

**A SITUATION ANALYSIS OF STDs/HIV/AIDS
PROGRAMME IN SOMALIA**

December 2000

Acknowledgements

Often the execution of any survey research project involves, directly or indirectly, a large number of individuals and groups that deserve recognition. In the case of the Situation Analysis survey in Somalia, those involved are far too many to mention individually, but some must be mentioned anyway. First and foremost, the following individuals at UNICEF Somalia Support Office in Nairobi and at the field offices in Somalia, deserve special mention: Mr. Eban Taban, Senior Epidemiologist and UNICEF Consultant, who conducted the study, Mr. Manuel Fontaine, Senior Programme Coordinator for giving direction and guidance needed to undertake this survey, Mr. Marcoluigi Corsi for providing technical critique and suggestions on the research design, Ms. Mehret Gebreyesus, who provided the technical supervision to the entire research process. Their support from the Nairobi Office was very helpful in gearing the survey process with the speed required to give rapid results. It is important to recognize UNICEF Resident Programme Officers: Dr. Romanus Mkerenga, Somaliland - based in Hargeisa, and Mr. Jonathan Veitch, of the Central and Southern zone based in the town of Baidoa and the Health Officer in Puntland, Dr. Willis Ouma Agutu for providing support in the field. There were people in the field whose assistance was indispensable and must be given special thanks and recognition for their technical inputs and guidance in planning and facilitating the field operations to be accomplished with least problems and these persons are: Ibrahim A. Shire, Amina Nur Musa and Awil Bashir Ahmed of Bossaso, Hargeisa and Baidoa, respectively.

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Table of Contents

Acknowledgements	2	
Executive summary	5	
• Data collection		5
• Findings	6	
Background	8	
Objectives	8	
Methodology	10	
Research Findings	11	
Conclusions	20	
Appendix:	21	
References	27	

List of figures:

Figure 1:Type of organizations providing health services	
in Somalia, 2000	11
Figure 2:Distribution of organizations by type of programmes,	
Somalia, 2000	12
Figure 3;Service delivery systems used by organizations	
working	
in health in Somalia, 2000	13
Figure 4: Range of services provided by the organizations in	
Somalia, 2000	14
Figure 6: Distribution of organizations by type of clients	
served,	
Somalia, 2000	15
Figure 7: percent distribution of projects by diagnostic type	
for STDs,	
Somalia, 2000	15
Figure 8: Counseling approached used by projects, Somalia,	
2000	16
Figure 9: Percent distribution of projects according to topics	
covered	
In STD counseling, Somalia, 2000	
17	
Figure 10: Percent distribution of projects by type of clients	
Receiving free condoms, Somalia, 2000	
17	
Figure 11: Percent distribution of projects by ability of	
laboratory	
Diagnosis of specific STDs, Somalia, 2000	
18	

EXECUTIVE SUMMARY

The Situation Analysis was conducted to describe the access and the availability of STDs, HIV and AIDS programme services in Somalia during the period September - October, 2000. The study was conducted by a consultant for UNICEF Somalia and entirely financed by UNICEF. The study collected information from a total of 28 Non Governmental Organizations and International Agencies working in Somalia. Some of these NOGs and International Agencies are based in Nairobi. The study used a set of structured self-administered questionnaires. The regions covered by the study include: Benadir, Beletweyn, Hudur, Baidoa and Berdera in the Central and Southern zone; Bossaso, Garowe and Galkaio in Puntland (NE zone); and Boroma and Hargeisa in Somaliland (NW zone). More than 40 questionnaires were distributed to the NGOs and Agencies but only 28 were returned before the deadline. Of the 28 questionnaires that were returned, only 23 were adequately completed. The Situation Analysis covered in this preliminary report is therefore based on only 23 questionnaires with complete information.

DATA COLLECTION

The basic data collection instruments used were developed by the consultant and customized for application in the Somalia situation during two days of planning in two of the zones. Monitoring and Evaluation officers in the two of the zones, NE and CS, and the HIV/AIDS focal person in the NW zone helped to distribute the instruments. Data was collected on a number of information items, including the following:-

- Availability of, and access to STD/HIV/AIDS services
- Availability of IEC materials in NGO/Agency program
- Availability of, and Laboratory services for STD diagnosis
- Geographical spread of NOG/Agency programmes
- Preparedness of clinic/facilities to provide a wide range of STD/HIV/AIDS and reproductive health services

FINDINGS

The main findings of the study were:

The provision of family health services, including SDT/HIV/AIDS services in Somalia, is largely dominated by NGOs and the International agencies, who comprise about 77.3%. Government and privately owned health care services provide only limited services for the control of STDs.

Nearly 96% of the organizations studied work in health projects while, 41 % work in emergency and water projects/programmes, respectively.

Nearly half (45%) of the projects/programmes are located in major regional towns. 25% are located in major administrative capitals, mainly in Nairobi.

Half of the projects have between one and two project sites, 18% did not indicate the number of project sites, and about one third have between three and sixteen project sites. Only 64% of the projects stated their project goals.

More than 90% of the projects are have both clinic and community based services compared to only 18% with only clinic/facility based services.

The services provided by the projects range from ante-natal (91%), post-natal (82%), curative (86%), control of sexually transmitted diseases (77%), well baby clinics (child health) 68%, family planning (45.5%0, and HIV education (36.4%).

