Indian Red Cross Society
HIV Programme 2008-2010

1. Executive summary

The purpose of the Indian Red Cross Society (IRCS) nationwide HIV programme is to scale up efforts in support of the national HIV and AIDS programme to reduce vulnerability to HIV and its impact. This will be achieved through the following outputs, targeting intravenous drug users, prisoners, youth in schools and colleges, and the community in general. Focussing on high-risk groups would not only ensure greater impact visibility, vis-a-vis the general population, it would also lead to cost efficiency on account of intensive rather than extensive coverage of target population. The concentration within schools and colleges would be on a segment of students who are nationally recognized as being potentially high risk (15-20 years age group).

- Preventing further HIV infection.
- Expanding HIV care, treatment and support.
- Reducing HIV stigma and discrimination.
- Strengthening Red Cross national society capacities to deliver and sustain scaled-up HIV programme.

To achieve these outputs, a number of approaches will be adopted, including peer education; information, education and communication (IEC) materials; voluntary counselling and testing (VCT); skills for personal protection, including condom use; assistance to orphans and other vulnerable children (OVC); care and support for people living with HIV (PLHIV); community support networks; livelihood and food support for most vulnerable; work place policy; volunteer and staff support management; strengthening programme cycle management; and partnerships (refer to logical framework). To implement each approach a number of activities will be carried out, where possible in partnership with PLHIV and key vulnerable populations.

The programme will be scaled up to cover **30 districts and approximately 0.5 million beneficiaries by 2010** from the initial 15 districts beneficiaries in 2007. The districts will be chosen on the basis of HIV prevalence rates, branch capacity to implement and government data.

This programme is part of the Red Cross Red Crescent South Asia HIV programme that is a component of the International Federation Global Alliance on HIV.

2. The Magnitude

The first case of HIV was identified in Chennai, Tamil Nadu, in 1986 while the first AIDS case was identified in Mumbai, Maharashtra. Currently, an estimated of 2.47 million (2 to 3.1 million) PLHIV are living in India. India is ranked the third highest country with most PLHIV worldwide, behind South Africa and Nigeria. At present, an estimated of 160,000 AIDS cases exist in India. The HIV prevalence rate is 0.36 per cent (0.29 per cent to 0.46 per cent) among the adult population[1].

About 86 per cent of HIV cases are transmitted sexually. Sixty-one per cent of cases are male. The epidemiological trends of HIV cases are as follows (NACO, 2007):

- HIV infection is spreading from groups at heightened risk to the general population.
- HIV infection is spreading from the urban to rural areas (57 per cent in rural area).
- HIV infection is spreading from high prevalence states to all states.
- Increasing feminization of the epidemic (39 per cent in women living with HIV).

[1] 15-49 years of age

- Increased sexual transmission between injecting drug users and their partners.
- High vulnerability of youth (40 per cent in youth 15 to 35 years).

India has a large sexually active population, illiteracy, poverty, poor awareness on HIV, male migration, gender disparity and high prevalence of sex workers, which renders India vulnerable to HIV. The map on page 6 provides the HIV scenario in India. Category A refers to high prevalence districts, category B refers to concentrated epidemic districts, category C refers to highly vulnerable and category D refers to vulnerable districts in India.

In 2007, the revised estimate on HIV prevalence shows that there are approximately 2.5 million cases as compared to a previous estimation of approximately 5.2 million. The revised estimation of 2.5 million was arrived after the data was extrapolated after combining the two nationally accepted survey methodologies of the national sentinel surveillance and National Family Health Survey. Table 1 provides key HIV and AIDS indicators in India.

