PORTRAITS OF THE PEOPLE OF THE AIDS RESPONSE

NACOSA

ANNUAL REPORT 2015

“I’m not a hero, this is my job.”

Written and edited by Sophie Hobbs
Photography and interviews by Sarah Schaffer
Designed by Flame Design
Printed by Signet Printing (Pty) Ltd

Capturing the portraits in this report was made possible thanks to the The Global Fund to Fight AIDS, Tuberculosis & Malaria

PORTRAITS OF THE PEOPLE

OF THE HIV, AIDS & TB RESPONSE

Contents

SALUTE TO THE PEOPLE

Funding, systems and plans are all important in achieving the global goal of ending AIDS by 2030 but it is people who ultimately influence the thrust of the AIDS response. UNAIDS's 90-90-90 treatment strategy acknowledges the importance of people in the attainment this goal, as does the Sustainable Development Goals Agenda, adopted by the United Nations General Assembly in September:

> ***"It is an Agenda of the people, by the people, and for the people – and this, we believe, will ensure its success."***

NACOSA's own journey over the last 13 years has shown us that it is a complex, multi-faceted and layered field of work that cuts across all areas of society – people and communities are therefore at the very centre of the HIV, AIDS and TB response.

The scope and coverage of our work has grown exponentially as we developed into an accredited training provider and grant manager, with a staff of over 70 and four offices around the country. We could not have achieved this without our people – staff, partners, funders, government and our valued network of members – all working together towards a common goal.

This year has been particularly fruitful as we finalise the transformation of NACOSA into a Non Profit Company and attractive B-BBEE partner, with the *pro bono* support of Norton Rose Fulbright. This team of experts has helped us to structure NACOSA NPC as a professional, accountable, sustainable organisation while staying true to our constitution and values. The founding document of the new legal structure renews our commitment to collectively turning the tide on HIV, AIDS and TB.

NACOSA has again been selected to be Principal Recipient for the next Global Fund country grant. Starting on 1 April 2016, our new grant will see an increased focus on young women and girls, while we continue our community systems strengthening, sex worker and gender based violence programmes. We are also pleased that the NACOSA Orphans and Vulnerable Children Community Systems Strengthening programme, in partnership with USAID and PEPFAR, will be implementing DREAMS in KwaZulu-Natal. DREAMS (Determined, Resilient, Empowered,

Dr Saadiq Kariem congratulates Dr Maureen Van Wyk on her 10 years at the helm of NACOSA.

AIDS-Free, Mentored and Safe) aims to prevent new HIV infections among adolescent girls and young women through a combination prevention approach targeting adolescent girls and young women, their families, their male sex partners and the broader community.

The NACOSA Training Institute has come into its own this year and now has over 40 skills programmes on offer, new training packages and a growing client base. NACOSA's network of organisations and individuals has also shown growth – going past the 1,500 mark. And we are proud to extend our networking globally by becoming a Linking Organisation for the International HIV/AIDS Alliance. Our network is a central part of who we are as an organisation and we look forward to many more years of linking, learning and working together.

This annual report is our salute to all the people who work in the AIDS response in South Africa – and beyond – without them, the ambitious goal of ending HIV, AIDS and TB by 2030 will simply not be possible.

DR SAADIQ KARIEM
Chairperson

DR MAUREEN VAN WYK
Executive Director

HIV, AIDS AND TB IN SOUTH AFRICA

South Africa is making progress. There has been a massive reduction in mother-to-child transmission (now at just 2.2%) and the improvements in testing and treatment have caused an increase in life expectancy. But while HIV incidence is declining overall, it has increased among women and key at-risk populations and tuberculosis (TB) remain significant concerns.

A young woman in SA is **4X** more likely to be HIV positive than her male counterpart.

6.8 MILLION South Africans are living with HIV.

HIV prevalence among young men who have sex with men (MSM) is **DOUBLE** that of the general population.

53,617 sexual offenses were reported in 2014-2015 but only **1 IN 13** report rape to the police.

HIV incidence in young women aged 15-24 make up **¼** of all new infections.

Over **2.5 MILLION** are on antiretroviral treatment (ART).

62% of TB cases are people who are also HIV positive.

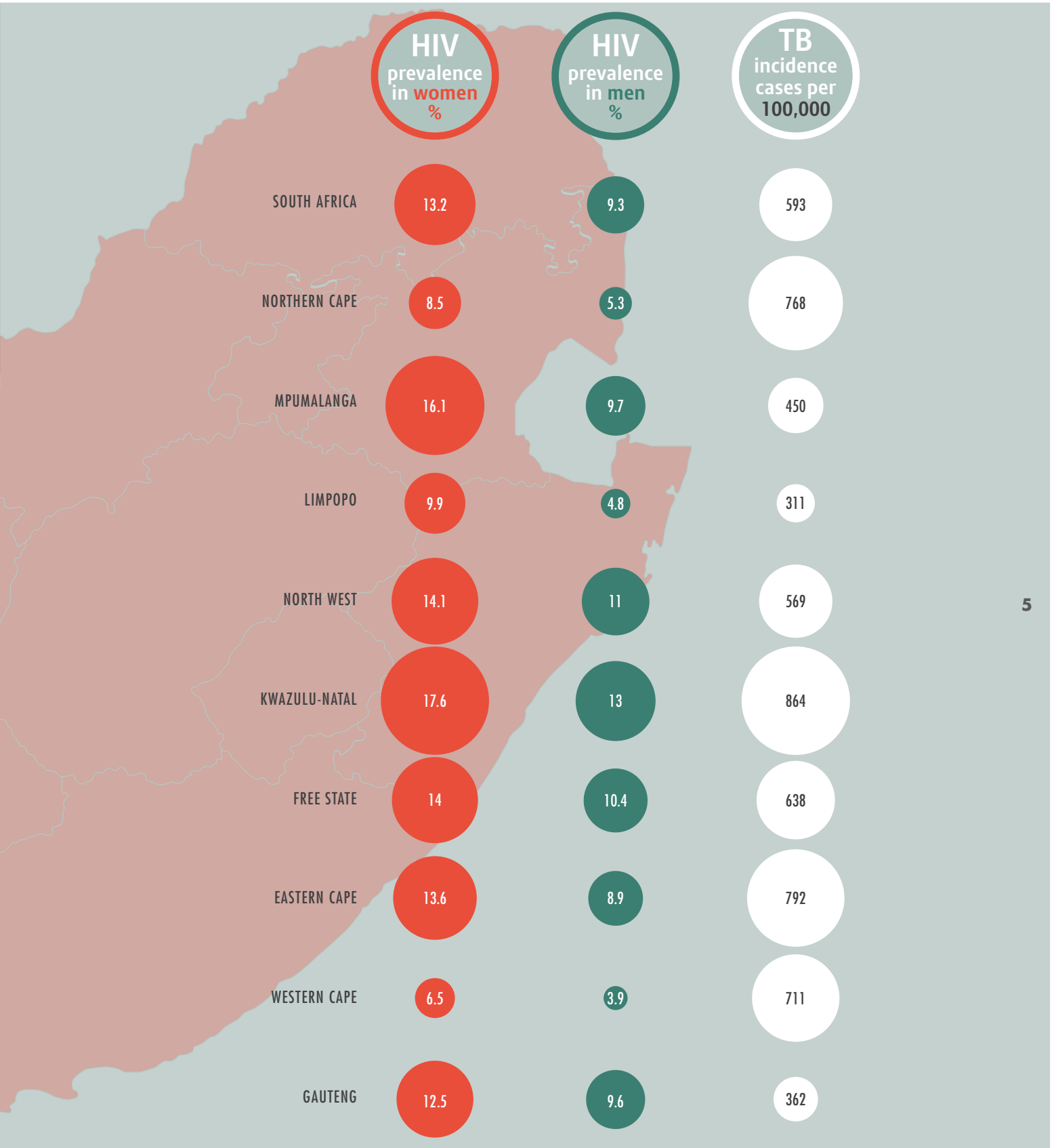
Sex workers in South Africa are estimated to have an HIV prevalence as high as **60%**.

Approximately **22%** of the country's 18.6 million children are affected by HIV and AIDS.

2.3 MILLION children have been orphaned by HIV and AIDS.

TB is the **LEADING** natural cause of death and we have the **3RD** highest absolute TB burden.

Sources: UNAIDS, Stats SA, Human Sciences Research Council, Institute for Security Studies, Health Systems Trust



Source: Health Systems Trust (2015), District Health Barometer

Dr Pren Naidoo is head of operational research at the Desmond Tutu TB Centre at Stellenbosch University and a NACOSA board member.

THE TB MOBILISER

Dr Pren Naidoo is a leader in the tuberculosis (TB) field in South Africa. She started her career in public health at a time when there were very few HIV services and the close relationship between HIV and TB was only beginning to be understood. Pren worked extensively with the late Dr Ivan Toms at the time, and she recalls one of the first meetings she had with him. "He said 'you need a 30-year horizon with TB'".

Pren has been studying national TB incidence by age and gender over the past 10 years. "We found a general decline in TB notification rates over the age of 35, suggesting that these individuals have less TB than they did previously. This may be attributable to the widespread rollout of antiretroviral therapy (ART). However, in most of the younger age groups we see an increase, suggesting that other factors that predispose to TB have not changed."

Although there has been progress with TB testing and diagnosis, Pren questions whether the TB response is on the right track. "A lot hasn't changed," she says.

> ***"It's a slow epidemic and our approach needs to be of continuous improvement and mobilisation."***

"We haven't mobilised community action. There needs to be a sense of common responsibility and we need to improve the quality of services rendered." Research shows that patients often ignore coughs and don't go to clinics to get tested right away. Then, there is often a delay in getting results and medication and, once on treatment, many default.