Although the majority of the projects target mainly the general population (86.4%), many have specific target audience, such as clients seeking MCH/FP services (55%), clients seeking STD treatment (55%) and women of reproductive age (68%). There appears to be less effort exerted to targeting adolescent (41%), in-school youth (30.4%) and out of school youth (27.3%).

Efforts are being made by some of the projects to screen clients for potential STD infections. About 46% of the projects confirmed that they do routinely screen their clients for STDs.

Laboratory services are lacking for many of the projects. This is confirmed by the finding from asking projects the methods their staff use to make diagnosis for specific STDs. The specific STDs were listed as syphilis, gonorrhoea, HIV/AIDS, candida and trichomoniasis and the two main means of making diagnosis are laboratory and syndromic approach. Only 43% of the projects report that adolescents have access to information and services for STD and HIV/AIDS. Topics covered during a typical STD counseling session include: prevention of STDs/HIV/AIDS (73%); risk reduction through safer sex (55%); treatment seeking practice/behavior (59%) and availability of treatment facilities (59%).

Free condom distribution and their use is not very popular/common in Somalia. Only 27% of the projects report that they provide free condoms to male clients presenting with STD symptoms, 14% provide condoms to female clients with STD symptoms, 32% to female clients attending MCH/FP clinics, possible as contraception. Less than 5% of the projects provide condoms to female adolescents and 23% do provide condoms to male adolescent youth.

Only 14% of the projects report that they provide voluntary counseling and testing for HIV sero status.

All the projects interviewed did not report availability community outreach services. Asked as to which IEC materials are available to clinic/facility staff to use, 46% of the projects mentioned posters, 32% mentioned pamphlets, 18% fact sheets and 9% mentioned other promotional materials and anatomical models, respectively. Less than 10% of the projects design/develop their own IEC materials, 14% get from national AIDS control programmes and NGOs, respectively, 23% get from international agencies and less than 5% get from other ministry of health departments.

More than 63% of the projects do not have budgets for STD/HIV/AIDS control programming.

Background

Rates of infection with the Human Immune-deficiency Virus (HIV) have continued to rise rapidly in Sub-Saharan Africa despite efforts undertaken by governments and international agencies. In Somalia however, the number of people infected cannot be accurately determined. Service statistics from existing health facilities also cannot be relied upon since these figures are always reluctantly compiled. Sentinel surveillance systems are yet to be started.

Services for managing sexually transmitted diseases (STDs) and HIV/AIDS prevention and control in Somalia has only recently currently received attention from the International community, governments, where these exist and local non-governmental organization movement, with introduction of the Syndromic Approach to the management of STDs. Prior to the introduction of this approach, STD patients were treated through diagnosis of specific diseases by referral of samples for laboratory testing. With the Syndromic Approach, a client is diagnosed, at the point of contact, through history taking and categorization into a broad syndrome according to a clinical algorithm, treatment is then made by syndrome rather than disease. Training in this approach to date has only recently been carried out by UNICEF.

UNICEF, together with other international and local NGOs, are currently developing a STD/HIV/AIDS prevention and control programme in Somalia. It was decided therefore that a situation analysis as well as a response analysis be conducted to inform the process of developing such a programme. Data from this situation analysis provides information on STDs services and HIV/AIDS interventions> This information can also serve as baseline measurements in the future to monitor and assess the impact of any STDs/HIV/AIDS intervention programmes. A second study, which is a response analysis, will form the second part of the study.

This study also provided the opportunity to strengthen the Situation Analysis methodology. This relatively new approach has not been used in Somalia.

Objectives

Ultimate objective:

To provide comprehensive information on the availability and functioning of STDs/HIV/AIDS services in Somalia, so that needed improvements and expansion can be planned and implemented.

Immediate objectives:

- 1) to document the level of preparedness (availability and function status) of STDS/HIV/AIDS programme's major subsystems to provide STDs and HIV/AIDS services using the integrated approach.
- 2) To determine the need for STDs/HIV/AIDS services among populations receiving these services at the health facilities.
- 3) To determine the integration of FP, STD management and AIDS prevention procedures at the clinic level.

Methodology

One approach to undertake this comprehensive study is to use the "situation analysis" approach. The data collection instruments used were developed by a consultant and approved by UNICEF Somalia. Data were collected on a number of information items, including:

- 1) Availability of, and access to STDs/HIV/AIDS services
- 2) Availability of Information, Education and Communication (IEC) materials in NGO programmes
- 3) Availability of laboratory services for STDs
- 4) Geographical spread of NGOs/Agency programmes
- 5) Preparedness of clinic/facilities to provide a wide range of STDs/HIV/AIDS and reproductive health service.

