

# GLOBAL AIDS RESPONSE PROGRESS REPORTING 2012

## Narrative Supplement 2010 -2011

**Somaliland, Puntland and South Central Somalia**



March, 2012

## List of Acronyms and Abbreviations

AIDS	Acquired Immune deficiency syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Ant-retroviral
BCC	Behavior Change Communication
CRIS	Country Response Information system
FSW	Female Sex worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GBV	Gender Based Violence
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
IOM	International Organization for Migration
INGO	International Non-Governmental Organization
IPTCS	Integrated Prevention Treatment Care and Support
KABP	Knowledge Attitude Behavior and Practice
M&E	Monitoring and Evaluation
MSM	Men who have sex with men
NAC	National AIDS commission
NCPI	National Commitment and Policy Instrument
NGO	Non-governmental Organization
OI	opportunistic Infection
OVC	Orphans and Vulnerable Children
PAC	Puntland AIDS Commission
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SCAC	South Central AIDS Commission
SF	Strategic Frame work
SOLNAC	Somaliland National AIDS Commission
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFG	Transitional Federal Government
UCC	UNAIDS Country Coordinator
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WFP	World Food Program

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## I Status at a Glance

### a) Background

Somalia is comprised of three entities which include; Somaliland, Puntland and South Central. With the exception of Somaliland which has made slight gains in a number of development areas, the social costs of war in the country have been enormous, leaving most parts with some of the lowest human development indicators in the world. According to World Bank, health indicators are also among the worst in Africa. Life expectancy is 47 years, and under-five and maternal mortality rates are a staggering 156 and 1013 per 100,000 live births, respectively. A majority of the population (71%) does not receive minimum dietary energy. Only 29% of the population has access to an improved water source and 25% to improved sanitation facilities. With this, all sectors face formidable socio-economic and political development challenges.

The Somali population is estimated at 18.8 million; and over 50 percent of the population is under the age of 15 years. The population consists in its majority of pastoralist nomadic communities, with agricultural communities' settlements in some parts; and is characterized by high mobility related to seasonal nomadic migration, and forced displacement due to the ongoing conflict in South Central and Puntland. Population movement occurs within various parts of the three major regions, and also across the porous borders into Kenya, Ethiopia and Djibouti.

The HIV and AIDS response is implemented through the AIDS commissions in Somaliland, Puntland and South Central. Thus wherever possible, the report attempts to present its data analysis according to the three administrative entities.

### b) Stakeholders' Inclusiveness in the Global AIDS Progress Reporting 2012

The compiling of the 2012 report has brought together representatives of all the stakeholders involved in the Somali HIV and AIDS response. Under the leadership of AIDS commissions in the respective zones, consultations on the key aspects of the report included; the civil society; International non-governmental organizations (INGOs) the national NGOs, organizations for people living with HIV (PLHIV) people living with HIV UN agencies, and some representatives of the line ministries. A working group comprising of UNAIDS WHO, UNDP, UNICEF, UNFPA and IOM have been instrumental in planning, coordination and technical guidance of the report.

### c) Planning

The tools and guidelines for the report were shared among AIDS commission and co-sponsors to familiarize them with the reporting process. After this, the Executive Directors of AIDS commissions,

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<sup>1</sup> USAID

respective M&E officers and WHO participated in the online training conducted by the AIDS reporting team focusing on reporting process and specific tools and indicators. After this a working group to oversee the reporting process was formed as part of the Joint United Nations Team on AIDS.

### c) Reporting Process

The zonal consultations were led by the Somaliland National AIDS Commission (SOLNAC), Puntland AIDS Commission (PAC) and South Central AIDS Commission (SCAC) with technical support by UN agencies. The zonal level workshops brought together various stakeholders to deliberate on key aspects of reporting, including the national commitment and policy tools and discussions on key aspects of reporting as guided by the format, data requirements and needs assessments. Apart from general deliberations on the process and other aspects of the report, civil society participants were tasked with completing part B of the National Commitment and Policy Instrument (NCPI) while the government participants delivered part A from each of the zones. Consensus on responses on all issues of the NCPI was reached on this stage. With the guidance of the NCPI and programme data shared by AIDS commissions, WHO UNICEF, IOM, UNDP and other organizations, a draft report was prepared. The draft report was circulated to the AIDS commissions and the technical working group for review and discussion. After this, further review and discussion was undertaken through one teleconference between Nairobi and the three zones. The teleconference was attended by the representatives of the national AIDS commission and UN representatives in Nairobi and at the zonal levels. Overall, the process was participatory, inclusive, and resulted in one shared report.

**Table 1: Global AIDS Progress Reporting (GARPR indicators)**

Target / Indicator	Value	Remarks
<b>Target 1: Reduce sexual transmission of HIV by 50 percent by 2015</b>		
I.1 Percentage young women and men of aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission*	<b>11.1%</b> Males = 8.7% Females= 13.4%	Source: Youth Behavioural survey 2011 by SOLNAC, PAC, SCAC and IOM
I.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	<b>4.2%</b>	Figure represents males only Source ( Youth Behavioural Survey 2011
I.3 Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	No data	
I.3 Percentage of adult aged 15-49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	No data	
I.4 Percentage of Adults aged 15-49 who had more than one sexual partner in the past 12 months and who report use of a condom during their last sexual intercourse	No data	
I.5. Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	<b>4%</b>  <b>7.8% ( 15-24)</b>	National UNICEF KAPB , 2004 <b>M=4.8% and F=2.5%) Youth Behavioural survey</b>

1.6 Percentage of young people aged 15-24 who are living with HIV	<b>0.94%</b>	Source: ANC sentinel survey 2004: other rounds did not cover the three zones
<b>Indicators for sex workers</b>		
1.7 Percentage of sex workers reached with HIV prevention programmes	<b>6%</b>	The total number of estimated Transactional sex workers is 0,6% of total adult women population
1.8 Percentage of sex workers reporting the use of a condom with their most recent client.	<b>24%</b>	Source : <b>Integrated Bio-behavioural surveillance (IBBS) 2008</b>
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results.	<b>0%</b>	Source: <b>IBBS 2008</b>
1.10 Percentage of sex workers who are living with HIV	<b>5.2%</b>	Source : <b>IBBS 2008</b>
<b>Indicators for men who have sex with men :</b> <i>None of the zones report having MSM, therefore the indicators not applicable</i>		
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	N/A	
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	N/A	
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 month and know their results	N/A	
1.14 Percentage of men who have sex with men who are living with HI	N/A	
<b>Target 2. Reduce transmission of HIV among people who inject drugs 50 percent by 2015</b>		
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	N/A	None of the three zones have programs or data on IDUS
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	N/A	
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	N/A	
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	N/A	
2.5 Percentage of people who inject drugs who are living with HIV	N/A	
<b>Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal death</b>		
3.1 Percentage of HIV- positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission	<b>3%</b>	Based on estimated 3091 women in need of PMTCT
3.2 Percentage of infants born to HIV- positive women receiving a virological test for HIV within 2 months of birth	<b>0%</b>	No Early Infant Diagnosis
3.3 Mother-to-child transmission of HIV (modeled)		
<b>Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015</b>		
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	<b>7%</b> <b>Adults 11%</b>	Total of ART : 1139 Estimates may be revised
4.2 Percentage of adults and children with HIV known to be on	<b>84%</b>	

treatment 12 months after initiation of antiretroviral therapy		
<b>Target 5. Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015</b>		
5.1 Percentage of estimated HIV- positive incident TB cases that received treatment for both TB and HIV	2%	Estimated TB co-infection is 2,100
<b>Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low and middle-income countries</b>		
6.1 Domestic and international AIDS spending by categories and financing sources	Ongoing	Data to be assessed through online tool
<b>Target 7. Critical enablers and synergies with development sectors</b>		
7.1 National Commitments and Policy Instruments(NCPI) prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	<b>Completed</b>	To be attached to the online tool
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence form a male intimate partner in the past 12 months	<b>No data</b>	
7.3 Current school attendance among orphans and non- orphans aged 10-14	<b>A: (Attendance 25.4% (Male=29.2%; Females=22.9%). B- (Attendance 29.6% - (Male=30.2%; Females=27.9%</b>	There is no difference in attendance between orphans and non orphans Multiple indicator cluster Survey (MICS)2006
7.4 Proportion of the poorest households who received external economic support in the past 3 months	<b>No data</b>	



## II Overview of the AIDS Epidemic

### I. Status of the Epidemic

The HIV and AIDS response is led by the AIDS commissions in Somaliland, Puntland and South Central zones. The analysis of the HIV epidemic in the three zones is based on limited data drawn from WHO sentinel surveillance supplemented by Integrated Biological and Behavioural Surveillance conducted among Female sex workers (FSWs) by SOLNAC with IOM's technical assistance. Ante-natal care (ANC) sentinel surveillance data is available for Somaliland and Puntland in the three rounds of surveillance 2004, 2007 and 2010. The 2010 data has not been published, and for validity reasons, it needs to be interpreted with caution in light of slight site reduction on sero-prevalence and increasing HIV co-infection. . South Central remains with only one data point making it impossible to observe the trends in prevalence. To date, no population- based survey integrating knowledge, behaviours and practices with sero –prevalence of AIDS indicator survey equivalent has been conducted. Due to this it has not been possible to link the status or outcomes of various behaviours to the impact level indicator of sero –prevalence. The drivers of the epidemic are not yet determined and so far only one priority sub-population (Female sex workers) has been singled out as having higher level of prevalence. Other studies linking other potentially interest groups such as; truck drivers, tea sellers and khat sellers are based on analysis of facility data which is prone to selection bias and not statistically attributable.

The national AIDS commissions considers to illustrate various contextual and setting attributes of the epidemic and considerations of the data available, a brief zonal overview follows below;

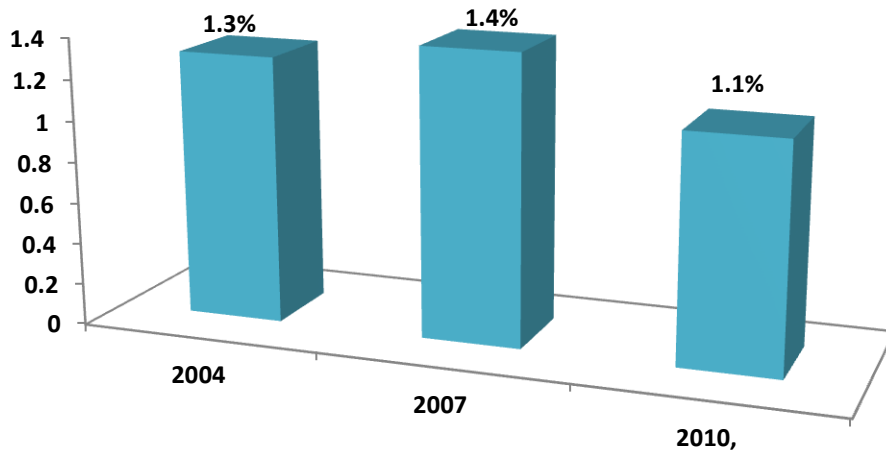
#### a) Somaliland

Somaliland continued to be politically stable and comprises key geographical areas including towns and port cities associated with more pre-disposing factors related to HIV transmission. The most recent results show a negligible change in sero-prevalence. However, results in such settings may vary due to small scale population dynamics such as mobility and sampling errors. Above this, there is an upward trend in TB and STI co-infection which needs further explanations.

Somaliland had three rounds of sentinel surveillance since the first one in 2004. In addition Somaliland was part of the national sero-prevalence survey that was conducted in 1999 covering the three zones. The three rounds of surveillance have firmly confirmed the status of Somaliland as a generalized epidemic after consistently surpassing the 1% sero-prevalence threshold. In addition the rates of TB and STI co -infection have remained above 5%.

Five sites have been consistently participating in surveillance rounds in Somaliland. The majority of the sites are in peri-urban areas. There are some variations in prevalence of the sites not necessarily based on the setting characteristics. Further analysis of the surveillance data did not find any statistically significant relationship between HIV prevalence and geographical setting.

