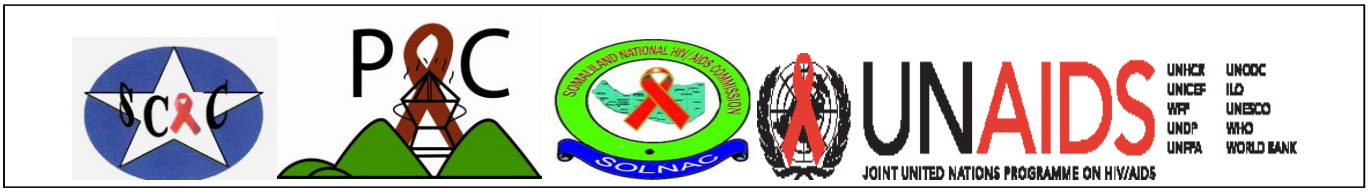
United Nations General Assembly Special Session on HIV/AIDS

COUNTRY PROGRESS REPORT 2010

Narrative to Supplement – Online Report March 2010



May 13, 2010

List of Acronyms and Abbreviations

AIDS	Acquired Immune deficiency syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Ant-retroviral
BCC	Behavior Change Communication
CBO	Community Based Organization
CDSS	Condom distribution strategy for Somalia
CCM	Country Coordinating Mechanism
CRIS	Country Response Information system
FBO	Faith Based Organization
FSW	Female sex worker
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GBV	Gender Based Violence
HBC	Home-based Care
HSC	Health Sector Committee
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological and Behavioral Surveillance
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
INGO	International Non-Governmental Organization
IOM	International Organization for Migration
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
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NGO	Non-governmental Organization
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAC	Puntland AIDS Commission
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SSS	Somali Support Secretariat
SCAC	South Central AIDS Commission
SOLNAC	Somaliland National AIDS Commission
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TFG	Transitional Federal Government
TSW	Transactional Sex worker
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children Fund
UNDP	United Nations Development Program
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WFP	World Food Program
ZAC	Zonal AIDS Commission

Acknowledgement

The Somaliland, Puntland and South Central AIDS commissions (ZACs) are grateful to all government sectors and line ministries for their insightful contribution and inputs to the UNGASS report 2010. Further gratitude is extended UN agencies and Non- governmental organizations (NGOs) for making available supplemental data without which the national indicators could not be completed. For their technical input, to the process, the ZACs are grateful to the Joint UN team on AIDS, WHO, UNICEF-GFATM and international NGOs. Special thanks to; the national NGOs the community based organizations, women groups, religious leaders and Associations for PLHIV whose linkage with the epidemic and response realities has helped shape key components of this country report.

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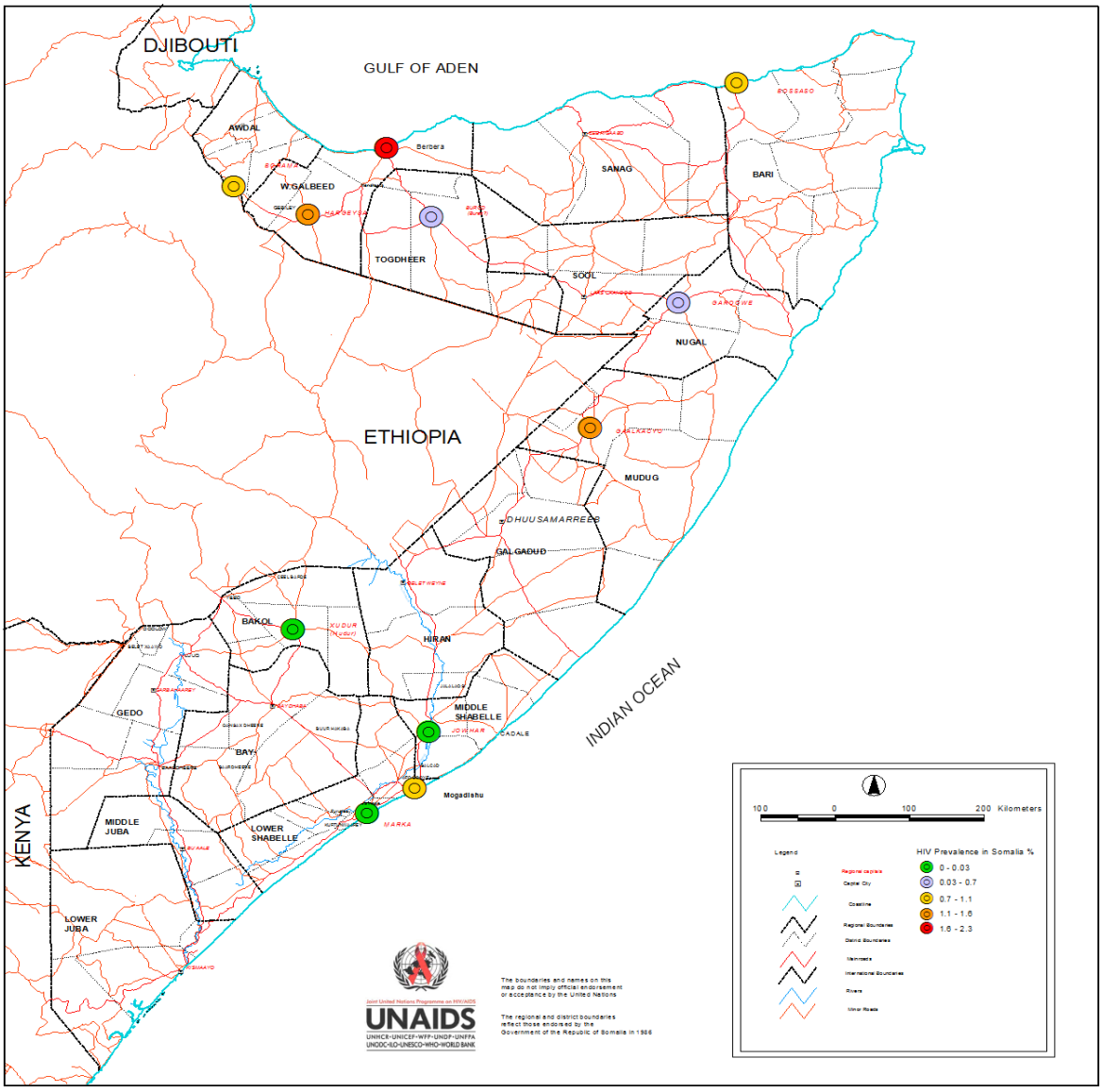


II. Status at a Glance

a) Inclusiveness of stakeholders in the reporting process

The country report for Somalia is a culmination of collective efforts from all stakeholders working together with the Zonal AIDS Commissions (ZACs) in the North West, North East and South Central Somalia zone, i.e Somaliland National AIDS commission (SOLNAC) Puntland National AIDS commission (PAC) and the South Central National AIDS commission (SCAC), respectively. UNAIDS provided technical support to the development of all sections of the report and checked adherence to the methodological structure and format of the report. Other UN agencies have provided data and technical input into the process along with partner NGOs and implementers whose programming experiences has been incorporated as a key component of this report.