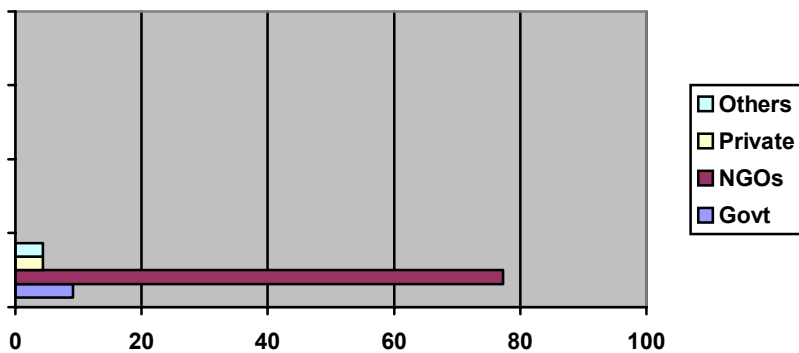
Two separate, but mutually reinforcing questionnaires (Situation Analysis and Response Analysis) were distributed to over 40 international and local NGOs working in Somalia. As it turned out, many of these agencies do not have health programmes, let alone STDs/HIV/AIDS interventions, only 29 questionnaires were returned and only 23 of these had complete information. The analysis reported in this report is therefore based on only the 23 questionnaires

Research Findings

In total more than 40 questionnaires were sent out to NGO, local and International to collect data on the availability of STD and HIV/AIDS and accessibility of population to those services.

Only 23 of the 29 questionnaires that were returned had acceptably complete information. As is clearly seen in the chart below, more than 77 percent of those organizations that returned questionnaires were non-governmental organizations compared with less than 10 percent governmental and less than 5 percent each, reflecting private and other non specified organizations, respectively. This suggests that the provision of family health services, including STDs and HIV/AIDS services in Somalia has been largely dominated by NGOs and the International agencies.

Figure 1: Type of Organizations providing health services in Somalia, 2000.

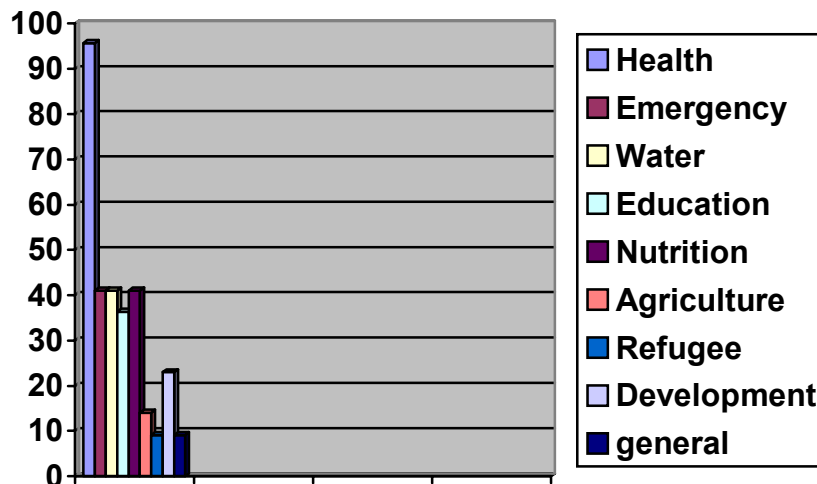


Over 95 percent of these organizations contacted have programmes in health, 41 also maintain emergency work while another 41 percent are also involved in the provision of clean safe water. The proportion of the organizations that have school education, nutrition agriculture, refugee and development work are 36.4%, 41%, 14%, 9.1%, 23%

and 9.1% respectively. These findings are presented in figure 2 below.

Nearly one half of the organizations tend to be located in the major regional towns and another 25 percent are located in major administrative capital, mainly in Nairobi while maintaining satellite field locations in Somalia. Table 1 below presents the findings.

Fig2: Distribution of organizations by type of programmes/projects Somalia, 2000.



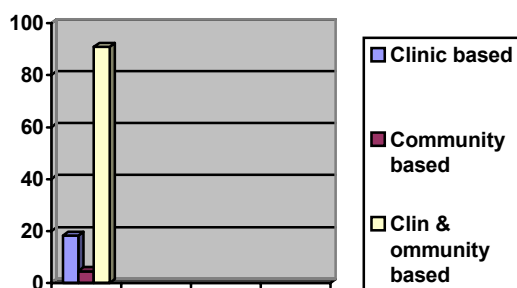
The organizations were asked to state where their programme or projects were located and the greater majority of them mentioned major towns (45%) compared to 25% of organizations being located in administrative capital (mainly in Nairobi). Only 10% of the organizations are located in rural areas.

The questionnaire also collected data on the number of project sites each of the responding organizations maintained. One half of the organizations have between one and two sites, one third have between three

and six sites and nearly 18% did not mention the number of project sites. Close to two thirds of the organizations (64%) stated any programme goals.

Data collected on the service delivery systems used by different organizations indicate that the majority of them, more than 90 percent, provide health care services in a combination of clinic-based as well as community-based approaches. Clinic only service delivery system was reported by 18 percent of the organizations, while nearly 5 percent reported providing services through only community based approach. (*note that the percentages do not add up due to multiple responses to each individual approach or strategy). These results are presented in figure 3 below.