**Fig1: Trends in Sero-prevalence 2004-2010 Somaliland**

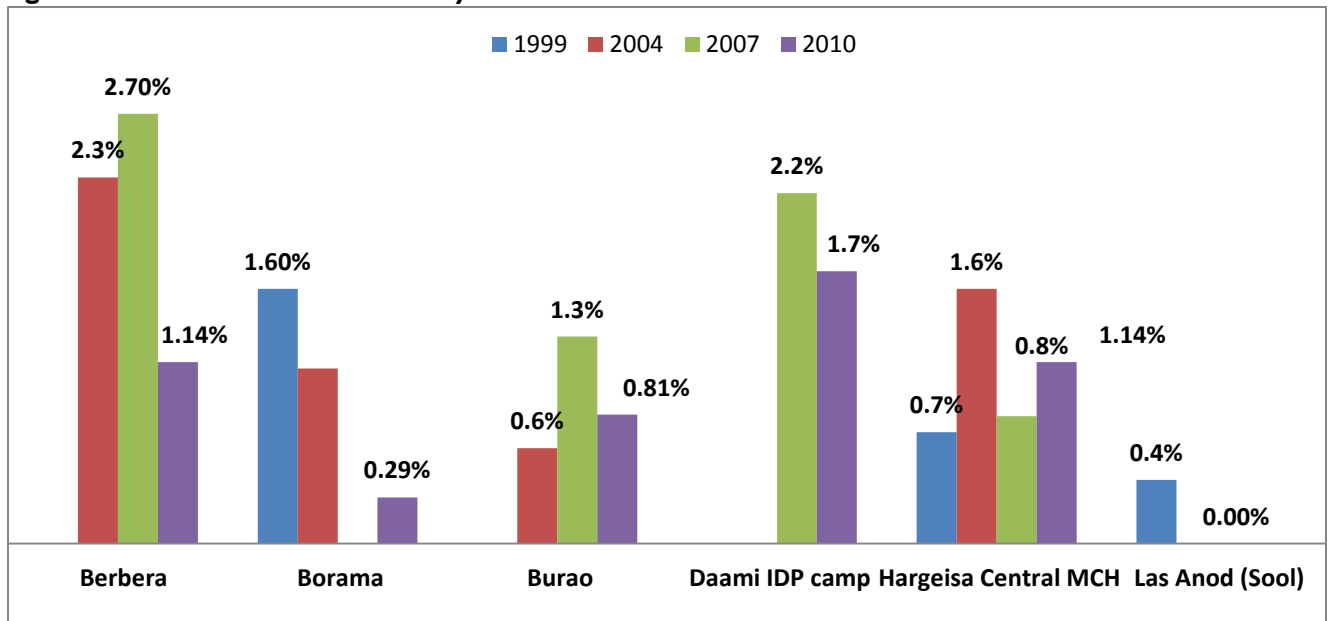


**Source: ANC sentinel Surveillance 2004, 2007 and unpolished 2010**

Continued surveillance has yielded varying trends on different surveillance sites. The port city of Berbera has been one site of interest in various rounds of sero-prevalence. In 2004, the site recorded the highest HIV prevalence amongst the three Somali zones, namely 2.3%, which increased to 2.7% in 2007, and 1.14 in 2010. The previous trend supported the ongoing indications that HIV prevalence was high in port cities which have been supported by findings of the hotspot mapping in the three zones.

In Borama HIV sero-prevalence was 1.6% in 1999 to 1.1% in 2007 and 0.3% in 2010. On the other hand, Burao has had a positive trend rising from 0.6% to 1.3% in 2007 and 0.8% in 2010. Daami IDP camp has been part of two surveillance exercises in 2007 and 2010. There is a slight variation in the prevalence of HIV from 2.2% in 2007 to 1.7% in 2010. Hargeisa Central Maternal and Child Health (MCH) Clinic recorded sero-prevalence of 0.7% in 2004, 1.6% in 2007 and 0.85% in 2010. Las Anod was part of only one surveillance round in 1999 which showed a prevalence of 0.4% hence it is not possible to review trends due to limitations of subsequent data points in the following years. Any shift in the sero-prevalence by site is not statistically significant due to small samples involved and cannot be generalized.

**Fig 2: Trends in Sero- Prevalence by Site Somaliland 2004-2010**



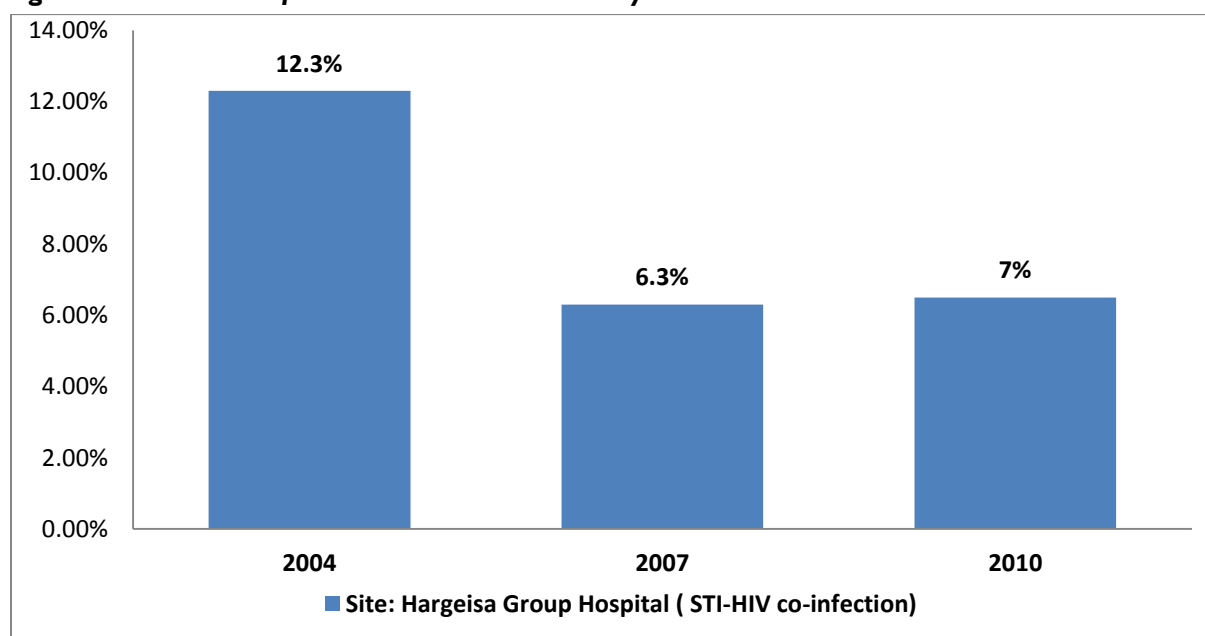
Source: ANC sentinel surveillance (NACs, MoH, WHO 2010, unpublished)

### HIV Co-infections

In addition to HIV surveillance among pregnant women, the exercise has been extended to TB and STI clinics in order to establish the co-infection rates. Data collection among 243 STI patients in Hargeisa Group Hospital found out that 12.3% were positive for both STI and HIV; the rate of HIV and TB co-infection in the same hospital was 6.3% and 7% in 2007 and 2010 respectively. During the same time the rate of HIV /TB infection was found to be 5.6% among TB patients in the Hargeisa TB clinic which has gone up to almost 15% in 2010. This rate of HIV among patients with STI syndromes points to potentially high transmission rates among people with multiple sexual partners considering the number of STI syndromes are equally high.

An integrated Biological and Behavioural surveillance targeting 237 Female Sex Workers (FSW) in 2008 revealed a sero-prevalence of 5.2%. Surprisingly, the prevalence of syphilis was 3.1%, while 0.4% were co-infected. None of the HIV positive FSWs reported use of injectable drugs, suggesting acquisition of HIV through heterosexual means. One in every 14 FSWs (7.8%) reported having genital discharge or sores. The difference between STI incidence and HIV prevalence was high suggesting a high likelihood of dual transmission within the core groups.

**Figure3: Prevalence of HIV in Patients with STI Syndromes**



Source: ANC sentinel surveillance (NACs, MoH, WHO)

**Table 2: TB, STI and HIV Co-infections in Somaliland**

Site	Number tested HIV positive	Total tested	Percent HIV positive
Hargeisa Group Hosp ( STI patients)	14	200	<b>7</b>
Borama TB Hosp	4	130	<b>3.08</b>
Burao TB Hosp	6	100	<b>6</b>
Hargeisa TB Hosp	44	300	<b>14.67</b>

Source: Sentinel Surveillance 2010 (unpublished)

In summary Somaliland continues to exhibit the characteristics of a generalized epidemic based on the consistent sero-prevalence above the threshold of 1% in general population. This can be attested to 1% prevalence in 1999, 1.3% in 2004, 1.4% in 2007 and 1.1 % in 2010. Further to this, the IBBS results indicated that 5.2% of FSWs were positive for HIV further within the threshold of a generalized epidemic. This shows that HIV is establishing in the general population.

## **b) Puntland**

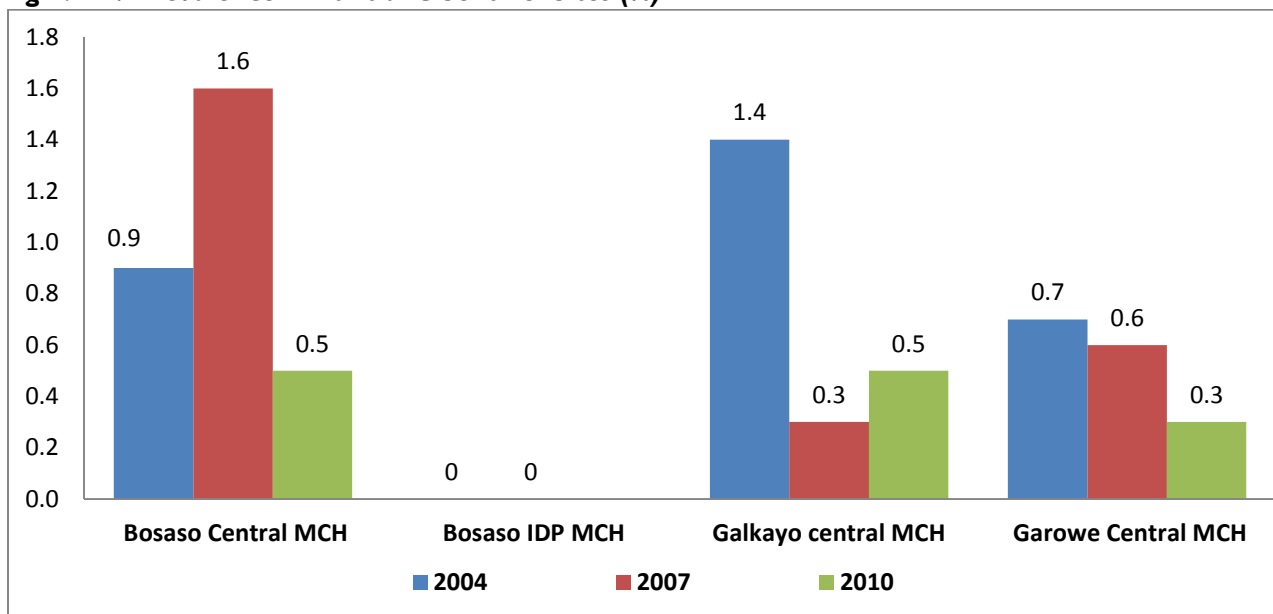
Most of the regions continued to be politically stable with factors favourable to population interaction. The zone is home to a substantial proportion of IDPs and with coastal towns such as Bossaso hosting various cross border and mobile population and other priority populations associated with HIV

transmission potential. Previous and most recent surveillance results do not show any marked differences in the overall prevalence. At the site level, there are slight differentials in trends in levels of prevalence as per the details below:

Five facilities in Puntland participated in the 2004, 2007 and 2010 sentinel surveillance. The results of 2004 showed that Puntland had a mean prevalence of 0.9% median (1%). In 2004 Bossaso central MCH recorded prevalence of 0.9% before rising to 1.6% in 2007 and 0.5 % in 2010. In all the three rounds of surveillance no single case was recorded in the Bosaso IDP camp center. Galkaacyo central MCH recorded the highest prevalence of 1.6% in 2004, 0.5% in 2007, and slightly increased to 0.5% in 2010.

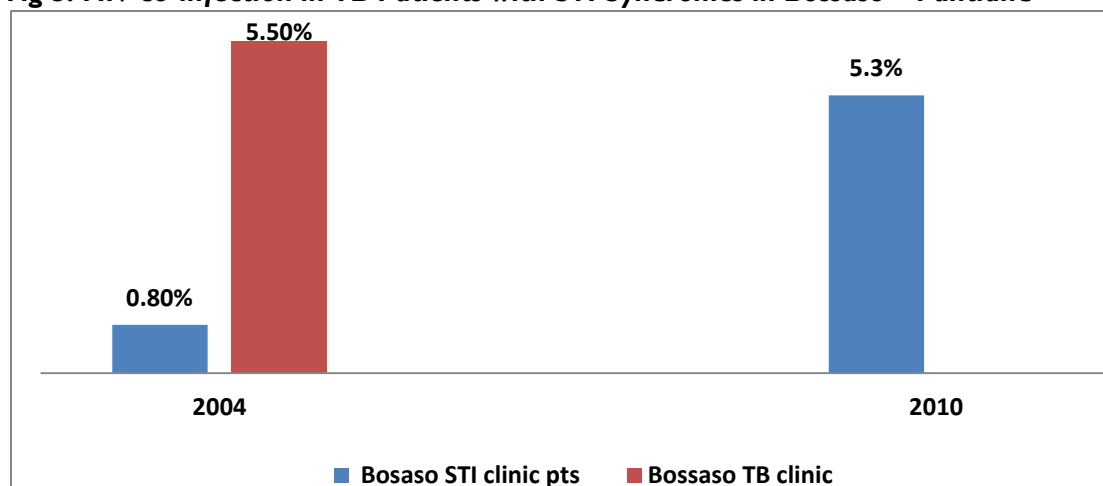
In Garowe the prevalence rate remained at the same levels over the three rounds. In 2004 the prevalence rate was 0.7%, in 2007, 0.6% before reducing to 0.3% in 2010.