Pren believes that the TB response failed at community mobilisation where HIV succeeded, and that the complex but always intertwined relationship between TB and HIV isn't always considered. "It's about getting individuals to take responsibility for their health. We need to have patients demanding their results." About one fifth of patients diagnosed with TB don't get onto treatment – "that's the black hole in TB control," says Pren. "These [problems] are avoidable if the delays are reduced."

"We will always have a relatively high burden of TB," says Pren, noting the number of South Africans living with HIV. About 350,000 people are diagnosed with TB in South Africa every year and more than half of them are also HIV positive. Pren believes that it will be a long time before we see a significant improvement and we need to gear ourselves for the long haul. Health services should focus on community mobilisation: "It's ridiculous to think that people coughing are not aware that they might have TB. People need to know more about TB and make use of free public health services for testing".

"We have new tests for TB but this alone will not solve the problem," she continues. And changing health services isn't going to be enough. "I'm a systems person. It's about *all* the systems and services surrounding health." But Pren is an optimist, she believes the situation will improve: "we will need to be smarter, provide better quality services and work more closely with communities".

THE CONNECTED COMMUNITY

Danielskuil is a dusty little town in the Northern Cape, with a population of about 30,000. Like so many rural communities, there are many barriers to HIV here – stigma, access and a lack of awareness. Parents are reluctant to take their children for testing and some even refuse to allow it. Organisations like the Kgatelopele Social Development Forum (KSDF) have developed trusting relationships with the community to improve testing and treatment.

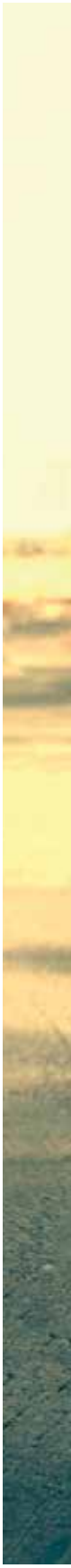
"People didn't want carers to visit," explains Elizabeth Baum, coordinator of KSDF home-based care services. "They were known as 'the HIV people'". KSDF's project manager, Jeanette Mqomo, recognised this early on: "I identified a need for a home-based care programme in 2006 and about 40 volunteers were trained." But it is KSDF's proactive approach that has made the difference.

In the vast and sparse Northern Cape, carers had to travel long distances and many in the community couldn't make the journey to the local clinic. So the team at KSDF worked hard to build relationships with local businesses and the health facility and were able to get a bakkie donated and staffed which now transports clients to the clinic and goes out into the community.

> ***"KSDF isn't just about sickness, it's about integration. We're a part of the community."***

KSDF takes into account the many factors that affect the community – health, education, psychosocial and emotional. And it shows. As the KSDF team drives through the town in their bakkie, people greet them, with smiles and waves. From mother and baby services and HIV counselling and testing, through to looking out for vulnerable children and helping TB patients take their medication, KSDF carers connect the health and social services dots.

The Danielskuil clinic is in the middle of town. It is spacious and friendly and community members chat in the shade of the waiting area. "It's a well-equipped clinic", says Elizabeth, "but our wish is for it to get the resources that it needs so that people can be treated locally." The nearest hospital is in Postmasberg, about 60km away.



Youth care workers watch over children playing in the street.

Juliet and her children wait at the Danielskuil clinic.

On Mondays, the Danielskuil clinic is dedicated to mothers and children and Juliet Pharoro waits patiently with little three-month-old Kimberley to see the nurse. The baby has had the flu and at this monthly check-up, Juliet wants the nurse to check Kimberley's chest. Juliet came here to get tested too. "Most people come here, we like this clinic." She is from Danielskuil and is unemployed. She dropped out of school in Grade 10 when she was pregnant with her oldest child, 11-year-old Princess. "It's very difficult to find a job here."

Duduetsang Seele and Tsholofelo Mogweng are KSDF child and youth care workers and they each look after about 40 children. "We don't always have enough time every day, so we'll often join up and do group activities," says Dudu as she and Tsholo watch over a group of children, from toddlers to teens, playing in a dusty cul-de-sac. They love their work and feel confident in their training, but are sometimes overloaded – 40 children is a big responsibility.

Jacob Links lives with his sister, mother and grandmother in Danielskuil. He has

Home-based carer, Sofia Reid, helps Jacob Links take his TB treatment.

TB and is still quite frail. When KSDF first discovered Jacob, he was bedridden and too weak to walk or talk. With the help of home-based carer, Sofia Ried (known affectionately as Baby by her colleagues), he has been on medication since last July.

Another member of the community who relies on the care KSDF provides is Evelyn Isaacs, who tested positive in 2011. “Ek was baie siek,” she remembers. “I didn’t think that I would live. Now I know, it’s not my time. I have three children and I will continue”. Since she began treatment, she has never defaulted and these days she feels healthy. A carer comes to her home regularly.

With support from NACOSA through the Global Fund, KSDF provides services to some 350 people living with HIV in Danielskuil. “If we can educate people to decrease their viral load and manage themselves,” says KSDF project manager, Jeanette “there shouldn’t be newly infected clients. Let it stay at 350! I’d like to add to their estimated lifespan and give them the grace of more years through the support that we can offer”.

FUNDING THE SOCIETY

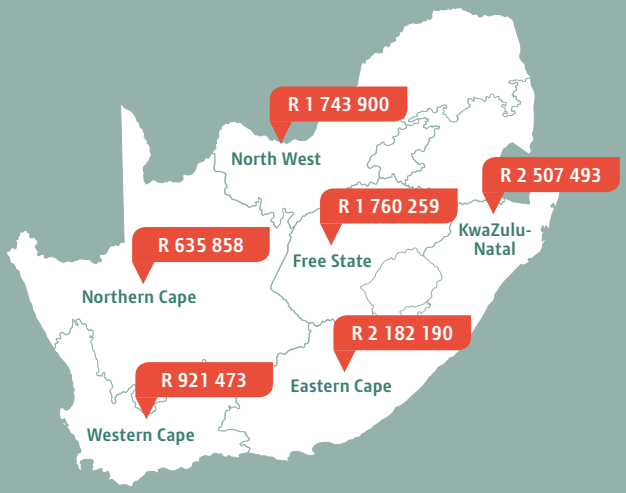
NACOSA channels resources from multiple donors to support service delivery on the ground, focusing on orphans and vulnerable children, key populations and women and girls. NACOSA's grant programme is underpinned by capacity building, networking and dialogue activities which work to strengthen community systems and create a supportive environment for the HIV, AIDS and TB response.

OVC COMMUNITY SYSTEMS STRENGTHENING WITH USAID & PEPFAR

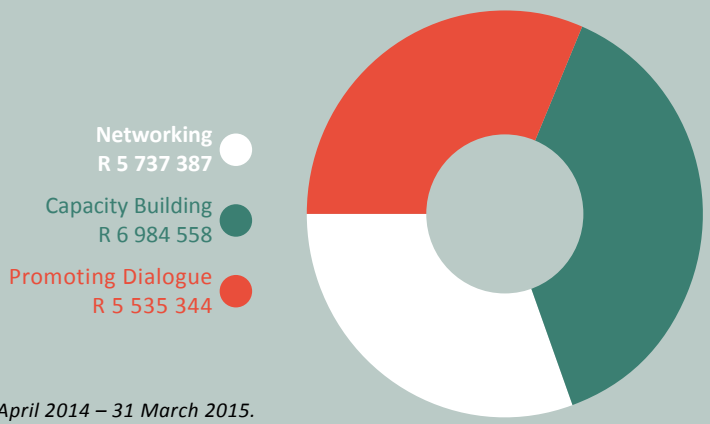
R 9 751 179
TO OVC ORGANISATIONS

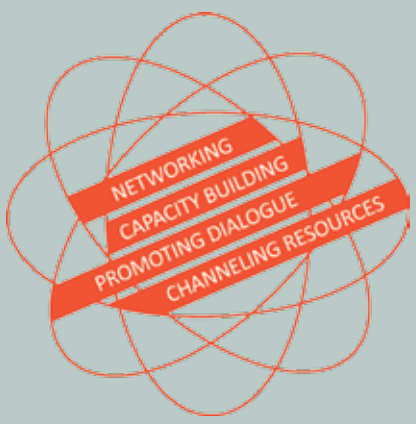
R 375 045
AVERAGE GRANT PER ORGANISATION

GRANTS BY PROVINCE



SYSTEMS AND ENVIRONMENT





Notes: 1 April 2014 – 31 March 2015.

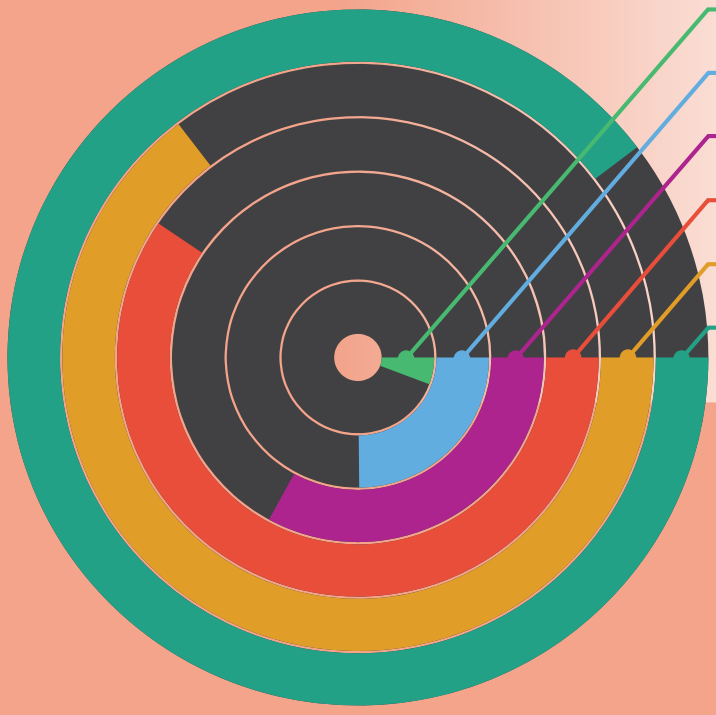
CIVIL RESPONSE

ANGLO AMERICAN CHAIRMAN'S FUND

R 294 589

Channelled to OVC organisations in the Eastern Cape

GLOBAL FUND PROGRAMME



R 3 447 297
Combination Prevention - MSM/LGBTI

R 14 905 046
Combination Prevention - Youth

R 19 763 255
Gender Based Violence programme

R 35 679 842
Combination Prevention - Sex Workers

R 38 773 769
OVC Support

R 53 804 878
HIV Care and Support

TO SUB-RECIPIENT ORGANISATIONS **R 166 460 827**

Notes: Networking includes Global Fund Supportive Environment; Capacity Building includes Global Fund Systems Strengthening; Promoting Dialogue includes Global Fund Systems Strengthening and National Department of Health Community Dialogues.