Table 1: Key HIV and AIDS data in India:

National data	
National population	1,103.1 million*
Human Development Index	127*
% of people with less than USD2 per day	79.9*
HIV and AIDS indicators	
Number of people (all ages) living with HIV	2-3.5 million**
Adults (15-49 years) HIV prevalence rate	0.36% **
Adults (15 and over) living with HIV	5,600,000*
Women (15 yrs and over) living with HIV	1,600,000
Deaths due to AIDS	270,000-680,000*
Children (0-14 years) living with HIV	Not Available
Orphans (0-17 years) due to AIDS	Not Available
% of pregnant women receiving treatment to reduce mother to child transmission	Not Available
% of HIV-infected women and men receiving ART	Not Available
% women and men separately (15-24 years) who correctly identify ways to prevent HIV	Not Available
% women and men separately (15-24 years) who used condom last time they had casual sex	51% women*, 59% men*

Source: * UNAIDS 2006 Report on Global AIDS Epidemic, ** UNAIDS website India page 2007

3. The Impact

HIV constitutes a global emergency and poses one of the most formidable challenges of the 21st century. Currently, 40 million people are living with HIV worldwide, of which 95 per cent are living in the developing countries. High density of population, low literacy rate, poverty, porous borders, frequent migration, growing economy and tourism contribute to increase HIV prevalence. It affects all social and economic strata and does not recognize any caste, class, age, gender, sexual preference, place, religion or country.

HIV is not merely a health issue but a huge developmental problem. It not only affects the infected person but the whole family, community and country. It causes absenteeism at the work place, low productivity, increases the number of orphans, breaks family ties and results in debt. In fact, it is the main cause of poverty in many HIV-affected families and communities.

In India, 57 per cent of women compared to 80 per cent of men have ever heard of AIDS[2]. Similarly, 35 per cent of women compared to 68 per cent of men are aware that correct and consistent use of condoms can reduce chances of becoming infected with HIV. Almost 73 per cent of young people have misconceptions about the modes of HIV

[2] National Family and Health Survey (NFHS-3), 2005-06

transmission. These findings clearly indicate that there is an urgent need to **step up efforts to increase awareness on HIV and AIDS not only among the general population but specifically addressing the female population.** One million out of 2.5 million HIV positive people living in India are women[3] and the 15 to 29 age group account for 31 per cent of the total burden of HIV in the country[4] which clearly implies the need for **youth peer education**. Furthermore, 86 per cent of HIV positive cases are due to sexual transmission which clearly indicates that there is a need to emphasise on behaviour change by promoting the **use of condom to reduce incidence through a comprehensive approach in programme**.

The high magnitude of HIV prevalence and high potential that it will become worse signals the need to **provide care and support to infected people and their families both at the institutional and community level**.

HIV positive persons and their families face stigma and discrimination from society on the whole and friends, relatives and institutions specifically. It is most detrimental when close family members also discriminate against positive family members. Many PLHIV have committed suicide as a result. It is the Red Cross Red Crescent's utmost duty to implement programmes and activities that eliminate **HIV stigma and discrimination**, and invest in and involve PLHIV as a key resource in the HIV response.

The Indian Red Cross Society (IRCS) HIV programme will contribute towards achieving Millennium Development Goal 6: *"To combat HIV and AIDS, malaria and other diseases".* The programme approaches and activities increase knowledge on ways to prevent HIV; improve the quality of life of PLHIV; address misconceptions against PLHIV leading to reduced stigma and discrimination against PLHIV; and **build capacity of IRCS national, state and district level staff in effective delivery of the HIV programme**.

In India, the HIV epidemic is now almost two decades old. During this time, it has emerged as one of the most serious public health problems in the country. Since the first HIV and AIDS cases reported, HIV has spread rapidly to the adjoining states.

4. Policy on HIV

The IRCS HIV programme is part of the South Asia regional HIV programme which is a component of the International Federation of the Red Cross Red Crescent Global Alliance on HIV. The purpose of the IRCS HIV programme is to scale-up efforts to reduce vulnerability to HIV and its impact in India, through achieving the following outputs:

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

The above outputs are bolstered by a fourth:

- Strengthening national Red Cross / Red Crescent society capacities to deliver and sustain scaled-up HIV programme.