The 2010 report reflects the political realities and representation of the three regions and their own zonal level approaches to the HIV /AIDS response. The status of the epidemic and it's drivers exhibit slight zonal variations which necessitated description of three separate epidemic scenarios. The three ZACs have used Monitoring and Evaluation (M&E) framework developed for the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) requirements but reporting formats lack uniformity for data to represent all zones and sectors. Due to the multi-sectoral nature of the response all, stakeholders including the line ministries of respective ZACs, the UN agencies and the civil society and PLHIV were fully involved in the process. The ZACs took the leadership of the reporting process after UNAIDS orientation and identified various stakeholders through the (Monitoring and Evaluation) M&E and the Integrated Prevention care and Treatment centers (IPTCs) working groups and briefed them on the process. The ZACs nominated the national M&E coordinators to lead the process in respective zones working closely with the UNAIDS counterpart for technical support and ensuring that the process was standardized and participatory to the largest extent possible. The WHO played a crucial role of providing data on a number of indicators and technical input for their computation.

i) Planning stage

The first phase of the reporting process was planning for each of the phases and components. The briefing of various stakeholders was done at the zonal level under the leadership of the National AIDS Commission except in South Central where it was not possible due to security concerns. In all locations, the UNGASS reporting process was rolled out in coordination with National AIDS commissions (ZACs) and Monitoring and Evaluation (M&E) working groups. The M&E working groups has representation from all stakeholders involved in HIV/AIDS response and include the government representation through the ZACs, the UN agencies, and the members of the civil society ranging from international NGOs, national NGOs and representatives of the persons living with HIV (PLHIV). The views and deliberations of the roll out meetings were used to improve subsequent components of the reporting process. Due to insecurity risk, the South Central team orientation and zonal level inputs into draft report preparation was done in Hargeisa Somaliland, whereby the team worked on some of the elements of National Composite Policy Index (NCPI) and input in key areas which was later supplemented and validated through data collection widely from other stakeholders

ii) Data collection and Report Preparation

After the roll out of the process and preparation of tools, the ZACs M&E coordinators spearheaded the collection of data in each zone with UNAIDS technical support. Since some of agencies involved in HIV response are based in Nairobi, UNAIDS provided support for data collection in order to ensure that the opinions of key stakeholders at this level was captured. The National Composite Policy Index (NCPI) data was collected from the line ministries of the national AIDS commission and supplemented by ZACs secretariat. These include; Ministries of Health, Family and Social Welfare, Education, Religion Affairs, Youth and Sport, Labor, Communication Planning and International Cooperation. Data for the Section B of the NCPI was collected from the UN agencies, national and international NGOs and the representatives of PLHIV. Due to parallel reporting systems, the indicator based data were collected from the ZACs, GFATM Principal Recipient (UNICEF), and WHO as key technical stakeholders in most of the facility based interventions other data was sourced from international NGOs (INGOs) and organizations for people living with HIV (PLHIV). Due to multiple sources, the data was taken through a verification process to avoid duplication that could potentially arise from the donor –sub grant double reporting possibilities. All the agencies were contacted for submission of data for all the components of this report and majority responded. UN agencies and international NGOs were contacted at the national level to avoid duplication of efforts and data at the zonal level, while local NGOs were contacted through their zonal networks or individuals. The PLHIV associations, networks and support groups were part of the process and contributed to the report. Significant efforts were made to collect data at grassroots of out of reach regions through the regional M&E officers in Somaliland and Puntland, while in South Central various officials of the SCAC provided regional specific information that was included in this report.

iii) Validation and Endorsement

Validation consultations were spearheaded by the ZACs at the zonal level after which feedback was shared with UNAIDS for inclusion in the report. The national level validation was held in Naivasha where [1]43 representatives of the ZACs, government, civil society, UN agencies and PLHIV participated. Emerging from the meeting was consensus on the process, the draft and group deliberations and identification of various areas of amendment before endorsement. From this, the report was circulated to all stakeholders and their inputs were included as agreed.

b) Status of the epidemic

i) Background

Somalia is located in the Horn of Africa, bordering Djibouti, Ethiopia and Kenya to the North West, South and South West respectively. In the East, an extensive coastline on the Indian Ocean surrounds

[1] Details in Annex 2

the country to a 3600 km Northern link to the Gulf of Aden. The country is characterized by arid landscape and scattered settlements with nomadic and agro-pastoralists livelihoods. With this, [2]36% of the population is urban for only 13 % of the land is arable.

After 18 years of relentless fighting that followed the fall of the government in 1991, Somalia has witnessed a number of changes that have shaped political and governance structures in the whole country. The emerging differences have culminated into three entities. The underlying contextual dynamics and resultant outcomes have impacted on the epidemiology, approach and programmatic aspects of the national response which is dynamic from time to time in order to accommodate these unavoidable realities.

An estimated population of [3]8.1 lived in Somalia in 2008, with over 50 percent of the population under the age of 15 years. Under five and maternal mortality rates are among the worst in the world, at 225 and 11-16 per 1,000 live births respectively[4]. Estimated per capita income was $226 in 2002 (UNDP 2003). Less than 1 in 5 children are enrolled in primary school, and out of the few who complete primary school only 1 in 8 are girls. Somali women suffer Sexual Gender Based Violence (SGBV); social norms often exclude women from decision making, access to and control of resources. At the household level, the ongoing conflict and instability has severely affected economic security, exacerbated disparities in gender relations, hence increasing the vulnerability of women and children, and created an environment for human rights violations. These factors increase the populations' vulnerability to HIV transmission and have potential reciprocal effects. The impact of this and the breakdown of social networks and institutions stemming from displacement result in reduced community cohesion hence weakening the social norms that regulate sexual behavior, leading to risky behaviors and may have increased risk of exposure to HIV transmission.

The three entities of Somali shares borders with countries where HIV is already generalized with stable transmission rates in Ethiopia and Kenya and epidemic on an upward trend in Djibouti. Somalia has socio-economic links in these countries and trade driven mobility is common within the three countries. Additionally, there has been an influx of internally displaced persons (IDPs) who operate between the neighboring countries. In various ways, the cross border mobility and interaction is potentially an entry point of establishment of new sexual networks within the three countries and an avenue of HIV transmission within and outside Somalia. The Somalia conflict and resulting insecurity and emergency has augmented HIV transmission related to, disruption of livelihoods, gender vulnerabilities and weakness of health systems to cope with other competing interests. The response is curtailed by cultural barriers that influence knowledge, behavior and attitudes and in turn limit full community participation, ownership and mobilization efforts in HIV response.

