

Annual report

 International Federation
of Red Cross and Red Crescent Societies

SOMALIA

Appeal No. MAASO001

29/04/2009

This report covers the period 01/01/2008 to 31/12/2008.



A patient being attended to by a medical staff in a SRCS clinic. IFRC

In brief

Programme purpose: Somali Red Crescent Society (SRCS) programmes are aligned to the Federation's Global Agenda goals and performance management and accountability framework. In line with Global Agenda Goal 2, the National Society's Integrated Health Care Programme (IHCP) provides essential health care to communities throughout Somalia. The services provided include promotive, preventive and curative health-care services to the vulnerable, with emphasis on mothers and children, in order to reduce deaths and diseases. The programmes also work towards building synergies with the National Society's disaster management, organisational development and humanitarian values programmes.

Programme summary: Security concerns limited access in many parts of Somalia as conflict remained high and humanitarian aid workers were specifically targeted in a number of incidents of attack and kidnap for ransom. Nevertheless, the SRCS continued to operate its programmes without interruption in its clinics and the hospitals it supports, as well as at branch level in disaster preparedness and community-based first aid (CBFA) activities. HIV and AIDS education sessions targeted groups at risk and trained new trainers in integrated prevention, treatment, care and support (IPTCS).

The National Society has continued to provide comprehensive community health services since the early 1990s in all regions of the country. With a steady build-up of activities over the past 15 years, the SRCS now runs 62 clinics (including four temporary ones for internally displaced persons) and two hospitals. A further strengthening of the services is planned through SRCS/Federation's Food Security interventions in 2009-2011.

Through the outreach activities of the stationary clinics and CBFA volunteers at sub-branch level, comprehensive community health services reached rural communities and remote villages. Increased mobility and a growing number of mobile units extended the coverage to include nomadic and otherwise isolated groups, coastal fishing communities and internally displaced persons (IDPs). Many of the beneficiaries live in remote, rural communities with strong vulnerability indicators, which had previously little or no access to professional health care.

Health risk reduction was carried out at SRCS branch and sub-branch levels through volunteers working with community representatives and structures. The NS' staff and volunteers underwent regular training, received technical support, supplies and equipment as required to respond to identified community needs. The SRCS will continue current core programmes in 2009 with some modifications from lessons learned to increase outputs further.

Financial situation: The total budget is CHF 5,302,140 (USD 4,626,647 or EUR 3,513,728), of which 72 per cent covered. Expenditure overall was 73 per cent of the funds received. The budget increased after changes were made on some programmes i.e. coordination and management and Allabady, Ainab and Galkayo clinics.

[Click here to go directly to the attached financial report.](#)

See also Horn of Africa exceptional food insecurity crisis

<http://www.ifrc.org/docs/appeals/08/MDR64003EA1.pdf>

No. of people we help: Through its maternal and child health/outpatient department (MCH/OPD) stationary clinics, mobile clinics, hospitals and outreach community services the SRCS reached an estimated number of over 600,000 people, of which some 250,000 in Puntland and Somaliland. The consultation programme reached 320,668 patients; these included 79,500 under fives and 110,780 women. The NS reached 118,270 people for immunization; with 71% being children. The growth monitoring component reached 24,380 people while the reproductive health component 67,745 people.

- Through the outreach and cross-border programmes, 19,925 beneficiaries in isolated communities were reached
- Training of trainers (ToT) courses were given to 33 peer educators from all branches
- 210 community peer educators were trained from all branches
- A ToT workshop on the HIV prevention, treatment, care, and support (PTCS) package for community volunteers was conducted with 75 participants
- 120 women from four branches in Puntland were trained on gender and sexuality, reproductive health, HIV and AIDS, and sexually transmitted illnesses (STI) counselling
- Public rallies, focusing on routes of transmission, prevention methods, reduction of stigma and discrimination, TB/HIV co-infection and availability of TB treatment, were held in the major regions of Somaliland. An estimated 3,600 people were reached.
- SRCS commemorated World AIDS Day public gatherings. An estimated 250,000 people were reached at branch level; and some 248,000 at the clinic areas, with 691 volunteers participating
- 3,200 T-shirts, 6,000 posters, 171'000 brochures, and 10 billboards with acceptable anti-stigma and anti-discrimination messages were produced and distributed in all three zones

Our partners: The SRCS work with several partners while implementing its activities. Movement partners include the British, Finnish, German, Netherlands, Norwegian, American, Saudi Arabian and Swedish RC Societies, the International Federation and International Committee of the Red Cross (ICRC). The NS has also maintained excellent working relationships with, and received support from the World Bank, key United Nations agencies including United Nations Children's Fund (UNICEF), World Food Programme (WFP) and World Health Organization (WHO).

