a questionnaire on knowledge, attitude and behaviour. But this questionnaire was administered individually to the staff in a routine manner and was collected from some staff. The directions for the questionnaire were not followed and eventually, there was no workplace policy on HIVAIDS. It was obvious that there was a lack of interest even though; there was talk of instances like getting PLHIV to the National Headquarters for a lunch party to reduce stigma and discrimination.

Similarly, the development of the work-plan on HIV/AIDS at the National headquarters level is still under discussion with a first draft at hand. There is a very basic framework at the moment. In the headquarters, there was talk of consolidation and focussing on target groups like IDUs, CSWs, MSM, Hizras, migrant labourers and their spouses and youth in education institutes. The target group seems very wide, especially in comparison to the capacity within the BDRCS.

There was some construction activity for a hospital in Jessore funded by the Federation. Though, not through this programme, it must be said that the funding of such an activity challenged a message being delivered through the present programme. It was not clear why the district branch wanted to have a hospital made specially targeting PLHIV, given the counter-productive messages such an activity would send, further stereotyping PLHIV as people who need to be kept separately.

It was not clear why the regular monitoring recommended by the mid-term evaluation were not carried out. Even within the BDRCS, only one visit by the National Society HIV Coordinator was carried out after the mid-term evaluation. The advice to increase the involvement of SARD in terms of visits to increase the trust and support to the implementation has not been fulfilled. No exchange visits were carried out either. For instance, the volunteers could have gained much from a hands-on learning experience working with volunteers in Andhra Pradesh (India) or Nepal, both of which were not very far from Jessore and not very expensive to travel to. However, this is also based on the premise that there was interest in sustaining the programme after the term of the present project.

INDIA

The quality of the programme in India, as expressed by the peers, is surprisingly good; many activities have had a significant importance for people's mental and physical health. In spite of their young age, they have become respected for the information they are carrying and by that they have also increased the positive perception of RC within their communities.

The Indian Red Cross, Andhra Pradesh State Branch outreach activities around HIV/AIDS in the communities has increased awareness of HIV as the source of a condition that is preventable and treatable and that stigmatisation of HIV/AIDS is both preventable and curable.

In Andhra Pradesh, the focus of the programme was more on raising awareness or prevention rather than on care and support but for one off examples (like one that came from a brilliant example from the Rajamudhary Central prison)

There are lots of lessons learnt but not systemically collected nor shared. For example, the Red Cross branches were able to take messages on life skills to school students and young people in college through youth peer education. The manner in which the Red Cross branches managed to do this work should have been documented and the lessons learnt should have been shared with other branches across India as well as the region.

Objectives for National Societies:

1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.

There has been a well-organised system of training by the Indian Red Cross Society in Andhra Pradesh. The training has included all – coordinators, counsellors and peer educators. It was also interesting to see a practical timing to the approach as the time-table for peer education coincided with the school activities and further outreach coincided with the school breaks.

- June Schools are identified
- July Sensitisation of headmasters. Identifying JRC/YRC counsellors

- August Training of JRC/YRC counsellors
- Sept to December Peer Group Trainings and Sessions
- Jan to March Follow up
- April and May Holidays and community outreach

The AP branch offered a good insight into how the training manual made by the Indian Red Cross Society could be put to practical use. The training manual is on Life Skills/ HIV/AIDS / Peer Education and the speed of scaling up activities looked very realistic.

What was evident was that there was good cooperation between the AP Branch and the State AIDS Control Organisation (affiliated to NACO at the central level). NACO's IEC material seemed of good quality and culturally appropriate and it was nice to see that the National Society used this rather than duplicate it with any IEC material of its own and run the risk of sending confusing messages. The AP branch activities were also common with SACO's, E.g. medical camps, Red Ribbon Club, observing World AIDS Day etc.

The programme can claim a high degree of sensitisation of stakeholders in AP – headmasters/mistresses, school and college principals and teachers. As must be expected, there were confrontations with parents which were handled very well by the students and this handling of such sensitive matters and situations at home gave a good indication of the students' grasp of life skills. However, it must also be said that in most cases, it was the mother that the students were freer with and this information of their knowledge on either sexuality, or on HIV/AIDS and STIs was most often, not known to their fathers.

The students, at most schools and colleges visited by the team, showed good grasp over life-skills: self esteem, communications, negotiation and respect for others and this message was also reinforced by a role play at some places. The knowledge on life-skills also had a good connect with the students who could explain how they could use the lessons learned on life skills in times of need.

The understanding of the concept/theories on life-skills seemed incomplete for younger school students who seemed well informed about elementary definition and problem solving. But, it was evident that they had to carry this knowledge further on into their youth so

that the application of these life-skills developed with the maturity that age brings.

There was also a good response to our question if the issue of HIVAIDS and life skills must be taken up internally by the school or college teachers and authorities or whether it calls for an organisation external to the institution (in this case, the Red Cross). The students preferred an external organisation while the teachers felt that it should be included in the curriculum and they must be trained/ oriented for this. The argument was that what is taught in schools is well-accepted and parents have faith in the school authorities when it comes to sensitive subjects as teachers command huge respect in society and parents had unquestioned confidence in teachers.

There were different views on the subject of when this information must be introduced in the life of a student. One approach was that the subject must be introduced early in life so as to sensitise the students and add topics that need a degree of maturity as the years roll by. This way the students can learn and master the skills and develop on these with maturity, especially in their upper teens when they need it most.

Similarly, on the issue of whether it should be a mixed group of students or same-gender groups, the students and teachers differed very much in their approach. In the women's college in Mehboobnagar, a young lady expressed her perspective clearly when she said that girls would like to know what are the problems boys face as well as let boys know of the problem of young women.

(Suggestion: Perhaps, the state branch of the Red Cross should consider addressing these basic issues to get teachers and students on board (and help teachers appreciate the students' points of view) in the early stages of the programme. In Andhra Pradesh, it was clear, that there was a degree of discomfort on these issues as both parties knew the respective viewpoints of each other.)

Further on the subject of life skills, the students expressed knowledge about HIV as a strictly medical issue which was too much for young school-goers – too detailed and too specific. While it distracts, information such as the precise name of drugs to be used for prevention of mother to child transmission is unnecessary and can also be counter-productive as the student may carry this message

throughout his or her life, even when treatment is changed. However, it is also argued that this is the recommended line from NACO.

(Suggestion: Trainings also increase the peer educators' circle of friends. This can be included in the primary material and training for engaging and enrolling peer educators. We learnt this from a girl in the women's college in Mehboobnagar.)

The system of supervision, monitoring and reporting around the trainings confirms to a method with regularity and school staff and students spoke profoundly of their good relationship with the local branch of the Red Cross.

On the issue of stigma and discrimination (for details, please see the section under Objective 2), it was felt that the issue was understood in theory and that the transfer of knowledge into attitude and behaviour depended on maturity. For instance, a young lady spoke of HIV/AIDS acquired as a sin, but felt that this must not be discriminated given the fact that there were other ways in which HIV spreads, so implying that PLHIV could be given the benefit of doubt as to the source of their infection. While it may be argued that this example also speaks of their conditioning, it is very possible that this thinking will undergo a change as the years pass and she matures.

The number of peers and peer educators (even within the institutions covered by the programme) is small which explains why the impact may be limited. Even within the school and colleges, the peer educators covered few peers and there was a huge gap waiting to be tapped. However, this is also an example of true volunteerism of today. Urbanised young people in the twenty-first century may not easily get attracted to volunteering and the fact that the AP school and college students we met were attracted to volunteering is anyhow heartening. The VIVA study conducted for this programme in Andhra Pradesh shows a high degree of cost-effectiveness of 1:14.

2 Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

Individual support provided together with information about HIV transmission and prevention has made it easier for PLHIV. We learnt

from a girl how she asked her neighbour to go for a HIV test when she learnt that she was pregnant.

We heard of cases of reintegration of PLHIV with the community (where people who had been isolated before the community was informed of the messages around HIV/AIDS) – from the community outreach programme run by the Aditya College in Rajamudhary. This was a healthy example leading to reintegration of the PLHIV and his family into the community. There were instances told to the evaluation team of PLHIV receiving food thrown at them from a distance on a plate and that the advocacy done by the young people helped to end this discriminatory practice.