THE POSITIVE WOMAN

Forty-year old Bazini Sinde Mjolo tested positive when she was pregnant. “I felt so dizzy. My response was very negative. That has changed though.” Now, “it seems like I was born with it. I accept it fully”. Woza Moya, a community organisation in the Ufafa Valley of KwaZulu-Natal, has played a crucial part in Bazini’s acceptance. “Since I engaged with Woza Moya and they counselled and advised me, things changed.” Today, she and her little girl are healthy and she has never defaulted on treatment. Her daughter, now 10, is HIV negative.

Woza Moya incorporates home based care, child and youth care, early childhood development, food security, paralegal advice and water, sanitation and hygiene services. They see about 1,000 HIV positive patients regularly (684 under the NACOSA-managed grant) and a third of them also have TB.

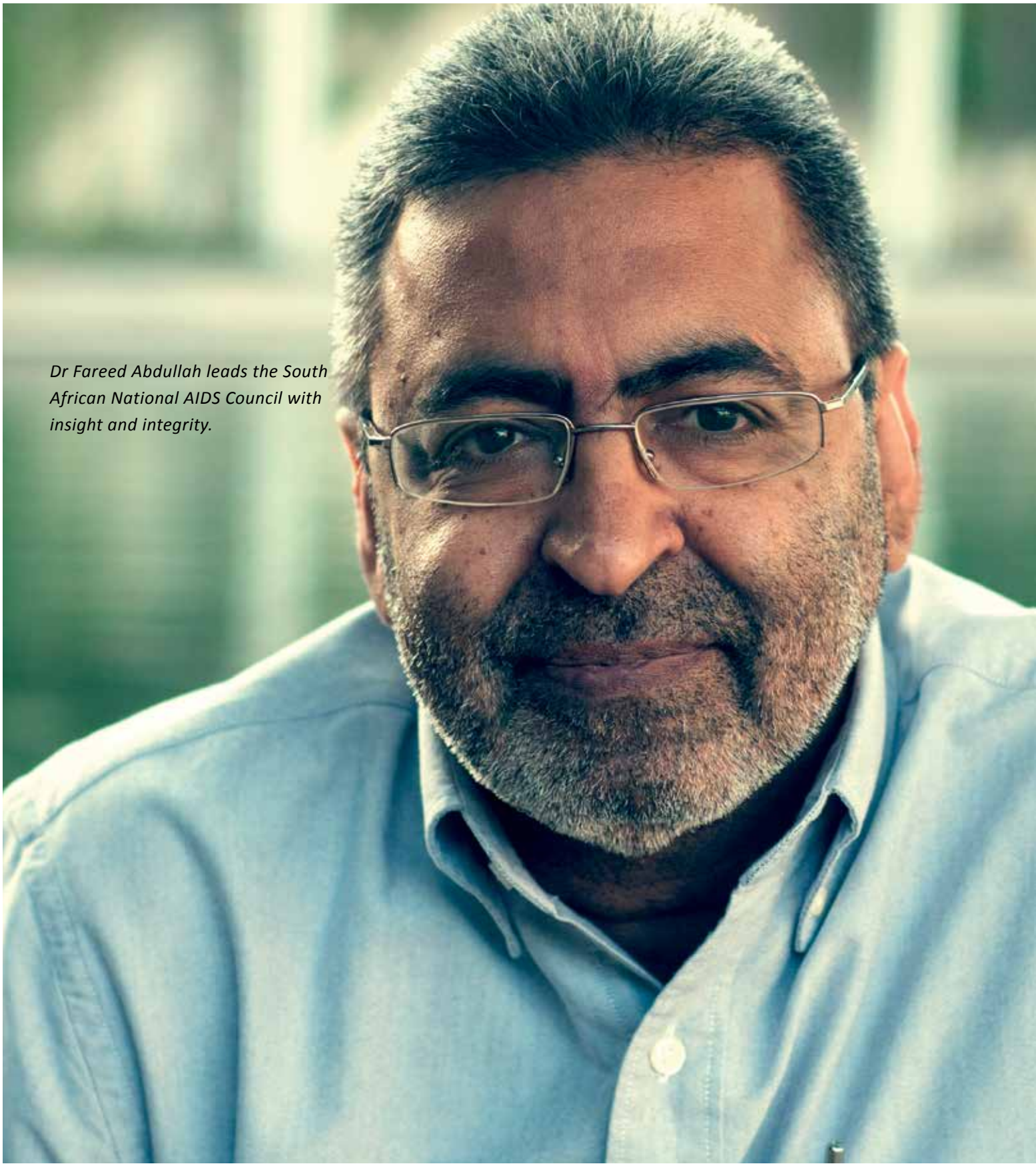
Bazini is involved with Woza Moya in many ways – she attends support groups, her daughter benefits from their education programme and she is a crafter at the Woza Moya facility which provides some income. Bazini hopes that she can be an example to other people: “it’s not the end of your life”.

> ***“You can do anything. Anything you want to be, you can.”***

Home based carer Jabu Jwasa views her work as a calling: “I love to help people who need me”. She is from the Ufafa Valley area herself and recognises the issues patients have. “Above all, the challenge is poverty. And the things that come with poverty,” she says. Woza Moya’s carers are known and trusted within their communities and give practical, focused support to people. The 35 carers each visit about 30 HIV positive clients like Bazini every month.

“People are happy to test now,” Jabu notes. “Before, it was so difficult.” The difference in attitude, she believes, comes down to education – “people get better with education”. Jabu also recognises how important it is to develop relationships with clients. “We must be connected with the people. At work, it’s like I’m family or something!”

Bazini, a crafter at Woza Moya, receives home visits from carers to support adherence.



Dr Fareed Abdullah leads the South African National AIDS Council with insight and integrity.

THE RESPONSE LEADERS

The South African National AIDS Council (SANAC) drives the country's response to HIV/AIDS, TB and STIs by building consensus across civil society, government and other stakeholders. CEO of SANAC, Dr Fareed Abdullah, is a veteran of the public health field and leads SANAC with insight and integrity. Dr Nevilene Slingers is the woman charged with coordinating the donors. Together, they are at the forefront of a complex, multi-layered and evolving response.

Fareed's interest in HIV began as a student and he was running HIV programmes for NGOs and trade unions before many South Africans were even aware of it. "I guess you can say it's been a long time," he jokes. Trained as a doctor in Natal, Fareed went to Cape Town to specialise in public health medicine and spent 12 years in government, restructuring health services in the Western Cape.

In 1998, preventing mother-to-child transmission (PMTCT) became a reality in public health. "We got a team together and started to implement immediately," explains Fareed. The problem was that the government wouldn't support the plan for another five years. It was a life-changing event for the young doctor. "I was faced with a difficult choice – I had to choose between my role as a public health doctor and as a loyal party member." He smiles wryly. "Actually, it wasn't such a hard choice."

By the time universal ARV treatment began in 2004, South Africa had one of the highest HIV rates in the world. It still does. Fareed joined SANAC after working at the International HIV/AIDS Alliance and for the Global Fund. He set out to transform SANAC into an independent, functional institution – coordinating, supporting implementing partners like NACOSA, providing monitoring and evaluation and, critically, moblising resources.

> ***"SANAC has always been good at bringing people together."***

Dr Nevilene Slingers is SANAC's Executive Manager for Donor Coordination and works closely with Fareed. Her medical background includes a balance of government and NGO work and she recently completed an EMBA. She says she is "motivated by managing complex situations". Nevilene realised early in her career that she wanted to influence policy: "A person who is HIV positive challenges you as a medical practitioner. You have to have a bio-medical response and it's very complex. There is medical knowledge but also cultural and social knowledge".

"Programmatically, there is now a much better balance between treatment and prevention," says Fareed of today's response. "There is more interest and investment, especially for young women and key populations." With access to more information, SANAC is able to monitor regularly, create reports, do evaluations and understand the numbers and long-term costs better. The HIV field is changing rapidly. "It's bursting with possibilities," says Fareed. He believes that it is possible to bring the virus under control but warns against using catch phrases like 'AIDS-free generation' and believes our focus should remain on prevention. "HIV isn't going anywhere, there is no magic bullet."

For Nevilene, the key to the AIDS response lies in seeing the bigger picture and addressing the gaps. The high number of new infections means we are not yet doing enough on prevention and, with three million South Africans now on ART and many more starting ART, the response will require billions in funding in the years to come. "How do we secure adherence for the rest of their lives? That's a crucial task. Can our systems cope with it?"

"I'm not scared of change," she says.

> ***"It's about finding the best plan that considers everybody's point of view. It's a dialogue about a complex problem."***

"We're small sticks on the earth," says Fareed. "One must always have perspective about what contribution you can make. My whole life I've been working for this… I grew up in the liberation movement, I was an activist. The South Africa project is the focus of my whole life."