[2] UNDP estimates 2006

[3] UNDP 2002. Estimates

[4] World Bank, Somalia: From Resilience Towards Recovery and Development

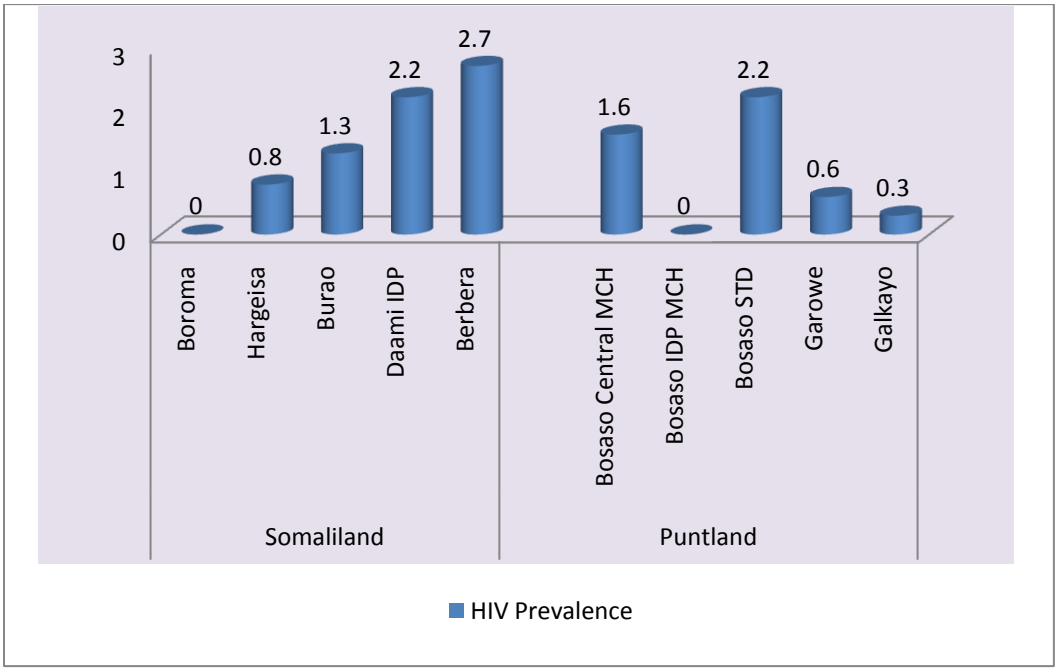
ii) Analysis of the epidemic

Since 2004, there has been no national population based survey to describe the HIV epidemic in Somalia. The last two years have however seen some efforts in epidemiological and behavioral studies with a national scope. Description of the HIV epidemic in Somalia is therefore based on zonal and sub group focused studies and facility based data as proxies for national wide extrapolation to reflect respective epidemic thresholds in each zone. Available data shows that the status of the epidemic varies within the three entities and has rural- urban and port- city differentials. Apart from this, the drivers of the epidemic are yet to be empirically identified and as a result, the national response over the last five years has been designed to address a generalized epidemic for prevention and mitigation purposes.

Existing data has defined the epidemic into three likely zonal based scenarios. The prevalence in Somaliland has consistently surpassed the 1% for a generalized epidemic and presented evidence of concentration in select subgroups. There are no recent studies on the general population in Puntland and South Central, but previous studies have shown evidence of concentration of the epidemic among sexually transmitted infections (STI) patients in Puntland. With exception of scanty evidence of concentration in a few sites, South Central continues to exhibit all characteristics of a low level epidemic but the ongoing emergency and data limitations have reduced the possibilities of understanding the epidemic fully. The 2004 sero-survey among antenatal care (ANC) attendees, showed variable prevalence with 0.6% in South Central, 0.9% in Puntland and 1.4% in Somaliland. Further analysis showed setting variations with Berbera port (Somaliland) recording the highest prevalence of 2.3%. HIV prevalence among (tuberculosis) TB patient was 5.6% pointing to a potentially generalized epidemic nationally.

The 2007 sentinel-survey in Somaliland indicated that HIV prevalence among ANC attendees was 1.5%. Additionally, the prevalence of HIV among sex workers (SWs) in the recent Integrated Biological and behavioral surveillance (IBBS) in Hargeisa in 2008 was considerably higher than among ANC attendees, 5.2% versus 1.4%, which points to high heterosexual transmission potential. The results further showed a slightly higher STI prevalence of 7.8% among Most at Risk Populations (MARPS) in absence of an effective strategy for addressing the sub-population. No meaningful trends analysis was done to establish changes in prevalence by years due to limitations of representation and methodological considerations. A number of qualitative and mapping studies have linked HIV transmission to sex work, displacement and trade driven mobility. With recent increase in magnitude of these factors and likelihood of cross border transmission within neighboring countries in which transmission is already generalized, the Somalia epidemic may have worsened.

Fig 1: Zonal HIV prevalence by Site 2007



Source: Survellailance data

iii) Policy and Programmatic Response

The Somali HIV response is set in a unique complex and dynamic political, security and socio-economic context. Consequently, this translates into varying sub-epidemics and response among populations and sub-populations that needs corresponding differentiation of the response. Somalia response continues to focus interventions in the general population but recent assessment of high risk behavior among various groups in Somali populations has indicated the need to prioritize the HIV response to identify and better target the drivers and risk factors that are fuelling the HIV epidemic. From 2009, the strategic framework (SF) has identified and prioritized these groups, with a particular focus on various sub populations which include; mobile cross border populations and MARPS. This has been supported by efforts to map out, identify and assess key hotspots for more focused prioritization and effective programming through support for existing cross border program implemented under the auspices of the Intergovernmental Authority on Development (IGAD) through World Bank and 'Canadian International Development Agency' (CIDA) funding. The funding for the overall HIV/AIDS response however mainly comes from the GFATM.

Somalia HIV/AIDS response is spearheaded by three Zonal AIDS commissions' representing Somaliland, Puntland and South Central. The ZACs were established by respective governments with multi-sectoral representation and one national harmonized monitoring and evaluation system in each of the zones. In 2008, the ZACs signed a memorandum of understanding to partner with all stakeholders in the national HIV response. In 2009 ZACs endorsed the steering committee to promote Somalis and civil society participation and provide oversight and leadership to collective all inclusive national response at all levels. The coordination of the response in the country is complex and therefore the role has been has been shared with the UN, the Health sector and country coordination mechanism for Somalia. Despite

this ZACs have shown improvement in capacity for coordination and programming for the response in their respective zones. However, there are concerns that Somalis participation and ownership of the response is limited.

iv) UNGASS data Overview

Table1: UNGASS indicators overview

Indicator	Value	Remarks
National Commitment and Action		
1. Domestic and International spending		NASA report attached to online tool
2. Policy Development and Implementation status		NCPI report attached to online tool
National Program Indicators		
3. Percentage of Blood units screed for HIV in a quality assured manner	**0**	No facility participates in any quality assurance standard procedures
4. Percentage of adults and children with advanced HIV infection receiving anti-retroviral therapy	**11%**	Spectrum estimates used for the computation of the denominator
5. Percentage of HIV positive pregnant women who received anti-retroviral to reduce the risk of mother to child transmission	**0.4%**	PMTCT- only reached 6 women reached in 2008- Denominator drawn from national targets compared with spectra out put
6.Percentage of estimated HIV positive incident TB cases that received treatment for TB and HIV	**2.8%**	Denominator drawn from WHO estimates for the country
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results	**4%**	National UNICEF KAPB , 2004 **M=4.8% and F=2.5%)**
8. Percentage of most -at-risk populations that received an HIV test in the last 12 months and who know their results	**0%**	Drawn from IBBS study in among female sex workers (FSWs) in Somaliland 2008
9. Percentage of most -at-risk populations reached with HIV prevention programs	**-No data**	National wide mapping has been done- Not possible to report
10. Percentage of orphans and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	**Not relevant**	This indicator is for high prevalence countries
11. Percentage of schools that provided life skills based education in the last academic year	**No data**	No school survey related to the indicator
Knowledge and Behavior		
12. Current School attendance among orphans and among non orphans aged 10-14	A: **(Attendance 25.4% (Male=29.2%; Females=22.9%).** **B- (Attendance 29.6% - (Male=30.2%; Females=27.9%** **There is no difference on attendance between orphans and non orphans**	
13. Percentage of young women and men aged 15-24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission	**4%**	Data captured from UNICEF multiple indicator cluster survey(MICS) 2006
14. Percentage of most-of - risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about transmission	**6.9%**	Drawn from IBBS study in among female sex workers (FSWs) in Somaliland 2008