**Fig 4: HIV Prevalence in Puntland Sentinel Sites (%)**



In examining the HIV prevalence among patients with STI syndromes in Bossaso STI clinic, 0.8% tested positive for HIV in 2004 which increased to 5.3% in 2010. The number of patients tested in each of the rounds was 513 and 130 respectively. There was no testing of TB patients in 2007; however, the rate of HIV co- infection among 217 TB patients tested in 2004 was 5.5%. In 2010, the rate of HIV and TB co- infection was 6.8%. Considering the trend on rate of HIV among STI remained at the same level the transmission potential still exists.

**Fig 5: HIV co-infection in TB Patients with STI Syndromes in Bossaso – Puntland**



**Table 3: TB, STI and HIV Co-infections in Puntland**

Site	Number tested HIV positive	Total Number tested	Percent HIV positive
Bosaso STI clinic	7	130	5.38
Garowe TB Center	6	172	3.49
Mercy TB Centre	12	176	6.82

Source: Sentinel Surveillance 2010 (unpublished)

In summary, the results from the 2010 surveillance suggest reduction in incidence of HIV in all the sites. With the exception of Galkaayo where an increase in prevalence was observed, a decline was witnessed in other sites. This has however happened when HIV prevalence increased from 0.8 % to 5.3 % in patients with STI syndromes in the same period. Like in other zones a comparison in what was predicted through spectra has some variations that are subject to some explanations. Global epidemiological evidence suggests that the presence of STI is a pointer to risk of HIV infection. Hence there is a need for further explanation on the slight decline of HIV sero-prevalence when STIs are quite common in the three zones.

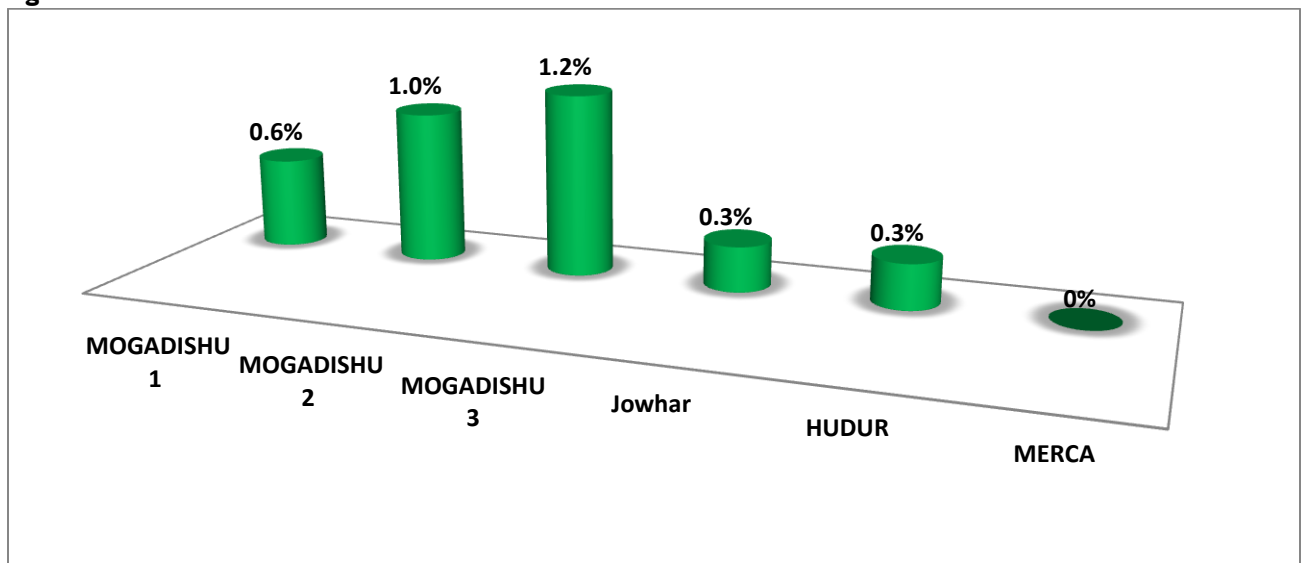
### **c) South Central**

South Central has not known peace for 2 decades now. The underlying security and contextual challenges have curtailed data collection efforts hence there has been a dearth of surveillance data since 2004. There could have been potential changes in the epidemiological aspects of the disease due to immigration and massive population displacements. However, lack of current surveillance data and behavioural data impedes the understanding of the dynamics of the disease for more evidence informed programming.

Little is known about zonal, population or site changes in the epidemic since 2004. The WHO sentinel surveillance 2004 showed prevalence rates ranging from 0% to 1.2% in Merka and Mogadishu respectively. The survey showed an overall zonal mean prevalence of 0.6%. HIV prevalence in other regions Jowhar and Hudur were 0.3% each. Since no specific group showed a prevalence of 5%, in this study and no other data is available, South Central is still considered a low epidemic zone.

South Central has been home to most vicious fighting with potential pre-disposing factors resulting from the conflict that include; displacement, gender vulnerabilities, establishment of new sexual networks and loss of livelihoods. These could lead to sexual exploitation, abuse and other violations with HIV transmission implications in the long-term. The impact of stigma and complexity of the HIV emergency setting are some of the obvious limitations of understanding the epidemic in the absence of recent sero-prevalence data. For the first time in 7 years, sentinel surveillance has been conducted in South Central since 2004. The analysis of data is ongoing implying the understanding of HIV epidemic in South Central is based on 2004 data.

**Fig 6: HIV Sero- Prevalence in South Central Sentinel Sites -2004**



#### **d) Summary**

The limitations of data for describing the national epidemic in absolute terms still persist. However, available data consistently conforms to a generalized epidemic in Somaliland. Previously, the prevalence of HIV in sub groups qualified Puntland to be a concentrated epidemic. More studies need to be conducted to determine the status of Puntland in view of preliminary results of the 2010 unpublished results. South Central data lacks currency since it dates back to 2004; therefore the status of the epidemic is not fully established with recent statistics. Over the 7 years there are possibilities of various epidemiological dynamics in HIV transmission, which could not be established in long absence of surveillance. However, the zone is considered as low epidemic zone on the basis of the available data.

There is also a disparity between the trends of TB, STI and HIV co-co infection which are not in line with overall sero-prevalence especially in the result of 2010 surveillance.

The pre-disposing factors and characteristics in some sites remains, there has not been any documented behaviour change on which the decline can be attributed. Since the surveillance methodology has not changed, the few working numbers are prone to changes that might have resulted in the decline. The next round of surveillance will confirm the status.

## **2. Knowledge, Attitudes and Behaviours**

Limitations of data on which to establish progress of a programmatic response on various outcomes extends to knowledge, attitude and behaviour. The last comprehensive study covering all age groups and key indicators was conducted in 2004. Since then, a few other studies have been conducted on a small scale for programmatic baselines, evaluations and for other use by individual agencies. From 2008 there has been a conscious effort to reach out to priority populations by understanding various knowledge behaviours and other associated factors. The 2008 IBBS study provided insightful information about FSWs which has been very valuable and contributed to improve targeting of the sub-group. In 2010, SOLNAC, PAC, SCAC with technical support of IOM conducted a study targeting the knowledge and behaviours among youth in the three zones. With this it has been able to compare progress on a number of standard youth indicators with the plausibility of methodologies. Trends on these indicators show slight improvement in comprehensive knowledge and behaviours among the youth. However the trends in awareness are very positive and almost universal. Finally, for information on cross border and mobile populations, IGAD (Intergovernmental Authority on Development) conducted a rapid assessment in the IGAD region targeting pastoralists. This further provides community level information on pastoralists and their host communities. A summary of the key findings on the status of various outcomes has been detailed below.

### **Pastoralism and HIV AIDS IN IGAD Countries: Extract for 3 Zones**

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A Rapid Assessment which was commissioned by (IGAD) to inform countries to develop improved regional response to the challenge of HIV and AIDS among pastoralists in 2010 has provided useful findings of the epidemic among pastoralists and host population. The relevance of the findings of this study is reinforced by the fact that 97% of the rural Somali population practice some form of pastoralism. Despite the limitations on the sample size, the findings point to the status of some indicators and are useful for specific targeting. However the results cannot be generalized due to limitations of sample size.

In Somalia the study was implemented in the three zones, Somaliland, Puntland and South Central. One of the key findings of the study was that there are interactions between most pastoral communities with the host communities. In Somaliland and Puntland the respondents indicated that although HIV is not common among them, STI s were widespread among the pastoral communities indicating the potential

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<sup>2</sup> Pastoralism and HIV in IGAD Countries



that exists for HIV transmission in this sub- population. Respondents' did not indicate existence of services within their reach.

Respondents in Somaliland and Puntland were unable to discuss about condoms with a person they had just met as condom use remains topic out of discussion for them. Regarding HIV testing none of the pastoralist (0%) knew a place where they could go for HIV testing in the three zones. Further, none (0 %) had undergone HIV testing at the time of the survey.

**Table: 4: Summary of correctly answered knowledge Questions Among Pastoral and Host Communities (Percentages)**

Questions	Somaliland		Puntland		South Central	
	Pastoral	Host	Pastoral	Host	Pastoral	Host
Can a person protect themselves from HIV by having one un-infected partner	100	100	25	50	0	100
Do you think a health looking person can be infected with HIV	0	100	63	83	0	100
Can a person get HIV from a mosquito bite	67	40	0	17	0	100
Can a person sharing cutlery plates and cups with someone infected be infected	83	20	38	67	0	100
Can a pregnant woman infected with HIV transmit the virus to her unborn child	100	0	63	75	0	100
Percent correct per zone	<b>61</b>		<b>48</b>		<b>50</b>	

**Source: Pastoralism and HIV and AIDS in IGAD countries - IGAD**

The study showed that among the 6 countries where the study was implemented, the three zones had the lowest knowledge about HIV, prevention, transmission and awareness of available HIV services and least exposure to HIV messages and information. For this reason this study among others recommended integration of HIV and Pastoral national strategy as a matter of policy concern. In conclusion the study indicates awareness of HIV and a number of related facts, but a lack of comprehensive knowledge and stigma remains significant. This is a pointer that progress has been made in sedentary populations around the urban and peri –urban areas but more needs to be done for the hard to reach and mobile populations.

## Youth Behavioural Survey Conducted by SOLNAC, PAC SCAC and IOM in Somaliland, Puntland and South Central

A study was conducted by three AIDS commissions with support of IOM focusing on knowledge, behaviour and practice and linkages to HIV vulnerability baseline study among youth aged 15-24 years. The preliminary findings indicate that although progress has been made on various behavioural aspects, the levels of age –specific vulnerability remains significant in the national response. The progress and levels of various national and global AIDS reporting indicators is summarized below:

**Table 5: Summary of key Indicators by zone**

National Program Indicators <sup>1</sup>	Somaliland		Puntland		South Central		Total	
(N)	M (241)	F (103)	M (242)	F (102)	M (278)	F (117)	M (761)	F (322)
Percentage of youth aged 15-24 who received an HIV test in the last 12 months and who know their results (modified from general population to youth)	9.1%	7.8%	12.4%	20.6%	1.1%	1.7%	7.2%	9.6%
Percentage of youth reached with HIV prevention programmes	4.6%	3.9%	3.7%	6.9%	0.4%	0.0%	2.8%	3.4%
Knowledge and Behaviour <sup>1</sup>								
Percentage of youth aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	14.1%	16.5%	6.6%	20.6%	5.4%	4.3%	8.7%	13.4%
Ever had sex <sup>3</sup>	17.9%	0.0%	5.8%	0.0%	9.0%	0.0%	10.8%	0.0%
Percentage of youth aged 15-24 who have had sexual intercourse before the age of 15	4.2%	0.0%	0.0%	0.0%	0.0%	0.0%	1.3%	0.0%
Percentage of youth aged 15-24 who have had sexual intercourse with more than one partner in the last 12 months (modified from general population to youth) <sup>2</sup>	3.7%	0.0%	2.9%	0.0%	1.4%	0.0%	2.6%	0.0%
Percentage of youth aged 15-24 who have had sexual intercourse with more than one partner in the last 12 months reporting use of condom during their last intercourse (modified from general population to youth) <sup>2</sup>	33.3%	0.0%	62.5%	0.0%	0.0%	0.0%	35.0%	0.0%
	(3/9)		(3/8)		(0/5)		(14/22)	
Attitudes and Risk Perception <sup>3</sup>								
Believes HIV is a punishment from God	96.7%	100%	91.3%	76.0%	95.8%	94.3%	94.8%	90.2%
Considers self at risk for contracting HIV	7.9%	2.0%	45.2%	22.5%	11.9%	3.5%	21.2%	9.2%

**Source: Youth Behavioural Survey**

## **HIV testing**

Compared to previous studies, there is a slight improvement in the proportion of youth who reported undergoing an HIV test and having received results. Less than one in every ten young people had undergone HIV testing for which results were received. There were slight sex and zonal differentials with slightly more females 9.6% than males 7.2% tested respectively. Reporting on testing is however prone to respondent bias. Looking at the zonal disparities, it is unlikely that one in every five girls in Puntland are tested for HIV and this is may not be supported by programmatic results.

