

**Global Alliance on HIV**



## **Somali Red Crescent Society**



**INTEGRATED HIV AND AIDS PROGRAMME  
2008-2010**

## **1.0 Executive Summary**

Somali Red Crescent Society (SRCS) continues to operate throughout the country and is credited as being the largest indigenous organization with countrywide representation. SRCS implements HIV and AIDS programme in all the 19 regions of the country. The programme is integrated within the Integrated Health Care Programme (IHCP) and focuses on prevention, reduction of stigma and discrimination, orphans and vulnerable children (OVC) support and the development and use of IEC materials.

Under its HIV and AIDS strategy 2000-2004, capacity building trainings were conducted at all volunteer and staffing levels and all the 19 regions and all the districts of the country were covered. During this strategy period, participatory education teams from the 19 branches were identified and trained. Two training of trainers (TOT) were conducted for 91 health officers and volunteer leaders who then trained 5,000 volunteers and identifiable community members. SRCS then developed the HIV and AIDS strategy for 2006-2009 which aims to guide its HIV and AIDS programming for this period.

Considering the increasing vulnerability to HIV and AIDS in the Somali population and the potential impact, SRCS proposes to accelerate and scale up its response through implementing an enhanced HIV and AIDS approach over the coming three years within the framework of its strategy 2006-2009.

The purpose of this programme is to reduce vulnerability to HIV and its impact in Somalia through the following outputs:

- Preventing further infection
- Expanding care, treatment and support
- Reducing stigma and discrimination

In order to achieve these three outputs, SRCS capacity will be strengthened to enable more effective, expanded, direct outreach to served communities.

This programme intends to train 42 trainers and 456 peer educators in HIV prevention, 76 trainers on care and support, 380 volunteers and 1,950 families/caretakers on home based care (HBC), antiretroviral therapy (ART) adherence, treatment literacy and preparedness; reach in excess of 640,000 community members with prevention messages; and provide education support to 280 OVC, over the course of the 3 years

The integrated HIV and AIDS programme seeks CHF **2, 764, 419** as budget support for the three-year implementation period

This Programme is part of the East African zone HIV and AIDS programme which is a component of the Red Cross and Red Crescent Global Alliance on HIV.

## 2.0 Magnitude



### 2.1 HIV and AIDS Situation

Due to the prevailing political situation and the lack of effective central and regional authorities, there is no established health information system. HIV statistics for Somalia are therefore scanty and the nationwide prevalence is unknown, although perceived to be low. However in relatively stable areas with some form of government such as Somaliland (NWZ) and Punt land (NEZ), there have been some attempts at establishing health and HIV data.

In 2004, the national HIV prevalence among ANC attendees was 0.9 percent with the range from 0.6 percent in south central zone to 1.4 percent in Somaliland. According to Joint United

Nations Programme on AIDS (UNAIDS), 44,000 Somalis were estimated to be living with HIV as at the end of 2006. Women aged 15 and over living with HIV account for about 23,000. An assessment in 2002 revealed that sero-prevalence of HIV among blood donors in Mogadishu was 0.8 percent, Gedo 4.4 percent, Sool and Middle Shabelle 2.9 percent, Benadir 2.2 percent, Sahel 1.5 percent and Hargeisa 1.2 percent. Somalia also has a highly mobile nomadic population, and with a high prevalence of sexually transmitted infections (STI) and tuberculosis (TB), HIV prevalence could rise unless measures for HIV prevention and control are put in place.

**Table 1: Statistics on HIV and AIDS as the end of 2006 in Somalia**

	<b>Total Numbers</b>
Number of people living with HIV	44 000 (23 000 – 81 000)
Adults aged 15 to 49 HIV prevalence rate	0.9 (0.5 – 1.6)%
Adults aged 15 and over living with HIV	40 000 (21 000 – 72 000)
Women aged 15 and over living with HIV	23 000 (11 000 – 45 000)
Deaths due to AIDS	4100 (2000 – 8000)
Children aged 0-14 years	4500 (1500-13000)
Orphans aged 0-17 years due to AIDS	23000 (11000-45000)
Percentage of Pregnant women receiving treatment	3.3%

to reduce mother-to-child transmission	
Percentage of HIV infected women and men receiving Antiretroviral therapy	1%
School attendance among orphans	14%
Schools attendance among none orphans	21%

Source: UNAIDS 2006 Report on the global AIDS epidemic

### 2.3 Determinants of the Pandemic

The main mode of transmission of HIV in the country is heterosexual. Although there are many factors that are known to promote the spread of HIV infection, the following have been identified as key factors that promote the spread of the disease in Somalia:

- A prevailing lack of awareness and denial. The percentage of young women and men aged 15-24 who can correctly identify ways to prevent HIV are 7.9 percent and 12.5 percent respectively. Data from focus group discussions in UNICEF KABP survey in 2004, reveal disbelief that HIV and AIDS are prevalent among Somali's; *"our communities have heard of AIDS but we don't have it in Somalia";... "Aids is a deadly disease, but it is only for non-Moslems"* Only 5 percent of youth of either sex considered themselves at risk of contracting HIV.
- High population mobility due to the nomadic nature of the population, drought, food shortage and clan warfare, and complicated by cross border movement and interaction with communities with high prevalence rates
- Culture and societal factors that include:
  - Gender discrimination against women
  - Female Genital Mutilation (FGM) with serious complications and immediate or delayed increased risk of contracting HIV.
  - Traditional surgical practices such as scarification's, uvulectomy and traditional episiotomy by TBA/THP.
  - High divorce rate, estimated at 17 percent of all married women.
  - High rate of polygamy and widow inheritance, a tradition in practice for generations
  - There are also extra marital sexual engagements, commercial sex practice and Khat chewing, all of which increase the risk of contracting HIV.
- ❖ Lack of infrastructure and inadequate health resources including blood banking and transfusion facilities.
- ❖ High prevalence of sexually transmitted diseases, STD
- ❖ Poverty largely resulting from the conflict situations that disrupt economic activities in the country.
- ❖ High stigma and discrimination: The majority of Somalis (51 percent of men and 58 percent of women) feel that teachers with HIV should not continue teaching in schools, and a higher proportion (61 percent men and 71 percent women) would not buy food from a HIV positive vendor (*KABP Survey, UNICEF, 2004*).

### 3.0 The impact of the epidemic

Due to lack of central government and political instability coupled with no proper functioning ministry of health, there is limited information and data about HIV in the country According to UNAIDS, it is estimated that about 4,000 deaths occurred due to AIDS in 2006. Currently 172 people are on ART. There is low uptake of services due to high stigma and discrimination among the community which in turn creates fear and limits

access to VCT and ART services. It is estimated that 23,000 are Orphaned by AIDS (UNAIDS, 2006).

An estimated 21,000 people develop TB yearly in Somalia with 80 percent of them occurring in the productive age group (15-44 years). In 2004, WHO survey reported a TB/HIV co-infection rate of 4.5 percent in Somalia. HIV prevalence among TB patients is an indicator of the level and maturity of the epidemic and hence the increasing burden of HIV related disease on the health care services

There is lack of cultural research and gender disaggregated data to support a proper understanding of multiple vulnerabilities of women and girls to HIV infection in Somalia. However, many global gender based vulnerabilities are undoubtedly applicable to women in Somalia. The spread and impact of HIV and AIDS disproportionately affects women and adolescent girls who socially, culturally, biologically and economically more vulnerable to HIV infection than men. Gender norms, often dictate that women and girls should be ignorant about sex and this greatly constrains their ability to negotiate safe sex or appropriate services. FGM prevalence in Somalia is about 98 percent. This in turn creates vulnerability from the increased incidence of reproductive tract and lower pelvic infections that provide a path for HIV to enter the body when in contact with virus.

#### **4.0 Policy on HIV**

The Somali Red Crescent Society HIV Programme is part of the Eastern Africa Regional HIV Programme, which is a component of the Red Cross and Red Crescent Global Alliance on HIV.

The **purpose of our programme** is to reduce vulnerability to HIV and its impact in Somalia through achieving the following **outputs**:

- Preventing further HIV infection
- Expanding HIV care, treatment, and support
- Reducing HIV stigma and discrimination
- Strengthening Somali Red Crescent Society capacity to deliver and sustain scaled-up HIV programme

We work in accord with the established principles of the International Red Cross and Red Crescent Movement to support our country's national HIV policies and programmes. The specific scope of the activities in this programme has been developed in coordination with and harmonised with tasks agreed under international assistance arrangements in Somalia (Coordination of International Support to Somalis, CISS) which is made up of UN agencies, international and local NGOs, local authorities and Zone coordination committees broadened the base of HIV and AIDS response.

#### **5.0 Track Record and Lessons Learned**

Somalia is striving with conflict consequences, deterioration of health and social services, mobility, armed conflict, traditional harmful practices coupled with low level of awareness on ways of transmission and lack of means of protection. The main area of interventions on HIV and AIDS in Somalia has focused on advocacy, trainings, sensitization workshops and awareness creation. With more recent emphasis on increasing commitment to the HIV response, there has been a new focus on improving strategic information and strengthening institutional and human resource capacity. The creation of coordination structures like the CISS which is made up of UN agencies, international and local NGOs, local authorities and Zone coordination committees broadened the base of HIV and AIDS response.

The establishment of the three zonal AIDS commissions (SCAC in CSZ, SOLNAC in NWZ and PAC in NEZ) has also enhanced the coordination of HIV and AIDS response efforts in their respective zones. Regional AIDS commissions are operational in all 19 regions of the country.