Context

The situation in Somalia remains volatile. Majority of the population is poor and vulnerable. Public infrastructure is minimal and fragile; and the country largely relies on external support for basic services. The vulnerability gets worse by unending armed conflicts and climatic disasters. Disease outbreaks, population displacement, minimal health care and education have caused huge humanitarian needs. A continuous succession of natural calamities (drought, floods, cyclones and tsunami) aggravate fragile livelihoods and infrastructures. The prospect of economic stability and recovery remains limited and will, under the best of developments, take a long time. Price increases of basic commodities in real terms affected everyone, with the biggest impact upon the poorest and most vulnerable. The reduced possibility for generating local resources leaves poor communities critically dependent on external assistance and with considerably weakened coping mechanisms.

As a result of the civil war and the ensuing years of severe and persistent insecurity in large parts of Somalia, the state health infrastructure in the country has been all but crushed. The health indicators for Somalia are among the worst in the world, with an infant mortality rate (IMR) of 86/1000 live births; an under five mortality rate (U5MR) of 135/1000 (UNICEF 2006); and a maternal mortality rate (MMR) of 1,044/100,000 (UNICEF 2007). Life expectancy at birth is 45 years for women and 43 years for men (UNICEF, 2002). Hence, the need for continuous basic health care is immense. At the same time, the deteriorating environment and the increased number of targeted assassinations and kidnaps reduced the ability of all humanitarian actors to work in the field.

Since the early 1990's, the Somali Red Crescent (SRCS) has provided comprehensive community health services. The Society provides health promotion, preventive and curative services, and health education in all regions of the country with a particular emphasis on mothers and children. With a steady build-up of activities over the past 15 years, the SRCS now runs 62 clinics (including four temporary ones for IDPs) and two hospitals. A further strengthening of the services is planned through SRCS/Federation's Food Security interventions in 2009-2011.

Progress towards outcomes

Disaster Management

Global Agenda Goal 1: Reduce the number of deaths, injuries, and impact from disasters.

Programme component 1: Disaster Preparedness: Community and institutional

Outcomes/Expected results

- Increased SRCS capacity to organise effective and efficient disaster response.
- Improved SRCS capacities (structural and human) to effectively respond to and recover from common disasters/emergencies (including drought, flood, cyclone, and tsunami).

Achievements: A vulnerability and capacity assessment (VCA) training was conducted for 23 volunteers and five Bosasso branch staff members in March 2008. The coastal districts of Bari region (Bosasso branch) were the worst hit by the December 2004 tsunami that left over 300 dead and thousands displaced in Somalia. The VCA training was followed by a practical exercise in Qardho and Iskushuban districts. In both districts, acute respiratory infection (ARI), malaria and diarrhoea outbreaks were identified as priority community problems, exacerbated by high illiteracy levels and a poor road network.

SRCS volunteers and staff planned to address some of these problems using the CBFA *in Action* approach. Recurrent droughts, windstorms and flash floods were identified as the major hazards. The strong volunteer network in the vast branch remained the chief response capacity. Other strengths identified during the assessment included participation of local councils, and water and sanitation committees. Other assets were the MCH clinic and health posts and the availability of clean spring water in Iskushuban district. However, these community-serving institutions still need to be strengthened in order to meet persistent needs. After the VCA training and exercises in Bosasso, the branch recruited a disaster management/CBFA/volunteer manager, to be responsible for disaster and volunteers management in the branch.