Parents have been involved together with the children in the activities to observe the World AIDS Day function in the town.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non remunerated blood donation.

In the schools and college, awareness has been built around the importance of donating blood as this is included among the messages spread by peer educators and peers. The importance for thalassemic children and dengue patients receiving safe blood or blood products is reinforced.

It appeared that while the branch had done some good work in reducing stigma and discrimination in the various schools, there were some out-dated ideas within the Red Cross blood bank which otherwise, was very professionally managed from the medical/pathological point of view. More could have been done on the knowledge, attitude and behaviour within the blood bank. It may be a case here that being managed by doctors, the branch officials running the HIV project may not be as respected when it comes to a subject like HIV/AIDS.

The presence of a counsellor from the State AIDS Control Committee raised a number of questions. While not a Red Cross staff, the presence in the premises does come across as a Red Cross counsellor. The approach seemed very perfunctory, people testing positive for HIV was always recommended or referred to the next level, not really counselled here. The Blood Bank had no system for finding or

approaching people who refused to be contacted to share the results with. The findings and counselling at the blood bank was limited to HIV and excluded any counselling regarding any other sexually or blood transmitted diseases like Hepatitis B or C.

As the team saw, the presence of the counsellor was more of a liability, given the reputation that any mistakes could bring to the Red Cross blood bank.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

It was repeatedly said that the HIV programme has had a great importance not only on the awareness of HIV within the organisation but also on how the Indian Red Cross Society is recognised by the community. Through a number of public activities it has provided for increased visibility.

Within the branch, we heard of how improved computer-skills helped to improve the personality of the staff who is becoming more open and adapting to change. The system for online reporting has brought about a new way of thinking. While much remains to be done to bring monitoring up to the mark, there has been some training and capacity development for better reporting and monitoring systems, both, in technical terms (now, on-line) and also in accuracy.

There was also mention of the State AIDS Control Society and District AIDS Control Council showing interest in cooperation with the Red Cross in Andhra Pradesh. This should be possible as the branch has shown good experience in coordinating with other government enabled structures like the self help groups.

The HIV AIDS programme with its life skills component has been well integrated into other Red Cross activities as CBHFA. This was shown by the peers involvement in fundraising and support during the recent flooding, vaccination campaigns and awareness on hygiene and sanitation.

Awareness of stigma and discrimination and its effect on PLHIV has increased within the organisation, except, as pointed out earlier, in the case of the blood bank.

While the global alliance stress on a huge quantitative achievement, the state branch has put emphasis on quality rather than quantity in the activities – they started in small scale and expended gradually. This was a right approach in the beginning but has not led to the expected further expansion with increased experience.

The high turnover rate of teachers has impacted the programme but the branch at the state and the districts levels have taken this into consideration. In Andhra Pradesh, teachers are said to be transferred every three year. For this reason, a second teacher to assist the teacher made sense as this helped retain some institutional memory and was crucial for carrying the programme forward. The same applies to peer educators who are engaged during the first year in college and high school to ensure retention.

The inter-state exchange with Tamil Nadu and the inter-district exchange (for trainings and exchange, knowledge-gaining visits within the state) have done the programme good. Conducting of trainings at the local level has brought the participants closer to realities.

There was little fund dependency for day-to-day activities at the institutional level. At the local level, there was some good fund-raising in schools, companies and communities in a small sale. Staffing and thereby costs have been reduced on state level, but kept on district level to ensure supervision, according to the Mid-term-evaluation, thereby increasing the possibility to sustain the activities after the present support from Swedish Red Cross has finished. But there is a danger that the programme becomes very dependent on a single staff. Only one staff carrying the institutional memory can make it very fragile. Though the Indian Red Cross headquarters has a weekly meeting system in place, it is not clear to what extent the documentation from such weekly meetings can help in case a vacuum were to arise.

NEPAL

The Regional Programme has shown a good performance in Nepal. But, much of this is largely due to the experience gained by Nepal Red Cross Society (NRCS) over years as the NRCS (along with the Centre for Development and Population Activities (CEDPA) and Family Health International (FHI) was a pioneer in the country in the area of HIV/AIDS having started a programme for young people in and out of school and college way back in 1994.

Nepal Red Cross has covered much ground in this area, especially with respect to raising awareness and reducing stigma and discrimination, The National Society wanted to take a step forward into the uncharted realms of care and support, while the regional programme had an emphasis on awareness building to reduce stigma and discrimination and felt a little held back in its aspirations to do a broader and more ambitious programme. While the Nepal Red Cross initially could have been used as a resource for other NSs, they were instead developing a model programme together with partners on national and local level, focussing on at risk populations rather than traditional youth awareness based programmes. This enhanced NRCS capacity to deliver HIV related services covering almost all components from prevention to continuum of care (except providing ART) and including VNRBD/Club 25 concept.

Objectives for National Societies:

- 1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.*

The programme is implemented in three districts with very high migration and higher than average prevalence of HIV/AIDS – Doti, Jhapa and Surkhet. Raising awareness on issues connected with HIV/AIDS and the stigma and discrimination it accompanies has probably contributed to a decrease of new cases. It was evident that young people interviewed individually and in groups by the evaluation team expressed that the knowledge they had gained through the Red Cross peer education programme meant that they knew the importance of indulging in safer sexual practices to prevent themselves and their partners.

The knowledge about HIV is widespread and seems to be accurate as is the understanding about the way to prevent it by proper use of condoms. It was heartening to see the demonstration on the delicate subject of using condoms and doing it in the proper way. Young people could answer the questions put forward to them regarding HIV/AIDS and other sexually transmitted infections and from their conduct and confidence, it was evident that they had good experience in doing such demonstrations.

The peers have, through their training and the creation of peer support groups, been able to overcome the initial shyness. Some mentioned that people often accused them of association with the sex profession and that they were often asked how they could know so much without being married. The implication was that their conduct was wanting in morals.

In many cases, peer educators have also contributed to early identification of people with risky behaviour and referred them to the VCT centres or mobile VCT units and for early access to diagnosis and treatment, including PMTCT.

Those not reached by peer educators have to a great extent been exposed to the messages through a number of different activities as creation of Youth Friendly Information Centres that serve as meeting places for young people, posters, wall-writings, street plays, folk songs, competitions, exhibitions and rallies on occasions such as the Condom Day and the World AIDS Day etc.

However, there was some lack in the area of development of life skills as achieved through this programme in Nepal. In the case of school going students, life skills trainings have been introduced and accepted. After some initial reluctance from parents and to some extent, from teachers who are sometimes embarrassed and not comfortable to speak about sexual health, the programme started with separate groups for boys and girls which merged later on. Training is conducted both inside and outside schools using different training methods – group discussions, role-plays, formal lectures, by use of IEC materials etc. Though the skills need to be tested in real-life situations, it was felt that the knowledge and exposure of life skills are still rather superficial and not always connected to sexuality, risks and responsibilities.

Yet, on a different plane, young women and housewives have displayed good life skills as they have proven themselves accomplished negotiators when it comes to persuading their husbands to use condoms and even go for VCT, especially because they have spent years as migrant labourers in India. In these situations, the goal is to have the husband tested and until that is performed, they would have sex only with the protection of a condom. This is certainly a delicate task but the women have increased their power through participating in groups to support each other. This is, undoubtedly, a great achievement by mostly illiterate women, living in rural settings and being socially totally dependent on their husbands.

2. Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

A strong focus has been on reducing stigma and discrimination which is thought to be due to illiteracy and ignorance. By increased awareness and knowledge through different means, it is said that discrimination no longer exist where the programme has been implemented while it is still strong in neighbouring communities.

Service providers have undergone trainings while PLHIV have undergone treatment literacy classes so that they know the importance of adhering to ART. PLHIV have also been exposed to community-based counselling, positive living and prevention. Training on stigma and discrimination has roped in PLHIV and this has helped in mobilising more PLHIV.

PLHIV have been included both as peer educators and in training sessions. Those willing to disclose their status have helped in de-constructing the image of a HIV positive individual in the mind of the other participants and this has also helped to make the trainings more effective in reducing stigma and discrimination.

NRCS has a workplace plan in place and the offices in the districts where the programme was implemented have employed at least one PLHIV. The respect for the Red Cross in the view of the peers in the district became obvious during the course of the meetings. Red Cross had often provided the platform for PLHIV to disclose their status and PLHIV preferred the Red Cross platforms to others' in this respect.