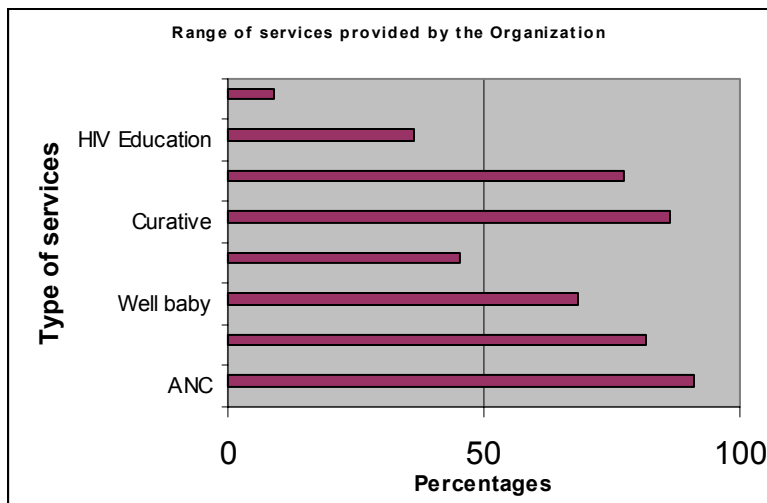
Fig 3: Service delivery systems used by Organizations working in health in Somalia, 2000



Availability of services:

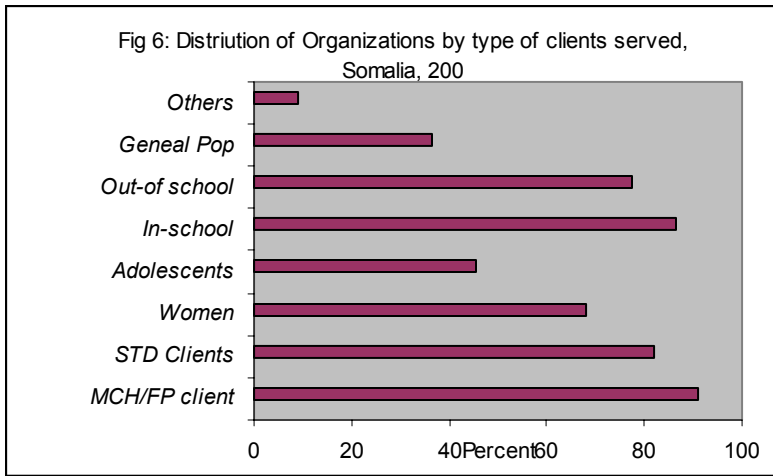
The range of services provided the different organizations included ante-natal, post-natal, child health (well baby clinics), family planning, condom distribution, HIV education and curative. The question asked each organization to check all that apply to their programmes. The results indicate that 91 percent of all the organization do provide ANC, 82 percent provide post-natal, 68 percent provide child health (growth monitoring, immunizations etc), 86 percent provide curative services, and only 36 percent provide education about HIV. It is interesting to note that some 77 percent of the organizations do provide condoms, while only 46

include family planning services. The findings from this information item should be of interest to programme managers who aim at designing STD/HIV/AIDS strategy for Somalia, especially the figures reflecting services for family planning, HIV education and condom distribution. The se results are presented in figure 4 above.

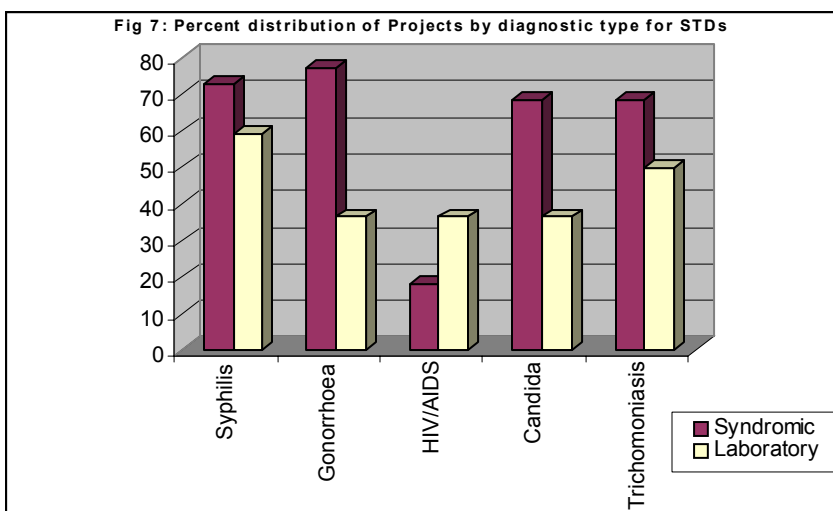


What target populations do organizations serve?

Data was collected on the type of clients or a combination of clients projects working in health in Somalia serve. Of interest here are the disproportionately less in and out-of school youth receiving any services. Only 27 percent of the organizations do provide some services to out of school and 30 percent to in-school youth. Other adolescents are provided services by about 41 percent of the projects. More than 54 percent of the projects provide services to clients seeking MCH/FP and those seeking sexually transmitted diseases. The majority of the projects report that they provide services to the general population (86 percent) as well as to women of reproductive age (68 percent). It is clear from this finding that generally, the youth is ignored or under-served by majority of the organizations/projects. This evidence further suggests that future any health programming, be it STD and HIV/AIDS or the whole range of reproductive health issues, should take the needs of the youth into account. (See figure 5 below)



Efforts are being made by some of the projects to screen clients for potential STDs, about 46 percent of the projects have reported doing so. This might not be enough and more effort needs to be exerted. It is also likely that the youth and adolescents are being missed out, even by the projects that have started screening clients for sexually transmitted diseases. Future projects should consider creating youth-friendly services where this vulnerable group can seek general reproductive health services to meet their needs. Project managers/staff were also asked to indicate which of two diagnostic approaches they use to determine who has any specific STDs. The two methods/approaches are syndromic and laboratory. From the study, it is clear that laboratory services are either generally lacking or inadequate for many of the projects in Somalia. This is confirmed by the findings presented in figure 7 below.