In March 2008, Berbera branch volunteers and staff started piloting CBFA *in Action*. Communities in three districts were orientated about the new approach. In Berbera and Sheikh Sub-branches 60 volunteers undertook refresher training in basic first aid. The most active of these volunteers will be trained as CBFA instructors with the task of coaching and supervising community volunteers in carrying out CBFA activities, using the new approach. SRCS organized a “CBFA *in Action*” master facilitator’s workshop in Hargeisa, Somaliland in April 2008. The workshop, which was the third of its kind included participants from 12 SRCS branches and National Societies of Eritrea, Ethiopia, Kenya, and Sudan. After the workshop, the participating SRCS branches drafted their plans of action that are to be implemented upon approval by the SRCS management.

Health and Care

Global Agenda Goal 2: Reduce the number of deaths, illnesses and impact from diseases and public health emergencies.

Programme component 1: Maternal, Newborn and Child Health

Outcome/Expected result

- Improved access to quality and gender-sensitive health services

Achievements

Maternal and child health/Out-patient Department

The SRCS runs 62 Mother and Child Health/Out-Patient Department (MCH/OPD) clinics and two hospitals in Somalia. Twelve stationary and two mobile clinics are located in Somaliland. Five of them were supported by funding from the Finnish RC, three from the Netherlands RC, and two mobile units from the Saudi RC, all through the Federation’s Somalia Delegation. Four of the clinics were supported bilaterally by the German RC.

In Puntland, there are 18 stationary and two mobile clinics. Twelve of them were supported by funding from the World Bank, two from the Norwegian RC, and two mobile units from the Saudi RC. Four of the stationary clinics were supported bilaterally by the German RC. Two of the mobile units, Sahil mobile in Somaliland and Galkayo mobile in Puntland, were added to the network in 2008. The remaining clinics in the Central/Southern part of Somalia were supported through the ICRC, while the CBFA, HIV and AIDS and OD activities were funded and supported through the Federation.

The stationary and mobile clinics covered the following components of comprehensive community health: curative services, immunisations, growth monitoring, safe motherhood/reproductive health, nutrition, HIV and AIDS, and health education. All clinics had a staff of one head nurse, one assistant nurse, and a midwife. Each clinic also drew on the experience and services of a varying number of Traditional Birth Attendants (TBAs). In addition, the stationary clinics each had at least 15 trained volunteers.

The clinics received one standard pre-packed kit containing drugs for the out-patient department and dressing materials from the Federation on a quarterly basis. UNICEF provided the clinics with all drugs and supplies for the MCH activities under an agreement with SRCS. WHO provided microscopes and reagents, and supervised the quality of the laboratory services.

Consultation

The most common diseases seen in the clinics were acute respiratory infection (ARI); diarrhoeal diseases; skin and eye infections; anaemia and malnutrition. The ARI is chiefly a result of poor housing conditions and improper hygienic practices.

Diarrhoeal diseases were related to the scarcity of clean water, poor hygiene and sanitation practices, intestinal worms, and poor breastfeeding and weaning practices. Diarrhoea was one of the chief health problems in major towns and IDP camps in Puntland. In 2008, there were outbreaks of diarrhoeal diseases in both Galkayo and Garowe. In response to the outbreaks, SRCS provided chlorinated water sources for 4,465 people.

Each clinic has an oral rehydration therapy (ORT) corner for the dehydrated cases. Management of the cases follows the Integrated Management of Childhood Illnesses (IMCI) approach. The clinic staff and volunteers mobilised the communities to take preventive measures on diarrhoeal diseases using ARCHI (African Red Cross/Red Crescent Health Initiative) tool kits.

Anaemia and malnutrition was due to frequent diseases, intestinal worms, and lack of food, and limited knowledge about a balanced diet and the mode of food preparation. Eye infections and skin diseases resulted from water shortages, lack of information/education, seasonal winds and poor hygiene.

Some 300,000 consultations were recorded in the Somaliland and Puntland clinics during 2008, out of which 61,000 people were seen by the four mobile clinics. The increase was 43% compared to 2007.

The north-western Awdal region is prone to malaria outbreaks. At Boon clinic all households received two insecticide-treated mosquito nets. There was a malaria outbreak in the Goldogob clinic area in the Mudug region in Puntland, in early 2008. A team of SRCS health officers, and a doctor and laboratory technician from the Ministry of Health was sent to the area. They took blood slides using a Rapid Diagnostic Test (RDT) and microscopy. 40 patients tested positive, and two children, aged eight months and two years respectively, died. The main reasons for the outbreak were (a) that the district hosts many IDPs from South/Central Somalia where malaria is endemic; and (b) water is stored in traditional open reservoirs (barkeds), giving mosquitoes a place to breed.