A strategic framework for the prevention and control of HIV and AIDS and STI, 2003-2008 and Zone HIV and AIDS action plans 2004-2006 have been developed. The HIV and AIDS prevention advocacy and communication framework has pushed forward the coordinated effort in HIV and AIDS information dissemination.

Special focus is put on positive behaviour change among the sexually active population through the promotion of culturally sensitive information, education and communication (IEC) materials targeted at educating the different segments of the community. Emphasis has also been put on the promotion of voluntary counselling and testing (VCT) services, safe blood supply, condom promotion, as well as guiding and supporting the implementation of HIV/ AIDS programme.

Access to ART and VCT and other HIV-related health services has improved since 2005, achieving the fast universal access target of reaching 1,000,000 Somalis with IPTCS services. Seven sites delivering comprehensive HIV related health services have been established across Somaliland, Punt land and South and Central Somalia in partnership with established NGOs and existing health facilities. Three of these sites (Hargeisa, Bosaso and Merca) one in each zone, are also delivering ART.

SRCS has developed an HIV and AIDS strategy 2006-2009 as an annex to its Health Strategy 2005-2009 which aims to guide its HIV and AIDS programming up to 2009.

The SRCS HIV programme was nominated by the Coordination of International Support to Somalis (CISS, formerly SACB) to provide the lead in communications initiative in developing IEC materials for the whole of the country. Various culturally and linguistically acceptable IEC materials and messages for various target groups, including posters, billboards, stickers, shirts, flip charts, leaflets, poems, audio and video cassettes were developed and distributed. The training of volunteer theatre groups for community awareness performances took off with a participatory educational theatre (PET), training of trainers workshop for 39 participants from the SRCS Branches. The PET groups are being used to complement, reinforce and clarify other messages as a behaviour change communication strategy in the prevention and control of HIV and AIDS in Somali communities while entertaining the very same community.

Capacity building of SRCS staff, volunteers and other identifiable community members was also accelerated. Two Training of Trainers workshops were held for 91 SRCS health staff and volunteer leaders that in the subsequent scaling up training for volunteers and identifiable community members, the trainers have so far trained 5,000 persons as community educators on HIV and AIDS.

All the 19 Branches of the Society organized and participated in their respective Branches/Regional community activities to commemorate the World AIDS Day on 1 December every year. The National Society mobilised over 1,500 volunteers and staff to carry out diverse activities including route marches, debates, drama performances and public awareness drives to mark the day. In 2006 alone, the number of people reached in the World AIDS Day and subsequent rallies on stigma reduction was estimated at 360,000 people.

The Regional Delegation and the Somalia Delegation sponsored a number of SRCS health staff to participate in the International Conference on AIDS and STI in Africa (ICASA) in 2003 held in Nairobi. This enabled the NS to interact and share their experiences in HIV and AIDS activities with other National Societies in the region as well as exposing them to the international gathering.

SRCS integrates its HIV activities in the IHCP programme which covers a network of 50 MCH/OPD clinics throughout the country. The staffs in the clinics disseminate the HIV information in their respective communities in collaboration with the volunteers, TBA and CHW connected to the clinics.

SRCS participates in networking and coordination meetings in HIV working groups in CISS and Zone AIDS Commissions as well as participating in the commemoration of significant days such as the World AIDS Day. As a member of the CISS Health Sector Committee, it has an active role in the proxy Country Coordinating Mechanism for the Global Fund to Fight AIDS, TB and Malaria (GFATM).

SRCS has developed, produced and distributed 560,000 brochures, 39,000 posters, 13,500 stickers, 6,000 polo shirts and designed 12 billboards as part of its 2006 programme activities.

SRCS also conducted 9 TOT training in the development and use of IEC materials, stigma and discrimination reduction in which 324 people from SRCS staff and volunteers, Regional AIDS commissions and other HIV players in the country participated

The implementation of the Somali Red Crescent Society HIV and AIDS strategy gained momentum in the past few years. There was marked improvement in the capacity building of SRCS health staff and volunteers. Awareness raising campaigns conducted by SRCS on stigma and discrimination using culturally sensitive IEC materials helped in breaking the silence on HIV and AIDS and some people were able to declare their status. The awareness activities enabled HIV positive cases to access treatment services whereby 172 people are on ARV.

The National Society has also realized the needs of the OVC in the country. As a result, the society has started to assist 80 OVC children in Hargeisa with the support of World Vision. The children are offered opportunities to attend formal and vocational training institutions. This has improved their social and economical well-being.