15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**No data**	
16. 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**	
17. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months reporting use of condom during their last intercourse	**No data**	
18. Percent of female and male sex workers reporting use of a condom with their most recent client	**24%**	Drawn from IBBS study in among female sex workers (FSWs) in Somaliland 2008
19. Percentage of men reporting use of a condom the last time they had anal sex with a male partner	**N/A**	No MSM data or programs
20. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	**N/A**	No IDU data or programs
21. Percentage of injecting drug users who report use of a condom at last sexual intercourse	**N/A**	No IDU data or programs
Impact		
22. Percentage of young women and men aged 15-24 who are HIV infected	**0.9%** **0.94%**	WHO sero-survey 2007 WHO sero-survey 2004
23. Percentage of most-at-risk populations who are HIV infected	**5.2%**	Drawn from IBBS study in among female sex workers (FSWs) in Somaliland 2008
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti retroviral therapy	**72.09%**	Data derived from WHO cohort analysis
25. Percentage of infants born to HIV- infected mothers who are infected	**No data**	No PMTCT interventions to facilitate modeling

III. Overview of the AIDS epidemic

a) Details of HIV prevalence

The Somali epidemic has been plagued by limitations of data for some time. The response has been informed by national sero–survey in 1999 and 2004 and zonal specific sero-surveys in Puntland/Somaliland in different surveillance rounds 2007 and by IBBS in Somaliland in 2008. Apart from Knowledge Attitude Behavior and Practices Survey (KABP) conducted by UNICEF in 2004, there is no other national wide behavioral and operational research studies that have been documented. However, there are few regional operational research, mapping and community level studies conducted by the civil society. Despite this, the support of relevant stakeholders has not been forthcoming; hence denying the response strategic information, a vital aspect of decision making. A few recent studies that exist are focused on population subgroups thus understanding of the epidemic is alternatively based on projections and extrapolation of data from previous studies.

HIV epidemic in Somalia is approximately 20 years now. The first case identified in Berbera (North West) in 1992. The epidemic has since generalized in Somaliland, low in conflict prone South Central and mixed in Puntland. Several studies have described the epidemic for the last ten years but none has analytically identified the key drivers. However, the first national wide sentinel surveillance conducted in 2004 provided useful baselines for programming decisions and has been crucial in assessing zone specific HIV trends and linkages with other related areas of focus. The description of the epidemic later on was informed by a number of biological and behavioral surveillance which has shown likelihood of HIV transmission to the bridging population and the general population. This has been highlighted in the zonal specific descriptions detailed as follows;

i) Somaliland

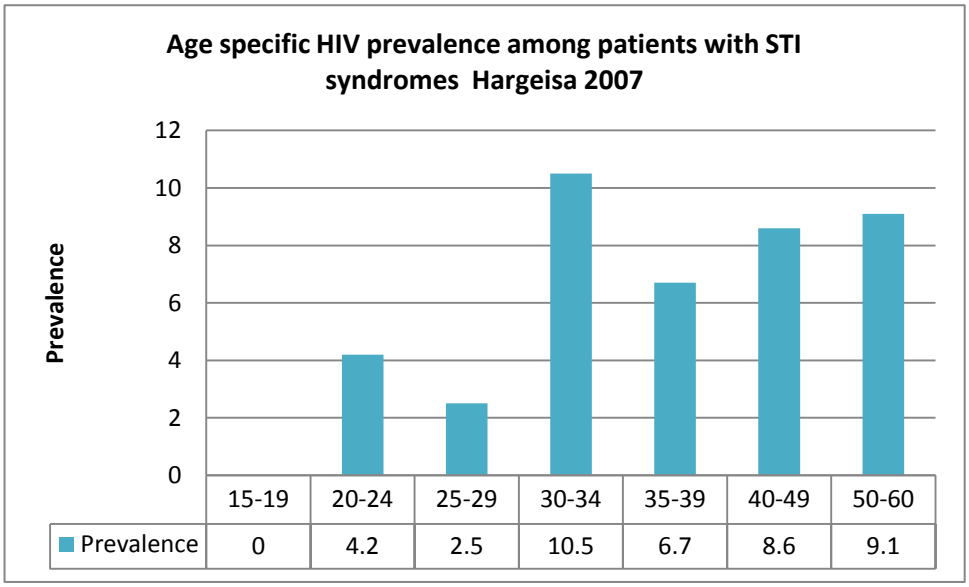
Somaliland continues to enjoy relative stability as a result of autonomy and this has increased an environment for population movement compared to the other zones. Due to this, the zone has become the epicenter of peoples traffic including; Somalis from other zones, residents and Somalis from diaspora, international Aid Workers and other interests groups. The regional port of Berbera has become a centre of offshore trade between Somaliland and extended transport based mobility hinterland and cross border with Ethiopia and Djibouti. The zone shares open borders with these two countries in which HIV is already generalized and frontier populations are prone to establishment of sexual networks within each other.

The first national ANC sero-prevalence survey revealed mixed regional results ranging from 0-2.6% with an overall zonal mean prevalence of 1.4%. Although the overall zonal average pointed to a potential threshold of a generalized epidemic; pockets of concentration in some sub-populations were confirmed by high prevalence 5.2% among STI patients. Similarly the prevalence was skewed in port cities and regional trade and transport centres with highest prevalence in Berbera (2.3%) followed by Hargeisa (1.6%) and 1.1% in Borama.

The second Somaliland survey was conducted in 2007, 1766 young women aged 15-49 women attending ANC recorded a HIV prevalence of 1.7%. Prevalence among patients with STI syndromes was 6.3% and was higher among males (7.4%) compared to the females at (5.4%). HIV continued to exhibit regional and strategic setting differentials which ranged from 0% in Boroma to 2.7% in Berbera, with a median of 1.3%. The ANC site in the port city of Berbera where there is high cross border mobility and trade has shown a steady increase in prevalence from 1999 (0.0%), (2.3%) in 2004 and (2.7 %) in 2007. This confirms the potential contribution of mobile populations and associated behaviors in transforming cross border towns and ports into potential cores of HIV transmission.

In examining the prevalence of HIV among Sexually Transmitted Infections (STI) clients in Hargeisa, the 30-34 year old was the age group with the highest prevalence (10.5%) followed by the older age groups ranging from 40-60 years. This is extraordinary because evidence globally reflect prevalence of STD as common among the young and sexually active with limited resources at their disposal to seek urgent medical attention. Overall, HIV prevalence among STI patients was above 5% indicating that a routine provision of HIV testing and counseling to STI patients should be intensified.

Fig.2. Prevalence of HIV among patients with STI syndromes in Hargeisa- 2007



Overall HIV prevalence among STI clients = 6.3%

Somaliland was one of pilot zones for IBBS in 2008; with a study conducted among 237 commercial sex workers. The findings of this study reinforced previous observations of subsequent studies on HIV prevalence, STIs and related behaviors. The prevalence of HIV among FSWs who were included in the study was 5.2% while syphilis was 3.1%, with 0.4% co- infected. This is twice higher than ANC prevalence in the same year indicating higher heterosexual transmission in this sub- population which has further evidence of multiple concurrent partners with potential to extend to the bridging population. None of the FSWs reported use of injectable drugs, suggesting acquisition of HIV primarily through heterosexual means. One in every 14 FSWs (7.8%) reported at least 2 STI symptoms which include genital discharge and sores.

ii) Puntland

The zone enjoys relative stability albeit lower compared to Somaliland. The zone has three urban centres, Garowe, Galkiao and Bossaso in which various sub-populations are found. Bossaso the main trade center is home to a large number of IDPs and hosts cross border and mobile populations of various types. Galkaio is on the border with the South Central zone while Garowe is the headquarters of the zone. The underlying population characteristics in these towns and their environs could have potential effect on the epidemiology of HIV.