Immunisation

The objective of the SRCS' EPI is to reduce the incidence and death rate of six major preventable early childhood infections; diphtheria, pertussis, tetanus (in particular neo-natal tetanus), poliomyelitis, measles and tuberculosis.

The programme focused on steadily increasing the immunisation coverage of under-five children and pregnant women. Daily immunisation sessions were carried out at the clinics and during outreach services. UNICEF provided the EPI with supplies and equipment. During 2008, there was a solid increase in the number of immunisations, up 67% for children in 2008 compared to 2007. This increase in immunisation coverage could be attributed to the resilient efforts of SRCS volunteers, community health committees (CHCs) and traditional birth attendants. They all helped with mobilising communities during the accelerated vaccination campaigns; they traced defaulters in the area; and encouraged mothers to have their newborns vaccinated.

Growth Monitoring

Through routine measurements of children in the programme areas, the IHCP aimed at reducing the risk of malnutrition and catch risk cases early. The health workers monitored children's growth using growth charts and if needed refer them to SFP and OTP. Children were registered and controlled monthly. Tracing of defaulters was carried out on a regular basis by SRCS and community volunteers with support from the community health committees and clinic health workers. The same practice was applied for the Expanded Programme of Immunisation (EPI) cases.

Children identified as moderate or severely uncomplicated malnourished were given a bracelet for documentation and received Unimax and Plumpnet provided by UNICEF. Families were referred to WFP in order to receive limited supplies of food to protect all family members.

In 2008, there was an increase in the reported cases of *oedema and severe malnutrition* compared to 2007. The increase in oedema cases in children was a staggering 581% in 2008. The UN Food Security Analysis Unit (FSAU) identified general insecurity, food insecurity caused by drought, hyperinflation and high food prices, and the outbreak of diarrhoeal diseases as the factors driving the high malnutrition levels in Somalia. The situation was further aggravated by limited access to health services because of the security situation. The SRCS and the International Federation made joint assessments and preparations for addressing the chronic food insecurity situation in conjunction with the Federation's Horn of Africa appeal.

Safe motherhood/Reproductive health

Safe motherhood was an essential health service provided by the clinics. Women of childbearing age were offered antenatal and postnatal care (ANC/PNC) services in order to detect high risk pregnancies early and refer them to the nearest higher health facility. During clinic visits, expectant mothers were given tetanus toxin vaccine and micronutrients. They were encouraged to come for at least 3-4 clinic visits during their pregnancies. Harmful traditional practices such as female genital mutilation (FGM) were discouraged.

According to statistics, most Somali children continue to be born at home with deliveries attended by TBAs. However, there was a significant increase in the number of deliveries at the clinics, attended by trained midwives. This increase is associated to the health awareness created by clinic staff, volunteers, and CHCs in the communities.

Between 2007 and 2008, the number of ante-natal and post-natal visits increased by over 100%. In a parallel development, the number of referrals decreased by 39% during the same period. This gives a clear indication of raised awareness among women, i.e. more pregnant women come to the clinics when they realise they are pregnant, thus making it possible for clinic staff to detect and deal with risk pregnancies early on.

Programme Component 2: HIV and AIDS

Outcome/Expected result

- Reduced prevalence of HIV and AIDS through community mobilization, outreach activities and advocacy

The figures of detected and reported HIV infections were low due to lack of data and infrastructure. In 2007, UNICEF estimated the average HIV and AIDS prevalence to be 1% with certain areas probably having twice that figure. Somalia is surrounded by countries with much higher prevalence rates, and increased cross-border activities could lead to an increased rate in Somalia.

Stigma and discrimination against persons who are HIV-positive is very real in Somali communities. There are examples of individuals being shunned or physically abused by family members, friends or other community members, because of their status. Therefore, the SRCS

paid special attention to the prevention of stigma and dogmatism of people living with HIV and AIDS. The SRCS continued to build the capacity of its staff and volunteers using the HIV and AIDS Prevention, Treatment, Care and Support (PTCS) package.