## **Awareness, Knowledge and behaviour**

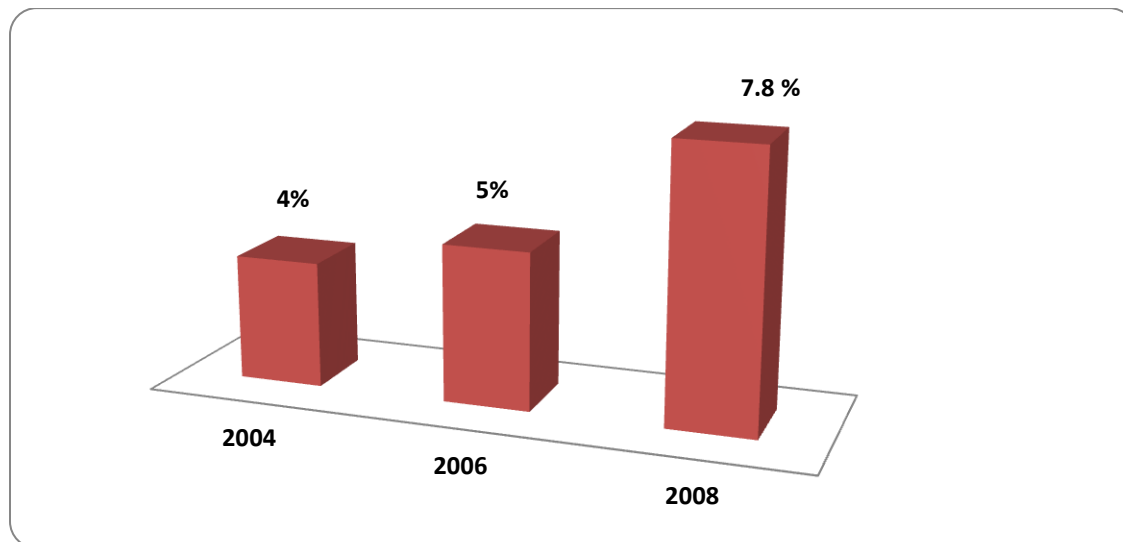
Comprehensive knowledge about HIV transmission was found to be strikingly low with a skewed level of 5.4 and 4.3% among girls and boys in South Central. Misconceptions of modes of transmission are still common. Only a third of males and females (30.4% and 29.8%) believe that condom is a means of protection in sexual intercourse. Around half of the youth 50% male and 42.9% females believe that people can protect themselves from HIV transmission through abstinence. In the same light one in every 5 young people (19.4%) believes that consumption of camel meat and urine are remedies for eliminating HIV virus. Despite this, more than 90% of youth reported having heard about HIV or AIDS implying that awareness is almost universal.

On a positive note, more than 80% of males and females know that a person can contract HIV through injection needles. More so two thirds of males and females knew that a healthy looking person could be HIV positive.

On the question raised on whether the youth had sex, only 10% answered in affirmative. More males reported having sex than females. Youth having sex were more common in Somaliland 17.9% compared to other zones. Overall only 1.3 % had sex before the age of 15 with a higher proportion of these 4.2 males in Somaliland having sex before the age of 15. The mean age of sexual debut is 15.9 years. It is of interest that the first sexual encounter is with peers, pointing to ongoing sexual relations between the youth.

Only 2.6% of the male youth admitted to having more than one sexual partner. Around one third of these (35%) reported to using a condom with their partner during their most recent sexual encounter, implying that the remaining 65% are at risk of infection. Condom use exhibited zonal differentials with more condom use reported in Puntland compare to Somaliland and very minimal use in South Central.

**Fig 7: Trends in Reported HIV Testing Among the Youth**



**Source: Youth Behavioural Survey, (KAPB 2004, MICS 2006)**

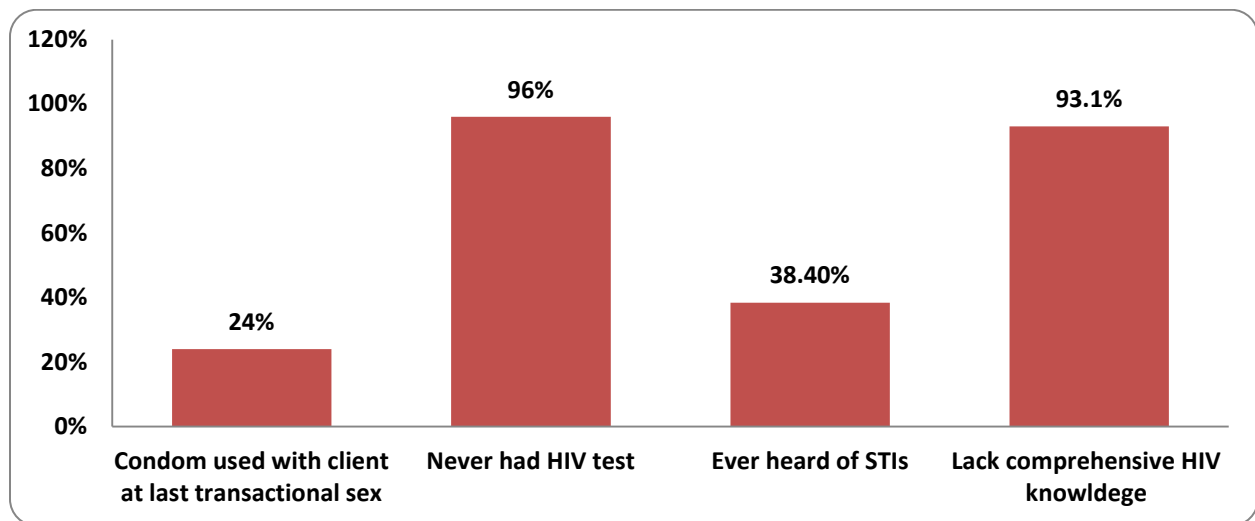
### **Beliefs and Risk Perception**

According to the study, almost all, 90% of both male and female youth believe that HIV is a punishment from God. Significant proportion of girls 24% in Puntland has a different opinion. Few females (9.2%) consider themselves to be at risk to HIV infection compared to 21.2% of males. Three in every four female youth (73.5%) believe that female circumcision reduces their chance of contracting HIV, which can potentially reinforce the practice.

On which groups through which HIV is spread, 61.9% and 50% of males and females respectively reported sex workers, while unmarried youth were reported by 32.1% and 25.2% of males and females respectively. Foreigners were perceived responsible for HIV transmission by 29.4 % of males and 17% females.

According to IBBS conducted by three AIDS commissions with support from IOM (2008) there was limited knowledge and practice of preventive behaviours among the FSWs implying that the potential for continued transmission still remained. Only 4% of FSWs were tested for HIV, while one in every four FSWs used a condom in the last transactional sex, while 93% almost all lack comprehensive knowledge on HIV with majority portraying various misconceptions. This is summarized in the figure below.

**Fig 8: Summary of knowledge and behaviours among Female Sex works – IBBS 2008**



Source: IBBS -2008

#### **d )Summary of Knowledge Attitudes and Behaviours**

Evidence from various studies summarized above indicates that variable progress has been made at various levels of awareness, knowledge, attitudes and behaviour. Due to programmatic response, awareness is almost universal. In terms of knowledge, significant progress has also been made, but comprehensive knowledge among the youth and other groups seems to be still limited. At the outcome level, there is also a slight change but considering the length of programmatic response this is in tandem with other results. Finally, to achieve more tangible results, the programmatic response on prevention, BCC and other related interventions need to be sustained and considerably scaled up.

## III National Response to the AIDS Epidemic

Despite a very challenging environment, the current HIV/AIDS programme has successfully strengthened the structures for coordination, managed to establish the framework for tracking the status of the epidemic and progress in the response starting from initially weak stand points. The programmatic response has been aligned to various demands in the zones in which the epidemic and demands seems to vary. In light of this, the needs in Somaliland remains slightly higher than the other zones and the consistency in sentinel results re-affirming a generalized epidemic indicates that the need to scale up interventions will be sustained.

The reporting period 2010/2011 saw sustenance of existing and launch of new initiatives in response to the HIV epidemic in the three zones. The response has taken a while to establish systems, build capacity and respond to various programmatic and contextual concerns. Lack of sufficient information to fully categorize the epidemic, the drivers and modes of transmission and cultural barriers has not made targeting easier. Despite this, crucial resources have been applied in the health systems and community level interventions to respond to HIV and AIDS needs with considerable effectiveness. At the zonal level, the AIDS commissions programming on key areas through the regional oversight structures received facilitation support.

The integrated Prevention Treatment care and support centres have remained central in the delivery of integrated services within the three zones. The delivery of services has been variable to the needs with Puntland and South Central calling for continued improvement of existing services while Somaliland focusing on scale up of the level of services. The unique needs and the situations of the three zones have been underscored in epidemiological analysis and differentiated response scales in the three zones. In general a range of services exist in priority geographical areas and their utilization has been improving over time. In some situations, staff turnover, stock out of commodities, low capacity of staff and stigma are common draw backs. For various programmatic and contextual reasons, it has not been possible to categorize any high risk group and provide outreach or separate friendly services to them. Below are key highlights on the status of various Policy and strategy prevention, treatment care and support and monitoring and evaluation progress made during the reporting period.

### 1. POLICY COORDINATION AND STRATEGY

This reporting period marked the midpoint of the Strategic Framework (SF) for the Somali response 2009-2013. So far, the SF has remained a useful guide to the response in a number of ways. There is an operational planning and costing exercise ongoing in 2012 to cover the remaining 18 months period. This will supplement the work plans and harmonized activities which is lacking beyond organizations represented in the current coordination mechanism.

Policy development started in the early inception of the response in 2006. By 2009 most of the policies were complete for review by parliamentary legislation. Few other policies and guidelines have been developed for upcoming interventions. The delay in endorsement of policies at legislative level continued

in the reporting period. A number of interventions have been delayed or implemented only partially in view of this.

During the reporting period, working groups and various other coordination structures had various input to the response. In the three Somali zones, there was sufficient information sharing through the Zonal HIV working groups although the meetings recommended that their TOR did not fit with accord wider responsibilities within the key areas of the response. The Zonal AIDS commissions meetings on a quarterly basis have also taken place regularly. Similarly, the IPTCS (Integrated Prevention Treatment and care and Support) meetings were regular and well-coordinated but some of the concerns highlighted by the participants include limited technical support from the key stakeholders. At the Nairobi level the HIV working group continued to provide good forum for the sharing of information and consultations on various programmatic activities. The steering committee proposed under the new structures was launched but not operationalized as envisaged. Other areas of coordination remained with the health sector committee. Compared to 2009, some substantial progress has been made in coordination particularly ongoing reforms which provide Somalis at all levels of the response to be represented in forums where key decisions are made.

At the zonal level, NACS received technical and coordination support for various activities that were implemented on a needs basis. In turn NACs provided oversight on all activities ensuring that various interest groups were targeted in line with the projects.

## **1 PREVENTION**

A detailed account of progress made and recommendations for each of the prevention interventions is detailed below. The overall rating of prevention interventions as per the national commitment and policy instrument (NCPI) is 60 percent indicating slight progress and confirming some satisfaction from stakeholders with a perception that more needs to be done.

### **a) Blood Safety**

For a long time, the country was not able to meet the standard requirements of blood safety. Consequently it was not possible to report on the indicator as external quality assurance and other conditions that formed the operational definition of the indicator were not met. During the reporting period, blood safety is an area where the response has made a lot of progress as per the 2010 recommendations. The programme has been finally reviewed and four blood banks have been established. For the first time in over 20 years, external quality assurance was undertaken covering 21 blood transfusion points in the three zones. Despite the security challenges, it was possible to do external quality assurance, including at 10 facilities in South Central. More efforts are being lined up to ensure that the external quality assurance is scaled up in more sites and additional staff trained to ensure that blood transfusion is safe. This is particularly very important for the South Central zone where emergency transfusion is necessitated by the context. The Blood safety programme has been hampered

by the unexpected delay in renovation of the banks. It is envisaged that this will be hastened from 2012 onwards in the spirit of scaling up. The new initiatives on blood safety need to be extended to Puntland where they have been lacking during the reporting period.