Two rounds of sentinel sero-surveillance were conducted in 2004 and 2007. The mean HIV prevalence ranged from 0.0% at Bosaso IDP MCH to 2.2% at Bosaso STD clinic with an overall mean prevalence of 0.5%. The mean prevalence at Bosaso Central MCH increased from 0.9% in 2004 to 1.6% in 2007. HIV prevalence was higher among pregnant women attending Bosaso Central MCH than in any other MCH clinic in other towns serving the general population and even higher at the Bosaso STD clinic. HIV prevalence among STD patients in the 2 rounds is below 5% while syphilis prevalence among ANC attendants was recorded as 1.9% in 2007 compared to 0.2% in 2004. In 2004, the mean prevalence in the zone was 1% with a median of 0.9%, which is indicative of uniformity in distribution of the prevalence. The Somaliland pattern of prevalence was also observed in trade and transport towns with highest prevalence recorded in Galkaio (1.4%), Bosasso (0.9%) and Garowe (0.7%). The prevalence of HIV among TB patients matched the Somaliland level of 5.5% and combined with observed prevalence of above 0% in all sites shows a slight upward shift in the absolute aspects of the low epidemic.

In 2007, HIV prevalence amongst STI patients, increased from 0.8% in 2004 to 2.2% in 2007. Similarly, syphilis prevalence ranged from 0% at the Bosaso STD clinic to 4.3% at the Bossaso MCH for IDPs. Among patients with STI syndromes, the mean HIV prevalence rate was 2.2% and higher among females (2.7%) than males (1.5%). Syphilis prevalence among ANC attendees in Puntland rose from 0.4% in 2004 to 1.9% in 2007. Global epidemiological evidence suggests that the presence of STI is a pointer to risk of HIV infection hence there is a need to fully address the high prevalence of STI cases in the Somali response.

Puntland remains a key destination of IDPs from South Central, and the two major towns Bossaso and Galkiao remains main trade hubs within the zone. Unpublished hotspot mapping findings documented presence of risky behaviors in Bossaso associated with transport trade, cross border mobility, displacement and khat trade. [5]In the zone, piracy has evolved into an influential industry that has attracted and pulled commercial sex workers from neighboring countries such as Ethiopia, Djibouti and as far as Eritrea. The interaction of these factors and their influence on sexual behavior are likely to have increased the epidemic potential in Puntland.

iii) South Central Zone

South Central has not known peace since the conflict started in 1991. Little is known about zonal changes in the epidemic since the last sero-surveillance in 2004. The survey showed prevalence rates ranging from 0% to 1.2% in Merka and Mogadishu respectively. The survey showed an overall zonal

[5] IRAPP Hotspot Mapping 2009

mean prevalence of 0.6% and a median of 0.6%. HIV prevalence in other regions Jowhar and Hudur were 0.3% each. Considering that two sentinel sites in Mogadishu show mean prevalence of more than 1% and Merka recorded 0%, this is characteristic of a low epidemic that could be concentrated in very small subpopulations.

South Central harbors close to 60% of the whole country population implying varying HIV dynamics and higher impact of the epidemic in the general population. The zone has been home to most vicious fighting with all pre-disposing factors to gender vulnerabilities resulting from displacement and loss of livelihoods which could lead to sexual exploitation, abuse and other violations with HIV transmission implications. The impact of stigma and complexity of HIV emergency setting are some of the obvious limitations of understanding the epidemic in absence of recent sero-prevalence data. Second generation surveillance needs to be conducted to establish the current status and in turn identify key drivers of the epidemic.

iv) Summary

The country has likelihood of three epidemic scenarios with evidence pointing to a generalized epidemic in Somaliland, an epidemic inclined to concentration in Puntland and a low level epidemic with negligible pockets of concentration in urban centers in South Central. However, apart from Somaliland which has continued to bring recent data for describing the epidemic in the general population and sub-groups, the dearth of data in other zones leads to inconclusive estimates.

In absence of recent nationally representative data, the analysis results to projections as an alternative to describe the magnitude of the Somali epidemic using input information from extrapolation of existing information into account of various zonal realities. According to UNAIDS and WHO estimates of 2009, 35,175 people live with HIV in Somaliland, Puntland, and South Central Somalia, among adults 15-49 years. The projections do not show significant sex differentials as 18,505 are females (52.6%, while 16,670 (47.4%) male. The number of estimated new infections according to projections has similar patterns, with 3462 (51.5%) females and 3250 (48.5%) males, making a total of 6,712. With more advanced projections from spectra which has more modeling flexibility, the number of people living with HIV (PLHIV) are estimated to increase two fold to 55,000 by 2012. Considering the current status of the epidemic; it is likely that the epidemic has outpaced the response in a number of ways. This warrants structured scale up of the interventions to address key drivers of the epidemic through prioritization of strategic information by country coordination mechanism which has been directly responsible M&E in the country for the last four years. The IBBS also found that no FSW had HIV test and for which results were received within 12 months preceding the survey further indicating that certain key sub-populations were previously overlooked in the response.

Table 2: Summary of Counselling and testing (CT) data by age and Sex-2006-2009

Age Group	Males		Female		Total	
	Tested	HIV (+ve) (%)	Tested	HIV (+ve) (%)	Tested	**HIV(+ve)**
>35	4304	656	2956	513	7260	**1169 (16.1%)**
25- 34	4411	327	4038	500	8449	**827 (9.8%)**
15-24	3692	70	3715	193	7407	**261 (3.5%)**
5-14	401	24	405	19	806	**43 (5.3%)**
<5	214	19	148	22	362	**41 (11.3%)**
Total	13,022	1,096	11,262	1,247	24,284	**2341 (9.6%)**

Source: WHO database

b) Knowledge and Behavioral characteristics of the epidemic

The Somali response focuses on the general population primarily for the reason that the drivers of the epidemic and associated behaviors have not been determined. Identifying key drivers has been hampered by varying priorities among key stakeholders, conservative nature of the society and probable security implications particularly in South Central. As a result, few programs have narrowed their response to MARPS. Until recently, behavioral and sentinel surveillance studies were implemented in separate ways with no linkages on the outcomes to underlying behaviors. However, the last national wide Knowledge attitude and practices baseline survey (KAPB) conducted by UNICEF in 2004 provided useful baseline estimates on which various HIV related behavioral dynamics could be assessed. This was not to be realized later on, because studies that followed were zonal specific small scale situational studies that could not facilitate comparability. In 2008 a KAPB study was conducted among internally displaced persons (IDPs) in Mudug region in Puntland/ South Central through GFATM; UNICEF sub-grant to Social Development and Research Association (SDRA). The findings of the study summarized below indicate that HIV knowledge is low in programmatically underserved areas of the zones and as such; knowledge has shaped various attitudes and behaviors hence populations remain vulnerable to HIV exposure in these settings.

c) KAPB Survey conducted among IDPs in Mudug Region – Puntland 2008

This study was conducted in IDP camps of Mudug region by SRDA with funding from UNICEF. A total of 1018 respondents were interviewed in14 IDP camps in rural areas of Mudug and per-urban areas of Galkaio town.