Livelihood support has played a key role in the area of care and support. Often, livelihood comes in the form of two or more goats, provided by the Red Cross for the affected family, to rear till these become big to breed off-springs and further as the off-springs grow up to be sold. This has raised the economic status of the family. Besides, it has also given these very vulnerable people some reason to hope ahead in life. There were cases of the goats dying and it may be a good idea to give some training before providing the goats. The idea of providing poultry/chicken was dismissed in Surkhet as the advice was to avoid the same because poultry/chicken could give rise to opportunistic infections among HIV positive people.

While beneficiaries often spoke of nutrition support as a way to increase adherence, more could be done to promote the culture of kitchen gardening among the beneficiaries to supplement diets.

The provision of educational support to OVCs was well performed and it was also clear that the children could go to and study in school as any normal children without being stigmatised for belonging to families of PLHIV or, where the case might be, being HIV-positive themselves.

There were good examples of partnerships both in the field as well as in Kathmandu and the evaluation team met with various partners. These included NGOs working in the field of HIV/AIDS, networks of PLHIV as well as government officials. It was clear that in keeping with its reputation of speaking for the most vulnerable, the Red Cross office played an active role in advocacy for PLHIV.

In Surkhet, the Red Cross has played an important role in the establishment of the PLHIV networks, especially Kankrebihar Plus, and in the time when the organisations needed a place to work out of, the Red Cross provided them with space to carry out their activities.

The presence of the District Health Officer, different NGOs and three different organisations for PLHIVs sent a strong feeling of the respect all these organisations and stakeholders held in the Red Cross. Likewise, in Kathmandu, it was evident that the NRCS enjoyed respect in the eyes of the government bodies.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non remunerated blood donation.

NRCS is mandated as the only provider of blood, blood products and related services in Nepal. There has been a high proportion of replacement donations in relation to voluntary donations in Nepal and it is difficult to convince young people to donate blood due to prevailing myths in this regard.

Voluntary non-remunerated blood donation (VNRBD) is encouraged by the NRCS through campaigns, regular blood donation camps and creation of Club 25s. Club 25 is a group of committed young people in the 18 to 25 years-age-group clubbed together to donate blood regularly. This has led to an increase in the collection of blood by mobile blood collection units. The reason behind VNBRD is well understood and explained by the members of Club 25 whom we met and they were well prepared to fight myths and perceptions on blood donation.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

The districts have been free to choose how to work within the parameters of the programme and they keep in mind their own capacities as well as the needs in the community. This confirms to a 5-year health policy and a strategic health plan (2006-10) which is broken down to annual plans for respective chapter with clearly identified goals, activities and when possible with measurable indicators. This is supplemented with a HIV/AIDS national plan. All is done in an excellent way and is an example for other countries.

The health service department acts as a focal point, coordinating the activities on national level. Technical support is provided through an advisory committee at the national level and a project committee at the district level.

Peer education guidelines, manuals and IEC material are updated and standardised. A multitude of trainings have been performed to ensure high quality of activities. At the regional level, PMER has been organised and the Global Alliance monitoring and reporting system has made monitoring and reporting more focussed and accountable.

To strengthen the capacity of district chapters and sub-chapters they have been financially supported to enhance infrastructure. The district branches have constructed a canteen in Surkhet, a training hall in Doti

and guest rooms in Jhapa from the grants received as part of this project and revenues proceeds to fund the sustenance of the programme at the district level. Even though this amount is not very high, it is a good way to begin.

The programme has been implemented in very remote areas often struck and isolated by the conflict and with limited accessibility and under-served logistical constrains. Still NRCS staffs from the district and the headquarters were very familiar with the community and the settings. This made it evident that they had been visiting the community often or regularly as part of their monitoring and evaluation.

The community has, through its partnerships with NRCS, been empowered and in a position to demand for improved health services. Peer educators have in many cases replaced the non-existence of health professionals. A governmental system with multipurpose Female Community Health Volunteers (FCHVs) existed but this has not been effective to provide HIV related information and service. These volunteers have been co-opted into the Red Cross programme as peer educators and have taken on the role of condom promotion as part of the NRCS team.

Education of the community is performed through a well-defined system of community mobilisation, via training in participatory learning groups of peer leaders and educators, peers and the community as a whole. There has been a strong concern about the special needs of girls and women by addressing old and traditional taboos in education about sexual and reproductive health.

A VIVA study was conducted in Surkhet district in April 2009 showing a 1:8 ratio, high cost-effectiveness and by that, most activities can possible be sustained.

Given its pioneering role in the area of HIV/AIDS information and service in Nepal, the lessons gleaned out of NRCS experiences are used by the government and other NGOs. IFRC's global manual on HIV/AIDS prevention, treatment care and support has been adapted by the National Centre for STI and AIDS Control (NCASC). Repeatedly, it was said by government representatives that the strength of NRCS is its widespread network and its ability to mobilise its very committed base of human resources, e.g. its staff and volunteers.

Interestingly, the evaluation team got to see an intervention among the Commercial Sex Workers through a programme in the tourist resort of Pokhara. Through this programme, the CSWs are made aware of their sexual and reproductive health, particularly HIV/AIDS and also provided with condoms. This programme runs out of a drop-in centre in the heart of the city and CSWs feel free to come and interact with the programme staff here. Though it was not part of the regional programme under evaluation, this offered a clear example of the capacity the programme had helped build for the National Society to pursue with an altogether new intervention programme targeted at CSWs.

PAKISTAN

After a slow start and limited activities due to several reasons identified in the Mid Term Evaluation, the last year has seen an impressive expansion and the very little coordination with stakeholders and other organizations working with HIV of the past is now replaced with a cooperative and information-sharing atmosphere with the NACP (and its provincial PACPs) based on trust and professional relationship. The National Society has also involved religious leaders to assist in formulating messages based on the Holy Quran.

A very friendly and warm working atmosphere was obvious and a good insight as well support from the coordinator on all activities performed on provincial level.

Objectives for National Societies:

- 1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.*

The programme has engineered a change in nomenclature to enable entry and suit the social and cultural settings of its target group. It has been called the Life Skills and Youth Peer Education Programme and it has been implemented on the provincial level in four regions: Punjab (Lahore), Sindh (Karachi), Balochistan (Quetta) and Gilgit Baltistan.

As a first step before implementing the programme and for the very same reasons, that is, the social and cultural sensitivities involved and the difficulties in taking up and talking about issues connected with sexuality, the programme has carefully sensitized (mainly through workshops) principals, school teachers and factory management.

Following prior interaction and some initial trainings performed by the PRCS, a few (and most) motivated and dedicated Peer Educators / volunteers from each branch were selected to undergo a Training of Trainers for Youth Peer Education Facilitators who would, in turn, deliver peer education training to peer leaders.

In a short period of time, mainly following the mid-term evaluation, the training has reached a significant number of people within the

target group through Peer Educators and volunteers coming from universities, high schools, colleges, technical and professional institutes. Besides these, some peer educators and volunteers from the Islamic religious schools (or madrassas) have also been trained.

Notably, PRCS has integrated issues concerning HIV or even added a module on HIV to a number of their existing trainings and activities. It was good to see such integration of HIV into CBHFA program and DM programs of the National Society.

The peer educators thus trained have focused on conveying preventive messages to dispel myths and misconceptions prevailing among young people (in the 16 to 24 years age bracket). The target groups has varied from factories in Lahore to schools in Karachi and Quetta, to people involved in business across the border with China (including traders, truck drivers etc) in Gilgit.

The Peer Educators in Lahore work with colleagues in garment and other factories. These are young people, most of whom are unmarried males, temporarily employed and they have often migrated from far-away places.

In Karachi, the programme has targeted policemen and police-women and PRCS staff has conducted sessions with them during their training. Barbers have also been trained to convey messages on prevention during their contacts with customers.

In most cases trainings have been gender-specific, that is, separate trainings have been conducted for men and women, boys and girls. This has made it possible for PRCS to provide an environment for the trainees to discuss issues regarding sexual and reproductive health and STI's. Considering these issues are usually talked about in hushed tones, this may be a good approach.