"One day, I'm just going to be a doctor at work somewhere." He smiles broadly, "One day. Not just yet".

Dr Nevilene Slingers leads Donor Coordination and is motivated by managing complex situations.

Semakaleng 'Sma' Motapho is saving lives at the University of Venda.

Semakaleng 'Sma' Motapho is project coordinator in the higher education men who have sex with men (MSM) combination prevention programme at the University of Venda. The campus, known as Uni-Ven, is in Thohoyandou in Limpopo, the centre of the Vhembe district and an area known for its conservativism, hostility to homosexuality and patriarchal attitudes. Being out and running a LGBTI-friendly programme in this environment is extremely challenging. But 27-year-old Sma has made the programme an expression of himself.

Sma is openly gay and cross-dresses but doesn't identify as a woman. "I'm just more comfortable in 'female' clothes," he explains. "I'm just Sma". He began his role at Uni-Ven timidly. He explains that homosexuality is regarded as 'matula' (taboo). "It's going against the culture," he says. "In the beginning, it was very hard. I experienced a lot of red tape from every direction."

"Being openly gay and dressing like me creates an immediate barrier here," Sma explains. "People found it problematic to be seen with me." But the LGBTI support group that Sma runs has grown and now has over twenty people attending.

THE GROUND BREAKER

> *They didn't have a space on campus to be who they were. It was an area that nobody wanted to entertain. It was a no-go area.*

"I can see momentum and progress but it needs to continue," says Sma.

Sma believes that one of the most important factors in making services accessible to key population groups like MSM lies in the language used by institutions. "Prevention messages about HIV shouldn't revolve around women and men. The commentary and the narrative is very heteronormative. We have to speak about the crossover." He cites University application forms as an example, "It creates barriers by putting people into boxes."

Uni-Ven runs a successful HIV testing programme but one of the difficulties that Sma faces in coordinating the MSM community within a conservative institution is that MSM students don't disclose that information easily and students can be hostile.

The University fully supports Sma's work and there have been anti-homophobia drives on campus with an article in the University of Venda magazine about embracing homosexuality. But there is still a long way to go, "Sometimes I think that if I leave here, it will be back to square one".

"It's been a journey for me… I realised that I was different when I was about six years old. My mom didn't want to buy me dresses and my dad didn't want me to put on makeup. But I did. At school I also realised I was different. Boys wouldn't accept me, and neither would girls. When I reached puberty, I told myself that I needed to stop. I observed men and I tried to mimic them. I tried to get rid of this hand gesture!" he laughs, nodding towards his effeminately gesturing right hand.

> *I do what I have to do. Sometimes, I've wanted to leave, but my conscience won't let me. I am needed here. I'm saving lives.*

He started smoking, drinking, and dating women. "My goal was to impregnate a woman. I wouldn't use condoms," he thought that this would give him credibility as a man. He became more and more unhappy. "I was trying to be somebody that I wasn't. But my hand still did this". Sma tried to kill himself in 2005 and again four years later. "Then I realised that I was missing something. It was me".

Coming out was a slow process but his family was understanding. "We don't have control over things. I can't change! It wasn't a choice. You wouldn't choose discrimination, nobody would. This programme has really helped me to understand myself more." Sma acknowledges that it's unusual in this community to have such a supportive family, "I've been blessed to have these people."

Sma is a rare student at Uni-Ven. "I'm the only obvious gay here," he observes. People stop and stare and talk about him loudly. He brushes it off: "I choose to not hear it and I'm not going to sit in my office and cry."

"You need to be resilient. You have to stand your ground. You have to be strong, as emotionally strong as possible because you see things and understand things that people don't get."

THE GOOD DOCTOR

Dr Makaziwe Mgobozi, or 'Doc', as she's known in Qumbu in the Eastern Cape, is a busy woman; her white coat flashing as she bustles around the small community clinic that she runs. What began as a small practice has become a shining example of an accredited non-medical site for HIV counselling and testing (HCT), reflecting the meaning of its name, Siyakhanyisa – *we are shining*.

In Qumbu, the path to HIV and AIDS awareness and acceptance has been long and difficult but today, the community sets an example. Doc explains: "it wasn't easy to disclose because even if you're in a safe place, there was discrimination. Even in church, people would move away."

During her training, Doc realised that "so much of medicine is psychosomatic more than physical." She opened a private practice in 1990 and was one of just two practicing doctors in Qumbu. "HIV wasn't a problem in South Africa then," she says. But in 1991, HIV test results started coming in positive. "I was surprised. What was happening?"

"We still knew it as a disease that was American." Suddenly, there were over 150 positive tests and people were scared. There was stigma surrounding the virus and to most, it meant death. "People were told to come to me but they didn't," Doc explains. Families didn't want to disclose HIV-related deaths. People in the community were guessing and nasty rumours started. The stigma became attached to her.

By 2000, the positive tests were down to single digits but it wasn't because HIV had miraculously missed Qumbu; it was because people were avoiding getting tested. Doc realised that she needed to do something. She ran her first awareness campaign with the help of a nursing sister from Mthatha. They talked to people about the signs and symptoms of HIV. The following year she ran the campaign again, handing out condoms and speaking about preventing the spread.

Slowly, people began coming to get tested again and Doc started the first support groups, where people could talk about living with and caring for people with HIV. When Doc found a way to access antiretrovirals for the community, there were immediate success stories. Positive women gave birth to negative children and previously bedridden patients were living healthy, happy lives.

"Lies have short legs," she laughs. People got to know and trust her. Her clinic began receiving support from the Department of Health, the Department of Correctional Services and local businesses. She received funding from the OR Tambo District Municipality and started 13 support groups, now attended by people from 23 surrounding villages.

Gretta Mthi has been working with Doc since 1999. She was a mentor at one of the very first support groups. When they started, she explains, "people were hopeless, basically bedridden. Those same people are working here now". She smiles, nodding toward other staff members. "Now, people are more open. The dynamics have changed. I'm proud of too much!"

Zimbini Gesi is the co-ordinator at the clinic. She found out that she was HIV positive about ten years ago and came to Siyakhanyisa for support. "I love Siyakhanyisa", she smiles, "it changed my life. If I didn't come, I don't know what would have happened." Mzolisi Nyembezi and Vuyelwa Gwexa are both

HIV positive support group members and have similar good stories to tell. Mzolisi lives in a nearby village and started coming to the support group in 2008. “I learn a lot. I can educate other men like me. Rural people need education. They know nothing about HIV and AIDS.” Vuyelwa tested positive in 2014.

“I feel better now. The support group takes the stress away. I’m happy. Life is easier. If you teach people, then they will go away with knowledge and it will help them.”

Doc has immense pride in her community and the fact that the numbers of new infections are declining. “I want this organisation to continue even without me. It’s not about money, it is blessings.” She gestures around her, “to see people like Zimbini, like Vuyelwa. To see people coming in to test, to see organisations like NACOSA supporting us. There’s reward everywhere.”

What drives Doc to keep at it? “It’s the oath. The patient always comes first.”

Dr Mgobozi founded the community HIV support group, Siyakhanyisa.

THE COMMITTED COORDINATOR

Chrisna is a busy woman. She chairs the Saldanha Bay multi-sectoral action team (MSAT) and also runs Siyabonga Care Village, just outside Vredenburg in the Western Cape. Each of the different organisations and services that form the MSAT, bring their own experience, expertise and commitment to the forum which provides a platform for resource sharing, capacity building, training, finding funding opportunities and improving the quality of services.

"There have been so many successes!" says Chrisna. The MSAT meets monthly, "It's a big commitment but we stick to our year planners." MSAT membership is voluntary and there are over 100 members – community organisations, clinics, government departments, private businesses and churches. "We learn so much all the time."

Stigma around HIV is still high, "it's like the 9 o'clock news – it just happens." Chrisna believes that awareness must begin early: "We must start with ourselves, with our families. It must begin at home. There can be a better future but we need to find it in ourselves first. My hope is that we take care of our children from the beginning. They are our future. If we don't, we compromise ourselves."

> ***"You can't do anything within the community if it doesn't relate back to the main issues that affect people. You can't just look at one aspect of an issue – we must look at the whole picture."***

Chrisna grew up in an abusive home and had to protect her mother from an early age. After leaving home, she became a nursing sister. "I've always just wanted to protect people. I never look away. I need to reach out."

"It was a Saturday morning in December, 2002. A guy was waiting outside for me. He was lying on the ground, too weak to walk. He was dying of AIDS. Everything stood still and God spoke to me." She knew that she had to open a place to care for people like him. "That is my life's commitment."

Siyabonga opened in 2005. "It was a faith decision. I didn't even have enough food or milk for people then. I worked 18 hours a day. After ten years, Siyabonga has eleven programmes, 155 staff and a budget of over R10 million! There's still so much to do."

"I love it when something grows and blooms," she says. She has noticed improvements in many facets of Siyabonga and other MSAT organisations. "It's governance, finance, report writing, training…alles! They [NACOSA] give the training you don't get anywhere else. We get the best! They see a need and they share knowledge."

Her energy is infectious. "Prevention is key. We must learn to live healthy and make good choices when we're young. I'm positive about it and I'll try to make a difference until the day I die. Everyone can live to the fullest." She looks around her at the colourful buildings that house Siyabonga Care Village and smiles broadly. "We love our work, né?"

Chrisna du Plessis chairs the Saldanha Bay multi-sectoral action team (MSAT) and also runs Siyabonga Care Village.

OUR REACH

FROM APRIL 2014 TO MARCH 2015,

NACOSA is a national civil society **network** of organisations working together to turn the tide on HIV, AIDS and TB in Southern Africa. NACOSA **promotes dialogue**, **builds capacity** with accredited training, mentoring and technical assistance and **channels resources** to support service delivery on the ground, particularly among key populations and women and girls.