With the support of volunteers and HIV and AIDS focal persons, clinic staff carried out health education sessions on HIV and AIDS facts and discrimination reduction. A total of 37,578 persons were reached, including truck drivers, youth, business people, travellers and students.

HIV testing is currently not done due to a lack of laboratory facilities and personnel trained in testing and counselling; although the clinics treat STIs. The SRCS does not provide home-based care, food or material support for chronically ill patients in the clinics.

Programme component 3: Community-based first aid (CBFA)

Outcome/Expected result

- Improved community basic first aid skills within target population

The SRCS implements its community based first aid programme building on the experiences from its comprehensive community health services. Since 2006, the SRCS has participated in testing the new *CBFA in Action* approach, in which “learning by doing” is encouraged within communities. The programme aims at engaging communities in public health emergencies; improving their involvement in preventing water and sanitation-related diseases; and improving basic first aid skills among target populations. In 2008, the CBFA programmes reached 14 branches, five in Somaliland and three in Puntland, and six in SCZ.

Most branches undertook VCA aimed at reducing health and disaster risks through better preparedness and early warning mechanisms. The major hazards identified included: conflict accompanied by a high level of population movements; drought and environmental degradation; disease outbreaks; poverty and the lack of educational facilities, which all combined to increase people’s vulnerability. A strong social network and volunteer base, livestock and livestock products and small businesses were identified as main capacities. Future CBFA and DM activities will be based on further analyses of the VCA findings.

A translation workshop for *CBFA in Action* materials (volunteers’ manual, implementation guide, household tools and facilitators manual) was held in Hargeisa in March 2008. The translation team comprised of national health officers, health officers and DM/CBFA managers from selected branches. In April 2008, the SRCS also organised a CBFA Master Facilitators regional workshop in Hargeisa; 24 SRCS staff and representatives from the national societies of Kenya, Eritrea, Ethiopia and Sudan participated.

All SRCS branches continued to train volunteers on basic first aid. Each branch trained between some 20 volunteers per session at regular intervals, creating a pool for selection of CBFA and other volunteers. In 2008, 42 volunteers and 14 clinic staff were trained as CBFA trainers. First aid kits were prepositioned in all SRCS branches for use at community level.

Rehabilitation services

The SRCS provides rehabilitation services for disabled people in Somalia. This activity is supported on a bilateral basis by the Norwegian RC and with ICRC providing technical assistance. There are three rehabilitation centres one in Mogadishu, covering South and Central Somalia; one in Galkayo covering Puntland; and one in Hargeisa covering Somaliland. These centres provide physiotherapy and prosthesis services to victims of war, landmines and vehicle and other accidents.

Health education

Health education sessions were carried out routinely, both in the clinics, during outreach activities, and by the mobile units. The sessions aimed at giving communities the information

they need to improve their health-seeking behaviour, and to utilise services offered by the clinics. Clinic staff, volunteers and community health committees were involved in these activities. Some of the topics covered are prevention of common diseases such as diarrhoea, malaria and respiratory infections, the importance of going for ANC/PNC visits, the health benefits of breastfeeding and the importance of immunisation. The sessions also cover sexually transmitted infections, HIV and AIDS and TB.

Basic health education is an integral part of the service delivery at all SRCS programmes and entities. Weekly health promotion sessions were held by the four mobile clinics and during the outreach sessions conducted by the clinics. Mobile clinic staff and volunteers in co-operation with the community health committees conducted 46 such sessions. A total number of 8,040 people were reached. Health education is also an important component of the community-based first-aid activities carried out by volunteers at the sub-branch level. Currently, statistics and data from these activities are under scrutiny.

Supported by volunteers and HIV and Aids focal persons, SRCS clinic staff reached 37,578 persons, including truck drivers and travellers, students in school and other youth, business men and women, through health education sessions on HIV and Aids and related matters.

Organizational Development

Global Agenda Goal 3: Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability.