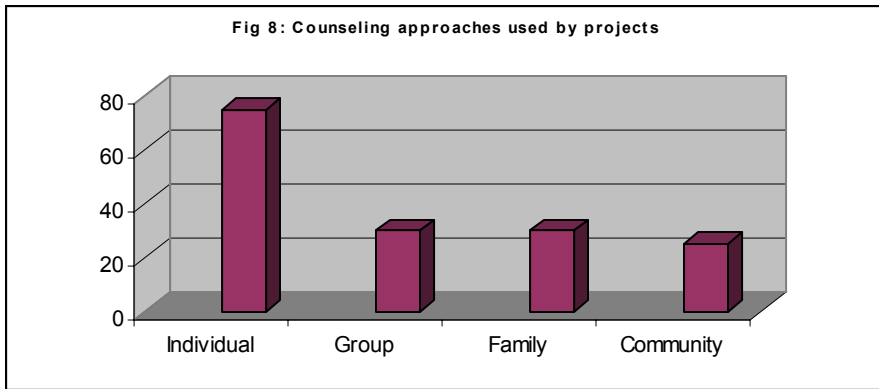


The study also found that very few clients report to clinics with STDs. 64 percent of the project report

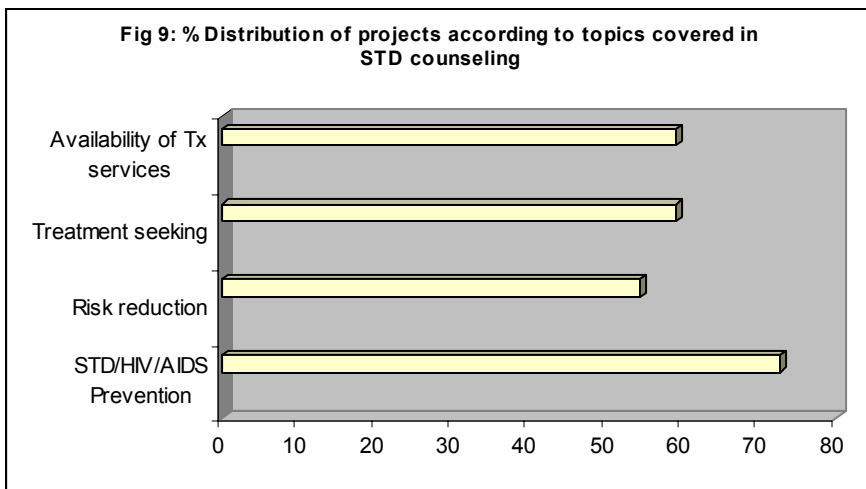
a daily average of less than 4 clients presenting with an STD. About 23 percent of the projects see between 4 and 6 patients while 14 percent see up to 9 patients per day. This may suggest that the majority of the STDs occurring in the population are either self treated or are simply asymptomatic. The use of syndromic approach to diagnose and treat STD may bring to surface most of the unseen cases.

We needed to know whether adolescents enjoy adequate access to information and services for STDs and HIV/AIDS. It is disappointing to note that only 43 percent of the projects in Somalia could provide these services. The topics covered during a typical STD counseling session which could benefit this vulnerable population group include: prevention methods, life skills, risk reduction and treatment seeking behaviour and availability of services. The majority of the projects (73%) reported providing counseling on STD and HIV/AIDS prevention, (55%) on risk reduction through safer sexual practices, (59%) on treatment seeking behaviour and another 59% on availability of treatment services.

For those clients reporting with an STD, 14 percent of the projects say they provide them with IEC materials and refer elsewhere for treatment while 23 percent of the projects would provide first, basic counseling, IEC materials and then refer. Only 9 percent of project clinics would make diagnosis, provide counseling, information, education and communication materials then refer for treatment. A good proportion (32%) of the projects would make a follow-up after performing all the other tasks already mentioned. Asked on how they actually perform the counseling, the majority of the projects preferred individual counseling (75%) to either family (30%) or group counseling (30%) or community counseling (25%). The pie chart (figure 8) below presents the distribution of how project staff handle counseling of clients with STDs.