2,280
Frontline workers with skills programmes and accredited training

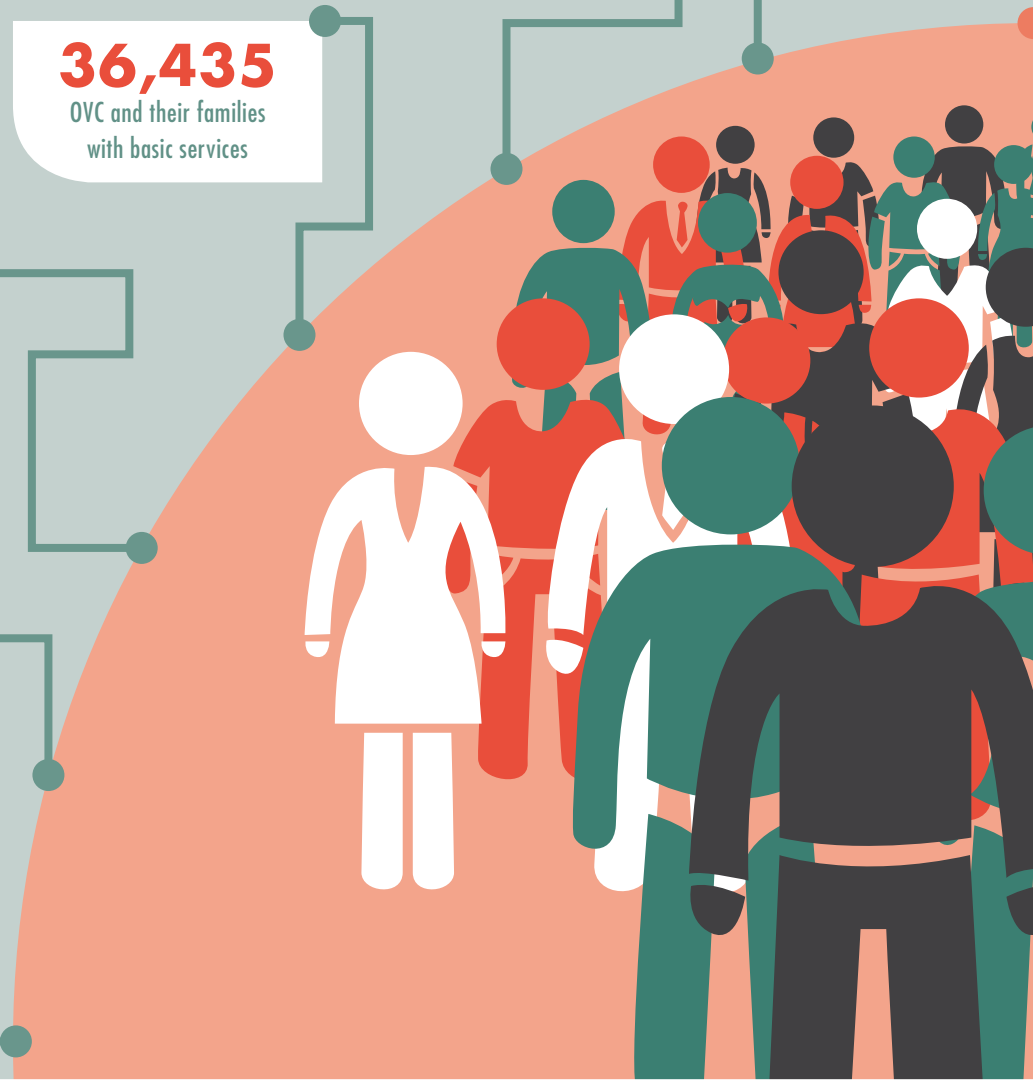
13,978
OVC with HIV counselling and testing

36,435
OVC and their families with basic services

86,534
People from low socio-economic groups with HIV counselling and testing

111,969
Patients on ART with adherence support

1,530
NACOSA Network members



WE REACHED...

34,425
Sex workers with peer support and information

13,980
Sex workers with HIV counselling and testing

1,015
MSM/LGBTI students with HIV counselling and testing

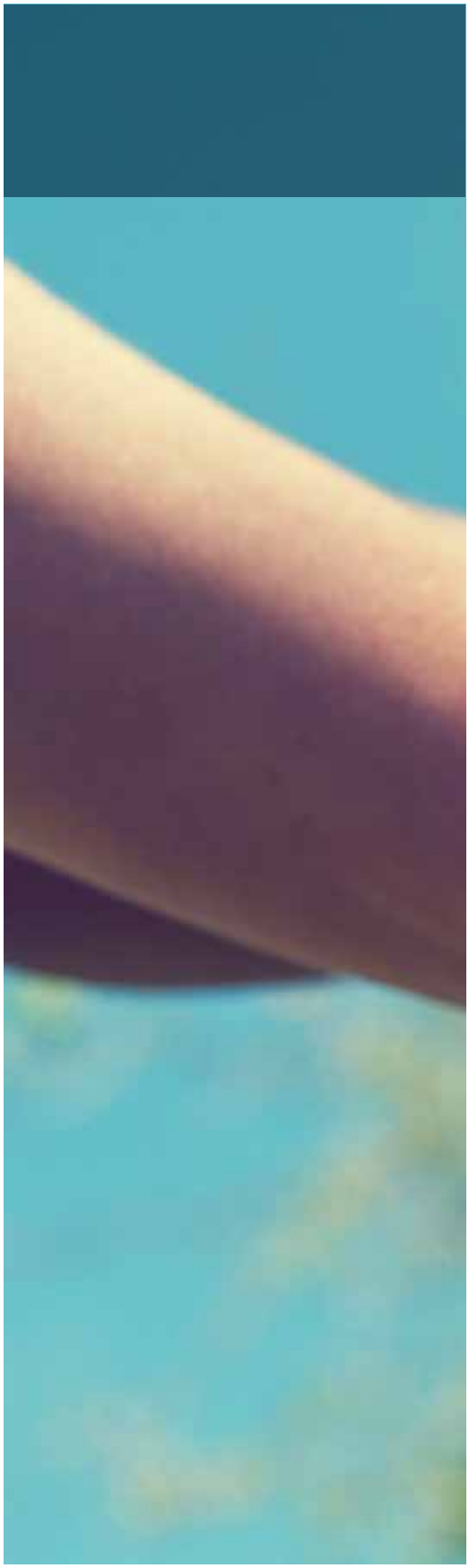
22,503
Sexual assault survivors with trauma support services

35,205
Domestic violence victims with HIV prevention education and services

25,255
Gender based violence survivors with an HIV test and follow-up

21,704
Young women and girls at school with a combination prevention package

> *"NACOSA, the support that you are giving us in terms of capacity building we really appreciate it. You may not know how many people you are touching by empowering us."*
>
> – Nokwanda Ntloko, We Care Ministries



The Networking HIV/AIDS Community of South Africa – NACOSA – is a national network of civil society organisations working together to turn the tide on HIV, AIDS and TB. As an enabling mechanism, NACOSA bridges the gap between small, grassroots organisations and the funding, skills and systems they need to deliver services in communities.

Born out of a national conference in 1991, NACOSA played a central role in mobilising an effective, multi-sectoral response in South Africa. During this time, the organisation discovered that when people come together to tackle social and health challenges, they have a stronger voice and are more effective at finding solutions. NACOSA's role is therefore not just to take services to people but to bring people and their ideas to the development of services. According to a NACOSA member organisation, interviewed for an external evaluation:

> ***"NACOSA takes forward the voices of the people on the ground."***

Civil society plays a critical role in the HIV, AIDS and TB repsonse, providing services to the most vulnerable and hardest to reach. But organisations, face serious capacity and resource challenges, often working in isolation and without access to appropriate tools, skills and networks. The people who work on the frontline of the battle against gender based violence, child abuse, poverty and HIV, AIDS and TB are always in need of support, tools and training. The private sector also has a crucial role to play in the AIDS response by empowering their own work force with knowledge and skills.

As a principal recipient of the Global Fund and in partnership with USAID and PEPFAR, government and the private sector, NACOSA is able to work at all levels – from international agencies and national government, right though to sub-district services and small, community groups. NACOSA helps organisations to access the resources and support they need but also builds the capacity of organisations and their frontline staff through the accredited NACOSA Training Institute. The Training Institute provides specialist training, skills programmes, mentoring and professional development opportunities.

NACOSA helps to strengthen community systems and mobilise a united response by facilitating collaboration and dialogue between government, business and communties. Regular district-level consultative forums and community dialogues help build understanding of the specific needs and challenges of affected commmunities and support the local implementation of the National Strategic Plan for AIDS, STIs and TB.

NACOSA believes:

> ***"We are stronger, together."***

THE BRIDGE

NACOSA acts as a bridge between people and health and social services.

Diane Kruger visited NACOSA on a journey to understand the AIDS epidemic.

THE GLOBAL AMBASSADOR

On a journey to understand one of our generation's greatest challenges and opportunities – ending the AIDS epidemic – Global Fund Ambassador and film actress Diane Kruger visited NACOSA and three Global Fund sub-recipient organisations Thembacare Grabouw, Yabonga and Rape Crisis.

"This experience filled me with hope because of the people I met in South Africa who wake up every day and choose not to accept the world they inherited," said Diane after her visit.

> ***"They work hard for a world where opportunity and equality spread faster than any disease."***

"Ending the AIDS epidemic for good will only be possible if we first end the disproportionate impact of HIV on young women and girls," said Diane. "This sobering reality is crystal clear in sub-Saharan Africa, where young women and girls are twice as likely to get HIV as their male peers."

HIV is the leading cause of death for girls aged 15–19 in eastern and southern Africa and in South Africa, one quarter of all new HIV infections are among young women aged 15–24.

Visiting ThembaCare Grabouw, a hospice facility which also offers HIV counselling and testing and adherence support, Diane learned of the tremendous progress being made in the fight against HIV and TB and the specific challenges faced by women and girls. She was treated to a special TB prevention song created by the ThembaCare home based carers!