Programme component 1: SRCS branch and volunteer development

Outcome/Expected result

- Increased impact of the SRCS volunteer network

Achievements: SRCS continued to support the construction of volunteers' clubs (*naadiga*) at branch level. A *naadiga* serves as a resource and multi-purpose centre for volunteers and to support their work in the branches. It is also used to generate income through internet services, and by renting it for public events. The *naadiga* for the Berbera branch was completed equipped and became operational in May 2008.

Programme component 2. Governance

Outcome/Expected result: Governance of SRC is strengthened

Achievements: An SRCS "All-Inclusive" meeting took place in Djibouti in July 2008. This meeting constitutes the highest governing body of the NS (equivalent to a general assembly). It brought together SRCS branch governance and management from all zones and levels of the NS. The meeting led to a reinforcement of the Executive Committee; it formally adopted a number of studies and evaluations; it reviewed the SRCS' current Strategic Plan (2005-09), and set the framework for the next strategic planning process.

Principles and Values

Global Agenda Goal 4: Promote respect for diversity and human dignity, and reduce intolerance, discrimination and social exclusion.

Programme component 1. Fundamental Principles and Humanitarian Values

Outcome/Expected result

- Awareness of Fundamental Principles and Humanitarian Values of the Red Cross Red Crescent among the target communities promoted
- Stigma and discrimination towards people living with HIV (PLHIV) reduced

Achievements: Promotion of Fundamental Principles and Humanitarian Values is mainstreamed into all SRCS community activities. HIV and AIDS stigma reduction sessions were carried out in Puntland and Somaliland that directly targeted some 57,500 people including the most vulnerable groups.

Constraints or Challenges

- Security concerns and difficulties of access increased considerably as humanitarian aid workers were specifically targeted in a number of incidents of attack and kidnap for ransom.
- Logistical and communication challenges also continue to be among the constraints of working in Somalia.
- SRCS has for some time kept losing personnel from its clinics, to other organisations. This trend puts quality services at risk, strained remaining personnel, and is costly in the longer-term.
- The risks faced by local aid-workers in 2008 are likely to lead to increased security costs also in 2009. The Society and the delegation will continue to pay close attention to developments in this sector.

Working in partnership

The SRCS worked with the support of several Movement partners, including the British, Finnish, German, Netherlands, Norwegian, American and Swedish Red Cross Societies and Saudi Arabian Red Crescent Society. The International Federation, these partners and the SRCS plans, implements, monitors and reports on programmes. The Federation's Somalia delegation enjoyed good working relations with the National Society. Individually and together, the partners work closely with the ICRC and constitute an example of a well-functioning Movement. The SRCS has also maintained excellent working relationships with and received support from the World Bank, key UN agencies including UNICEF, WFP and WHO, which also provide material support in form of medical supplies and equipment, and technical advice on implementation and training.

There is a global recognition of the crucial role played by SRCS in the humanitarian sector in Somalia. It is therefore essential that the Movement continues to assist the National Society and guarantee its long-term economic security and sustainability.

Contributing to longer-term impact

SRCS approach to programming and service delivery is directed by its Strategic Plan for 2005-09 which has been consistently supported by its Movement partners. The programmes carried out in 2008 have contributed to all the four Global Agenda goals. The framework for the development of the National Society's new five-year strategic plan was agreed upon during the "All-Inclusive" meeting in July 2008.

Response to emergencies including drought and AWD outbreaks has reduced the impact of the disasters. The health programme continues to reduce illnesses and deaths of vulnerable women and children, and other patients who have no access to other health facilities. The community approach to health care provision and disaster management by SRCS builds local capacities to address communities' own vulnerabilities.

Looking ahead

In 2009, SRCS will establish a new Strategy 2010-2014, which will provide a basis for continued partner support. Its reflections should include a further integration of the Society's comprehensive community health concept. Further strengthening of both governance and management will be on the agenda.

How we work	
<p>The International Federation's activities are aligned with its Global Agenda, which sets out four broad goals to meet the Federation's mission to "improve the lives of vulnerable people by mobilizing the power of humanity".</p>	<p>Global Agenda Goals:</p> <ul style="list-style-type: none"> • Reduce the numbers of deaths, injuries and impact from disasters. • Reduce the number of deaths, illnesses and impact from diseases and public health emergencies. • Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability. • Reduce intolerance, discrimination and social exclusion and promote respect for diversity and human dignity.
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