Any talk on HIV or AIDS is sensitive in Pakistan. To be able to talk on HIV/AIDS, the programme has routed its messages through the topics of Hepatitis B or Hepatitis C (which are transmitted similarly to HIV/AIDS). In the process, there has been a conscious effort to avoid talk on pre-and extramarital sexual relations, For the same reason, demonstration of condoms and their use in prevention against HIV has also not been prioritized. In the process, while a lot of emphasis on HIV/AIDS has been relegated (as compared to Hepatitis B or C), the message on safe sex has either not been taken up, or, where it has been

taken up, this has been done very feebly in comparison to the blood-borne route of transmission.

The blood-borne route here is thought to be common due to high number of unsafe injections. In the same breath, there is an over-emphasis on the risks from blood transmission as compared to unsafe sexual practices. In the social and cultural settings of Pakistan, this has meant that stigma is still attached to HIV for the general perception is that it only spreads through unsafe sexual contact. Therefore, much work still needs to be done to de-stigmatize HIV.

While this programme has confined itself to the National Headquarters and provincial branches, the PRCS has shown interest in devolving the messages regarding HIV/AIDS (given the experience they have got from this programme) further down to the sub-branches. To this end, young people from sub-branches and the federally administered areas have been involved in awareness raising activities, specifically around World AIDS Day and youth camps. While this does not seem to fit into any strategic objective around the present programme, it is interesting to see that there is a vision and willingness to take the messages around HIV/AIDS and its prevention further on after the programme has ended.

PRCS has sourced the IEC and BCC material developed by other organizations, including NACP and WHO. This material has been translated for targeting people who only understand Urdu and/or Arabic. A multitude of material (printed and electronic) and outdoor publications have been used.

In Pakistan, religious leaders have been involved in (and partnered with) the programme for the purpose of reaching messages around HIV/AIDS. Texts from the Holy Quran have been interpreted by the religious leaders to explain the importance of seeking and using knowledge to prevent infections and seeking ways to treat the infected in a decent way, without discrimination. PRCS has also emulated this. This is a good way to enter the community on a sensitive issue like HIV/AIDS that has the potential to stir sentiments.

Following up on the mid-term evaluation, a baseline study on KAB was conducted by PRCS. The study sourced its information from a youth camp assembled on World AIDS Day, 2008. The results from this study influenced further trainings.

After the mid-term evaluation, the programme has also found effective ways and means to reach a diverse range of recipients with its messages, including seminars, workshops and talk-shows. Besides the general public, WAD activities have sensitized the targeted groups of health professionals, journalists, parents, teachers, IV drug users, members of the Girl Guides Association and last, but not the least, PRCS staff and volunteers.

Interestingly, there is some evidence of new partnerships developed with the USAID which has financed the establishment of a Youth Friendly Information Service within the premises of an existing PRCS maternity hospital and medical dispensary in the Orangi town in Karachi. With the USAID collaboration, PRCS has been able to offer trainings in computer skills and sewing. Facilities such as a gym and a carom-board for a game have also been included. These have provided an opportunity for the members of the Youth Welfare Association to reach out with messages about prevention against STIs, including HIV.

2. Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

A steering committee for the implementation of the programme has been formed and this also includes a person living with HIV/AIDS. A PLHIV has also been employed by the Lahore branch and his experiences and views are considered in programme implementation.

A VCT centre was established by the Punjab branch in Lahore in 2004. The running of this centre has provided the branch with some experience that is used during the training of peer educators. Besides, with the pre and post-test counselling and testing, the branch knows of a few cases of HIV in the province. Those tested positive are referred to and followed up at one of the government-run ART clinics for further, treatment care and support. PRCS has also provided trainings in positive living with HIV through counselling to infected persons and their families and skills to reduce effects of stigma and discrimination associated with HIV/AIDS. Apart from this support PRCS does not run any livelihood programme.

The national programme of the government would like the PRCS to use their experience from Lahore to expand VCT Centres across the

country and detect more PLHIV. At present, only five per cent of HIV cases are supposed to be identified, which gives very misleading figures on prevalence.

As mentioned under Objective 1, issues around stigma and discrimination have been raised and addressed through awareness sessions, outreach activities and also by involving religious leaders.

Over the years of the programme, PRCS has made contacts with other organisations working with PLHIV in Pakistan. A meeting was facilitated by the PRCS with six PLHIV, who expressed the need for medicines and that Red Crescent should provide them with treatment. They said that they lived far off and wanted a dispensary that would provide them with ART closer to their homes.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non remunerated blood donation.

Given the prevalence of blood-transmitted infections in Pakistan, PRCS is laying emphasis on providing information on safe blood through recruitment of VNRBD through blood camps and awareness raising sessions in educational institutions, offices, factories and market places. The National Society has undertaken a special programme (School Based Blood Safety Education Programme) reaching 200 urban and rural schools in and around Islamabad.

Beginning January 2010, the NACP launched a German government supported programme on VNRBD. As part of this programme, PRCS will be involved in increasing its recruitment of blood donors.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

The Regional HIV Programme had a slow start in Pakistan. Many reasons have been offered, primary among which is the socio-cultural milieu of Pakistani society. Other reasons include the initial lack of commitment by senior staff and the absence of a HIV coordinator. The mid-term evaluation led the leadership of the Pakistan Red Crescent Society to renew their commitment to the programme. The newly appointed Secretary General is strongly committed as are the secretaries at provincial level. A knowledgeable HIV coordinator is now employed and she is respected by all staff both on HQ and

provincial level. She has a structured approach to the programme but she certainly needs an assistant both to reduce the already big burden of her work and to help the programme become stable.

The pace of the programme following the mid-term evaluation has been notable. There is a higher degree of ownership now than before when the staff at the country delegation were running the programme. All of them have recently quit their positions for different reasons.

The change is obvious as there now is coordination with stakeholders and other organizations working on HIV and cooperation and information-sharing with NACP and its provincial PACPs. This cooperation is encouraged and based on trust and professional relationships. However, there is no participation of PRCS in CCM and, thereby, PRCS has no access to the funding from the approved appeal from round 9 of the Global Fund.

MoUs have been signed with many partners and a draft HIV plan is in place. This will fit into the National health plan which has also been developed. There is no workplace policy in place yet, although issues around KAB have been discussed.

A management committee for this programme has been established, and a first meeting held, with representatives from PRCS headquarters different departments and the provincial branches. Similarly, the first meeting of the steering committee (involving important partners from NACP, UNAIDS, WHO, FHI and Association for PLHIV) has held its first meeting. Further biannual meetings are planned. Meetings are scheduled and careful minutes are kept on the discussions and decisions taken.

There is also a realization of the importance of support to volunteers so that they can be retained. A VIVA study was done with help from the regional delegation in Delhi. It has to be considered that this study was performed in an early stage of the implementation when the findings are compared with the results from other countries. Well understood and partially performed integration of HIV in disaster management and CBHFA has added more skills to the trained volunteers, creating a training ladder and thereby increasing their motivation and retention.

It was encouraging to see that senior staff at provincial level was strongly sensitized to the programme. A dynamic, young secretary in

Lahore with extensive management training sees the importance of finding new ways of working. For example, he has initiated an agreement between the branch and Honda on Road Safety and First Aid and this will help get access to the universities.

Factory owners too seemed to understand the value of this programme for their staff. This interest is shown by the fact that while earlier the workers were only allowed to have their sessions during lunch-breaks, they now have these sessions during their paid working hours.

The staff in Pakistan has developed and tested its own reporting format and this together with training on monitoring and evaluation and human resource management skills have certainly improved these parts of the programme but can and must be further strengthened.

The strengths and weaknesses of PRCS are well understood by partners through information sharing and their involvement in the steering committee. Partners see the widespread network of PRCS and their volunteers as a major strength and can see a future role in expanding the VCT centres from provincial to district level as well as in blood donor recruitment and screening for safe blood. However, there are limits to the PRCS capacities so far and these same partners advise PRCS not to undertake care and support of PLHIV. Due to the close connection PRCS enjoys with the government, it is not seen advisable to work directly with IVDU and CSW as the activities of these groups are illegal, thereby risking a negative perception of the PRCS.