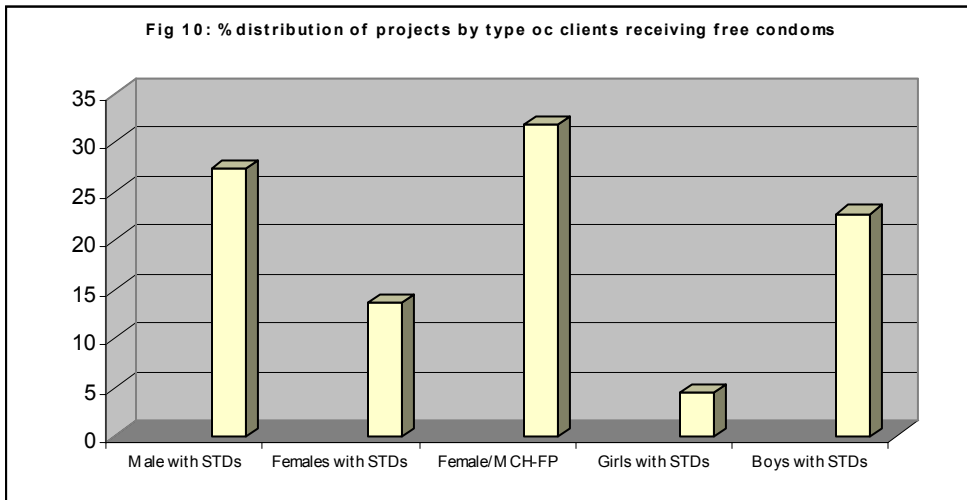


Project staff were asked to state whether the following topics were covered in a conventional STD counseling session: prevention of STDs and HIV/AIDS, risk reduction through safer sex, treatment seeking practices, availability of treatment services and facilities. The figure below presents the findings.

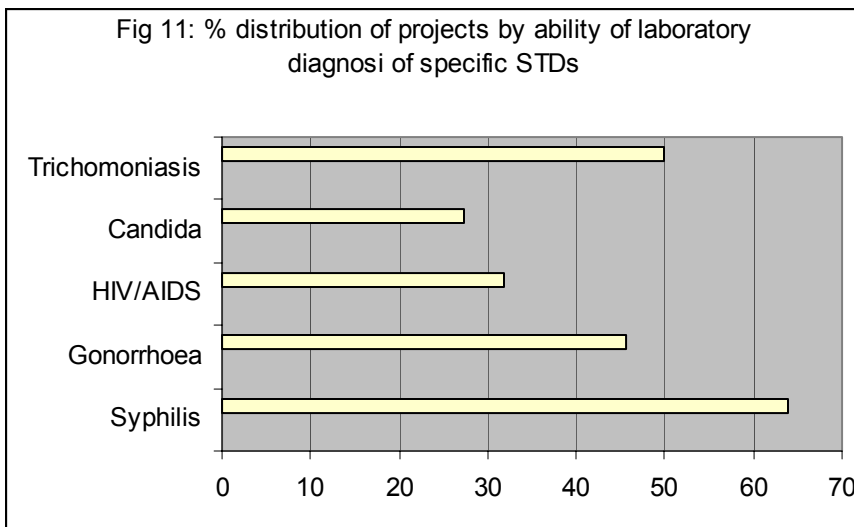


The study also wanted to know whether projects were providing/distributing free condoms to particular type of clients. The different groups of clients covered include: male clients presenting with symptoms of STDs; female clients presenting with symptoms of STDs; female clients attending MCH/FP; young adolescent girls with STDs and young adolescent boys with STDs. A higher proportion of the projects (32 percent) seem to be giving free condoms to females attending MCH/FP. This comes as no surprise since condoms are provided to married women in MCH clinics as a method of family planning. Male clients with symptoms of STDs also receive free condoms from about 27 percent of the projects. It is very surprising to note that about 23 percent of the projects give young adolescent boys free condoms and yet only less than 5 percent are giving free condoms

to young adolescent girls. The findings are presented in figure 10 below.



A set of two questions were asked of all projects. The question asked if there were any laboratory services available for diagnosing STDs. The second question demanded to know if the laboratories were able to provide diagnostic services for a range of specific STDs (syphilis, gonorrhoea, HIV/AIDS, Candida, and Trichomoniasis). The findings show that one half of the projects have laboratory services for diagnosing specific STDs. 64% of the projects suggest that the laboratories are able to make syphilis diagnosis, 46% are able to diagnose gonorrhoea, 32% can diagnose HIV/AIDS, 27% candida and 50% able to diagnose Trichomoniasis. According to this finding, it appears that most of the available diagnostic laboratories in Somalia are not equipped adequately enough to be able to diagnose Candida. (See figure 11 below for graphical presentation)



Only half of the projects stated that they are able to trace the sex partner of any STD client who received treatment from their clinics or treatment centers. Asked how they make contact tracing, 50 percent say they make appointment with clients to come back with their sex partners, 32 % each say they provide written messages and do home visits, respectively.

For clients presenting with complaints suggestive of HIV/AIDS infection, staff of the clinics follow a set of procedures, ranging from provision of IEC materials, referral to higher level medical facility, provide basic counseling, pre and post test counseling, test clients for HIV sero status or do absolutely none of the above. Very few questionnaires contained this information and it is not considered worthwhile reporting here. Having said that, it is worth noting here that three of the projects (14%) said they provide voluntary counseling and testing to clients who request.

Projects were also asked which IEC materials they have for staff to use with clients. It turned out that posters are the most available are reported by 46 percent of the projects, followed by pamphlets (32%) and facts sheets (18.2%). Anatomical models and other promotional materials were each reported by only 9.1 percent, respectively. Only 9.1 percent of the projects said they developed their own IEC materials but for most, their IEC materials come for other sources, including international agencies (23%), NGOs (14%). (The numbers involved in the analysis of this variable are very small that they are not worth presenting here). Only one of the

projects has ever done any meaningful project evaluation.

More than half of the projects do not have provision for funding STD and HIV/AIDS programme, while between 18 percent of them have budgets ranging from 5 to 10 percent of their total country programme. Nine percent of the projects have budgets of range from between 11% to 20% of their budget leaving another nine percent with budgets more than 20%.