IRCS work in accordance with the established principles of the International Red Cross and Red Crescent Movement to support the country's national HIV policies and programmes. The specific scope of the activities in this programme has been developed in coordination with the National AIDS Control Organization and harmonized with tasks agreed under international assistance arrangements in India, including UNAIDS and other UN agencies, non-governmental organizations and civil society groups, and donors. These organizations are regularly invited to attend the meetings held at the national headquarter on issues related to HIV. At the state and district levels, the project staff actively collaborates with other organizations, including the local PLHIV network, for a collective and effective response against the epidemic.

[3] http://www.nacoonline.org/Quick_Links/Women/
[4] http://www.nacoonline.org/Quick_Links/Youth/

5. Indian Red Cross Society: Track record and lessons learnt

- IRCS has developed HIV policy (2005-08).
- The IRCS has been implementing an HIV programme through the Red Cross HIV and AIDS India Consortium in five states and 15 districts targeting prisoners, factory workers, youth and the general population.

The IRCS secretary general is the chairperson of the Consortium which consists of IRCS, the International Federation Secretariat, and partner national societies, including the British, Canadian, Danish, Spanish and Swedish Red Cross Societies. In two states, the programme is supported by the Swedish Red Cross through the International Federation Secretariat. In the other three states, the programme is supported by the British, Canadian and German Red Cross Societies. The IRCS has also singed a memorandum of understanding with the Italian Red Cross which has an HIV component.

Table 2 provides output details of states, districts, and results of the ongoing IRCS HIV programme for 2006-2007:

Table 2: IRCS HIV programme outputs for 2006-2007

Output	States	Districts	Target population	Total beneficiaries reached
1.Preventing further HIV infection	5	15	Heads of Institutions Junior/youth Red Cross counsellors (teachers from within the institution, who disseminate Red Cross Red Crescent principles and conduct activities) Peer educators Community members in the villages	400 principals sensitized on basics of HIV in ten districts 560 junior Red Cross/youth Red Cross counsellors trained in seven districts 2,800 peer educators trained in seven districts 912 group sessions held in ten districts with peer educators/members; 1,103 individual sessions held in ten districts with peer educators/members; 1,600 community members sensitized on HIV basics in eight districts 1,000 inmates (prisoners) sensitized on HIV basics and life skills

			Prisoners	
2. Expanding HIV care, treatment, and support	1	2	Positive in-patients in Thambaram Hospital	4,800 PLHIV (in-patients) provided hygiene kits in a year 72,,000 PLHIV (in-patients) provided nutrition support in a year 2,700 individual counselling sessions with PLHIV (in-patients) in a year 1,800 group counselling sessions in non ART wards and 600 counselling sessions in ART wards in a year (an ongoing activity)
3. Reducing HIV stigma and discrimination	5	15	Local positive networks	Working with five state level positive networks and ten district level positive network groups Organize regular interactive session with positive network groups at state and district level Conduct street plays, competition, rallies and walking plaza to raise awareness on HIV and AIDS. (These street plays, and awareness in walking plaza are a yearly event conducted by the district branches.)
4. Strengthening national Red Cross / Red Crescent society capacities to deliver and sustain scaled-up HIV programme	National headquarter and 5 states	15		75 HIV project staff trained in life skills, basics of HIV, monitoring and reporting, financial management

RCRC Comparative Advantages

There is an experienced health unit staff member at the national headquarter and two separate personnel for HIV projects. Keeping in mind the significance of capacity building of the staff, the IRCS HIV programme have provision for training their staff on the basics of HIV and AIDS and life skills. Apart from this training, an orientation training is organized for the newly recruited staff to orient them to the Red Cross Red Crescent principles and their roles and responsibilities. There is constant effort at the IRCS towards convergence of HIV with other programmes and departments. The Indian Red Cross Consortium is an ever-growing body formed in leadership of the IRCS with the International Federation and other partner national societies for effective and coordinated response for HIV in India. IRCS believes in decentralizing the project implementation through the state and district branches.