Awareness and Knowledge

The study shows five in every six respondents are aware of HIV, while slightly more 91.2% are aware of AIDS. Knowledge on the modes of transmission is limited to slightly over half (51.9%) who knew that HIV could be transmitted heterosexually while 6.5% and 2% were aware that HIV could be transmitted through infected blood and sharing of un sterilized needles respectively. About 37% of respondents were aware that that a healthy looking person could be HIV positive and one in every five (23%) reported that a healthy looking person could transmit HIV.

Awareness on Prevention Methods: Faithfulness was reported as the main mode of HIV prevention at 42% followed by abstinence (29.8%) and non-sharing of sharp instruments (5.2%). Less than 1% of the respondents identified PMTCT as an important intervention for prevention HIV transmission of HIV to the unborn baby.

Risk of Contracting HIV: Five in every six respondent s (82.2%) did not consider themselves at risk of contracting HIV; Two out of every five of them 41.7% reported they were faithful to their partners while the rest of respondents didn't consider themselves at risk of contracting HIV for these reasons; 22.6% practiced abstinence, while others perceived themselves too religious to contract the virus.

HIV Testing: About 48% of respondents are aware that one's HIV status could be known by taking an HIV test and through opportunistic infection manifested illness. One in every six was willing to take a HIV test if made available; however only 2.4% were tested and knew their status. Majority of the respondents (64.4%) cited interest to know their status, 9.3% concerned about protecting others and 8.7% indicated need to enroll into care. Other common reasons include; decision to get married, procreation and desire to plan ahead

Knowledge and Use of Condoms: Slightly over half (51.9%) of IDPs have heard of condoms. Of this portion, 29.2% confirmed having seen condom and 12% reported using it. Major reported reasons for condom use included; protection against STIs, more specifically HIV, and pregnancy. Pharmacies/Drug shops are the major providers of condoms. Talking about condoms publicly in Somalia in general is almost taboo and badly perceived by most of the society. For this reason, the study explored qualitatively in-depth views about people who use condoms. The vast majority of respondents associated condom use with promiscuity with only a handful recognizing the preventive role of condom use.

Awareness and Incidence of STIs: Majority of respondents had ever heard of AIDS (96.8%) while awareness of gonorrhea and Syphilis was lower at 91.2% and 71.2% respectively. On STI syndromes; 10.5% of respondents who had ever heard of STIs reported to have experienced signs of STIs within six months preceding the survey. Similarly, very close portion (10.2%) of either sex confirmed contracting STIs at some time in their lives. Treatment and care was mainly sought from public health facilities (77.6%) and private clinics (10.3%) and local herbal medicine among the rest.

Perceptions towards PLHIV: The levels of discrimination were high with 77.4% of respondents against HIV positive patients from teaching in schools. Slightly higher proportion (85.1%), reported their unwillingness to buy food from an HIV+ food vendor. At the family level, stigma and discrimination is likely to be less with 60% of respondents reporting that they would take care of HIV+ family member

and 41% indicated feeling sympathy for PLHIV. However, one in four (26.1%) respondents still attribute HIV to immorality and judge the PLHIV as immoral people.

d) Trade Mobility and HIV study conducted by Handicap International in Somaliland

This survey was conducted by Handicap International to identify HIV transmission risks related to trade and mobility in Cross border regions of Somaliland. The study targeted the general population and key informants, who included traders, truck drivers, religious leaders, HIV/AIDS NGOs, government officials; community leaders and UN agencies, among others. Four regions of Somaliland were covered: Togdheer, Woqooyi Galbeed, Saaxil and Awdal. Specifically, the study covered both urban and rural areas of Burao, Sheikh, Berbera, Hargeisa, Gabiley, Tog'Wajaale, Boroma, Hayade, and Lowyacado. Eight hundred and six respondents were interviewed.

Knowledge and Attitudes

The survey indicated that 5% of respondents still believe HIV is non-existent. In the same way, two in every three respondents (66%) perceive themselves as not in any risk of contracting the disease. A sizeable proportion 11% still believes HIV is a preserve of foreigners and therefore they are not at risk. There is a growing misconception that there is a cure in camel milk and local herbs and this seriously undermines any meaningful behavior change and health care seeking in some communities.

HIV testing

Analysis of VCT data for 2006-2008 showed that risk of HIV transmission is higher in some sub-populations explained by mobility and probability of engaging in risk behavior. Although the analysis is not scientific, the findings are a pointer that trade and mobility could be potential drivers of HIV transmission in Somaliland. Trade related sub population of truck drivers, tea sellers and small scale informal trade accounted for almost ¾ of all HIV positive cases.

Table3: HIV positive cases distribution by Occupation

Category	Percent
Truck drivers	37
Khat traders	21
Tea shop attendants	15
Housewives	14
Former Housemaids Cross border(Djibouti)	6
Former soldiers	2%
Retail shop owners	1.8
Livestock traders	0.2
Others	5

Source: Study data

Risk Perception and Sexual Behavior

The survey further brings out evidence of risky sexual behavior among various subgroups that can be associated with mobility. Sixty two percent of truck drivers indicated to having more than one regular sexual partner. About 60% are regularly absent from their wives for more than one month. All those interviewed regularly travel to Ethiopia, Djibouti and the Middle East. They are generally between ages 15 and 25 years. The study found that majority of tea shop attendants are women who are paid about 10 dollars per month on average. Tea shops, which are found in all urban centers and markets, operate 24 hours. Most of the respondents did not believe they were at risk of contracting HIV despite being sexually active and with multiple partners who they normally met at the shop. This corresponds well with the truck drivers who indicated that most of their leisure time is spent chewing khat which accompanies the tea service. Khat is imported from Ethiopia into Somaliland by road. The supply chain has importers, Exporters, transporters, wholesalers and retailers. The business of sale and chewing goes on daily all year round. Khat dealers accounted for 21% of HIV positive cases recorded in the assessed VCT centers. Majority of those interviewed did not believe they were at risk of contracting HIV despite having unprotected sex with multiple partners. Conversely, the existence of high risk sexual behaviour, the attitude, acceptance and use of condoms is alarmingly low; only 2% of respondents believed condoms could provide protection to HIV infection. HIV prevention and knowledge is characterized by misconceptions among surveyed sub-groups.

e) Integrated Biological and Behavioral Surveillance conducted among Female Sex workers in 2008

The study was conducted by IOM, WHO and UNAIDS in a sample of 237 female sex workers in Somaliland to establish baseline epidemiological and behavioral information and HIV/STI risk factors and their correlates. Additionally, the study sought to establish and contribute to information and develop an evidence –informed response among in particular FSWs. The study further provides a benchmark to measure progress on MARPS programming and should be repeated to establish the trends. Due to the invisible nature of sex work in Somaliland, estimation of the sex workers population in size and location is quite complex. To maintain its secretive nature, sex work has assumed unique patterns and typologies with no sex work preference of any select sites. This is uncommon in sex work practice in other settings and will have implications on mapping and delivery of interventions targeting them.

Characteristics and Dynamics of sex work

The study showed that transactional sex work starts as early as 19 years; following sexual debut at 16 years in half of the Female sex workers (FSWs). The number of clients per FSW in a typical day ranges from 2-7 but the mean is 2. In a month, 2 in every 3 FSWs (67%) see five different clients on average. Their common clients included; businessmen, Khat dealers, truck drivers and civil servants in that order.