Conclusions

The above findings suggest that the health care services and other family welfare programmes should pay immediate attention to the following issues to improve service accessibility and quality, through which the demand for STD/HIV/AIDS and reproductive health services will likely increase.

1. Staff preparedness to provide MCH, FP, STI and HIV/AIDS services: There is need to provide staff of health facilities with a adequate training in the whole range of reproductive health, especially STI and HIV/AIDS.
2. Apart from training the service providers in the management skills for the individual services, there is a need to train them on how to provide these services using the integrated approach.
3. The findings also suggest that adolescents do not receive adequate access to reproductive health information and services, as do adults. There is a need to design youth focused and comprehensive youth-friendly reproductive health services, including STI and HIV/AIDS.
4. Providers must receive adequate training in counseling.
5. Provision of improved laboratory diagnostic equipment and supplies must be made to all the facilities currently providing blood screening and STI diagnosis.
6. Efforts should be made to encourage free condom distribution in order to increase their use for double protection against unwanted pregnancy and STI and HIV/AIDS infection.
7. Provision of culturally acceptable IEC materials should be increased to all static and outreach services in order that information reaches who are otherwise difficult to reached.
8. Introduce school based STI, HIV/AIDS and reproductive health services to in-school youth in order to target young adolescent girls and boys completing schools.

9. Introduce street theatres to target out of school youth with HIV/AIDS prevention information so that they can make informed decisions about their own sexual and reproductive health behavior.

PART ONE: SITUATION ANALYSIS

**HIV/AIDS/STDs Situation Analysis model Questionnaire
For use in Somalia, 2000.**

UNICEF Somalia Support Office is conducting a Situation Analyses on HIV/AIDS and STDs in Somalia in order to identify who is vulnerable to HIV/AIDS and why, the most serious obstacles to expanding the national response and the most promising opportunities for expanding the response. This questionnaire is being distributed to all agencies, local or international, currently in Somalia. Please complete all the questions as accurately as you can possible make it and return it to the UNICEF liaison office in your zone of operation as soon as possible, preferably before mid September, 2000. **PLEASE RESPOND TO BOTH PARTS, ONE & TWO SIMULTANEUOSLY. THANKS**

IDENTIFICATION INFORMATION:

1. Name of the Organization: _____

2. Type of organization: [Tick all that apply]

- Government Ministry
- Private Voluntary Organization
- Non-Governmental Organization
- Private Sector/Company
- UN – Specialized Agency
- Other: _____ (specify)

3. Type of Programme/Project: [Insert a 1 for a “Yes” and a 2 for “No” for all that apply]

- Health
- Emergency
- Water
- Education
- Nutrition
- Agriculture
- Refugee Affairs
- Development
- General purpose programme

4. Name of the Respondent: _____

5. Official Title of respondent: _____

6. Full Address of Project: _____

7. Telephone Contact: _____ Fax Number: _____

8. E-Mail Address (if any) _____ Other contact: _____

9. Location of the Programme/project:
 1 = Yes 2 = No
 Administrative State capital []
 Major zonal []
 Major regional town []
 Other major urban centers []
 Rural community []
 Any other area not listed above (Specify) :
-

10. How many sites does the programme/project operate in? Give Number: [|]

- Q11. Does the project have stated Goals/policies/guiding principles?
 1 = Yes 2 = No []

Please state them as in the original project document:

- Q12. What are the service delivery systems used in the programme/project? [Tick all that apply]
 [] Only clinic/facility based
 [] Only community based
 [] Combined (both clinic and community based)
 [] Other (specify):
-

- Q13. Which of the following services are provided within this programme/project?
 [Tick all that apply]
 [] Ante-natal (MCH)
 [] Post-natal (MCH)
 [] Well Baby Clinic (Child Health)
 [] Family Planning (FP)
 [] Curative
 [] Sexually Transmitted Diseases (STDs – Control/Treatment)
 [] HIV/AIDS (Education/Prevention)
 [] Other (specify);
-

- Q14. What is/are the target population(s) for the programme/project?
 (Tick all that apply)
 [] Only clients seeking MCH/FP services
 [] Clients seeking STD treatment
 [] Women in Reproductive age group
 [] Adolescent/young people
 [] In-school youth
 [] Out-of-school youth
 [] General population
 [] Other: (specify)
-

HIV/AIDS/STDs

- Q15. In this programme/project, are clients asked questions that would screen them for potential STD infections?
 Yes = 1 No = 2 []

Q16. Which clients get asked screening questions for potential STD infections?
 [Tick all that apply]
 Yes = 1 No = 2 []

Q17. Once the initial screening has taken place, what are the methods used to make a diagnosis for the following STDs? (tick for a yes and an x for a no)

Type of STD	Method used for Diagnosing		
	Syndromic	Laboratory	None
1. Syphilis			
2. Gonorrhoea			
3. HIV/AIDS			
4. Candida			
5. Trichomoniasis			
6. Other (specify)			

Q18. In general, what is the number of STD cases seen at the clinic/facility daily?
 Give numbers: [|] cases per day.