Over the years, the IRCS has developed effective reporting and monitoring systems for effective programme delivery. This has led to regular feedback and improved quality of programming. The youth peer education programme of the IRCS is implemented through the junior and youth Red Cross active in schools and colleges respectively. The junior and youth Red Cross units in the educational institutions are meant to disseminate information on Red Cross Red Crescent Movement and activities and to foster a feeling of social service.

Strong junior and youth Red Cross at educational institutions

- Experience of working with youths, factory workers, prisoners and parents of school children and children in the community care centre.

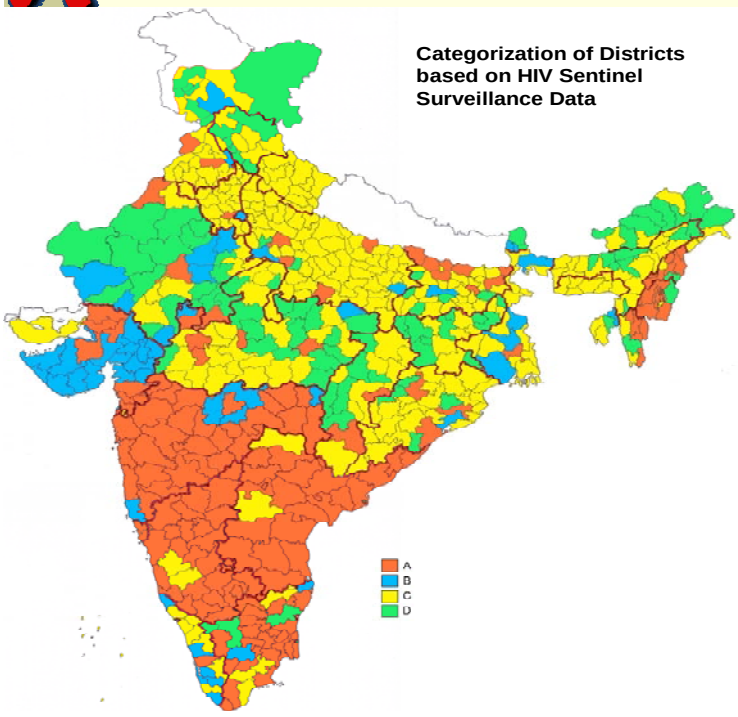
Challenges

Non-availability of state-specific information, education and communication (IEC) material.
Baseline study and data from various projects are absent.
Non-availability of uniform reporting format until recently.

Lessons Learnt:

Baseline to be introduced to every new project.
Introduction of a uniform reporting format (this has already been done).
Development of state specific IEC material (process has already started).

HIV/AIDS Scenario in India



Based on HIV Sentinel Surveillance Data for the last three years, all the districts have been classified into four categories A – D which serves the program planning purpose.

Present Status:

- **156 A Category Districts**
- **39 B Category Districts**
- **Rest 414 Districts in C & D**

08-07

The IRCS HIV programme will be scaled up from 15 districts in 2007 to 30 districts in 2010. Table 3 provides the distribution of states and districts:

Table 3: IRCS scaled-up HIV programme in each state (the break- up of beneficiaries is provided in the annexure):

State	Number of Districts (2006)	Number of Districts (2007)	Total Districts during this Programme (2008-2010)	Total
Andhra Pradesh	4	4	**2**	**6**
Uttar Pradesh	0	3	**2**	**5**
Tamil Nadu	3	3	**1**	**4**
Maharashtra	1	3	**2**	**5**
Karnataka	2	2	**0**	**2**
Tripura	0	0	**4**	**3**
Punjab	0	0	**2**	**3**
Goa*	0	0	**2**	**2**
Total	10	15	**15**	**30**

* Provisionally newly selected in 2008. Districts have yet to be decided
(*Note:* In the national family health survey 3, it has been found that there are districts with high prevalence HIV rates, although the district itself is in low prevalence state.)

6. Output 1: Preventing further HIV infection

To achieve Output 1, the below approaches and activities will be implemented in specific geographical areas, focusing on key populations.