### **5.1 Comparative advantages of Somali Red Cross Society**

In spite of the collapse of the central government in 1991, SRCS has maintained its unity by upholding the fundamental principles of the RCRC movement, and is operating throughout the whole country. The mission of the SRCS is to prevent and alleviate suffering by working with communities, local authorities and other partners to provide quality services to vulnerable people in accordance with the fundamental principles of RCRC movement. After the eruption of the civil war in the country, with the support of the ICRC, SRCS was involved in relief services and provision of First Aid to the war-wounded which has increased the image of the society with its stakeholders and constituents.

In the absence of a Central Health Ministry, the Somali Red Crescent Society (SRCS) has for nearly a decade provided primary health care and other basic essential health services to the most vulnerable populations in the three zones of the country. Since 1993, the Integrated Health Care Programme (IHCP) has been the core activity of the Society. The Society currently manages a network of 50 MCH/OPD clinics (10 in Somaliland, 16 in Punt

land and 24 in Central and South Somalia) and three rehabilitation centres (Galkayo, Hargeisa and Mogadishu), and supports two hospitals (Keysaney and Garoe).

Being a community based organization, the national society managed to implement HIV and AIDS programmes through the networks of regional and clinics volunteers. Community mobilization, education and awareness activities on HIV are conducted in the community using participatory and innovative based approaches. The SRCS largely and actively participates in the commemoration of significant days such as the World AIDS Day. SRCS is member of HIV and AIDS working group within the CISS health sector committee. It has strong relationship with zone AIDS Commissions and other HIV actors.

## **5.2 Lessons Learned**

- Continuous comprehensive awareness raising campaigns enhance the uptake of the available IPTC services leading to positive health seeking behavior.
- Health workers and caretakers of people living with HIV (PLHIV) do not have adequate knowledge on how to care for the clients which perpetuates stigma and discrimination and above all leads to low utilization of IPTC services
- The integration of the HIV and AIDS activities in the ongoing health programme increases the reach and reduces vertical expenses in implementing the programme.
- Establishment of close collaboration with the community and other stakeholders through coordination meetings improves the visibility of the NS in the country
- The involvement of the Community Health Committees at all stages of the programme enhances community participation and facilitates programme implementation.
- A feedback meeting with the communities strengthens the community involvement and ownership of the programme.
- Use of different and innovative approaches such PET groups, traditional folklore dances and information education communication (IEC) materials to educate the community on HIV and AIDS, stigma and discrimination reduction is vital
- Need to consider matching the expansion of programme component with capacity building to strengthen the skills sets (theoretical and practical skills) for programme, to be able to effectively implement the programme
- Monitoring and supervision of programme activities should be done at all levels. The Federation Secretariat team should make time to go the national society, assess progress, provide technical support and respond to issues early rather than depending on reports
- Close monitoring and reference coaching system encourages volunteers and reduces fed up and drop out tendency
- Staff training needs should be continuously monitored hence the need for allocation of a staff development budget line, to facilitate training of staff, considering the new problems that are emerging within the field of HIV and AIDS management

## **5.3 Challenges**

- Lack of a designated HIV and AIDS officer makes it difficult to properly document, monitor and supervise HIV and AIDS programme.
- Few VCT centres with limited services; thus people who are identified in need of VCT might not be able to access services.
- Privacy in the clinics when counselling patients. HIV needs specially prepared and client friendly environment to facilitate easy access.
- There is still a great deal of stigma and discrimination associated with HIV and AIDS in the community.

- HIV may not be the first priority when conducting outreach activities as the officers have other mandated priorities such as health, tracing, dissemination etc leading to missed opportunities.
- Condom use - it is culturally challenging to promote the use of condoms for HIV prevention in Somali context.
- HIV and AIDS is not well incorporated in the SRCS health information system and reporting formats leave unreported a lot of work that has been done in the field.
- Insecurity and political instability at times leads to disruption of programme activities.
- Sustainability/donor dependence remains a challenge.
- Motivation, as a result of the deteriorating economic situation and conflicts. The programme volunteers can offer little time as they have their own economic struggles.
- Discussions around HIV and AIDS are challenged by gender based cultural barriers as the two genders do not share the information.
- Communities expect medical intervention to be made ready.
- Access to health care facilities is very limited in most of the country and there are no referral facilities for the clients who need higher level intervention.
- The characteristics of the target populations may require specific tools / strategies / human resources.
- Nomadic communities are hard to reach and they represent a large proportion of the Somali rural population.