Q19. Do the staff at the clinic/facility see a lot of STDs among women who make sex for money? 1 = Yes 2 = No [] How many per day [|]

Q20. Do adolescents have equal access to information and services for STDs and HIV/AIDS or the whole range of reproductive health matters through this programme/project?
 1 = Yes 2 = No

Q21. What procedures does the staff at the clinic/facility undertake for clients presenting with complaints suggestive of STD infection?

- [] Provide IEC materials but refer elsewhere for counseling [skip to Q22.]
- [] Provide basic counseling & IEC materials, then refer to specialized center, but no follow up.
- [] Make diagnosis, provide counseling & IEC, but refer for treatment elsewhere
- [] Make diagnosis, provide counseling, treat then refer elsewhere for follow up
- [] Make diagnosis, provide counseling & IEC materials, treat and follow up.

Q22. How are counseling services on STDs provided to clients in your programme/project?

- [] Individual counseling
- [] Group counseling
- [] Family counseling
- [] Community counseling
- [] Other (specify):

Q23. Are the following topics are covered in STD counseling?
 For each that applies check: 1 = Yes 2 = No

- [] Prevention of STDs/HIV/AIDS
- [] Risk reduction through responsible (safe) sex
- [] treatment seeking practices
- [] Availability/location of treatment facilities
- [] Other (specify):

Q24. Are condoms provided free in your programme/project to the following groups of clients? Check 1 = Yes 2 = No for each that applies.

- Male clients presenting with symptoms of STDs
- Female clients presenting with symptoms of STDs
- Female clients attending MCH/FP
- Young adolescent girls presenting with symptoms of STDs
- Young adolescent boys presenting with symptoms of STDs

Q25. If a laboratory is used to make diagnosis for STDs, where is it located?
1 = On site 2 = off-site []

Q26. Is the laboratory usually able to provide diagnostics services for the following STDs? Check 1 = Yes and 2 = No for all that apply.

- Syphilis
 - Gonorrhoea
 - HIV/AIDS
 - Candida
 - Trichomoniasis
 - Other (specify):
-

Q27. As part of the programme/project activities, is contact tracing undertaken for those seen with STDs?

1 = Yes 2 = No []

Q28. How is contact tracing or follow-up of clients seen at the clinic/facility usually done in this programme/project?

- None
- Through appointments to come back
- through written messages
- Through home visits
- other (specify):

Q29. Which of the following procedures does staff in your programme/project undertake for clients presenting with complaints suggestive of HIV/AIDS infection?

- Provide IEC materials but refer elsewhere for counseling [skip to Q30]
- Provide basic counseling, IEC materials & refer to specialized center, no follow-up.
- Test, provide pre & post counseling & IEC, but refer for treatment of complications elsewhere.
- Test, provide pre & post counseling, treat complications but refer elsewhere for follow-up
- Test, provide pre & post counseling, IEC materials, Treat complications and follow-up
- None of the above, staff/programme/project does nothing.

Q30. Is HIV Voluntary Counseling and Testing provided as part of this programme/project activity?

1 = Yes 2 = No []

If the answer above is NO, Please indicate where HIV testing is performed for your programme/project:

Q31. Are there any other facilities readily accessible facilities that provide management of the complications associated with HIV/AIDS to the following groups of people living in your project area? (Check 1 = Yes and 2 = No)

- Young adults
- Women of reproductive age
- Adult men
- General population
- People living with HIV

Q32. Are there any community outreach services or activities that provide care and Support to AIDS patients within your programme/project?

1 = Yes 2 = No [If No Go TO Q34]

Q33. If the answer to Q32 above is YES, Please describe the community activities.

Q34. Does the programme/project develop and distribute any HIV/AIDS/STDs education materials for use by clinic/facility-based staff in educating the population?

1 = Yes 2 = No (if No GO TO Q37)

Q35. Which of the following IEC materials are available for use by the staff in your programme/project?

- Poster
 - Pamphlets
 - Promotional Materials
 - Fact Sheets
 - Anatomical Models
 - Other (specify):
-

Q36. What is the source of the IEC materials that are used by staff in your programme/project?

- Designed and distributed by programme/project
 - National AIDS or STD Control Programme
 - Other Ministry of Health Programme
 - International Agencies
 - Non-Governmental Organizations
 - Other (specify):
-

Q37. Indicate whether the programme has done any of the following activities: (Check 1 = Yes and 2 = No for all that apply) For all Yes or 1 answers, please include a copy.

- Studies / research on STDs/HIV/AIDS?
- Obtained results of the studies/research mentioned above?
- Included an programme evaluation plan into the design?
- Obtained any results of previous evaluation

Q38. What proportion of your overall programme funding/budget is allocated for HIV/AIDS and STD Prevention and Control activities?
Give percentage:_____ percent.

References:

1. Guide to the strategic planning process for a national response to HIV/SIDS: UNAIDS Best Practice Collection, Introduction, May 1999.
2. Guide to the strategic planning process for a national response to HIV/SIDS: UNAIDS Best Practice Collection, Situation Analysis ,May 1999.
3. Guide to the strategic planning process for a national response to HIV/SIDS: UNAIDS Best Practice Collection, Response Analysis, May 1999.
4. Guide to the strategic planning process for a national response to HIV/SIDS: UNAIDS Best Practice Collection, Strategic plan formulation, May 1999.
5. Guide to the strategic planning process for a national response to HIV/SIDS: UNAIDS Best Practice Collection, Resource mobilization. May 1999.