## **b) Voluntary Counselling and Testing**

This is one of the areas in which consistent gains in utilization and coverage has been made. Every year has seen substantial increases in the people undergoing HIV testing and counselling which has facilitated a link to referral and other intervention.

The VCT programme started in 13 Point-Of-Care (POC) centres in 2005, with a total of 900 people counselled, tested for HIV and received their result. This paved way for an expanded intervention that has seen more centres and people undergoing counselling and testing, receiving results and proceeding to other interventions.

In 2011, the number of facilities offering VCT has increased to 51, four times from 2005. The 51 facilities includes: 26 hospitals (referral and TB), 14 peripheral health facilities and 4 mobile VCT in IDP camps. In addition through the IRAPP project 7 more sites provided VCT services targeting cross border and mobile populations in the three zones. The distribution of the centres overall include; (23 in Somaliland, 17 in Central-South Somalia and 11 in Puntland). In addition Somaliland has been able to implement working mobile VCT centres during the reporting period.

By the end 2011, 100% of the hot-spots have at least one facility offering HIV services and a total of 49,121 people (43% female) benefited from VCT in the three zones. Those found HIV positive were enrolled in pre-ART and started CTX prophylaxis. VCT normally have higher rates as represent people testing usually due to health provider advice, or fear of exposure to HIV. Almost 60% of the VCT was provider-initiated.

Despite, the progress made so far, the coverage of VCT overall remains quite low. There needs to be a scale up of the VCT programme and integration with other services to increase availability and access within sustainable approaches. Going by the mobile nature of populations, it is important to increase mobile centres for the mobile populations and consider friendly centres for priority populations such as truck drivers, sex workers and IDPs so as to have more targeted testing, while focusing on the rural pastoralist out of reach population which may not have had a chance For HIV counselling and testing.

From programmatic and contextual stand points, the VCT programme continues to suffer from high levels of stigma among the health workers, and clients. This is due to lower levels of counselling for the clients and limited counsellor supervision and support among the health workers. Due to unforeseen increase in demand, there has been a shortage of test kits which will need to be addressed as the response gets into other phases operational planning and programming.

## **c) Prevention of Mother to Child Transmission**

PMTCT has been one of the key areas of concern among the preventative interventions in the country response. The 2010 report UNGASS recommended special attention to ensuring that the PMTCT programme is revitalized. From 2010 the PMTCT programme was re-launched by first developing a



policy through an inclusive process that involved participants from the Ministries of Health, the zonal AIDS Commissions, the UN and the civil society in the three zones. This was followed by the review and adoption of guidelines for the delivery of various PMTCT interventions that were agreed upon through various technical and context considerations.

Currently, 34 health facilities (8 in South Central, 6 in Puntland and 20 in Somaliland) are providing the full PMTCT package with a total of 20,397 women counselled and tested for HIV during the reporting period. 82/96 (85%) of the HIV pregnant women received ARVs prophylaxis or ART and 58 (60%) out of the 96 HIV exposed babies received ARV prophylaxis. Revitalizing PMTCT within the short period has been a very important programmatic achievement, however, considering an estimated 3091 HIV positive women are in need of PMTCT this amounts to 3%. Therefore, the estimated unmet need is over 95%. Starting from 0 in 2010, this is some progress that the response can build on through intensification of efforts to bring more women into the PMCT programme.

In the first two years of implementation, the PMCT programme has recorded fairly good demand and utilization. However, utilization is still hampered by high stigma and denial. Based on the national estimates on mothers who are eligible for PMTCT services beyond testing, the coverage of the service in terms of the target populations remains very low. There is need to consistently sustain existing facilities and expand PMTCT in others areas through a model that encourages more women to undergo HIV testing including reaching out to the rural remote and pastoralist settings. Besides what the PMCT programme is also to achieve, it is important that ANC seeking is given adequate attention from a broader perspective as an entry point to PMTCT at all levels. From operational perspectives, the programme experienced shortage of test kits as the demand increased and due to staff turnover which had significant effect for this specialized intervention. It is acknowledged that there is still a need to improve access, equity and sustainability. Additional emphasis needs to be put on the other PMCT prongs recommend by WHO to include early infant diagnosis, reproductive health and community level interventions. A further recommendation is to integrate VCT centres into MCH centres to expand the scope of HIV counselling and testing.

#### **d) Behaviour Change Communication**

Significant progress has been made implementing behaviour change interventions during the reporting period. Capacity building and mentorship of local organizations of local implementing partners various preventive approaches has been done at the zonal level. Similarly the BCC programme has made sufficient progress in expanding the BCC programme to a wider population while ensuring specific targeting of key groups such as the youth through peer education. Further achievements have been made in expanding school based prevention programmes that have reached more in school youth with key preventive messages and other relevant information. Cognizant of the importance of key population in prevention there are more extensive programmes targeting them.

It is important that more effort is made to extend prevention and BCC at the work place. In addition various stakeholders need to develop a standardized BCC tool kit to enhance a common focus to

behaviour change communication. To further streamline BCC interventions, a common approach and system of distributing materials has been recommended. NACs are working with other partners with support from the UNICEF-GFATM to develop a Communication strategy which is expected to address these concerns.

### **i) Youth Prevention Programme**

Training of Trainers for school-based and out of school Youth Peer educators have been done by the three commissions with the support of IOM. 90 peer educators were trained in 2010 and 191 trained in 2011. In total 271 PE were trained. The training covered HIV prevention, life skills education and reproductive health. The peer educators conducted various outreach sessions in schools and youth centres within the three zones also targeting youth from among key and vulnerable populations. A total of 1,727 Youth were reached during the outreach sessions.

Peer education for youth was effective in reaching youth, often for the first time, with HIV prevention messages. In some cases student clubs and weekly meetings were formed - critical for sustainability and mainstreaming HIV through day-to-day school activities. HIV related dramatic performances were implemented regularly –beyond project implementation within youth centres. School-based training created HIV dialogue between students and teachers, and student engagement in raising of HIV awareness went well beyond project activities within their schools.

Challenges include maintaining the same Peer Educators and providing continuous refresher trainings due to lack of funding. Challenge in getting 'skilled' youth with a HIV background. Challenge in convincing some schools on the outreach as they themselves may not know much about HIV and felt that the students should not be exposed to information on 'sexual behaviours'. It was a challenge to conduct the peer education TOT training using the existing toolkits as some were outdated, and the UNFPA youth toolkit was not translated into Somali. However, this challenge was over come when UNICEF provided the LSE training toolkit that had been translated into the Somali language.

To improve the efficacy of youth programmes, improvement of training materials which are sensitive and friendly to the youth has been recommended. Furthermore, the programme should be expanded to consistently target the out of school youth to get better outcomes. In school the integration of HIV education has been further recommended. To make further progress at the impact level there is need to have the youth friendly services that have been recommended in place.

### **II) Prevention for Key Priority Populations**

The reporting period saw more focused prevention programmes for FSWs who have so far been identified as key priority populations and a number of activities were implemented with quite some progress. A number of outreach sessions targeting Female Sex Workers (FSW's) and as a result 42 FSW's were reached in 2010 and 715 were reached in 2011. A total of 757 FSW's were reached within

the two years. In addition outreach (with 48 trained peer educators trained in HIV prevention, stigma reduction, care and support, and facilitation skills) to a total of 2,273 key and vulnerable populations in 2010 within the three zones and 2,837 people in 2011. A total of 5,110 key and vulnerable populations were reached through HIV prevention outreach. Though it was a challenge to get the FSW's to identify them. Implementing partners of IOM managed to identify them through networks among women's umbrella groups.

Stigma remained a barrier in reaching more FSWs. There is also limited support from the bridging population because of lack of capacity to link the programme with the FSWs. Despite the progress made so far, there is need to engage in more participatory process in the development of IEC materials engaging all stakeholders. Additionally sensitization of the government, consistency in messages among various stakeholders, increased targeting of mobile populations and continued prioritization of key populations has been recommended. The table below shows transactional sex among the youth which further justifies the need to have more focused programming for key priority populations.

**Table 6 Transactional Sex among Youth 15-24 who have ever had sex**

Variables	Somaliland (43)	Puntland (14)	South Central (25)	Total (82)
Ever given or received money, gifts or other favours in exchange for sex	9.3%	50.0%	24.0%	20.7%
Mean number of transactional encounters per month	2.5	4.0	1.2	2.7
Mean number of transactional partners per month	2.5	4.3	1.2	2.9

**Source: Youth Behavioural Survey 2010**

### iii) Behaviour Change Communication- Media

In pursuit of continued coverage of HIV and AIDS messages, HIV Media Project with 4 Radio Stations in the three zones was undertaken by BBC media action through UNDP-GFATM and AIDS commissions' facilitation. Through this initiative formative research to better understand the audiences' views, values and attitudes towards HIV/AIDS was conducted. A 5 day training conducted in Hargeisa for the representatives from 4 radio stations, AIDS commission and CSOs to develop Radio Message Briefs (37 people). This was followed by 5 Days technical training for Journalists and producers on production of radio message briefs (8 people). Fifteen (15) Radio messages developed and endorsed for use by AIDS Commissions in Puntland and Somaliland

Through the expertise of the contracted organization the facilitation of the media activities was quite successful. In addition uniformity in messages with adequate consultation with NACs, Ministry of Health, and People living with HIV, Journalists and CSOs working on HIV ensured that appropriate non stigmatizing messages were aired to the public. The participation of local journalists who were very

much interested and involvement of key stakeholders ensured that participation and ownership of the initiative.

Despite the success of this initiative, there are limited opportunities to work with the media to spread messages on HIV & AIDS, due to other competing issues, and airtime costs. From media experiences during the reporting period, it has been recommended that, media campaign is more useful for Stigma reduction and not used to address sensitive issues like female sex work. Consistency in HIV work carried out with the Media and partnership with other community level initiatives is important for uniformity in approach and messages.

#### **iv) Community Conversations**

The community communication model was adopted and initiated in two zones with the aim of strengthening individual and community capacity to understand the nature of the HIV epidemic, exploring community perspectives around sensitive issues such as VCT, rights of PLHIV, gender issues as well as stigma and discrimination. Through it communities have a forum to discuss how best to address HIV in their area and strengthen individuals and local institutions to address HIV in their area.

With coordination of SOLANC, PAC and SCAC and implementing partners, Community Conversations on HIV were initiated in 4 HIV 'hot spot' districts in Somaliland and Puntland in 2011. A total 3,375 persons participated (were reached) through Community Conversations on HIV across Somaliland and Puntland since Jan 2011. Introducing the Community Conversation concept was far easier than envisaged as the approach appeared to resonate well with communities. Community Conversations provide an opportunity to establish linkages between communities and health services such as VCT services (by inviting doctors or nurses to come and speak at CCs), which has led to greater uptake of VCT services in areas where CCs are being rolled out. One of the challenges faced is a longer time to build up a team of experienced Community Facilitators to lead this programme, to ensure that the quality of each Community Conversation is carried out to the highest standards. The program was however, not able to take off in some parts of Puntland and efforts will be made to revitalize in 2012.

#### **V) Distribution and Use of Condoms**

Currently condoms can only be distributed through specific targeted health facilities integrated in other services due to cultural barriers and social stance on them. There is evidence that pharmacies are key points of access. Through the programmes a total of 14,447,126 condoms were made available by UNICEF-GFATM for distribution in 2010. Compared with previous years, this has been a consistent trend. There is no condom distribution policy in each of the zones so far. One of the notable progresses made is the drafting of a condom distribution strategy in Puntland.

There is also no information on utilization of condoms in high risk sex except the IBBS conducted in Somaliland among sex workers whose findings indicated that 24% FSW used a condom in their last high risk sexual encounters. The other source of information on availability access is from Youth Behavioural Survey of 2010 summarised below.

**Table 7: Access and Use of Condoms**

Variable	Somaliland 43	Puntland 14	South Central 25	Total 82
Condom used at first sex	7.1%	21.4%	0.0%	7.4%
Condom used at last sex	21.4%	57.1%	0.0%	22.6%
Knows a source to obtain condoms*				
Private Sector (Shop/pharmacy/market)	60.5%	53.8%	56.0%	58.0%
Health Facility (Clinic, Hospital, CHW)	2.3%	23.1%	12.0%	8.6%
Friends/ Guest House/ Hotel	0.0%	0.0%	4.0%	1.2%
Don't Know/No response	41.0%	30.8%	32.0%	36.3%
Can obtain condom every time needed	51.2%	7.7%	28.0%	37.0%

\*Multiple responses therefore does not add up to 100%

**Source: youth behavioural survey 2011**

## VI) Universal Precautions and Post Exposure Prophylaxis (PEP)

According to WHO, all health facilities public and private observed various standard of infection prevention. In addition facilities had in stock PEP for occupational exposures. According to the findings of the NCPI PEP for non-occupational exposure was reportedly need prioritized and very negligible number have access to it. This puts victims of rape and other potential avenues of exposure at risk of HIV transmission.