SRI LANKA

This is based on visits to the SLRCS Headquarters in Colombo and field visits to branches in Nuwara Eliya, Matale (Dambulla) and Gampaha

Given the depiction of the Red Cross Movement as being close to the “terrorists”, meaning the Tamil Tigers, during the recent conflict that gripped the island nation, it was difficult for the Sri Lanka Red Cross Society to be seen as working as one with the community. Past history of HIV/AIDS interventions by NGOs also worked against the Red Cross programme. There were references to NGOs coming to the district to work on HIVAIDS and returning without delivering on promises made.

The programme in Sri Lanka is strongly focused on prevention and pivots around the use of local people and working on culturally-sensitive issues in an appropriate, non-controversial manner that enables the Red Cross to establish entry into communities or professional groups and work with them over a long term.

The national society could not select its target communities by itself, based on a vulnerability and risks assessment, as the MoH is the sole authority for HIV prevention in Sri Lanka. The MoH requested SLRCS to target the tea estate workers as this was a vulnerable community. One reason behind this was high incidence of STIs among tea estate workers. Besides, most organisations working in the area of HIV prevention were reluctant to work with the tea estate workers. On the score of vulnerability, the tea-estate workers seemed to be among the most disadvantaged; their rights have for long been compromised and their development not given much attention.

Objectives for National Societies:

- 1. Contribute to reduction in incidence of new infections among young people through youth peer education through life skills development.*

The initially identified target group was tea estate workers in two estates, one each in Badulla and Nuwara Eliya districts. The target group was further extended to five estates in each of these districts during 2008. Three more districts were involved in 2009. In Kegale, the target population was the tea estate community and three-wheeler

(or tuk-tuk) drivers. Three wheeler drivers, truck/lorry drivers, small scale hotel workers, market labourers / helpers and commercial sex workers were seen as the target community in Dambulla, a strategically located trading centre for the entire country. Gampaha has a large free trade zone employing a number of young males and females in mainly garment factories. Gampaha is also a tourist area with coastal resorts where “beach boys” offer sexual services to tourists of both sexes.

Agreements have been established but there is no MoU in particular with tea estate managers or with market management, hotel owners and local health authorities. However, there is enough communication and documentation that shows the commitment of the partners, like the tea estate management.

In Dambulla, the local branch mentioned the challenges posed to taking up awareness campaigns in the very traditional community. There were references to instances where the community reacted, often violently, to bringing up the issue of HIV/AIDS. Visits and interactions with the communities and beneficiaries showed that this fear of hostile reactions to messages around HIV/AIDS was no exaggeration and people were indeed conservative and often denied that any sexual activity existed outside marriages in the district.

Police personnel were also sensitized. This was important, considering the hostility that the Red Cross could receive from the community and a possible role the police could have in allaying fears in the community.

Awareness rising on STI and HIV/AIDS and how to prevent transmission is performed through peer educators, selected among respective target population, or through Red Cross volunteers trained by trainers. Training programmes were conducted on life skills and on HIV for these peer leaders.

The programme in the tea estates revolves around centres of activities – at the workplaces or around community health and day-care centres established for the children of the workers. Training by peer educators included information on basic hygiene, sanitation, nutrition, alcohol and narcotic drugs. This was seen as an acceptable issue to gain confidence and entry into the community.

There are a diverse range of activities, because the activities target men and women of definite age-groups. The close connection and agreement with the tea-estate management has helped. This positive role of the local branch of the Red Cross is acknowledged, especially because the tea estate owners are concerned about being seen as offering a friendly and dignifying environment for their workers to become more competitive in the business. This is indeed interesting, considering that managements had earlier resisted Red Cross activity on their estates. Of particular interest are the activities around the day care centres where nursing mothers have access to condoms (which are replenished at regular and frequent intervals). Young people had a meeting place in the health centre which also served as a youth friendly information service where condoms were available.

This also made Red Cross staff and volunteers privy to disclosures around child abuse and child protection as staff and volunteers were perceived as friendly people in whom children found comfort to divulge their feelings. These cases, though stray, were often linked to alcohol and other substance abuse.

There was an interesting and coloured array of IEC material – posters, pamphlets, flash cards, signboard, stickers, flyers, door handle hangers, T-shirts and caps developed by SLRC or adapted from other organisations. These have been widely distributed. At the Matale branch and at Dambulla National College, there were dedicated IEC Centres that targeted young people.

Anti-stigma awareness programmes have been carried out in all branches. This has been complemented by campaigns like the ones on World AIDS Day.

What was particularly interesting was the baseline surveys performed and followed up with a mid-line survey in the tea estates showing reduced sexual contacts, increased use of condoms and reduced consumption of alcohol. Some of the baseline studies of the Matale branch were performed in collaboration with the local university. This must be seen as a really good initiative and a practice for further learning inside the National Society.

Globally, the Red Cross works to address needs in the community. In Matale, the programme, though much needed (considering the sexual activity), was either not perceived as needed by the community. For

this reason, the local branch of the Red Cross undertook many different and innovative means to make an entry into the community and the target groups and to create an environment to speak and discuss about safe sex, STIs and HIV/AIDS. Examples of these were the temporary health promotion clinic established at the Dambulla Economic Centre in collaboration with the Ministry of Health where answers to questionnaires on safe and health practices were facilitated.

There were other ways too of establishing a relationship with the target groups. The Dambulla Youth Unit (Rangiri youth volunteer team) is a good example where young people got together and participated in different campaigns, like cleaning the market-place. These young people were interviewing target groups regarding the questionnaire for the baseline surveys. They also provided information sessions for parents and these activities have led to increased openness to talk about sexual and reproductive health.

It was interesting to note how issues around HIV were tackled as part of the curriculum in schools. Hitherto, teachers were very embarrassed and reluctant to teach lessons on HIV/AIDS even though this has been provided in the school curriculum. Here, an understanding was reached with the Red Cross branch so that staff and volunteers can enter the school, take up issues on health and hygiene and move on the HIV/AIDS as the teacher takes lead. This is done in an imaginative and friendly way.

Similarly, the three wheeler or tuk-tuk drivers were roped in on the alibi of road safety and slowly approached on HIV/AIDS. This was a very long process as there was always the fear that the initial goodwill created among the tuk-tuk drivers could be lost if the message on HIV was taken up. A campaign to identify the best three tuk-tuk drivers is on and their images are agreed to be displayed on a bill-board with the message – “I can drive you home safe; but I cannot assure you of safety against AIDS.” On similar lines, negotiations are ongoing for an information centre with first aid as a cover-up for info on STDs.

The project in Matale stands out for the work of a very active and creative project coordinator. It was obvious that the project coordinator's own initiative was the vehicle for the project, but it was not clear how the vehicle was being fuelled – there could be more support on strategic inputs from the headquarters, with which the

branch had been in communication through the project. This was obvious from the nature of the messages that the project sent out as they could not come up with a clear message on prevention. For example, there were messages around faithfulness that were conflicting with messages on condom use.

The emphasis on HIV seems misspent, given that there was perhaps only one detected case of which the branch had heard but was not sure. Had someone advised the branch, the message could in fact been turned on STIs, of which there are many cases in the district. Showing pictures of AIDS in the same poster as of other STIs could send rather conflicting messages and this could have been avoided with supervision from the headquarter.

In Nuara Eilia, the exposure of the project coordinator to regional meetings showed that his project management skills (particularly on ME&R) were enhanced.

The branch in Dambula has come up with some projects to sustain the benefits of the programme, though it is not clear to what extent the projects will mobilise resources. The Red Cross sells a luncheon packet for office goers that could be a good business. However, it is not clear if the branches and the national headquarters has the capacity to write proposals to sell to partners for future projects.

2. Contribute to improving the quality of life of PLHIV and their families through care, support, anti-stigma and anti-discrimination activities with their greater involvement of PLHIV.

The programme in Sri Lanka is strong in information provision that can contribute to the reduction of stigma and discrimination, through specific training sessions, general awareness programmes, drama performances and mass media programmes. There have been special sessions held for health care personnel who are often perceived as discriminating PLHIV. Besides, they are also among the first PLHIV have to deal with and any discriminatory behaviour on their part can influence one's decision on seeking further treatment. It was repeatedly stated by PLHIV networks that stigma in hospital settings had reduced, more so, in the case of the AIDS and STD clinics of the government hospitals.