#### **5.4 Recommendations**

- Recruitment of HIV and AIDS zone focal persons is required to ensure proper documentation, monitoring and supervision of HIV and AIDS programme
- Capacity building of the staff and volunteers should be continuously improved through trainings and exposure visits
- Improvement of HIV and AIDS information system is needed by adapting Global Alliance reporting formats
- Scaling up of awareness campaigns with special consideration to the high risk groups, IDP and nomadic population through peer education and community mobilization.
- Strengthen the community involvement at all levels.
- Maintain coordination with the community, partners and other stakeholders involved in HIV prevention, treatment, care and support.
- Accelerate HIV information dissemination on prevention, stigma and discrimination reduction through sensitization meeting with the community sectors.
- Adapt IFRC PTCS training package for community based volunteers so as to empower and ease volunteers activities in the community on HIV prevention, care and support

### **6.0 The new HIV and AIDS programme - 2008 – 2010**

#### **OUTPUT 1: Preventing further HIV infection**

##### ***Approach 1.1 Peer education and community mobilization.***

Activity:

- Adopt and translate IFRC peer education training manual
- Develop peer education tools/materials
- Peer education TOT training for 42 participants from regional branches
- Training of community peer educators at the community level

- Peer education sessions for targeted community groups (focus group discussions and one-to-one approach) through volunteer networks.
- Public health talks on the aspects of HIV and AIDS
- Marking global and national events e.g. World AIDS Day.

### ***Approach 1.2 IEC for targeted vulnerable groups***

Activity:

- Development, Production and distribution of appropriate IEC/behaviour change communication (BCC) materials for different target groups tackling thematic issues in HIV and AIDS.

## **OUTPUT 2: Expanding HIV care, treatment, and support**

### ***Approach 2.1 Assisting children and orphans made vulnerable by HIV***

Activity:

- Provide educational support to 280 OVC

### ***Approach 2.2 Providing treatment, support and care (home or community based and through health institutions) for people with HIV.***

Activity

- Training on HBC and nutrition for volunteers and care takers of PLHIV.

## **OUTPUT 3: Reducing HIV stigma and discrimination**

### ***Approach 3.1 Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in the National Society***

Activity

- Develop HIV in workplace policy
- HIV workplace policy orientation meeting for SRCS staff and volunteers
- HIV and AIDS education sessions among SRCS staff and volunteers

### ***Approach 3.2 Tackling gender inequalities and sexual and gender based violence***

Activity

- Train women group members who reports gender based inequalities and violence in each region
- Provision of reproductive health kits to rape cases

### ***Approach 3.3 Peer education, community mobilisation, and population-based IEC***

Activity

- Integrate the reduction of stigma and discrimination activities in the peer education and community mobilization sessions.
- Develop and use specific IEC materials for stigma and discrimination reduction.
- Monthly community sensitization sessions on stigma and discrimination reduction.
- Organize debates on stigma and discrimination reduction among youth groups

## **OUTPUT 4: Strengthening National Red Cross / Red Crescent Society capacities to deliver and sustain scaled-up HIV programme**

### ***Approach 4.1 Improving governance, accountability and leadership of RCRC National Societies for discharging planned commitments***

Activity

- Recruit three zone officers for HIV programme
- Organize orientation meeting for SRCS senior staff to share the GA concept and strategies.
- Adopt the standardized GA operational tools that are relevant to the national society

**Approach 4.2 Improving volunteer and staff support and management**

Activity

- Establish volunteers motivation mechanism and retention packages
- Provide continuous training for SRCS staff and volunteers to enhance their knowledge and skills on HIV and AIDS in order to delivery quality services

**Approach 4.3 Strengthening programme cycle management**

Activity

- Train core staff on programme cycle management to improve accountability and proper monitoring evaluation system for service delivery
- Establish strong volunteer working system to enhance volunteers contribution towards HIV and AIDS interventions
- Provide logistics support at all levels

**Approach 4.4 Widening partnerships and expanding resource mobilisation**

Activity

- Collaborate with other actors in HIV and AIDS activities to avoid duplication in the programme
- Advocate strategies for resource mobilization
- Participate in the health and HIV coordination meeting to share information among HIV players

**7.0 Scaling up Targets**

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
<b>Approach 1.1 Peer education and community mobilization</b>					
Target group 1: Trainers		42	-	-	42
Target group 2: Peer Educators		78	230 new PE	152 new PE	456
<b>Approach 2.1 Assisting children and orphans made vulnerable by HIV</b>					
Target group 1: OVC		80	180 (80+100)	280 (80+100+100)	280

<b>Approach 2.2 Providing treatment, support and care (home or community based and through health institutions) for people with HIV</b>					
Target group 1: Trainers		76	-	-	76
Target group 2: Volunteers		380	380	380	380
Target group 3: Families/caretakers					1950
<b>Approach 3.1 Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in the National Society</b>					
Target group 1: SRCS senior staff		42	-	-	42
Target group 2: SRCS managers and health officers		150	-	-	150
Staff and volunteers					1680
<b>Approach 3.2 Tackling gender inequalities and sexual and gender based violence</b>					
Target group 1: women		150	200 (new)	250 (new)	600
<b>Approach 3.3 Peer education, community mobilization and population-based IEC</b>					
Target group 1 women		150	200 (new)	250 (new)	600

## **8.0 Implementation and Management**

The programme will be implemented by Somali Red Crescent Society with the support of International Federation Secretariat (Somalia Delegation), Partner National Societies and other donors. A steering committee of these stakeholders will be set up and chaired by the SRCS/IFRC Somalia Delegation. The steering committee will meet on at least a three-monthly basis

The management mechanism will be set up on bottom-up approach to ensure that the project activities are implemented in accordance with the project objectives and activities. Volunteer Action Teams for HIV will be mobilized to carry out the planned activities in the community.