At Yabonga in Khayelitsha, Diane participated in after school activities with the children. Yabonga offers support to children and young people who have been affected by HIV. "We must recognise the intrinsic connection between education, empowerment, opportunity and health," said Diane. "A girl who completes secondary school is less likely to get married early, get pregnant early, or to be infected with HIV."

Diane also spent a morning with Rape Crisis first responders at the Karl Bremer Thuthuzela Care Centre, learning about the challenges and progress being made supporting survivors in the immediate aftermath of rape. And how proper care and services like post-exposure prophylaxis are helping to prevent survivors from becoming infected with HIV.

"This is the beginning of a new journey for me to understand the role I can play in ending the AIDS epidemic."

Asanda Nhlangulela is 14 years old. She's in grade 9 and goes to school at Kwathathani High School in the Ufafa Valley, KwaZulu-Natal. She lives with her grandparents, uncle and younger brother. Her mother died in an accident and she does not know her father. An average day for Asanda is busy. She wakes up early and tidies the house, after washing and making breakfast for the family, she leaves for school. Although it's a 30 minute walk, Asanda loves school and is a diligent student. When she gets home in the afternoon she does housework, then cooks food and does her homework.

English is Asanda's favourite subject and she wants to be a lawyer. "Sometimes I see that people don't respect each other, or the rules. I want South Africans to all be served equally," she says.

Girls of Asanda's age are at greatest risk of contracting HIV – four times more likely than boys. Rural KwaZulu-Natal has the highest HIV prevalence rate in the country (17%) and it is as high as 28% amongst those of reproductive age. Although staying in school has been shown to protect girls from acquiring HIV, girls in grades 7, 8 and 9 have the highest school dropout rate. The odds are stacked against Asanda.

> ***"This programme has taught me to stand up for myself. I know to confide in people that I trust."***

So she is part of the MIET Africa Keeping Girls in School programme funded by the Global Fund through NACOSA. The programme, launched by the Department of Basic Education and welcomed by schools like Kwathathani, offers tutoring, peer support networks for promoting sexual and reproductive health, out-of-school support to access services, career guidance and health education with the aim of keeping girls like Asanda in school and safe from HIV.

Asanda enjoys the programme and likes doing homework with a tutor. "When I was really young, I hated school. It was so boring. Now, I love it. I wish that we could come here on the weekends!" The programme has given Asanda new hope.

Nompilo Hlengwe is a peer group trainer at Kwathathani High School and Sibongile Sondi is her supervisor. Nompilo lives nearby and has been with the programme for two years. "I want to help my community and help the youth," she explains. Sometimes, if she sees that girls are really struggling, she makes home visits.

Sibongile used to work as a health promoter and because of her background in health, she incorporates health education into her work. "In my community, children are under a lot of stress, especially the girls. There is often an unhealthy home background and many are orphans, live with their extended family and experience alcoholism and abuse within their home environment. Often, they're the primary caregivers in a home. I have so much respect for them." Sibongile encourages her girls with certificates of excellence for things like homework, neatness, classwork and friendliness.

In rural areas like Ufafa, girls are expected to stay at home and cook and clean or to look after elderly family members, while boys are encouraged to go to school. There are more than double the number of boys in school than girls. Sibongile is concerned that there are still many girls who stay at home and hopes that they realise they will be warmly greeted at school. "I just want to tell them, 'if you like school, just come'. That's all we want from them. The gates are always open," agrees Nompilo.

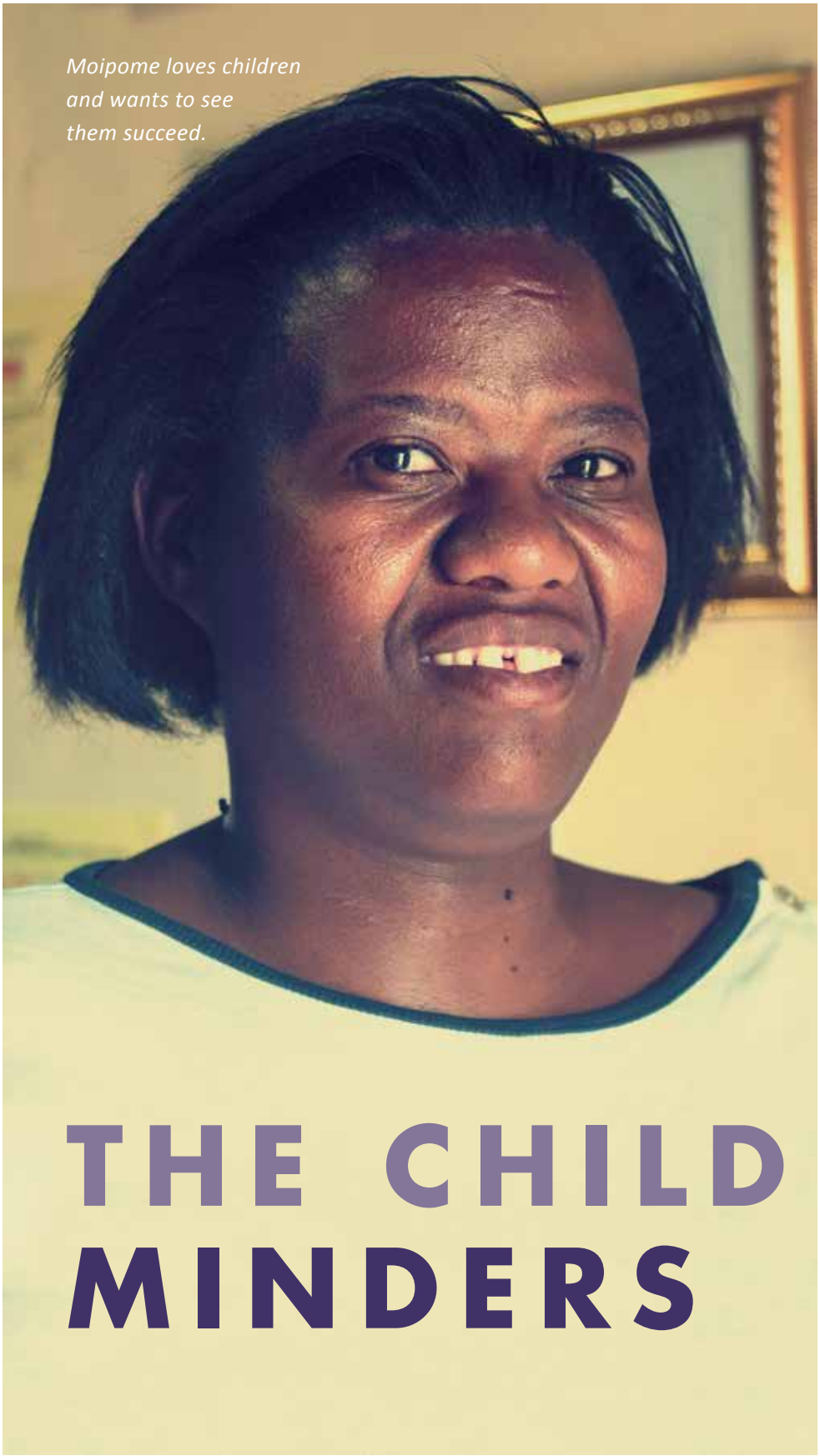
> ***"When you get girls together and talk with them, they begin to see value in themselves."***

Sibongile and Nompilo care deeply about the girls and have developed close bonds. "We are there for them. These vulnerable girls now have someone to talk to," says Sibongile. "It's so good to see my girls achieving!" says Nompilo.

Asanda loves school and wants to be a lawyer.

THE SAFE IN SCHOOL GIRLS

Sibongile and Nompilo encourage girls like Asanda to value themselves and stay in school.



Moipome loves children and wants to see them succeed.

THE CHILD MINDERS

Moipome Ntamo is a care worker at Dr ML Maile Development Centre in Bothaville, Free State. She is softly spoken, with an easy smile and a quick sense of humour. She visits about 17 families a month through NACOSA's children and youth programme, caring for orphans and vulnerable children and providing support for those on antiretroviral therapy (ART). She helps children with schoolwork and checks on the primary caregivers too.

"I love children and I love seeing them happy," she says. She grew up with a single mother after her father left when she was young. "When I see children with no parents, I want to motivate them." In her spare time she offers traditional dancing and majorette classes.

Moipome knows how critical practical support is for children: "They need time for school and so they need help with housework too. We just can't let them down." She is confident in Dr ML Maile Development Centre and her colleagues, "they give me and each other a lot of support." She speaks lovingly of her group of children. "I want to go forward with this group," she says.

> ***"I want them to finish school. I want them to be successful, live happy, better lives."***

Moipome is one of 20 care workers at Dr Maile. The organisation, which opened in 2010, sees about 350 new clients every month for HIV counselling

and testing. Adherence is generally good, thanks to home visits from care workers like Moipome, but distances in the area are great and travel can be a challenge. Teboho Moleme, the coordinator of the Orphans and Vulnerable Children Community Systems Strengthening programme recognises that there is still a lot of work to do but, if it continues on its current trajectory, Dr ML Maile will achieve great results.

The Tharollo Child Care Forum takes place at least once a quarter in Bothaville and is hosted by the Dr Maile Development Centre. The Forum chair is Oupaki Tata who coordinates input from all the local stakeholders like the South African Social Security Agency (SASSA), Home Affairs, the Department of Heath, the Bothaville Men's Forum, the Departments of Cooperative Governance and Correctional Services and the South African Police Service. "Different stakeholders know where they fit. Each issue needs interventions from different angles," says Oupaki who thinks they all need to lead by example. "Why not start here? How can we teach something that we don't understand? We need to support one another."