Table 4: Output 1 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Group(s)
1.1 Peer education and community mobilization	• Yearly sensitizing of headmasters / principals on HIV life skills • Yearly training of trainers of the YPE staff/junior Red Cross (JRC) and youth Red Cross(YRC) counsellors and peer educators on HIV and life skills • Bi-weekly topical sessions by the YPE counsellors with the peer educators • Monthly individual and group counselling sessions by the YPE counsellors • Bi-weekly interactive sessions and experience sharing by the peer educators with their peer member group	Andhra Pradesh Karnataka Maharashtra Punjab Tamil Nadu Tripura Uttar Pradesh + 1 new state	172,000 youth[8] (Students, principals, JRC/YRC counsellors, parents)
	Injecting Drug Users (IDU) • Awareness generation is in regards to the relation of drug use and HIV. Awareness generation would emphasize	Punjab, Tripura	200 IDUs

[5] Community opinion leaders include PRIs, ICDS staff, health staff
[6] Designated shopkeepers for condom demonstration and promotion and display of HIV material
[8] Includes students, principals, JRC/YRC counselors, parents

Approach	Key Activities	Geographical Target Areas	Target Group(s)
	on safer injecting practices and overdose management generation through regular outreach activities to IDUs with focus on HIV and substance use • Increase awareness through half yearly trainings on the hierarchy on addiction with focus on harm reduction, overdose management, safe injecting practices, abscess and vein management. etc with the staff of the de-addiction centres • Counselling and referral services to organizations offering needle syringe exchange programmes, care and treatment homes for IDUs and bupernorphine maintenance treatment (BMT) • Integration of HIV and substance use		30 staff members of the de-addiction centres
	Prisoners • Awareness on HIV prevention counselling • Life skills education for better quality of life	Andhra Pradesh	2,000 prisoners
	Community • Yearly sensitization of block and village level opinion leaders[5] • Yearly orientation meeting with the community inducers[6] and representatives of key vulnerable populations • Yearly training plus refresher for capacity building of peer educators • Regular home-to-home interaction of the peer educators with the community • Half yearly experience sharing meeting of the peer educators • Half yearly exposure visits of peer educators to home cares and PLHIV and key vulnerable populations networks	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	120,980 community people[10]
1.2 Information, education, communication (IEC) for targeted vulnerable groups	• Review and development of state-specific IEC • Yearly workshop on development of innovative IEC material with staff and community inducers and community peer educators • Translation of the IEC material in local language and keeping in mind the	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	Same as at 1.1

[10] Includes community opinion leaders at block and village level, community inducers at village level, community peer educators and community population

Approach	Key Activities	Geographical Target Areas	Target Group(s)
	cultural sensitivities • Quarterly IEC campaigns at community level in partnership with PLHIV and key vulnerable populations.		
1.3 Voluntary counselling and testing (VCT)	• Once a year capacity building of the HIV staff on issues and processes of counselling including a component/ session on VCT • Networking with the existing voluntary counselling and testing centres (VCTC) in each district • Development of VCTC directory at the district and state level with the complete contact address of the key responsible person at each VCTC • Encourage the community and spouses of positive people to take up testing in VCTC • Encourage partners/ spouses of the person having an STI to test, thereby promoting the concept of partner notification at the community level by providing incentive to the community peer educator	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	10,800 PLHIV, 300 community members
1.5 Skills for personal protection, including condom use	• Capacity building through an yearly three-day training of trainers on life skills and safer sex practices of the various target groups and stake holders • Condom demonstration to and by peer educators and members of the institution, community inducers and community peer educators • Promoting condom use through IEC material and interactive activities		1,575 peer educators and peer members; 120,980 community members

7. Output 2: Expanding HIV care, treatment and support

To achieve Output 2, the following approaches will be implemented:

Table 5: Output 2 programme activities, areas and key populations

Approach	Activities	Geographical Target Areas	Target Groups
2.1 Assisting children and orphans made	• Needs-based advocacy with the local education authorities including school principals for the admission of the	Tamil Nadu	HIV+ children and children of HIV+ parents

vulnerable by HIV (OVC)	infected/affected children • Needs-based community mobilization for community-based care and support for the children • Regular awareness of the parents and community at large on the basic nutrition and food habits, including recipes made through locally available material • Needs-based counselling on home-based care for children living with HIV	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states Tamil Nadu and Maharashtra	**100…..A**
2.2 Providing treatment, support and care for people living with HIV	• Regular counselling of PLHIV and their families • Provision of hygiene kits to be distributed to newly admitted in the ward • Provision of daily supplementary nutrition to the PLHIVs admitted in Thambaram Hospital where the Tamil Nadu care and support project is being implemented • Encourage PLHIVs and their families to visit VCTC and avail the counselling and testing facilities	Tamil Nadu, because HIV counselling centres are at every district, run by the government. Having the counsellors from the Red Cross would be duplicating the efforts. Secondly, Tamil Nadu is chosen as the care and support project is being implemented inside a big government hospital for the HIV in- and out-patients and their families	14,400 PLHIV (hygiene kits) 216,000 nutritional packs **230,400……B**
2.3 Developing community support groups and networks	• Formation of the joint action group (JAG) to act as representative group for the project at grassroots level • JAG as a link between the community/ target group and existing facilities • Develop a local resource directory of the available facilities for the infected and affected	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	PLHIV networks **30……C**
2.4 Providing livelihood and food support for the most vulnerable	• Providing daily nutritional support to the HIV positive clients in Thambaram and the community care centre • Providing regular nutrition counselling to PLHIV and their families	Tamil Nadu; providing nutrition is a very cost intensive activity and this is an activity where the impact is not measurable	Same as in 2.2; children of HIV+ parents

8. Output 3: Reducing HIV stigma and discrimination

To achieve Output 3, the following approaches will be implemented:

Table 6: Output 3 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target Group(s)
3.1 Developing community support groups and networks of people living with HIV, and partnerships with PLHIV organizations	• Formation of JAG to act as representative group for the project at grassroots level • JAG as a link between the community/ target group and existing facilities • Develop a local resource directory of the available facilities for the infected and affected (community group for advocacy at the grassroots level)	Andhra Pradesh Karnartaka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	Same as in 2.3
3.2 Ensuring that HIV in the workplace policy and programmes for all staff and volunteers are in place in Red Cross Red Crescent national societies	• Session by legal expert on rights of HIV+ persons to be included in any capacity building training • Yearly sensitization of staff and volunteers on basics of HIV • Sessions by PLHIV on stigma and discrimination to be included in every capacity building training programme • Use of folk media in quarterly campaigns to address the issue in the community	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	350 Red Cross Red Crescent staff and volunteers
3.3 Peer education, community mobilization and population-based IEC	Same as 1.1.	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	Same as in 1.1

Output 4: Strengthening national Red Cross / Red Crescent society capacities to deliver and sustain scaled-up HIV programme

To achieve Output 4, the following approaches will be implemented:

Table 7: Output 4 programme activities, areas and key populations

Approach	Key Activities	Geographical Target Areas	Target group(s)
4.2 Improving volunteer and staff support and management	Same activities as 1. 1	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3	Peer educators members; same as 1.1

		new states	
4.3 Strengthening programme cycle management	• Yearly training of project staff in project management cycle. On-the-job mentoring is provided to the district coordinators by the state coordinators through formal, informal meetings, in-house trainings, etc. The same process is taken up between the coordinators at national headquarter and the state • Development of monitoring and reporting system • Financial reporting training is an integral part of the induction training of the staff. Such trainings are also provided on a need basis in the states and districts)	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	40 project staff
4.4 Widening partnerships and expanding resource mobilization	• Strengthening programme development skills of the staff financial reporting training training of project staff in financial management	Andhra Pradesh Karnataka Maharashtra Tamil Nadu Uttar Pradesh + 3 new states	

6. Implementation and management arrangements

The HIV programme will be implemented by the IRCS with the support of the International Federation Secretariat at the regional, zonal and global levels; partner national societies of Britain, Canada, Denmark, Germany, Italy, Spain and Sweden national societies, NACO, Nestle, WHO, UNAIDS and UNICEF, amongst others. A steering/technical committee of these stakeholders will be set up under the chairmanship of the Secretary General (SG), IRCS and will meet at least once a year.