Contacts with groups organizing PLHIV – Lanka plus and Positive Women’s Association have been established by the Sri Lanka Red Cross Society. Livelihood support is provided to PLHIV through a MoU with the networks. In 2009, 42 PLHIV have received this support and selection has been based on their specific vulnerabilities, irrespective of where they reside. PLHIV groups we met mentioned that the livelihood support had a good impact. Firstly, these projects made it possible for PLHIV to earn some money, and, secondly, families who had earlier discriminated and thrown them out of their homes were willing to accept them back due to their self-employment. In doing so, the livelihood support programme was good to restore the dignity of its recipients.

SLRCS has not directly provided care to any PLHIV. One of the reasons for this is that Sri Lanka has very few PLHIV and there are barely any in the districts SLRCS works in.

A referral system of people with symptoms of STIs has been established with the local governmental STD clinic in Gampaha. This clinic has also been provided with some material support. The clinic and its staff showed appreciation for the role of the Red Cross staff and volunteers.

One HIV-positive woman and one HIV-positive man disclosed their status on a Red Cross forum over a TV programme in connection with World AIDS Day in 2008. However, there is no workplace policy in place and no PLHIV have been employed by the SLRCS. The workplace policy plan has been postponed to 2010.

3. Contribute to the reduction of transmission of HIV by blood transfusion through increased voluntary non remunerated blood donation.

Blood banks in Sri Lanka are run by the Ministry of Health (MoH). SLRC role is to recruit blood donors and has by virtue of this, has a good relationship with the blood banks in the country. The proportion of voluntary non-remunerated blood donation has increased in relation to replacement donors. SLRCS were charged by the MoH to recruit blood donors in four districts with high replacement donations. Information on safe blood and recruitment of blood donors through recruitment campaigns and drives now comes with messages on HIV. In

this way, there is good integration of HIV programming with VNRBD plans.

The promotion of VNRBD through formation of “You and me” clubs, with integrated education on HIV prevention, is a good initiative on the part of the SLRCS. This is on lines with Club 25 but with a slight difference – the age bracket for the donors is briefer and the expectation is limited to 10 units of blood.

4. Strengthen the capacity of National Societies to effectively deliver HIV interventions.

Having very knowledgeable HIV staff in HQ and at branch level, HIV has become a flagship programme within SLRCS. Branches have been doing awareness activities on their own, whether or not these branches are supported through the present programme. This is one impact of this programme and promises to remain for some time. Awareness on HIV-related issues is rising in every branch, though, in case branches need to carry forward any other activities, they will have to base these on local resources. While SLRCS headquarters provided much input during the design phase, very little was provided during the programme’s implementation. The communication between the headquarters and the branch did not include more strategic inputs.

Enthusiastic and proud volunteers were seen in all the districts, conveying that they were the SLRCS’ single-most important asset. The volunteers not only worked on the programme to carry forward its objectives, they also provided a unique spirit to the programme that kept it going. There is, however, a real concern about the high drop-out rate of volunteers as few return to the Red Cross fold once out of school.

Sri Lanka and Nepal participated in peer review in Pakistan in connection to their VIVA study, which increased their learning on how to perform a review, apart from learning from each other.

The mapping of the tea estates and other targeted areas, followed by focus group discussions and a baseline study showed low awareness of STIs and HIV before implementation in 2007. It was good to note that there was a balanced participation of men, women and young people in the trainings as well as in the selection of leaders.

The basket-of-techniques was a good approach with a multitude of activities including the addressing of stigma and discrimination, alcohol and drug use, child abuse and domestic violence, recruitment of blood donors – school awareness programmes, sports tournaments (cricket dominated!!!), street-plays, camps etc went hand in hand with some good documentation for monitoring and reporting, especially since 2009. The ME&R standards really improved after the PME&R Workshop in Nepal in early 2009. Training session on programme cycle conducted as part of PME&R was highlighted during out visits to the branches. Interestingly, this was not brought up elsewhere and this denotes the interest the National Society and the branches showed in the process.

Regular staff meetings at the district level ensured that the entire district branch was involved in the programme. Internal exchange visits and coordination meetings helped to share knowledge and experience. At the central level, a HIV health policy committee has functioned from 2005 (this lasted till 2009) and this included SLRC board, the MoH, representatives from the PLHIV network and sometimes UNAIDS.

There has been too much focus on AIDS and too little on life skills (which was new to SLRC and there was a dearth of trainers) which is identified as a gap, probably based on too little real exposure to reality of the disease and no involvement of PLHIV as there are no identified PLHIV at the branch levels. It did appear that HIV was not relevant (addressing STIs was a more important need) to many of the districts and the stakeholders did not find it relevant to them either.

Although SLRC representatives participated in the first national meeting on MSM and HIV/AIDS, difficulty has been expressed regarding Red Cross participation in the national HIV plan as the process focuses on specific vulnerable groups such as IV drug users, MSM and CSW. For legal reasons, the Red Cross finds it difficult to target these groups.

There was awareness in Sri Lanka Red Cross on the need of linking HIV programming (and the capacity gained to carry out this) to community based health programmes and to integrate it in other programmes as well. In all branches, there was evidence of integrated projects conducted in collaboration with the Youth, Disaster Management, First Aid and other units of the Sri Lanka Red Cross

Society. A five year development and strategy plan exist with HIV included as a cross-cutting activity in all health programmes.

Sustainability can be questioned as projects were implemented late in the programme cycle without any plans regarding further funding. Neither has SLRCS any strategy to tap into the Global Fund even if there are expectations that SLRCS can become a secondary recipient of the money meant for prevention activities in the tea estates.“ SLRC has not marketed itself well enough.” This refrain was heard more than a couple of occasions. An avoidable linkage with the ‘Tamil Tigers’ during the recently concluded conflict in the country has limited the possibilities to act in advocacy.

People met

IFRC – SARD (New Delhi, India)

- § Dr Mahesh Gunasekara , Regional Health and Care Coordinator,
- § Ahyan Shandilya, Regional Health Information Officer
- § Dr Bhanu Pratap, Regional Senior Health Manager
- § Jesper Fridolf, Regional HIV /AIDS Delegate
- § Michael Higginson, Regional Programme Coordinator
- § Cecilia Anshelm (previous SRC delegate, by phone)
- § Manan Ganguli (previous Health Coordinator, by e-mail)

Bangladesh Red Crescent Society (Dhaka)

- § Dr A S Haider, Director, Health Division
- § Dr Motia Kaderi, HIV Coordinator
- § Dr Reuel Biswas, Project Manager PHC, previous HIV Coordinator
- § Dr Mohsin, IFRC Country Delegation Health Manager
- § Rana, IFRC Country Delegation, Finance officer

Bangladesh Red Crescent Society – Jessore Branch

- § Zahid Hassan Tukun, Branch Secretary
- § Staff, patients and their parents at the blood bank
- § Teachers, students, staff at Saviour (local NGO), CSW

Indian Red Cross Society Headquarters (New Delhi)

- § Dr S P Agarwal, Secretary General
- § Dr A K Dash, Health Coordinator
- § Dr Jaya Lakshmi ,Health Advisor
- § A S Shimreingam ,HIV Coordinator
- § Saurabh Raj, HIV Programme Coordinator

IFRC Country Delegation (New Delhi, India)

- § Peter Ophoff, Head of Delegation
- § Dr Avinash Sadashivaiah , Health Manager
- § Aruna Sehgal, Health Programme Assistant,
- § Rajeev Sadana, American Red Cross representative in India (in his capacity as previous IFRC Country Health Programme Manager)

State Branch Headquarters (Hyderabad, Andhra Pradesh)

- § A Lakshmana Rao, Hon Secretary
- § Vijay Kumar Babu, HIV coordinator
- § Staff, blood donors, patients and their parents at the blood bank

NTR Govt Degree College for Women, Mahboobnagar district, Andhra Pradesh

- § M Ravindranath Reddy, College Principal
- § Supervisors, Teachers, Peer Educators and Peers

Government Model Basic High School, Mahboobnagar

- § K V Krishna Gopal, School principal
- § Supervisors, Peer educators and Peers