## 3. TREATMENT, CARE AND SUPPORT

One of the key recommendations of the 2010 report was to increase the coverage of treatment as evidence pointed out low treatment access rates. With exception of ART and TB other treatment interventions had positive utilization rates during the time. During the reporting period, significant progress has been made in the programmatic aspects of treatment. However, as illustrated below, treatment is not yet to the scale of the estimated needs.

### a) Anti- Retroviral Treatment (ART)

The according to AIDS commissions and WHO databases, the number of people on ART has increased from 569 in 2009 to 878 in 2010 and 1139 in 2011. This presents an increment of 200% for the last two years. Based on the programmatic limits within which the treatment programme is operating, some

significant progress has been made. According to available estimates, the current ART need is 16404. Based on these estimates, the proportion of patients receiving ART is 7%. The adult enrolment based on the estimates is 11%. These figures need to be validated in line with the prevailing situation in the country. More attention is needed to establish more realistic and precise estimates for ART.

Apart from enlisting more people on ART, a number of other programmatic achievements have been made. ART monitoring tools have been updated and implemented by WHO. To provide more focus on management of other infections guidelines for chronic care Integrated Management of Adult infections (IMAI) has also been developed.

At the outcome level, the ART programme has achieved commendable retention rates linked to adherence and survival. The rates of retention are 84%, 81.4% and 51.3% at 12, 24 and 60 months respectively. This adherence has been attributed to effective counselling approaches that have been adopted over the reporting period. The adherence to counselling has also improved resulting in better outcomes to retention and other positive outcomes for ART programme.

Considering the previous achievements of the ART programme, significant progress has been made at the programme level. The two fold increase on the people on ART is a commendable achievement. Had this been the trend since the onset, the programme would have made more remarkable gains. Overall estimated ART need in the country remains high and the unmet need remains high. It is important that the current trend is sustained while making additional efforts to scale up treatment with focus on bridging this gap. A case in point is Somaliland which accounts for over 60% of the people currently under treatment. Considering that Somaliland is a generalized epidemic, it is important to consider scaling up in terms of devising more strategies on getting more people on treatment and expanding the ART centres from 4 to a more effective number in key geographical settings .

Although the ART programme has improved during the reporting period, a number of challenges have been experienced. These include; weakness in the procurement and supplies management systems of ART, for which technical assistance was sought to ensure effective flow of commodities. The procurement and supplies management system review and redesign along with Logistics Management Information Systems (LMIS) tools development and roll out has been done. Once this is done it will be easier to manage the existing demand for ART and enlist more.

## **b) Tuberculosis and HIV Co- infection**

The incidence of TB in the country is estimated at 160/100,000, but the magnitude of co-infection is limited by lower prevalence of HIV in the country. The 2010 reporting process found complex systems for case detection, referral and reporting that needed to be addressed during the reporting period. So far it has been possible to introduce tools to streamline documentation and reporting of TB screening and this has increased the screening from 0-35% during the initial months of introduction.

Out of the 66 TB centres 24 (36%) of them are providing HIV testing and counselling. During the reporting period, 87% of TB patients voluntarily underwent testing for HIV. Out of these 5% were found to be positive for HIV and either received treatment or were referred. Programme statistics

continue to show consistent positive trend of testing in TB centres to build on for wider reach of other TB patients in the remaining centres once the services are established in them.

Like other interventions, the performance of the TB programme has faced a few obstacles; these include shortage / erratic supplies of TB kits and security challenges in South Central. Stigma and denial were also found to have an effect on overall demand and utilization of TB/ HIV services.

From 2012, recommendations that have been made for the TB programme include; scaling up of HIV services through expansion to the remaining centres, improvement of utilization and quality in the existing TB/HIV centres and streamlining of TB procurement and supply management system to be able to respond to rising demand with the geographical and contextual challenges that some centres operate in. Due to the technical aspects of the TB interventions more supportive supervision has been recommended to strengthen TB/HIV activities at the site level. Through supervision emphasis of adherence to various management and treatment guidelines has been made to ensure standards are maintained in the delivery of related services.

### **c) Treatment of Opportunistic Infections**

In IPTCS care of patients with opportunistic infections is well integrated in ART. HIV counselling and testing is part of package provided for patients with opportunistic infections in the same settings. In continued quest for the improvement of the service, IMAI guidelines have been finalized and set for adaptation in all IPTCSs in early 2012. A total of 1,970 patients enrolled in care received co-trimoxazole (CTX) prophylaxis (according to national guidelines). This accounts for the 99% of the total enrolled in care.

### **d) Management of Sexually Transmitted Infections**

Like OIs management of sexually transmitted infections has been integrated within the IPTCs and this has facilitated increased utilization of HTC services. During the reporting period, many people were treated for various sexually transmitted infections using the syndrome management approach. In addition syphilis was integrated as part of sentinel surveillance and treatment. Out of a total of 3030 pregnant women who were tested at Antenatal care in the three zones, 265 (8.7%) were positive and all of them were treated. Training and supportive supervision in syndromic management of STIs has been ongoing in the three zones on a regular basis.

It has not been possible to fully get a wider picture of STIs because coverage of surveillance has been limited while the overlap between urinary tract infections has been common in the health facilities. STI management among high risk groups need to be prioritized for its relevance and an avenue through which the sub-population can be reached for other integrated services within these sub-populations. Training and supportive supervision for the syndromic management of STIs continues.

## e) Care and Support

One of the objectives in the Somali AIDS response is “to improve availability and access to quality treatment, care, and support services for PLHIV”, in order to improve the quality of life among people living with HIV, including the lives of affected families and communities . According to UNICEF, Care and support programmes are provided both at health facilities and directly at the home and community levels through both trained community health workers and facility health workers. As of 31 December 2011, about 10,000 PLHIV or people affected by HIV and AIDS and about 1,400 OVCs benefited from care and/or support programmes like OI treatment, support to PLHIV (HBC, nutritional, psychosocial and financial support) and OVC service (food, school fee, learning material, school uniforms, etc.).

A “PLHIV needs assessment survey” was conducted by a partner, Biofit, in Puntland in 2010 to identify and assess the current psychosocial, economic, nutritional and health conditions of PLHIV in Bari and Karkaar regions, in an effort to better plan for supportive and effective programmes based on real needs. Despite limitations, the survey found that 29 % of the respondents had no source of income, and the main source of income for the others was from friends and grants from the HIV project. All the interviewees indicated that their monthly expenses were higher than their income.

Handicap International conducted an assessment of “Livelihood activities, market & micro-grant support for PLHIV and their families in Somaliland” in 2011 and developed guidelines for the management of micro-grant savings groups. The purpose of the assessment was to define the feasible frame or modalities of livelihood activities and micro-loans that suit PLHIV and their families by assessing and analyzing the existing situation and practices related to the areas of livelihood and micro loan in Somaliland and Puntland.

Currently, through its national partners, WFP is carrying out a “National nutrition and vulnerability profiling study of pre-ART, ART, and TB-DOTS patients in Somalia/Somaliland to establish a baseline of the nutritional status and household food security situation of pre-ART, ART, and TB-DOTS clients in Somalia/Somaliland for advocacy purposes, and to inform programme planning and design. It will provide a rationale for developing a nutrition care and treatment protocol for TB and HIV patients in Somalia/Somaliland. Currently, WFP is providing food assistance for the chronically ill patients and their families through 8 ART and 19TB centres 27 in total.

At the community level, establishment of support groups has been on-going on a consistent basis. Home based care givers have been recruited among the PLHIV and been proactive in linking the people who need care to the programme. In addition PLHIV have been trained as the main care givers. Those ownership of home based care and management has been even more effective with their direct involvement and participation.

The care and support of PLHIV within their own homes and communities helps them live healthier, positive lives. Moreover, working with the community, helps to reduce stigma and discrimination against PLHIV; prevent the further spread of HIV and mobilize community resources for PLHIV and their families. Very positive results in changing standard of life due to the educational support to OVCs, and many children have already passed primary school with good scores and are at intermediate schools.



## IV Best Practices

### **i) Political Support**

Despite the political differences between the three zones, the AIDS Commissions have taken collective positions in a number of issues prioritized and cushioned the response against the effect of contentious issues between the zones. Thus, there has been harmony in the delivery of various programmatic commitments in line with the context and epidemic scenarios in the three zones. This stand and consensus has challenged other key sectors such as the respective ministries to work together cognizant of the importance of HIV and multi-sectoral interventions and this has resulted in more effective programming in the three zones. There has been a clear show of commitment to objectives and goal of the overall Somali response. However, funding for the response by the government entities has been absent especially for the work with the line ministries. SOLNAC has presented the HIV policy and the other acts to the council of elders and Ministers who have been very supportive and committed to the principles of the HIV and AIDS response. In South Central, SCAC has met and discussed the response with high ranking officials who pledged to start HIV units in key line ministries. In Puntland, the President and high ranking officials played an instrumental part in the world AIDS day.

### **ii) Adherence and Retention of and increased enrolment in Anti- retroviral Therapy**

The trends in adherence and retention of ART remained positive over the reporting period. This has been due to the impact of adherence to counselling and enabling environment. There has also been enlistment of more people on ART during the reporting period with good survival outcomes. Overall cohort analysis points to comparatively better outcomes compared to even more favourable settings. The two fold increase in ART enrolment is due to establishment of VCT centres in TB centers where the rate of co-infection is high. Compared to stigma that is associated with HIV, the success of this intervention needs to be documented for possible replication in other areas of treatment and other programmatic areas. Furthermore SOLNAC has been instrumental in soliciting for free mobile phones for ART centres to keep track of ART patients to ensure that they adhere to the schedules.

### **iii) Exposure Visits to Model Countries and Community Conversations**

A number of exchange visits in countries and settings where programmes have won success over cultural barriers have been organized during the reporting period. Such visits have been organized for religious leaders and other opinion leaders and the representatives of zonal AIDS commissions to countries which include; Morocco, Egypt and Djibouti. The criteria used in the selection of countries was based on the cultural and religious similarities in the three zones and ability of religious leaders and the national AIDS commissions to deliver model project and practices that could be replicated or applied in the context. These exchange visits have exposed the leaders to approaches used in programming in other countries of similar settings and changed their perception and stand on key prevention and other relevant interventions in the country response. Expanded and sustained exposure

of this kind remains an important approach in engaging cultural leaders in a holistic approach in the HIV and AIDS response.

The community conversations implemented so far have proven to be a high impact, low cost intervention which is advantageous to support the sustainability of this work. The Community conversation approach reaches people at the heart of communities who are rarely reached through other HIV awareness activities. Within a short time of implementation, the initiative has made significant gains in the areas of focus.

#### **iv) Cross border initiatives under the IGAD Regional HIV and AIDS Partnership Programme (IRAPP)**

The IRAPP project funded by the World Bank through IGAD has opened a new forum of interaction on HIV issues between the three zones and IGAD countries. In 2010 the project supported the development of harmonized protocols where the representatives of AIDS commissions and respective Ministries of Health participated. In addition the zones participated in cross border meeting between IRAPP sites with neighbouring Ethiopia and Djibouti. This has promoted exchange of information, collaboration and regional integration as a key to success of programming for cross border and mobile populations and the general country responses. Through the IRAPP project, it has also been possible to get easier referrals and other services cross border.

#### **v) Peer Education and prevention Interventions for Female Sex Workers**

Working closely with implementing partners with experience of working with FSW was a best practice in insuring ethical, effective and targeted engagement of key and vulnerable populations. Engagement of FSWs in BCC interventions and reaching 757 in this context where social stigma is widespread is not a minor achievement. The numbers reached directly by peer Education confirm that this is working model whose ideals need to be replicated.

#### **vi) Support to people Living with HIV ( PLHIV)**

People living with HIV have been supported through special initiatives such as; in Somaliland through micro-credit programs, nutritional support to school children and free mobile phones provided to HIV positive persons. In addition, they have participated in key meeting and given a chance to voice their concerns in some key forums and decisions.

## V Major Challenges and Remedial Actions

A number of factors hindered the implementation of various components of the response in variable ways. Some related to the context, and others to the programmatic experiences are summarized below;

### a) Challenges

#### i) Socio-cultural Context and Social Stigma

Stigma and discrimination for PLHIV among health workers and at community level remains high. Provision of some services to PLHIV and uptake of services and adoption of some practices such as condoms are still challenged by social norms. In addition, VCT services continue to encounter the effect of cultural barriers which influence utilization of services and disclosure. Due to the same issue, it is not possible to label any population as most- at risk due to fear of persecution.