The national headquarter HIV manager/coordinator, with guidance from the IRCS secretary general, will manage the programme primarily through providing standard systems, coordination, and technical assistance to the state level. At the state level, a state HIV coordinator will drive implementation with guidance from the state secretary. Similarly, at the district level, the district coordinator will mobilize implementation with support from the district secretary. At the district level, the coordinator will be assisted by a team of counsellors and officer assistant. At national and state level, a finance person will support the HIV programme team. The other components are managed by the state coordinators at the state level.

Technical support in HIV programme management will be available to the IRCS HIV programme team via the International Federation Secretariat regional health team, including partner national society experts as needed. The broader International Federation South Asia regional delegation and Geneva HIV Global Alliance team will provide support as necessary for clarifications and inputs.

7. Monitoring and reporting arrangements

This programme subscribes to the principles of the seven ones of the Global Alliance on HIV, including one performance monitoring system. Programme reviews (including financial reporting) will be conducted on a regular basis (six-monthly and annually). A consolidated programme report 2007- 2010 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.

Monitoring: Periodic monitoring visits will be conducted to assess the project implementation and take course corrections. Project staff members at national headquarter, state and district branch will be responsible for project monitoring.
From the national headquarter, there will be a quarterly monitoring visit to each HIV state for programme review. The state coordinator will undertake monitoring visits to each district at least once in two months. The district coordinator will visit at least ten institutes each month.

A uniform monthly reporting system will be used for monitoring and reporting.

Reporting: The district coordinator will provide a monthly report to the state coordinator, who will consolidate the state report and send to the national headquarter. The national headquarter will consolidate state reports and provide these to the International Federation Secretariat. The monthly reporting system will facilitate semi-annual report.

8. Risks, assumptions and undertakings

Risks

1.1 Absence of long-term funding commitment from the partner agencies for the implementation of the programme.
1.2 Frequent staff turnover at all levels due to absence of an effective human resource policy.
1.3 Negative and aggressive attitude of the local authorities on issues related to HIV and life skills education.

The risks mentioned above can be mitigated by having a human resource policy at all levels for employee motivation and retention. Secondly, the partnership with the funding agencies be for a minimum period of two years with the provision of performance-based salary increase and incentives to the staff. Mobilization of resources remains the major risk. To scale-up there is a need to mobilize both in-country and outside financial resources.

Development of resource mobilization strategy for funds is a major challenge. Both Red Cross Red Crescent and external partners should be targeted to raise resources.

Advocacy and sensitization activities for key stakeholders and target group are a part of the proposal to reduce negative and aggressive attitudes

Assumptions

1.1 No policy level changes on HIV.
1.2 Occurrence of natural calamities.
1.3 Adherence to seven ones.

Undertakings

IRCS HIV programme will be designed and implemented as per the guidelines provided by the Global Alliance.

9. Summary of results-based budgetary framework

OUTPUTS	2008	2009	2010	TOTAL (CHF)
1. Preventing further HIV infection	886,535	1,060,182	1,279,398	3,226,115
2. Expanding HIV care, treatment, and support	92,492	92,736	94,377	279,605
3. Reducing HIV stigma and discrimination	33,435	37,994	42,553	113,982
4. Strengthening national Red Cross Red Crescent society capacities to deliver and sustain scaled-up HIV programme	15,198	15,198	15,198	45,594
5. Monitoring and evaluation*	30,830	36,183	42,946	109,959
6. Programme support recovery (6.49% of the total)	73,585	86,362	102,503	262,450
TOTAL	**1,132,075**	**1,328,655**	**1,576,975**	**4,037,705**

* 3% of all output costs