These teams will report to the HIV and AIDS focal persons.

The branch and national health staff will provide regular assistance to the volunteers in project planning and implementation on daily basis in accordance with the programme objectives and strategies. SRCS is intending to integrate HIV Programme into other SRCS run projects including IHCP, CBFA, water and sanitation, disaster management etc. PNS will provide financial support while the IFRC Somalia Delegation will provide both financial and technical support.

The Coordination offices and General Secretary in the Liaison office in Nairobi will oversee the overall programme implementation.

### **9.0 Monitoring, Evaluation and Reporting**

This programme subscribes to the principles of the “seven ones” of the Global Alliance on HIV, including one performance monitoring system. .

Regular supervision and motoring will be conducted at all levels of the programme sites. The national health staff will monitor the activities at the branches on monthly basis while Federation Secretariat and PNS will monitor the programme on need basis.

The staff and volunteers will supervise the HIV activities on weekly and daily basis to ensure early adjustments. The existing M and E tools will be reviewed in line with the GA principle and to capture the HIV programme activities and objectives.

The SRCS staff and volunteers will maintain regular and timely reporting system. The Reporting arrangement of HIV will follow the existing SRCS health programme reporting system at all levels:

- Volunteers will submit weekly/monthly individual report to SRCS Branch Health Officers.
- Branch staff will submit monthly report to assistant project officer and work under supervision of SRCS Branch Health officer
- National Health Officers will compile all reports from all zonal branches and submit on monthly, quarterly and annually basis to the Federation secretariat and donors
- The Administrative and Finance section will be responsible for accounting of the programme and keep Programme Account book, Ledger Book and Inventory Book.

General accountants will prepare monthly financial statement and submit it to the Federation secretariat and donors

Programme Reviews (includes financial reporting) will be conducted on a regular basis (six-monthly and annually). A Programme Completion Report will be produced at the end of the programme period. An external evaluation will be conducted in the final six months of the programme period

### **10.0 Assumptions and Risks**

The SRCS makes the following assumptions;

- The security of the project area is calm and stable
- Availability of adequate resources to implement the programme

The members of this programme have agreed to undertake the obligations and accountabilities agreed under the framework of the Red Cross Red Crescent Global Alliance on HIV.

## 11.0 Summary of results-based budgetary framework

OUTPUTS	2008	2009	2010	TOTAL (CHF)
1. Preventing further HIV infection	269,100	289,100	318,010	<b>876,210</b>
2. Expanding HIV care, treatment, and support	100,000	100,000	110,000	<b>310,000</b>
3. Reducing HIV stigma and discrimination	141,319	125,515	138,066	<b>404,900</b>
4. Strengthening National RC Societies' capacity to deliver and sustain scaled-up HIV programmes	321,118	322,654	354,919	<b>998,691</b>
<b>IFRC Somalia Delegation Support (6.5%)</b>	57,807	58,205	58,603	<b>174,616</b>
<b>TOTAL</b>	<b>889,344</b>	<b>895,474</b>	<b>979,598</b>	<b>2,764,416</b>

## CONTACT INFORMATION

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## Annex 1: Logframe

Annex 1

Log frame for the Somali Red Crescent Society HIV and AIDS Programme 2008 – 2010

Narrative Summary (NS)	Objectively Variable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
<b>Goal:</b> To reduce vulnerability to HIV and its impact Eastern Africa	<ul style="list-style-type: none"> <li>• Declining HIV prevalence rates for the general population</li> <li>• Declining HIV prevalence rates among pregnant women aged 15-44 years</li> <li>• Survival and improved quality of life</li> </ul>	<ul style="list-style-type: none"> <li>• UNAIDS Global HIV and AIDS pandemic reports</li> <li>• National Sero-prevalence surveys/DHS</li> </ul>	
<b>Purpose:</b> To reduce vulnerability to HIV and its impact in Somalia	<ul style="list-style-type: none"> <li>• Reduced incidence of HIV among target population</li> <li>• Percentage of pregnant women aged 15-44 years who are HIV positive</li> <li>• Survival and improved quality of life for 44,000 PLHIV and 23,000</li> </ul>	<ul style="list-style-type: none"> <li>• Population surveys</li> <li>• Programme review and assessment reports</li> <li>• Antenatal clinic HIV surveillance</li> </ul>	
Outputs	Objectively Variable Indicators (OVI)	Means of Verification (MOV)	Important Assumptions
1. HIV infections are prevented	1.1. 7,500 peer education tool/materials developed and used in the community 1.2. 42 Peer TOT educators were trained and working in the community 1.3. 456 Community peer educators were trained and working in their respective communities 1.4. 127,000 people reached through peer education FGD and one-one sessions 1.5. 640,000 people reached through public health talks sessions 1.6. 600,000 people were reached in World AIDS day events	<ul style="list-style-type: none"> <li>• Population survey</li> <li>• National demographic health survey</li> <li>• Health facility reports</li> <li>• National society reports</li> <li>• Interviews with target groups</li> </ul>	<ul style="list-style-type: none"> <li>• Willingness of the target population to modify their cultural beliefs about sexual behavior</li> <li>• Availability of donor support to implement the programme</li> </ul>