IRCS, Mahboobnagar District Office

- § Khaja Khutubuddin, District Secretary

East Godavari District Branch, Kakinada

- § P Durga Raju, Hon Secretary

Central Prison Rajamudhary

- § K Venkateswara Rao
- § Prisoners

Aditya Degree College, East Godavari District

- § Principal – K Chandra Sagar
- § Director – Gangi Reddy
- § Supervisors, Peer Educators and Peers

NKV School at Rajamudhary

§ Staff and students

Nepal Red Cross Society Headquarters (Kathmandu)

§ D R Dhakhwa, Secretary General

§ Umesh Prasad Dhakal, Executive Director

§ Karuna Shrestha, Director, Health Services Department

§ Balkrishna Sedai, Senior Officer HIV/AIDS Programme Manager

§ Pitambar Aryal, Director, DM, (in his capacity as previous Director Health Services, SARNHA Coordinator and Health and Care Delegate in Afghanistan)

§ Dr Sushma Bhusal, Programme Officer, Health and Care Department,

§ Victoria Bannon, IFRC Country Representative

Officials

§ K K Rai, Director, NCASC, Government of Nepal

§ Damar Prasad Ghimire, Director, HIV/AIDS & STI Control Board, Nepal

§ Madhu Koirala, Officer, HIV/AIDS & STI Control Board, Nepal

Surket district

§ Red Cross Surket chapter staff, board members and volunteers

§ Balkumar Shakya, Kakrebihar-Plus

§ Narayan Sapkota ,SDF

§ Devendra Sharma , Navkiran Plus

§ Chandra BK, National Association of PLHIV, Nepal

§ Rita Poudel, Secretary, Satakhani Subchapter, NRCS

§ Dhanna Sapkota, Women group

§ Jai Bahadur Birkatta, YPE Leader

§ Narhari Poudel, School Principal

- § Peer educators, Peers, support group members, PLHIV receiving different kinds of support, teachers and other community members

Pokhra, Kaski District

- § Hari Prasad Baral, President Red Cross Kaski chapter
- § Red Cross district and project staff
- § CSWs, hotel owners
- § Sunita Tiwari, Project Coordinator, HIV Programme, Sidhartha Club

Pakistan Red Crescent Society (Islamabad)

- § Pepe Salmela, IFRC Head of Delegation
- § Mohammad Ilyas Khan, Secretary General, Pakistan Red Crescent Society
- § Dr Sadaf Sardar, HIV Coordinator, Pakistan Red Crescent Society

Officials

- § Dr Hasan Abbas Zaheer, National Programme Manager, National AIDS Control Programme, Ministry of Health, Pakistan.
- § Dr Quaid Saeed Akhuzada, National Officer HIV/AIDS, WHO

Punjab province Lahore:

- § Dr Adnan Saeed, Secretary, Pakistani Red Crescent Society
- § Syed Gulfam Haider, Manager, Stylers International Ltd, a textile factory
- § Dr. M. Sajid Askri, Medical Advisor, in a local textile industry factory
- § Dr Admer Nareed, Branch Health Manager, PRCS
- § Shahzad Qausar, Psychologist, PRCS
- § Ejaz, Social Mobiliser, PRCS
- § Sumbla Magsood, Youth Peer Facilitator/Motivator
- § Fauzia Saeed, Psychologist/Counselor VCTC, PRCS
- § Shahzad Majid, Psychologist/Counselor VCTC, PRCS

- § Fariq Zaidi, Associate Prof., Urdu Dept GC University
- § Amjad Tufaril, Psychology Dept, M.A.O. College
- § Dr Ziaud Hassan, Urdu dept Punjab University Oriental College
- § Prof. Dr Muhammad Riaz, Project Director, Silver Lining, an organization working with IV Drug users
- § Dr Noshi Butt, Psychologist, Senior Coordinator, Silver Lining
- § Anwar Khokhar, General Secretary, Shaheen Welfare Society
- § Elisabeth Yaqub, Health Worker, LHW LALDY
- § Teachers, peer educators and students from different colleges and universities, educational wing city traffic police, PLHIV and RC volunteers

Sindh province, Karachi:

- § Kanwar Waseem, Provincial Secretary, PRCS
- § Shameim Kazmi, Vice Chairperson, PRCS
- § Dr S.M. Ali Warei, Branch Health Officer, PRCS
- § Dr Syed Muhammad, Youth Peer Educator
- § Naurean Kamal, Youth Peer Educator
- § Zahid Ali Shah, Disaster Management
- § Rana Anwar, CBHFA coordinator

Project area in Orangi town in Karachi:

- § Aisha Zia, Chairperson, Youth Welfare Association, PRCS Orangi Town
- § Dr Asim Hussein, Project Coordinator, Youth Welfare Association, PRCS, Orangi Town
- § Dr Syed Hikmat Ali, Medical Officer, PRCS Dispensary, Orangi Town
- § Sofia Riffat, Family Planning
- § Teachers, Peer educators and students from different colleges and nursing institutes, madrassas, senior and students from city traffic police, Allviate Addiction Suffering Trust, Barbers Association

Afghanistan Red Crescent Society and IFRC Country Delegation – Kabul

- § Phillip James Charlesworth, IFRC Head of Afghanistan Delegation
- § Nuran Higgins, IFRC Health Delegate
- § Dr Sultan, IFRC Health Programme Manager
- § Dr Sailab, IFRC Health Officer
- § Abdul Ghani Kazimi, Secretary General, ARCS
- § Dr. Salim Bahramand, Head of Health Department, ARCS
- § Dr Fatima, Programme Coordinator, ARCS
- § Dr Sheba, Health Officer, Kabul District Programme ARCS

Officials

- § Dr Fahim Paigam, Director, NACP, Afghanistan
- § School Principals, teachers, students and parents District 5 Kabul

Sri Lanka Red Cross Society national headquarters - Colombo

- § Dr Lasantha Kodithuwakku, Executive Director
- § Prem Tilakratne, Assistant Director
- § Surein Pieris, Deputy Director General
- § Dr Prasad, Programme Manager
- § Nimal Kumar, Hon. National Secretary
- § PLHIV from Lanka Plus and Positive Women's network

Officials

- § David Bridger, Country Coordinator UNAIDS
- § Dr Dayanath Ranathunga, Social Mobilisation Officer, UNAIDS

Nuara Eilia

- § Budilika Attanayake, PedroTea Estate Manager
- § Pradeep Prereia, Pedro Estate Medical Practitioner
- § Workers and their families

Matelle District Branch, SLRCS

- § S. K. D. Dassanayake, Honorary Chairman
- § R. M. Gunathilaka, Honorary Secretary
- § Ruwan K Rathnayaka, Branch Executive Officer

Dambula

- § Market Committee Members
- § Representatives from Hotel Owners' Association and Tuk-Tuk Association
- § Students and Red Cross volunteers

KatunaYaka

- § Dr Ahljk Siriwardena, In-charge of HIV/AIDS and STI Clinic
- § Red Cross supervisors and Beach Boys (Beach Sex Workers)

AN OBJECTIVE-BASED TABULATION

<i>Objective 1: Contribute to reduction in incidence of new infections among young people through youth peer education and life skills development</i>						
Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No. of Peer Educators Trained in Life Skills	1,484	No Data	1,952	4,829	6,585	No Data
No. of Peer Educators Trained in HIV Prevention	1,820	No Data	1,952	33,785	6,585	No Data
How many Peer Educators were RC volunteers	336	No Data	No Data	10 % (aprox)	633	No Data
How many of peer educators remain / are active	1,801	No Data	All	55 %	714	No Data
Estimated drop-out rate/year	198 (in 2008-09)	No Data	400	5-10 %	40 %	No Data
No of youth contacted per PE by individual sessions	10,846	No Data	10	20,500	60-70 %	No Data
No of youth contacted per PE through group sessions	119,317	No Data	10	57,500	80-90 % of total	No Data
Of these, how many were school-going	57,060	No Data	No Data	48,000	64 %	No Data
Of these, how many were out of school	50,509	No Data	No Data	30,000	36 %	No Data
Average time spent on an individual	30 min	No Data	15-30 min	30 min	30-60 min	No Data
Time is spent on HIV/STI prevention and life skills development in CBHFA training	2 days each on STI and AIDS according to CBFA guidelines - ARCS not using CBHFA approach	No Data	No Data	No Data	At least 30 mins. But in some branches, over 3 hours.	No Data
Ratio of peer educators to a supervisor	20 : 1	No Data	10 : 1	160 : 1	8 : 1	No Data
How often is monitoring performed	Monthly	No Data	Weekly	Monthly	Monthly	No Data
No of school teachers provided RC trainings on life-skills and HIV prevention?	90	No Data	40 per year	177	2,658 parents	No Data