"We must always report back. We should hold everyone here accountable. All hands on deck!"

Dialogue and collaboration are key and the forum is an example of how all sections of a community can work together to ensure access to services for vulnerable children and their families.

Teboho and Oupaki recognise there is lots still to do for vulnerable children.

Milant leads a team of peer motivators on the Red Umbrella sex worker programme.

THE MOTIVATOR

Milant Nyundu is a trans woman sex worker in White River, Mpumalanga. She grew up in a rural town and started working in the sex trade at 17. "I'm gay," she told people and her first client was a young man. Milant tried to go back to school to complete Grade 10 but "I was not free at school, everyone wanted me to behave like a boy. My mother too, she said I should be playing with other boys." She shrugs, "I'm just like this, I've always played with girls' things".

Milant is no stranger to discrimination and verbal abuse. "People still call out 'stabani' (gay) and 'mbishisaga' (hermaphrodite)." There are many challenges that face sex workers, especially those working on the street like Milant. "Sometimes a client will force you to do things that you don't want. Sometimes they'll take you into the bushes. Sometimes they'll have weapons. Sometimes we're victims of rape and murder. We're vulnerable."

Milant is HIV positive and has been on treatment since the end of 2013. She adheres strictly. "It's fine now there's treatment. I know that there's no need to be scared." Milant is open about her status, "this is my life." She is careful to tell each client.

"I'm the only gay sex worker in White River. It wasn't easy for me but I realised that I need to be who I am." There are about 130 sex workers in the small town and over half of them are part of NACOSA's national sex worker programme, Red Umbrella, funded by the Global Fund. They all know their HIV status and are on treatment where necessary. A large proportion of them are HIV positive.

Sex worker's relationships with each other can be difficult – there is competition and jealousy. "But we need to protect each other," says Milant. The Red Umbrella programme provides health services (testing and referrals), risk reduction, human rights advice and material distribution (condoms, lubrication and leaflets) through 18 implementing partners. The Greater Rape Intervention Project (GRIP) is the implementing partner for White River.

GRIP's programme coordinator, Wandai offered Milant training to join the programme as a peer motivator. She learnt about HIV, AIDS and STIs and human rights, as well as how to run workshops, and negotiate safely with clients, other sex workers, the South African Police Service and health and social workers.

At first, Milant was the only sex worker in White River working with Red Umbrella. Now, many are part of the programme. The group grew quickly and Milant was promoted to team leader supervising three other peer motivators. The most enlightening part of the programme for Milant was the human rights aspect: "I didn't know that I had rights as a human being!" The police and clinic staff treated sex workers badly.

Milant has developed a network of trust between the sex workers and clinic staff but relationships between sex workers and the SAPS remain strained. The programme also looks after the families of sex workers – providing 'home safe care' where they can bring their children. "We try to link the Red Umbrella programme to people's lives directly," explains Wandai.

> ***"We know that in South Africa selling sex is not legal but we are all human beings. I learned so much with the programme. I know my rights and I know about HIV."***

Milant hopes that sex work will be decriminalised. "It will decrease the stigma. We could have designated areas. In other countries, it's just a job." Sometimes, the work is enjoyable, Milant explains. But not always. Many sex workers are abused and have addiction problems. "I'm free now and I'm happy. I'm not always proud but it's who I am."

Milant lives with her younger brother and sister, who she helps to support. "It's not easy work to quit and it's hard to find other work with my school grade 9." But she remains hopeful and has plans for her future. "I'm getting old," she laughs. "I can't do this work forever." She wants to be able to have a 'proper job' and hopes to have a family one day.

Retired nurse, Nstiki, keeps busy managing a team of Sinako care workers.

THE NURTURERS

Nontsikelelo 'Ntsiki' Mtandana is a retired nurse who has become integral to the operation of the Sinako Orphans and Vulnerable Children (OVC) programme. Sinako – 'we can' – is a small but effecitve organisation in the Eastern Cape town of Whittlesea and part of NACOSA's OVC Community Systems Strenghtening Programme, in partnership with USAID and PEPFAR. Ntsiki had barely retired when she joined the programme, "I didn't rest when I retired. If I sit at home I'll develop contractions or something!"

The impact of HIV and AIDS on children and their families is complex and multi-faceted. Organisations like Sinako recognise the importance of addressing all aspects of a child's life – education, health, social connections, safety and poverty. "We deal holistically with children. Sometimes, a child is physically fine but you don't know everything that happens at home. It's emotional and social and spiritual and environmental," explains Ntsiki.

Ntsiki has worked all over South Africa, as a theatre nurse and midwife and spent the thirteen years before her retirement in palliative care centres. "What I wanted was to serve the community." So Sinako's approach suits Nstiki: "It's home-based, within the community. In a centre, you don't always know what's happening

Notemba makes sure that Sinako always meets its targets.

out there." Nstiki oversees Sinako's 24 care workers; reporting, doing spot checks, training and advising. She is full of admiration for her team and the support they provide to orphaned and vulnerable children.

> ***"We as communities need to give them skills and keep them safe."***

"They are children. They could be abused. They could turn into criminals. Taking care of them gives them skills for life. They can learn about the quality of life," she says.

Ntsiki is hopeful that programmes like Sinako's will last. "If they do, they [the children] have a bright future. Home visits need to continue. The majority will be able to change others too. I'm very hopeful."

Organisations like Sinako are responsive to community needs and hold themselves accountable. It is not always the same in public clinics, explains Notemba Makunga, who has run Sinako since 2001. "At Sinako, we're doing comprehensive and integrated primary health care," she says. "Our core philosophy is to be holistic." Thanks to the efforts of Notemba, Ntiski and her team, Sinako always meets its targets: "There is lots and lots of work but it's rewarding. We sleep well!" laughs Notemba. "It's wonderful to see progress in patients. They might be bedridden but then, in a few months, they'll be up and about again. Before, people would lose hope. Now, they know that they can be hopeful."

She and Ntsiki have a wonderful working relationship, filled with respect for one another and an affinity for Sinako's values. "Ntsiki is a listener, she'll pick up on things", smiles Notemba. "We are advocates of wellness and we are the examples."

Monica Mlaza works at the South African Police Service (SAPS) station in Bellville South as the senior admin clerk. She has a long history working at SAPS and knows its systems well. Although Bellville South has relatively low rates of reported sexual assault and domestic violence – about ten a month – it is still significant in comparison to many other places in the world.

Monica knew from an early age that she wanted to combat crime: "I love my country and I've always wanted to protect it". Monica enjoys her work at SAPS because of the interactions that she has with people. "I'm able to listen carefully and I'm careful to give the person privacy," she explains. Monica began working with SAPS as a reservist in Khayelitsha and proudly recalls that she was the first reservist in Khayelitsha to use the computer to capture data. As a shop steward and local office bearer for the Police and Prisons Civil Rights Union (POPCRU), Monica understands the attitudes and challenges faced by SAPS members.

"I've been described as *lastig,*" she laughs. "I'm curious about things. I always have questions."

Monica attended NACOSA's Dealing with Gender Based Violence training for members of the South African Police Service, funded by the Global Fund. The training aimed to help people like Monica, who work on the frontline of domestic and sexual violence, understand and respond to survivors effectively and compassionately.

As one of just two employees from the Bellville South Station to attend the training, Monica believes that more SAPS officers should be made aware of the causes and consequences of gender based violence:

> ***"It will help everyone understand victims and prevent secondary victimisation."***

This sentiment is echoed by Jubreytha Papier, the coordinator of the Bellville South trauma room, who thinks more female officers should be trained. "Women don't always want to speak to men," she explains. "It can traumatise them further." But ultimately, says Jubreytha, "everyone at SAPS should receive training".

South Africa's stark gender based violence statistics mean that many women experience violence at some point in their lives. Monica has also experienced abuse, so she understands the complexity of these cases and that survivors don't process information in the same way. This is why Monica advocates strongly for SAPS being able to provide a more effective and compassionate service to survivors.

Monica Mlaza believes gender based violence sensitisation will help police understand victims and prevent secondary victimisation.

THE PROTECTOR

Dithuso Monare from the Free State Department of Social Development advocates for a multi-sectoral approach to service delivery.

THE PROBLEM-SOLVER

Dithuso Monare's middle name is Confidence. As the Social Work Manager in the Free State Department of Social Development, responsible for the HIV/AIDS sub-programme, she leads the Free Sate Provincial Action Committee for Children Affected by AIDS (PACCA) with all the assurance that her middle name implies. Dithuso cut her teeth as a social worker and worked in the non profit sector before joining the Department of Social Development.

Official figures put the number of orphaned and vulnerable children receiving services in the Free State at 5,289. But, says Dithuso, "the plight of children is much too big. This information excludes all the other stakeholders who are providing services to children in need of care. This just shows a gap and challenge that we as a province have to work on, so that we can determine the extent to which we are reaching out to communities."

"Working together acknowledges that someone has what you want and that you have what someone else wants. It makes integration possible. Our mandate is to focus on families, ensuring psycho-social support," she explains. "If you want to support a household, the intervention needs to be holistic."

Whenever vulnerable children are identified, a network of service providers must attend to the psychosocial support, material and placement needs of those children. "No one service provider can have all that," says Dithuso. "Not even government has the capacity to address the need to the extent that it now exists. This therefore requires inter-connectedness between partners."

The Child Care Forum approach was developed when communities and families first started feeling the devastating impact of HIV and AIDS.

> ***"There is integration and collaboration between stakeholders who have various expertise and capacity to deliver certain aspects of a service."***

"They were established to create safety nets within communities and ensure that child protection services are in place and the rights of children are promoted. Our role is to ensure that they are functional and that capacity is built to ensure that good quality services are provided. And that there's an information management system that will help track these children."

Dithuso Monare throws herself headfirst into challenges. She recognises that she is a problem-solver and loves her work. Where others might be overwhelmed by the challenges, Dithuso's response is "here is an opportunity to come up with something effective. No one is going to stop me!"