Sex work thrives on networking with majority getting clients from rooms shared with other colleagues. Due the concealed nature of sex work, only one in every eight (13%) FSWs stalk get clients from open places. One in every ten FSWs used mobile telephone to get their clients; these are innovative forms of networking that are motivated by the stringent stand of the community on sex work.

HIV and Sexually transmitted Infections

The prevalence of HIV out of 237 FSWs who were included in the study was 5.2%. Surprisingly, the prevalence of syphilis was 3.1%, while 0.4% were co-infected. None of the commercial sex workers 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 is not high suggesting high likelihood of dual transmission within the core groups.

Condom use

Only one in every four (24%) FSWs used a condom is their last sexual intercourse with a client. However, only 25.3% of FSWs knew where to get condoms and 28% have never heard of the male condoms. Non use of condoms is attributed to clients' objection and negotiation limitations among the FSWs. For those that used condoms, the client had suggested it; implying the role of clients in decision making. Condom use has location and client related dimensions, whereby FSWs were unlikely to use condoms in the homes of their clients. There are questions about access to condoms as one third of FSWs indicated not knowing where to get condoms. Further analysis showed that the frequency and consistency of condom use is equally low with 75.6% having not used a condom one month preceding the survey. In total, only 4.3% used condoms every time they had sexual intercourse which further points to high vulnerability to heterosexual transmission considering high HIV prevalence among this subpopulation.

HIV Knowledge

Although 96% of FSWs had heard about HIV, just 6.9% responded correctly to both questions and probes about knowledge and rejected misconceptions about HIV transmission. Considering all forms of vulnerability exist and condom use is low, more targeted evidence based prevention programming is recommended among FSWs. This should be expanded to cover, mobile populations within and outside various hotspots and the country due to trade driven reasons and displacement.

Table 4: Summary of Findings of IBBS study Somaliland- 2008

Indicator	Number	Percent
Infection Status		
HIV-infected	13	**5.2**
Syphilis-infected	8	**3.1**
HIV-syphilis co-infected	1	**0.4**
Condom Use		
Condom used with client at last transactional sex	55	**24.0**
Consistent condom use with clients during past one month	5	**4.3**
Condoms never used with clients during past one month	148	**75.6**
Condom used with partner at last non-transactional sex	4	**1.8**
Sexually transmitted infections		
STI symptom/s in past 12 months (genital discharge or ulcer/sore)	18	**7.8**
Genital discharge and genital ulcer/sore in past 12 months	9	**3.1**
HIV Testing and Experience		
Know where to go for confidential HIV test	10	**2.6**
Ever had HIV test	12	**4.0**
Had HIV test in past 12 months and know result	0	**0.0**
Substance Use		
Injected drugs in past 12 months	0	**0.0**
HIV and STI Knowledge and Attitudes		
Ever heard of STIs	100	**38.4**
No misconceptions about HIV prevention – UNGASS (5 items)	13	**6.9**
No misconceptions about HIV prevention (9 items)	9	**7.0**
Forced Sex		
Forced to have sex in past 12 months	40	**10.4**

IV. National response to the AIDS epidemic

a) Policy and Strategic planning

A number of factors challenged progress to the implementation of priority interventions stated in strategic framework (SF) 2004-2008. The response made significant efforts in the implementation of the current framework (2009-2013), and foundations have been laid to rapidly scale up the response to guide progress towards the achievement of the universal access targets. However, efforts to intensify and scale up programmatic interventions, is far from being achieved due limited strategic information to inform the response. In the same way Somali ownership participation and engagement through the government and civil society in the response is still limited. In line with the principles of greater involvement of people living with HIV (GIPA), ZACs supported forums for intensifying structured role of PLHIV in advocacy and prevention in 2009. The current SF has prioritized greater participation of women in leadership role, and active and meaningful engagement of civil society organizations that are working with women and girls, and most-at-risk populations as well, as to promote gender equality to reduce vulnerabilities of women and men to HIV infection. This calls for discreet measures that strengthen their capacity and participation in all aspects of the response.

One of the ZACs responsibilities is policy formulation for HIV response in respective zones. So far, the three zones policies are being updated to reflect emerging epidemic scenarios and contextual realities in all zones. The ZACs have received some support to formulate and review policies and develop guidelines for various components of the response during the period under review. Through, the greater involvements of people living with HIV (GIPA) initiative PLHIV were able to voice their concerns in various aspects of legislation that address their welfare. Although such efforts have been made; the policy formulation in respective zones lacks political good will and commitment for review or completion in a timely manner.

Table 5; Rating of strategy , Planning Efforts in 2009

	Poor										**Good**
2009	0	1	2	3	4	5	[6]	7	8	9	10
2007	0	1	2	3	4	5	[6]	7	8	9	10

The rating of strategic planning in 2009, matched the 2007 one, as planning efforts remained at the same level. The 2008 report coincided with strategic planning which may have been used as a guide to the rating of the time. In 2009, efforts were made to develop zonal differentiated operational plans for respective entities. The operational plans for each zone are currently in the process of completion and participation in the development has deepened the role of all stakeholders including key line ministries in prioritization of key interventions and leverage of their efforts. Through this, various stakeholders have been able to prioritize interventions along with achievable targets for the implementation period. Strategic planning suffers from limited strategic information on the drivers of the epidemic and some

sub-populations to better design the scale of the response in the right sub-populations. In future; rating will gain from their collective ownership and appreciation of the strategic and operational planning process among all stakeholders

b) Political Support

The three ZACs in respective entities of Somaliland, Puntland and South Central were formed as government authorities and overseen by presidents in each of the respective zones. Regardless of the political opinion; the three ZACs signed a memorandum of understanding (MOU) which ascertains their willingness to collaborate within the "'three ones'" and emphasizes their collective vision and objectives for HIV response in 2008. In 2009, the ZACs ratified the decision to form a national steering committee to oversee and coordinate the HIV /AIDS response from a collective stand point. The establishment of the steering committee was supported and endorsed by ministers of health and Executive director of each of the zones later on.

The political leadership has been supportive in all HIV social mobilization and mass communication during awareness campaigns and World AIDS days. The presidents of respective zones and other high ranking officials were supportive of relaying HIV messages in their public addresses. The regional leadership has also replicated the same approach and support to other stakeholder's efforts to openly communicate and support various HIV /AIDS programming initiatives. The same support and leadership has been extended to support regional HIV programming initiative including Intergovernmental Authority on Development (IRAPP) (IGAD) which the country is part.

HIV/AIDS programming has received support from the ZACs in the delivery of various interventions. Although the capacity of ZACs is variable and deficient in some technical areas, they have played a proactive role in key areas of the response and accorded agencies good will that is vital for program delivery. ZACs have been central in coordination of activities and meetings through technical working groups and continued to provide the link between various target groups and various agencies. This has guided various initiatives into successful programs.

Policy formulation and support in legislative process for HIV response has been complete but dissemination has been rather slow. In all zones efforts to review the consistency of national AIDS control policies has not been comprehensive in terms of bills and laws. The ZACs and various stakeholders have made substantial efforts in identifying various areas and mobilized inputs for legislation for target groups such as PLHIV; but such efforts need to be supported by the political leadership for legislation, endorsement and enforcement.