	1.7. 45,000 posters, 64 billboards, 450,000 brochures, 12,000 T-shirts and 9,000 stickers are developed, printed and distributed		
2. Care, Treatment and Support expanded	2.1. 280 OVC are assisted with educational supports 2.2. 76 TOT are trained on PTCS training packages 2.3. 380 volunteers and 1,950 families/caretakers are trained on HBC, ART adherence, treatment literacy and preparedness and nutrition	Health facility records Focus group discussion Key informants interviews Programme reports	Willingness of the government to support the expansion of care and treatment interventions Availability of programme resource to implement the activities
3. Stigma and discrimination associated with HIV and AIDS are reduced	3.1. 1,680 staff and volunteers participated in SRCS workplace policy orientations 3.2. 12 HIV and AIDS education sessions per year in 80 workplaces are conducted 3.3. 600 women are trained on gender based inequalities and sexual violence 3.4. 600 women are provided with reproductive kits for rape cases 3.5. 9,000 calendars, 90,000 pens, 9,000 key-holders, 90,000 notebooks are produced and distributed in the targeted communities 3.6. 640,000 are sensitized on stigma and discrimination against PLHIV and AIDS 3.7. 128,000 youths (in/out schools) participated in stigma and discrimination reduction debates	Interviews with key informants Households and community survey Focus group discussion Records of health facilities, VCT centers and employers	Willingness and commitment of government institution and stakeholders including communities to reduce stigma and discrimination
4. Capacity of SRCS is strengthened to enable more effective, expanded, direct outreach to served communities	4.1. 80% of staff and volunteers recruited and retained in the programme through out the period 4.2. Volunteers management and	Programme reports Reviews and evaluation reports Interviews with staff and volunteers	Willingness of the NS management to culture of work to fit into 21 century approaches to management

	<p>human resource policies developed, reviewed and implemented</p> <p>4.3. Timely, quality and accurate reports are produced as required</p> <p>4.4. 2,164 staff and volunteers are provided refreshment trained on HIV and AIDS so as to deliver quality services to community</p> <p>4.4. 2,164 staff and volunteers trained in planning, reporting, monitoring and evaluation</p> <p>4.5. 47 core staff are trained on programme cycle management to improve accountability and proper M and E</p> <p>4.6. 100% of programme officers are provided with logistic, administrative support, equipment and infrastructure</p> <p>4.7. Resource mobilization conducted and strategic partnership and alliance established</p>		
<b>Activities</b>	<b>Objectively Verifiable Indicators (OVI)</b>	<b>Sources of information</b>	<b>Activity to output</b>
<p><b>Output 1:</b></p> <ul style="list-style-type: none"> <li>▪ Adopt and translate IFRC peer education training manual</li> <li>▪ Develop peer education tools/materials</li> <li>▪ Peer education TOT training for 42 participants from regional branches</li> <li>▪ Training of community peer educators at the community level</li> <li>▪ Peer education sessions for targeted community groups (FGD and one-to-one approach) through volunteer</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of peer education training manuals adopted, translated and distributed</li> <li>▪ Number of peer education tools/materials developed and distributed</li> <li>▪ Number of TOT peer educators trained</li> <li>▪ Number of Community Peer Educators trained</li> <li>▪ Number of PE sessions conducted</li> <li>▪ Number of public health talks conducted and number people reached</li> <li>▪ Number of IEC materials</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monthly programme reports</li> <li>▪ Reviews and evaluation</li> <li>▪ Focus group discussions</li> <li>▪ Interviews and observations</li> <li>▪ Distribution list</li> <li>▪ Samples of IEC materials</li> <li>▪ Training reports</li> </ul>	<ul style="list-style-type: none"> <li>▪ Willingness of the community, local governments to support the implementation of the programme at the local and community level</li> <li>▪ Availability of volunteers who are willing to participate in the programme</li> </ul>