THE UNSUNG HERO

"I often spend the day listening and hiding feelings and that's hard," says Dinah Moasoane, a first responder at the Ntabiseng Thuthuzela Care Centre (TCC) at Chris Hani Baragwanath Hospital in Soweto. In these 24-hour, one-stop sexual assault centres, the first response counsellors employed by non profit organisations play a critical role in supporting and advocating for survivors. Dinah works for Johannesburg Child Welfare and supports the children that arrive at the TCC which is part of NACOSA's Gender Based Violence programme, funded by the Global Fund.

"A child is a child," says Dinah, which makes her work challenging. "Children don't talk. Teachers or parents notice something over time. And so most will miss PEP [post-exposure prophylaxis – ARVs to prevent survivors from contracting HIV]."

Dinah started her professional career as a teacher. "I worked with dire cases in Orange Farm while it was still informal. I would see very serious issues. There were no public schools and things were really bad." After joining Johannesburg Child Welfare as a volunteer, she trained as an auxiliary social worker and graduated in 2012.

The children who come to the Ntabiseng TCC are sometimes walk-ins but most are accompanied by parents, caregivers or community care workers, or referred by teachers or social workers. Sometimes Dinah will talk to children one-on-one and sometimes with their parents present. She makes an effort to assess family dynamics as many of the cases involve abuse within the family. Often, there is frustration and denial: "How do the doctors tell the family that there's no sign? They're convinced that the child is lying".

> ***"I'm not a hero. This is my work."***

Like many first responders, Dinah found the work shocking at first. "It was a surprise for me to realise that these things happen here. I was disappointed, shocked. I really got sick. I'm usually the strong one and I'd never seen anything like it. I think I slept for three days. It was shock." But Dinah stayed on, "I had to grow into it".

Dinah deals with five to six cases each week and the overwhelming majority of victims are girls. "You don't only hear about the rape. Often, parents will tell you their stories too." Many parents are victims too.

"I'm a granny now," says Dinah. "When my grandchildren go somewhere, I count the seconds that they're gone. I'm fiercely over-protective. I lock doors behind me all the time. You become vigilant. Any man is a suspect and that is a problem."

Dinah puts it simply: "If the system makes the child a priority, things could be different. We have to strengthen the services that protect. We inform people but as service providers, we're not interlinked." And this is precisely the kind of impact the TCC initiative is hoping to have: linking services and providing support to smooth people through the system towards justice.

"I make sure that when people leave, it will be with a positive message and a smile. I try my utmost, whatever the situation." Often, clients return to say hello to Dinah. "It is rewarding for me."

As a first responder, Dinah must be both supporter and advocate for young victims of sexual assault.

ANNUAL FINANCIAL STATEMENTS

EXTRACTED FROM THE AUDITED FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2015

Statement of Financial Position

	Figures in Rand	
	2015	2014
Assets		
Non-current assets		
Property, plant and equipment	2 523 252	2 882 263
Intangible assets	28 970	1 806
Other financial assets	3 311 335	3 160 481
	5 863 557	**6 044 550**
Current Assets		
Trade and other receivables	2 901 837	2 764 499
Cash and cash equivalents	6 475 090	5 710 823
Cash and cash equivalent administered as Principle Recipient	11 236 858	15 556 697
	20 613 785	**24 032 019**
Total Assets	**26 477 342**	**30 076 569**
Equity and Liabilities		
Equity		
Reserves	3 006 434	3 098 058
Retained income	3 017 482	2 376 386
	6 023 916	**5 474 444**
Liabilities		
Non-Current Liabilities		
Other financial liabilities	-	32 538
Operating lease liability	95 991	83 122
	95 991	**115 660**
Current Liabilities		
Other financial liabilities	32 564	35 460
Trade and other payables	6 077 228	2 064 157
Deferred income	14 247 643	22 386 848
	20 357 435	**24 486 465**
Total Liabilities	**20 453 426**	**24 602 125**
Total Equity and Liabilities	**26 477 342**	**30 076 569**

Statement of Comprehensive Income

	Figures in Rand	
	2015	2014
Revenue		
Funding income	73 014 879	40 135 010
Other income	359 674	3 925
Operating expenses	(73 641 683)	(38 775 566)
Operating (defecit) surplus	**(267 130)**	**1 363 369**
Investment revenue	839 240	280 501
Fair value adjustments	(16 832)	31 177
Finance costs	(5 806)	(9 178)
Surplus for the year	**549 472**	**1 665 869**
Other comprehensive surplus	-	-
Total comprehensive surplus	**549 472**	**1 665 869**
Transfer to reserves		
Transfer to/from asset funding reserve	339 962	(1 465 578)
Transfer to travel reserve	(265 171)	(314 223)
Transfer to/from revaluation reserve	24 051	-
Transfer to fair value adjustment assets-available-for-sale reserve	(7 218)	-
Net surplus (deficit) for the year after transfers	**641 097**	**(113 932)**

Detailed Statement of Comprehensive Income

	Figures in Rand	
	2015	2014
Operating expenses		
Human resources		
Consulting fees	(462 260)	(29 784)
Salaries and wages	(19 144 783)	(3 386 526)
Staff recruitment	-	(66 381)
Personnel development and wellness		
Workplace skills plan	-	(9 122)
Overheads		
Auditors remuneration	(419 000)	(498 477)
Bank charges	(90 639)	(82 365)
Loss on disposal of assets	(5 391)	(5 311)
Legal expenses	(1 701)	(5 433)
Marketing materials	(429 227)	(160 807)
Printing and stationery	(253 016)	(469 487)
Cleaning	(12 523)	(24 525)
Computer expenses	(111 961)	(263 234)
Courier and postage	(27 961)	(20 147)
Depreciation, amortisation and impairments	(640 626)	(508 876)
Insurance	(165 752)	(104 242)
Hire of equipment	(79 533)	(44 891)
Motor vehicle expenses	(478 020)	(477 370)
Rent, security and utilities	(1 699 871)	(1 431 354)

	Figures in Rand	
	2015	2014
Training centre fifth floor	-	(189 659)
Repairs and maintenance	(117 216)	(12 915)
Outreach	(284 588)	-
Parking and shuttle hire	(22 914)	-
Human resources	(35 452)	-
Small assets	(2 631)	-
Staff and board expenses	(207 359)	(366 485)
Subscriptions	(17 393)	(31 482)
Sundry expenses	(262 910)	(177 997)
Telephone, fax and internet costs	(226 579)	(239 254)
Communication materials		
NACOSA newsletter	(116 874)	(145 584)
Governance		
Annual general meeting	(87 712)	(35 793)
Management meetings (including internal and provincial)	(23 044)	(20 006)
Programmes		
Capacity building		
Mentoring	(372 248)	(156 078)
Training	(1 536 342)	(1 103 754)
Networking		
Consultative meetings	(387 109)	(252 702)
Sub-district meetings	(287 494)	(397 924)
Promoting dialogue		
Travel, accommodation, conference fees	(797 100)	(142 983)
Phase I Expenditure by Service Delivery Area		
Care and Support for the Chronically Ill	-	(1 691 139)
General office equipment	-	(982)
Health Systems Strengthening: Community Systems Strengthening	-	(1 239 888)
Implement Behaviour Change Management	-	(523 535)
Institutional Support and Programme Management	-	(1 467 005)
Monitoring and Evaluation	-	(564 981)
Provide HIV Testing and Counselling	-	(22 499)
Support for Orphans and Vulnerable Children	-	(809 702)
Phase II Expenditure by Service Delivery Area		
Gender-based violence	-	(173 696)
Health Systems Strengthening: Community Systems Strengthening	(1 073 928)	(1 963 042)
Institutional Support and Programme Management (Supportive environment)	(5 048 990)	(3 596 912)
Men Who Have Sex with Men Programme	(62 228)	(759 679)
HIV Care and Support	-	(12 000)
Sex workers	-	(26 875)
Support for Orphans and Vulnerable Children	(13 160 992)	(709 946)
Global Fund Phase II	(11 535 601)	-
Orphans & Vulnerable Children Community Systems Strengthening Programme	(13 952 715)	(14 352 737)
	(73 641 683)	**(38 775 566)**
Operating surplus	**572 110**	**1 675 047**
Finance costs	(5 806)	(9 178)
Fair value adjustments	(16 832)	-
	(22 638)	**(9 178)**
Taxation	-	-
Surplus for the year	**549 472**	**1 665 869**

Audited by Grant Thornton Cape. Unabridged, signed audited financial statements are available from the NACOSA Finance team.

THANK YOU

We've had an extraordinary, busy and productive year. We could not have done it without the people and partners who support our work. Together, we're strengthening the HIV, AIDS and TB response so that we can achieve the end of these diseases by 2030.

The Global Fund

USAID
FROM THE AMERICAN PEOPLE

SOUTH AFRICANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS
PEPFAR

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Western Cape Government
Health
BETTER TOGETHER.

Irish Aid
Government of Ireland
Rialtas na hÉireann

CITY OF CAPE TOWN
ISIXEKO SASEKAPA
STAD KAAPSTAD
Making progress possible. Together.

PROUDLY SUPPORTED BY ANGLO AMERICAN

Synergos

NATIONAL LOTTERY
NLDTF

“We’re stronger, together.”

NACOSA
COLLECTIVELY TURNING THE TIDE ON HIV, AIDS AND TB

NACOSA.ORG.ZA
3rd Floor, East Tower | Century Boulevard | Century City | Cape Town
T. 021 552 0804 | F. 021 552 7742 | E. info@nacosa.org.za
NPO 017-145 | PBO 18/11/13/1602 | VAT 484 024 0990
Health & Welfare SETA Accredited | Level 2 B-BBEE Entity (125% recognition)
18A Tax Exemption Status