#### ii) Limitations in Strategic Information

There has been limited national and zonal representative data for behavioural aspects of the epidemic since 2004. In 2010 a national youth study related to this has been made available, which is important for establishing behavioural patterns and levels but information on the trends due to shortage of data points has been lacking. Significant efforts have been made in surveillance but South Central has been absent from the process for the last 7 years. Again it was not possible to extend surveillance to more priority populations implying that epidemiological analysis of the response can only be understood or done from general perspectives. This has only been supplemented by the IBBS conducted among the Female sex workers in 2008. Besides, there have been few studies linking behavioural outcome and epidemiologic impact, to be able to establish the outcomes and impact of interventions and other aspects of the response that are informed by such evidence

Most efforts to generate strategic information on behaviours have concentrated on project level baseline surveys and a few KAPs covering small geographical scopes that cannot be generalized. Other substantial efforts have gone to hotspot mapping conducted in cross border areas which are the main IRAPP priority geographical areas. In 2011 successful formative assessment for various interest groups have been conducted, these include; port workers, truckers, Female sex workers among others. Overall, the response has continued to generate more qualitative data for specific sub-groups but representative data for zonal and national level remains elusive. A study for the general population and priority groups with a national scope and with flexibility for zonal level analysis are recommended. Such studies need to reflect standard criteria, methodology and indicators to address the outcomes of the response at behavioural level which is yet to be fully established.

Due to various factors impeding the finalization and implementation of the M&E framework, the response felt the absence of it in some ways. It has not been possible to generate programmatic data as

expected from various levels within streamlined flows and feedback to various levels. The generation of data was not uniform in approach and therefore it was not possible to have comprehensive data that could be generalized and disaggregated by all zones in respect to key aspects of the response. The Research and Advisory group proposed in the M&E framework should be established to implement a more holistic agenda to generate relevant information needed to understand the epidemic and the efficacy of various interventions and the overall response.

### **iii) National Participation and Ownership**

Compared to 2010, substantial efforts have been made to improve participation and involvement of Somalis in all aspects of the response through development of structures to guide various engagements. However, most of these structures have not been fully operationalized and the implementation of key components in specific aspects of the responses has not been fulfilled. The AIDS commissions have not been able to fully oversee all the key aspects of the response due to absence of structures and other internal problems. Revitalization of the steering committees and proposed structures is needed to enhance participation from grassroots to the national level. To actualize this however, capacity building is needed at all levels. The participation of the AIDS commissions in Health Sector Committee has been sporadic due to travel and related issues. The NACs have expressed the need to hold the meetings at the zonal levels unless the travel issue and participation is guaranteed in all meetings in order to contribute to key decisions and ensure ownership of the AIDS commissions.

### **iv) Limited Coordination and Effectiveness in Resource Mobilization and Allocation**

Overall most of the funding for the HIV and AIDS response comes from the GFATM. A sizeable amount also comes from the IGAD World Bank funded IRAPP project. There are funding resources that fund various other activities that remain the preserve of the individual agencies / organizations. This lack of coordination has the potential to duplicate activities and skewed investment of some interventions over others. Better coordination in budgeting and resource mobilization is important for a more focused response in terms of resources and activities for more efficiency and effectiveness. Information sharing between zones is one of the ways recommended to ensure that all stakeholders are engaged in various processes within the funding mechanisms that are in place in the national response. The AIDS commissions have expressed the need to be supported to mobilize resources considering changing programmatic funding landscape.

### **v) Limited Local Capacity for Implementation of key Activities**

Considering the status of capacities that existed at the start of the response, substantial gains have been made in improving the local capacity. A lot of effort has gone into improving the local capacity in a number of programmatic areas. However due to limited requisite capacity for some technical areas , additional strengthening and external support is still needed in operational and coordination mechanisms , health services and the civil society. There is still need to support the MoH and the three AIDS national commissions at all levels (coordination, policy, monitoring and planning and management capacity) to ensure more effective and harmonized delivery of health and HIV/AIDS interventions. The institutional capacity of the local civil society organizations remains low. This warrants systems strengthening for accountability and sustainability reasons. Overall, a more long term capacity building

plan is likely to yield better capacity outcomes. At the service delivery level there are infrastructural, staffing and issues related to equipment that needs to be addressed.

**vi) High Logistical costs and Supply chain complexities**

Key commodities for various interventions have experienced procurement and supply chain issues. For this reason stock outs have been experienced along with inconsistency in supplies as a result. Costs of distributing drugs and commodities are exceptionally high. Drugs and supplies first have to be brought to Kenya, and then transported to each of the zones. The fact that a number of staff are based in Nairobi and using three separate arrangements for all interventions as per the zonal structures remains a challenge.

This issue has been further compounded by security, geographical spread and other contextual challenges. These challenges amount to additional costs of managing logistical cost manifested in transport and other specific costs.

**vii) Gender Disparities in key aspects of the response**

Skewed representation of women in key aspects of the response has been noted. Even in the gender sensitive aspects of the response where direct contribution of women is critical, the disparities are common. This extends to technical areas such as M&E and programme delivery. Although this has some cultural basis, it is important to give women more opportunities of engagement. This has the potential to increase the ownership of the response and contribute to better outcomes in a number of interventions.

**viii) Delays in completion of key policy documents**

The findings from the national commitments and policy instruments have revealed a lot of pending policy documents and guidelines that have remained in draft form for some time. These include; Gender policies, HIV policies, National prevention Acts, Human rights, condom distribution strategies among others. The much needed guidance on some of the interventions has been derailed by delays in finalization and endorsement. Finalization of these documents is a key to operational aspects and application of various approaches in all interventions from a more focused perspective. The commitment and efforts that were levelled on the development of these documents need to be extended to their completion for their programmatic utility.

**ix) Limited Involvement of the private sector.**

Although the response is geared towards a multi-sectoral approach, there has been minimal participation of the private sector. SOLNAC has been able to harness the support of the private sector on a number of occasions and demonstrated a lot of unexploited potential in the sector. There have been no interventions targeting the business community and limited attention to work place

programmes. The distribution of condoms goes on in the private sector through pharmacies and reports show that is a successful avenue for the intervention. If well exploited, the private sector could be a potential entry point for programmatic and research interventions targeting priority interventions among sensitive areas associated with stigma in the general population. Therefore closer engagement of the private sector is important in understanding the socio-cultural dynamics of sensitive interventions and how to scale them up with minimal resistance. It has been recommended to have private sector representative in coordination meetings of the AIDS commissions in order to sensitize them and draw on their resources and skills when needed including encouraging them training of HIV in the workplace.

## **b) Concrete Remedial Actions Planned to Ensure the Achievement of Targets**

### **i. Socio –Cultural Context and Social Stigma**

Strategies to alleviate the impact of the context and social stigma to the response were consistently put in place and implemented during the reporting period. To address socio-cultural issues involvement of religious and other cultural leaders in various programmes have been consistent. Exposure visits to model countries with similar cultures and where programmes work have been done. This has been done to suggest ways of working a similar cultural context on programs through information exchange and sharing. For reduction of stigma, a number of guidelines have been put on place and AIDS Commissions have taken the lead role in supporting PLHIV and encouraging them to participate actively in some relevant activities. In addition PLHIV have been involved in key decisions at the zonal level and mobilized for home based care support and related activities for ownership purposes.

### **ii. Limitations in Strategic Information**

During the reporting period, a few studies have been made available. Recommendations to mobilize funds to implement more Biological and Behavioural studies have been made. For the first time since 2005 sentinel surveillance was conducted in South Central. This will give more insights into the epidemic which has been lacking for some time in the zone and guide programmatic response. Results of the population based comprehensive studies such as MICs will be available to inform some key areas of the response. The draft M&E has taken this into account and areas of focus for generating strategic information from the programme, surveys, assessments and surveillance has been made.

### **iii. National Participation and Ownership**

Structures to enhance national participation and ownership have been put in place. Implementation has been ongoing in some part of the reporting period. It is anticipated that the principles of the structures will be implemented in full to ensure that the Somalis have meaningful participation at all the levels of the response.

### **iv. Limited Coordination and Effectiveness in Resource Mobilization and Allocation**

To address this, existing and new structures have been made flexible to allow wider participation of various stakeholders in key decisions. Through these forums information sharing on budgets and

resource mobilization will be better facilitated. The collective approach to these issues will reduce any duplication in the application of resources and lead to more effectiveness. This however depends on how much the structures are owned and operationalized in line with the objectives of the establishment.

**v. Limited Local Capacity for Implementation of key Activities**

Most of the interventions included capacity building of various forms including; orientation, training and exposure. Institutional strengthening of civil society has been partially done; training in programme management areas and M&E has been done during the reporting period. With various capacity building efforts, the understanding of many aspects of programming and performance on key sectors has improved considerably.

**vi. High Logistical costs and Supply chain complexities**

In view of continued procurement and supply chain management issue, a review of the same has been undertaken by key stakeholders to ensure that commodities are available whenever needed. Health facility supplies for treatment and testing received special attention in the procurement and supplies review with intention of alleviating delays and any potential stock outs. With the improvement of the prevailing security situation in South Central, the burden of logistics within these areas is envisaged to reduce.

**vii. Gender Disparities in key aspects of the response**

There are a number of underlying issues within the context which have contributed to the disparities. So far, there is no specific focus of gender issues within the response. In non HIV programmes various mainstreaming efforts have been made. Since the response is multi-sectoral in approach and does not operate in isolation, it is expected that such efforts will go a long way in addressing issues of gender in all sectors.

**viii. Delays in completion of key policy documents**

Most of the policy document and guidelines that lie in the programmatic domain have been completed. However, there is back log of policy documents, Acts and other legislations lie in the government system. Ratification of this is beyond the technical support that agencies provide. However, the national AIDS commissions need to be regularly reminded and encouraged to finalize documents and be committed to lobby for endorsement of various pending documents through their respective legislation systems.

**ix. Limited Involvement of the private sector.**

The involvement of the private sector has not been formalized so far. A number of interventions are delivered through the private sector which accounts for significant coverage of the health systems. All HIV and AIDS treatment and other facility based interventions are however delivered through the public sector. Distribution of condoms has been more widespread in the private sector but for a number of reasons no efforts have been made to try social marketing and other approaches due to cultural and other contextual restrictions.

## VI Support from the Country's Development Partners

### a) Support Received from the Development Partners

#### i) Funding

The HIV and AIDS mainstream response is primary funded by the GFATM with other supplemental support from World Bank through IGAD/IRAPP to address key cross border and mobile populations that are not addressed through the national programme. The Global Fund is the most important funding mechanism for Somali having sustained the response for the last six years. Questions have been raised on overdependence of one donor and the sustainability of the model in the coming years. The support extended by IGAD constituted around 10% of the entire budget for the whole response and any cessation in funding may lead to serious disruption of main services and other interventions funded through this mechanism. There are other sources of funding by a number of agencies but most of these support operational costs with few extending to fund some programmatic activities.

According to the Somali National AIDS spending assessment (NASA) conducted in 2010, a total of US\$ 10,502,830 was spent on HIV and AIDS in 2009. Out of this, the GFATM contribution was estimated at 84%. Further analysis pointed out that the highest proportion of the total expenditures went into programme management and administration (39%) while the rest went into direct programme delivery

One of the recommendations by NASA was to allocate more resources to the enabling environment to strengthen local capacity and human rights and have more ownership in the Somali response. It was not possible to address these recommendations as no mechanism was established by various HIV and AIDS working mechanism to mobilise alternate / additional funding.

#### ii) Coordination

Various development partners have continued to play a crucial role in the coordination mechanisms that are in place by advocating for a greater multi-sectoral approach in the HIV response. Donors and other development partners remained active in the Health Sector Committee, and various implementing partners remained active in the HIV working group to provide strategic and operational guidance to various interventions and coordination support.

Additional efforts were made to initiate decentralized coordination structures at various levels. At the zonal level, development partners remained central to most coordination structures e.g, the IPTCs working group and M&E working group and active in various policy and advocacy forums at the zonal level. The input and feedback of the development partners through their representatives has been important for coordination of various activities at the zonal level.



In 2012 UNAIDS is actively taking its role in coordination of HIV and AIDS issues together with UN and other development partners, in order to advocate for more technical assistance and to address issues of support of PLHIV and the civil society.

## **b. Actions needed from the development Partners to Ensure the Achievements of Targets**

While considerable efforts have been made by donors and various other development partners in the HIV and AIDS response, there remains a funding, technical and coordination issue in which additional action is crucial. There are concerns for scale up of most of the interventions especially in Somaliland where HIV is generalized with calls for aligning the response to the demands of the epidemic. In the same light, as demand for services increases, utilization is putting a strain on the budgeted supplies which is magnified by the supply chain costs related to the challenges of the context. With expected reductions in funding from the Global Fund, the response may need diversifying of funding sources.

It is also important that the development partners and donors lead the way to strengthen coordination at all levels. This will be achieved by intensifying efforts to address any concerns within the response by providing technical support, effective feedback and follow up at implementation level. At policy level, and strategic planning development partners have a role in providing direction to finalise a number of policy documents and various response guidelines that have remained in draft form for some time now. Further efforts need to extend to decentralizing various aspects of the response as proposed by various coordination structures and existing initiatives such as 'community conversations' and district level engagement implemented through IRAPP.