<p>networks.</p> <ul style="list-style-type: none"> <li>▪ Public health talks on the aspects of HIV and AIDS</li> <li>▪ Marking global and national events e.g. World AIDS Day.</li> <li>▪ Development, Production and distribution of appropriate IEC/BCC materials for different target groups tackling thematic issues in HIV and AIDS</li> </ul>	<p>developed, produced and distributed to the targeted areas</p> <ul style="list-style-type: none"> <li>▪ Number of people received IEC materials</li> </ul>		
<p><b>Output 2:</b></p> <ul style="list-style-type: none"> <li>▪ Provided educational support to the OVC</li> <li>▪ Training on HBC and nutrition for volunteers and care takers of PLHIV.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of OVC received support</li> <li>▪ Number of family members/caretakers trained on HBC and nutrition</li> <li>▪ Number of volunteers trained on HBC and nutrition</li> </ul>	<ul style="list-style-type: none"> <li>▪ Monthly, quarterly, annually reports</li> <li>▪ Training reports</li> </ul>	<ul style="list-style-type: none"> <li>▪ Willingness of the caretakers and community to identify the OVC,</li> <li>▪ Willingness and availability of volunteers and caretakers of PLHIV to participate in HBC</li> </ul>
<p><b>Output 3:</b></p> <ul style="list-style-type: none"> <li>▪ Develop HIV in workplace policy</li> <li>▪ HIV workplace policy orientation meeting for SRCS staff and volunteers</li> <li>▪ HIV and AIDS education sessions among SRCS staff and volunteers</li> <li>▪ Train women group members who reports gender based inequalities and violence in each region</li> <li>▪ Provision of reproductive kits to the rape cases</li> <li>▪ Integrate the reduction of stigma and discrimination activities in the peer education and community mobilization sessions.</li> <li>▪ Develop and use specific IEC</li> </ul>	<ul style="list-style-type: none"> <li>▪ HIV workplace policy is developed</li> <li>▪ Number of HIV workplace policy orientation meetings held</li> <li>▪ HIV and AIDS education sessions among SRCS staff and volunteers conducted</li> <li>▪ Number of women group members trained on gender based equalities and violence</li> <li>▪ Number of reproductive kits provided to rape cases</li> <li>▪ Number of IEC materials specifically developed for stigma and used</li> <li>▪ number of community sensitization sessions on stigma and discrimination reduction held</li> </ul>	<ul style="list-style-type: none"> <li>▪ Programme reports</li> <li>▪ Distribution lists</li> <li>▪ Meeting minutes</li> <li>▪ Availability of workplace policy</li> <li>▪ Interviews</li> <li>▪ Availability of IEC materials on stigma</li> </ul>	<ul style="list-style-type: none"> <li>▪ Willingness and commitment by government institutions, stakeholders including communities reduce stigma and discrimination</li> <li>▪ Availability of programme resource</li> </ul>

<p>materials for stigma and discrimination reduction.</p> <ul style="list-style-type: none"> <li>▪ Monthly community sensitization sessions on stigma and discrimination reduction.</li> <li>▪ Organize debates on stigma and discrimination reduction among youth groups</li> </ul>	<ul style="list-style-type: none"> <li>▪ number of debates on stigma and discrimination reduction organized among the youth and number of youth participated</li> </ul>		
<p><b>Output 4:</b></p> <ul style="list-style-type: none"> <li>▪ Recruit three Zonal officers for HIV programme</li> <li>▪ Organize orientation meeting for SRCS senior staff to share the GA concept and strategies.</li> <li>▪ Adopt the standardized GA operational tools that are relevant to the national society</li> <li>▪ Establish volunteers motivation mechanism and retention packages</li> <li>▪ Provide continuous training for SRCS staff and volunteers to enhance their knowledge and skills on HIV and AIDS in order to delivery quality services</li> <li>▪ Train core staff on program cycle management to improve accountability and proper monitoring evaluation system for service delivery</li> <li>▪ Establish strong volunteer working system to enhance volunteers contribution towards HIV and AIDS interventions</li> </ul>	<ul style="list-style-type: none"> <li>▪ Number of staff recruited</li> <li>▪ Number of staff, volunteers trained on planning, reporting, monitoring and evaluation</li> <li>▪ Volunteers motivation mechanism and retention established</li> <li>▪ Number of staff trained on program cycle management</li> <li>▪ Partnership developed</li> <li>▪ Number of coordination meetings attended</li> </ul>	<p>NS human resource report Training reports Programme reports</p>	<p>Availability of resource to implement programme activities</p>

<ul style="list-style-type: none"><li>▪ Provide logistics support at all levels</li><li>▪ Collaborate with other actors in HIV and AIDS activities to avoid duplication in the program</li><li>▪ Advocate strategies for resource mobilization</li><li>▪ Participate in the health and HIV coordination meeting to share information among HIV players</li></ul>			
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