Objective 2: *Contribute to improving the quality of life of PLHIV and their families through care, support and anti-stigma and anti-discrimination activities with their greater involvement of PLHIV*

Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No. of PLHIV (females and males) referred for care	Nil	No Data	Referrals not formal activity	2,474 persons	19 persons	No Data
No. of PLHIV supported by the programme	Nil	No Data	Nutrition support for 8.632 & hygiene kits for 400 PLWHA/families	980 persons	1 PLHIV employed as social mobiliser	No Data
No of PLHIV estimated to need such support	Nil	No Data	No Data	1,600	15 to 20	No Data
No of anti-discrimination activities targeting health care workers	Nil	No Data	No Data	17 activities	30 sessions	No Data
No of health-care workers reached	Nil	No Data	No Data	75 health service providers trained	1,910 health workers	No Data
No of staff who have participated in discussions, seminars or workshops on stigma and discrimination	300	No Data	All staff in AP Branch	Over 90 per cent staff	All HIV/AIDS programme staff	No Data
Networks or PLHIV groups formed with RC support	Nil	No Data	None	27 support groups	2 groups in Lahore	No Data
No of PLHIV recruited as staff in the NS	Nil	No Data	1 (in field)	3 staff	1 staff	No Data
Does the NS have a workplace policy in place?	Under Progress	No Data	Under progress	Just adopted guideline	Planned for 2010	No Data

Objective 3: *Contribute to reduction of transmission of HIV by blood transfusion through increased voluntary non-remunerated blood donation.*

Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
Have donors been recruited through HIV programmes in health-care settings, garment industries, schools, tea estates etc.? How many of these become regular donors – two times a year of more?	Blood donors recruited in 8 targeted schools in Kabul city. 90 of these have donated blood upon request of the national central blood bank.	No Data	Donations received through donors for programme, but not a regular occurrence as staff capacity needs to be built.	Yes, donors been recruited from the +2 (senior) schools and 225 are regular donors (80%+)	Yes. Aprox 5,000 volunteer blood donors per year of whom, 1,500 are regular donors	No Data
No of RC/RC staff and volunteers are regular blood donors/members in Club 25	6 ARCS employees and 90 volunteers donate whenever approached or requested by the central blood bank.	No Data	No Data	20% staffs & volunteers are regular donor but not Club 25 members	17 PRCS staff and 48 volunteers. No Club 25.	No Data
How many Club 25s have been formed in the districts covered by the programme?	12 Clubs in 8 schools of Kabul city.	No Data	9 Club 25s	22 schools	None	No Data
Has there been creation and support of networks for voluntary blood donors?	VNRB donation committee is	No Data	No Data	Yes, NRCS have been	Yes. PRCS is working with	No Data

	established with ARCS health director as focal person; MoUs between ARCS and Ministry of Public Health and Ministry of Education; Club 25s recognised by Central Blood Bank			closely working with the Nepal Blood donors association (BLODAN).	other voluntary blood donation organisations, Also working with National AIDS Control Programme for safe blood with focus on VNRBD.	
--	---	--	--	---	---	--

Objective 4: *Strengthen the capacity of National Societies to effectively deliver HIV interventions?*

Indicators	ARFC	BDRCS	IRCS	NRCS	PRCS	SLRCS
No of trained volunteers and others trained and involved in the HIV programme retained	124,261 trained YPEs, YPE trainers, VNRBD motivators volunteers, peers, CBFA team leaders and volunteers, ARCS staff, teachers and principles are involved in the HIV programme.	No Data	Most working with Health and DM programmes on a regular basis	5,206 (including trainer, PEs and RC members)	90 % staff 60 to 70 % volunteers	No Data
How many PLHIV are represented in the National Society's HIV/AIDS Advisory Committee/ Steering Committee/ any other committees or forums?	Nil	No Data	No formal allocations done	One person in national level advisory committee and one person in each programme district.	PLHIV represented by Association of PLHIV in the steering committee (NHQ).	No Data
How many meetings/workshops/seminars have been organised together with other key players targeting policy makers on different levels (HIV prevention,	Regularly with government AIDS Control Authorities on	No Data	Total number not available – however	9 meeting at central level and 32 meetings in	NACP organised VCCT training for	No Data

<p>care and treatment, human rights issues, stigma and discrimination, employment, legal aspects, blood safety)?</p>	<p>advocacy and communication s; blood safety policy; POP meetings and workshop; Finalising of Police Training curriculum meetings; WAD working group meetings have been organized with NACP.</p>		<p>stakeholders have participated in events such as World AIDS day forum.</p>	<p>the districts</p>	<p>PRCS staff.. 15 workshops conducted in Sindh branch with various associations/ authorities.</p>	
<p>Have RCRC representatives been invited to deliver talks or conduct workshops or workshop sessions in the programmes of other organisations working on HIV/AIDS at national level?</p>	<p>National AIDS Control Programme has invited ARCS HIV master trainers to facilitate life skills based youth peer education ToT to MoPH youth supported by UNICEF twice. ARCS hosted the first HIV and Reproductive health symposium in</p>	<p>No Data</p>	<p>No</p>	<p>At least on 20 occasions.</p>	<p>One PRCS staff co-facilitated a training on VCCT organised by ANCP.</p>	<p>No Data</p>

	Kabul.					
Have RCRC representatives been invited to deliver talks or conduct workshops or workshop sessions in the programmes of other organisations working on HIVAIDS at district level?	ARCS HIV local coordinators and YPE trainers invited to conduct sessions and train schools students outside coverage areas in Kabul, Mazar, Herat and Jalalabad cities and invited local coordinator to distribute national IEC materials to people at community	No Data	No	At least on 50 occasions.	At the provincial level too, many trainings have been facilitated by PRCS staff.	No Data
What is the percentage of budget allocated to HIV programme/activities relative to the total budget of the national society?	4-5 percent of the IFRC supported health budget.	No Data	No Data	5 – 6 % annually.	2005: 0.00% 2006: 0.039% 2007: 0.08% 2008: 0.73% 2009: 1.56%	No Data
Please provide (in percentage terms) the budget allocated to HIVAIDS programmes in the National Society since 2005.	2006: 70,000 2007: 107,000 2008: 129,000 2009: 130,000	No Data	No Data	2005: 4.1% 2006: 4.6 % 2007: 5.8 % 2008: 5.75 % 2009: 5.35%	2005: 0% 2006: 0.04% 2007: 0.08% 2008: 0.68% 2009: 2.0%	No Data

How is HIVAIDS reflected in the current national strategic plans of the National Society?	The HIV and AIDS project is reflected as one of the priority areas in the ARCS strategic plan (2008-2012)	No Data	HIV/AIDS occurs prominently in the strategic plans and guidelines of the National Society	HIV and AIDS are prioritized issues in the 4 th and 5 th development plan of NRCS.	HIV/AIDS is a priority area in the PRCS policy document. PRCS strategy for health and HIV is being developed.	No Data
How many HIVAIDS programme coordinators have changed during the course of this programme at the National level?	At national level, only a HIV officer left in the beginning of 2010	No Data	2	1	None	No Data
How many HIVAIDS programme coordinators have changed during the course of this programme at the district level?	Nil		Turnover has been frequent	None	No Data	
How much of internally raised funds have been allocated to this program?	None / Nil		No formal allocations – however funds have been raised for events like World AIDS Day at various levels in the field.	150,000.00 NPR was raised by JRC members for WAD Campaign in 2007.	None.	
Has your National Society put in proposals for other	None.		Yes. A	At least 10	Put in one	

<p>HIVAIDS programmes - and how many?</p>		<p>proposal was put to HKRC through the IFRC. National Society also has bilateral funding programmes with other PNSs.</p>	<p>times (two times for PR of GFATM)</p>	<p>proposal with AmCross in 2009. Sindh Branch established a HIV AIDS Prevention and care project win collaboration with other agencies funded by USAID.</p>	
---	--	---	--	--	--