The AIDS commissions have been instrumental in overseeing various aspects of the HIV and AIDS response including leading various coordination efforts at the zonal level. However, even after being in place for six years now, the AIDS commissions are still limited in standard program management systems, financial management systems, M&E and data management systems. There needs to be more attention in all these areas and more concerted efforts to strengthen AIDS commissions in the coming years. This will enhance accurate reporting, accountability and sustainability of the HIV and AIDS response at the zonal level and in turn contribute to achievement of the overall goal. As one of the sectors that contributes to most HIV and AIDS interventions it is important that further support is extended to the respective Ministries of Health through coordination with the national AIDS commissions to streamline coordination, policy M&E and planning to ensure more effective harmonized delivery of health and HIV and AIDS interventions. Similarly, other key line ministries such as; Education, Labour, Youth, Family and Religious affairs needs to be supported in order to promote a multi-sectoral response.

In an effort to promote ownership and participation, which have been key concerns for the civil society and local Somalis, it is important that development partners create an enabling environment by supporting structures that encourage engagement of these groups. At the grassroots there is a need to build the capacity of civil society and empower communities and relevant local institutions by providing opportunities of engagement and exposure in order to make them fully part of the HIV and AIDS response.

## VII Monitoring and Evaluation Environment

### a) Overview of the Current M&E System

The M&E environment is discussed on the basis of progress and challenges faced in the implementation of the 12 components recommended for national M&E systems.

#### **Organizational structure for M&E**

Each of the three AIDS commission has national M&E coordinator and several regional/ sub-zonal M&E staff. A number of organizations have M&E and program officers who take charge of reporting and data management. A comprehensive structure that covered all levels of M&E from data collection was proposed and agreed on the M&E framework, but the framework is not yet rolled out. The zone retains the structure of national M&E officer with the regional sub-zonal M&E officer linking various data catchment areas within the IPTCs within their jurisdiction. During the reporting period SOLNAC has added a Data Management officer to the M&E unit to take charge of the data generated from all interventions working closely with the national M&E officer in coordination and other oversight roles. M&E organizational structures remained the same over the period.

#### **Human Capacity for M&E**

In line with the recommendations of the 2010 report and funding from UNICEF -GFATM ten day M&E training courses were conducted in Somaliland and Puntland. In total 49 participants were trained, 24 in Somaliland and 25 in Puntland. The objective of the course was to equip the participants with skills and key competencies on M&E using the 12 components approach recommended for national M&E systems. The training was modular in approach with 21 modules for training M&E staff in low generalized and concentrated epidemics adopted for Middle East and North Africa countries. In addition other modules were developed by UNAIDS drawing on the participants needs and training focus. Other field level training included 1 day orientation and familiarization with the IRAPP M&E tools which was conducted for M&E officers and focal points from the three zones.

In addition WHO and UNICEF organized M&E training in Mombasa which targeted program and M&E staff at various levels. In this training the M&E framework was discussed and various amendments and recommendations were made. However, this was an integrated course where participants for the HIV and malaria grant participated.

Despite the substantive efforts made in M&E training targeting various the groups described above, it has not been possible to see much application of skills in delivery of various M&E activities at the field level. This is primarily due limited hands on mentorship of the national and regional M&E staff from various partners. Considering the trainings sessions last 1-2 weeks, it is important that further mentorship and

coaching on the job is extended to the M&E staff through respective units to enhance understanding and standard application of various M&E skills.

### **M&E plan**

The M&E framework for the Somali AIDS response was prepared through consultations with the M&E working groups in the three zones. This followed zonal level disseminations of the draft, amendments and adoption of the framework. Due to several varying views it was not possible to build consensus on a number of issues and the document was not collectively endorsed. Although the documents remains in draft form awaiting finalization, SOLNAC has adopted it as a guide for the M&E activities in Somaliland since most of the indicators which were drawn from UNGASS, UA and a few other national program indicators. UNICEF/GFATM had started process of finalizing a M&E plan as per the project requirements and considering that the project is national in scope, this provides an opportunity to review the two documents and come up with a unified document agreed by all. However, due to the short time that remains between the current and the next strategic framework, the M&E framework will need to be flexible enough to incorporate potential changes in strategic direction and measurement demands that may be in the strategic planning cycle 2014. In 2012 UNAIDS will undertake this role in ensuring that the Global fund project forms part of the M&E framework for the whole country.

### **Costed M&E work plan**

There has been no M&E costed work plan for the three zones. The development of the costed M&E work plan was to be part of the operations manual which was to follow the finalization and endorsement of the M&E framework. With this not happening as planned, this process was delayed. SOLNAC has developed a zonal level costed work plan in line with the M&E framework that was adopted. UNICEF-GFATM is also in the process of finalizing costed M&E work plan for the project. Despite the absence of a national costed M&E work plan there is renewed commitment to finalize the draft documents for adoption. This will be facilitated further by programmatic and zonal level working documents that are in use or whose finalization has been collectively accepted.

### **Routine Program Monitoring**

Routine monitoring has been done on a project basis. Data collection and reporting has been consistent through the data flow channels that exist. However there has been limited unified analysis of data in respect to any relevant indicator in any unit of the three national AIDS commissions. In absence of the output monitoring most of the monitoring is done by agencies and M&E units at the process level by taking stock of progress on various work plans. The finalization of the M&E framework is important in order to harmonize routine monitoring through indicator selection and approach in the zones. The response need to build on the successes of process monitoring to ensure other levels of monitoring are implemented on a routine basis.

### **Surveys and Surveillance**

In response to previous recommendations to have more knowledge and behavioural data, IOM with funding from UNICEF –GFATM conducted a survey targeting the Youth in the three zones. In 2011 UNICEF implemented a multiple indicator cluster survey in which aspects of knowledge, attitudes and

behaviours were integrated. The findings will be released in mid-2012. Despite these efforts, the dearth of knowledge and behaviour based data still persists. The last national survey targeting all the groups focusing on the HIV and AIDS was conducted in 2004. Since then there has been no other follow up study targeting the same groups and using similar methodology on which to base any trends analysis to establish various outcomes of the response. Similarly, apart from the IBBS conducted in Somaliland in 2008, no other study targeting behaviours, knowledge and attitudes of MARPS has been done.

To make the best use of the surveillance data, expansion to new sites with rural considerations has been recommended. The current frequency of surveillance is 2 years, annual surveillance would be more appropriate to keep informing the response on any time variant aspects of the epidemic. Based on the nature of the epidemic, consistent surveillance of most – at risk populations remains very critical. The last IBBS among sex workers was conducted in 2008; it is important this is expanded to other zones with increased frequency to allow comparative analysis with other studies. This will enhance understanding of the epidemic from a more collective and informed stand point. Since funding to support IBBS is still limited, there is need to mobilize more resource to conduct studies among Female Sex workers and target other priority groups. There is also need to address cultural issues through religious leaders and other conservative groups who remain opposed to bio-behavioural data collection.

In the area of surveillance the response has done relatively well. There have been 3 rounds of surveillance within the last five years, every 2 years. The result has continued to inform the response in a number of ways. Issues of quality assurance have been raised and addressed. Participation of key stakeholders has been an issue resulting to data ownership issues. Validation of surveillance data in line with other existing information needs to be given a chance.

### **Supervision and Data Auditing**

During the reporting period supervision has fared well at all levels. Programmatic supportive supervision has been done by various agencies taking lead for facility based and other interventions. The AIDS commissions have made significant efforts in supervising M&E activities at regional level through coordination with other stakeholders. Through the UNICEF-GFATM, onsite verification of data has been done for a number of IPTCs. In Somaliland there has been inter-agency sharing of the data with the SOLNAC to ensure that all data were harmonized and uniform between all.

There is need to get more financial support for supervision and harmonized the process so that uniform tools and approaches are used. Wider coordination and post-supervision feedback has been recommended in the future to ensure that supervision has both programmatic and M&E relevance.

### **M&E database**

The M&E units of the national AIDS commissions have several database templates as per the various data requirements. Most of the templates were developed through the GFATM mentorship program on which the M&E staff underwent 4 years ago. These databases are for retrieval and basic analysis of data. Various other lead agencies on key interventions have databases on which data entry; analysis can be done at the zonal level in a consolidated form. It is from these databases that consolidated data can be generated. However, the need for a standardized database has been expressed by AIDS commissions to

have a harmonized system between zones with UNAIDS technical support in the process. Further support is needed in equipments.

The M&E framework currently in draft form proposed integration of HIV and AIDS data generated from the health sector to go through the Health management Information system (HMIS) that has been under development in the two zones. Consultations on this were made in 2010 and 2011 but slowed down by the M&E framework that was yet to be finalized and operationalized. There is need to harmonize data collection and summary tools even before settling on issues of an M&E database.

The Country Response Information System (CRIS) is an appropriate database to use in national level programs. However, for the Somali response the database needed to be customized in line with zonal arrangements as it is only through this that its use would be acceptable to all. The most recent version was not however flexible to be customized in the zonal format and not acceptable to all the three zones. UNAIDS will hold further consultations to customize the software to be used at all zones. CRIS may however be applied only in the M&E units of the AIDS commissions due to infrastructural and other software limitations at the regional and lower levels.

### **Evaluation and Research**

Evaluations for individual projects for programmatic utility have been done on a low scale. In the first quarter of 2012 GFATM project is undergoing an external valuation. With the exception of evaluations undertaken by specific projects at the project level, the national response has not been evaluated so far

There have been delays to establish a Research Advisory group to spearhead research initiatives in the three zones. With this, very few efforts have gone into evaluative and operations research. The research and advisory group was envisaged to be a link between programmatic and academic research interests through which networking with local and external universities could be made.

### **Data Dissemination and Use**

The three zones have been able to report to the UNGASS after the declaration in 2006/ 2008 and 2010. The three zones have been able to submit consolidated reports for universal access in the last two reporting rounds. In addition the surveillance data has been disseminated and used in estimations, projections and in other aspects of decision making within the response. During the reporting period, survey data generated for various studies by AIDS commissions supported by IOM has been disseminated as well. Most of this data has however been shared in analyzed form. It would be beneficial to have access to the raw data in order to undertake further analysis. There is limited documentation of programmatic data and routine monitoring data and good practices and lessons learnt. A new letter or response and website have been recommended by various stakeholders. Efforts to participate in existing websites should be explored.

## **b) Challenges Faced in the Implementation of a Comprehensive M&E system**

### **Delays on the finalization of the M&E framework**

There is disharmony and lack of uniformity due to lack of standard guidance that a finalized M&E framework and operational plan would have provided. As a result, zones have either adopted individual approaches or used the GFATM tools for M&E. The M&E has been disseminated at all zones and all changes made, but so far not received endorsement from all stakeholders. There is commitment to finalize and operationalize the framework in 2012. The M&E framework is important in the sense that it will harmonise and unify various M&E efforts involving multiple sectors and stakeholders which seems to be scattered.

### **Funding for M&E activities**

The response has not been furnished with current strategic information generated from biological surveillance due to lack of funds committed to deliver studies every 2 years. The extension of IBSS to cover more priority groups is a sure way of understanding the epidemic better. It has not been however, not been possible to mobilize more resources targeting this initiative during the reporting period. There is also need to provide more funds to operational aspects of M&E such as routine monitoring and supervision whose frequency remains low due to limitation of funds. There is also a need to allocate more funds to equip the regional and sub-zonal offices to facilitate their M&E activities which is lacking in a number for now.

### **Limited local capacity to implement select M&E activities**

The weakness in capacities of the M&E units of the zonal AIDS commissions was identified through a formal workshop in 2008. After these considerable efforts has gone into the improvement of the skills and competencies through mentorship and training. Through this it has been possible to improve skills of the M&E staff to some requisite levels, but more needs to be done by working closely with M&E officers through on the job coaching and providing opportunities for more technical exposures. Furthermore, it important not only to improve on the knowhow, but also provide the right means on delivering various M&E role by equipping the units with the right infrastructure and space from which to operate.

### **Limited prioritization of M&E**

There has been little advocacy, communication and any other efforts from various stakeholders on the importance of M&E. There has been more focus on other areas of program delivery without much of M&E overall. The civil society has not embraced M&E at the scale enough to trigger its visibility at all levels.

### **Lack of coordination between stakeholders**

The M&E working group remained active exchanging information on various activities in every zone. Beyond this, there has been limited M&E coordination but more retroactive efforts to support any

common activities on an ad hoc basis. At the zonal level the AIDS commissions have not fully engaged the civil society and MoH counterparts in the respective ministries of health. However, there has been substantial coordination in reporting and information sharing on activities but little of this in strategic areas such as budgeting.

### **Contextual Challenges**

It was only possible to conduct sentinel surveillance in South Central in 2011 since 2004. This and other M&E activities have been affected by insecurity, fear and geographical spread. Supervision of M&E and other programmatic activities have not been easy to implement in other zones as well.