Table 6: Rating of political Support for the HIV and AIDS programs in 2009

Poor										**Good**	
2009	0	1	2	3	4	5	6	[7]	8	9	10
2007	0	1	2	3	4	5	[6]	7	8	9	10

The period under review has witnessed continued political support from the authorities through respective ZACs. The establishment of a steering committee to institute the "three ones" and collective HIV response at the national level is worth noting. Comparatively, 2009 has enjoyed and utilized more political support than 2007 confirming the role of various stakeholders in nurturing such support through capacity building. However, the political leadership has not been proactive in support for legislation of various policy formulation initiatives that has emanated from key sub-populations and rights based perspectives. Overall, there has been significant improvement in rating for the political support component in facilitation of the HIV response, but for program effectiveness; intensification of legislation for PLHIV, prevention, MARPS and other warrants more political commitment.

c) Universal Access

Somali HIV response was party to the 2008 global commitment towards scaling up HIV prevention, treatment and care through the health sector response. A number of universal access (UA) interventions have been described in detail in the foregoing sections of this report. In 2009, Somalia submitted the universal access report detailing progress made in various interventions in 2008.

The Somalia response has remained committed to universal access despite the ongoing political instability. The ZACs are being strengthened to improve coordination and leadership and enhance the participation of ownership of the Somalis in the HIV response. The three zones are in the process of developing their operational plans to intensify prevention treatment and care and support services in a multi-sectoral approach.

The coverage of key universal access interventions has increased significantly. However, the scale remains very low and Somali is unlikely to achieve universal access targets. The response will have to fully identify drivers of the epidemic and priority populations' for more focused programming. Additionally, the response will continue addressing cultural norms and gender inequalities which are barriers to overcoming stigma and discrimination which slows engagement of Somalis in various programmatic initiatives.

c) Programmatic Response

i) Prevention

Somalia has a chance to contain the epidemic before it fully gets out of control through effective prevention strategies. Recent projections indicate that the magnitude of response is way below programmatic needs for prevention treatment, care and other support services. Addressing the unmet need in service utilization and appropriate behavior adoption, increasing access, creation of demand through quality improvement and creation of awareness remains a top priority of HIV/AIDS programming in Somalia. The prevention component has facility based service delivery and community level interventions that focus on adoption of appropriate practices and behaviors. Apart from GFATM support, various stakeholders have played a substantive role in prevention than any other areas of the

response. There is progress in some key components of prevention and not others. The ensuing section details of the status of progress of various interventions.

- **Blood Safety**

The 2008 report did not include the indicator on blood safety as existing blood screening procedures of the time did not meet the criteria of set standards for the intervention. Since then, nothing much has changed in the management of blood for transfusion as there are no blood banks in the three zones and the sites conducting blood transfusion did not participate in external quality assurance. In all 48 blood safety units, the blood donor is screened for HIV, Hepatitis, syphilis and other pathogens after which the donated blood is eligible for transfusion. Therefore, reporting for this indicator is not possible because individuals are screened instead of actual blood units, which is the standard. Considering that all blood donors are screened in the same way, there is no denominator against which the performance of this indicator can be assessed. Besides, there being no blood bank on which management of blood can be monitored, implying that the standards of blood safety may not have been met. In 2008, 8634 blood donors were screened for HIV while the number decreased in 2009 to 6327 attributed to under-reporting. All donors were screened for HIV pre-transfusion to rule out any possible contamination. Considering South Central is a conflict prone zone, occasioned by violence and emergency blood transfusion requirements, establishment of blood banks is needed to serve as reservoirs for emergencies and regular use especially when situations call for urgent transfusion. Participation in external quality assurance through linkage or establishment of external referral laboratories is recommended.

A sizeable number of health providers have been trained on blood safety and providing blood screening services services. Due to high turnover however, more trainings are needed. Review and operationalization of national blood safety strategies and guidelines and observation of quality assurance is a priority of the intervention from 2010 onwards.

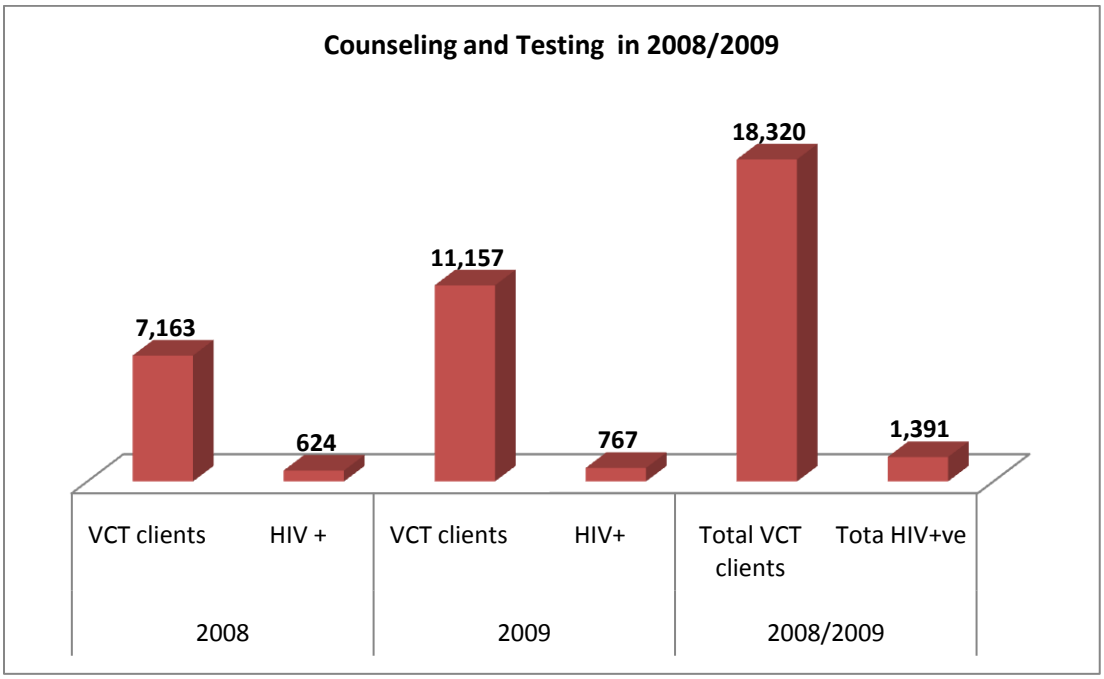
- **HIV Counseling and Testing**

There has been a consistent upward trend of the number of clients receiving voluntary confidential counseling and testing (VCT) for the last five years. This is a show of improvement in availability of, and access to counseling and testing services and demand for their utilization. Despite this, counseling and testing (CT) has not been undertaken to the desired scale. The 2004 KAPB conducted by UNICEF indicated that only one in every 20 adults was tested by then. From 2006, a total of 24, 284 client have been counseled and tested out of which 2,335 (9.6%) were HIV positive. So far, there are 20 functional VCT sites; 9 in South Central, 4 in Puntland and 7 in Somaliland. In 2008 a total of 7,163 clients were counseled and tested while number increased by 55% (11,157) in 2009. Compared to other services, CT has done considerably well and provided a platform for expanding treatment care and other interventions. However, outcomes of CT have not been prioritized by other interventions as the scale of the other components in Somalia is still low.

Six hundred and twenty four (8.7%) out of the overall tested clients since 2006 were positive while in 2009, 767 (6.8%) were positive. However, this reduction could be attributed to increased sample of clients undergoing HIV testing and not reduction in the prevalence of HIV. Provider initiated counseling

and testing continues to account for close to two thirds of the all HIV tests in South and central zones implying existing opportunities for up scaling HIV counseling and testing that are yet to be fully exploited through community level advocacy. Despite success in CT, referrals systems of HIV positive clients are weak and need to be improved for treatment and other subsequent interventions for be implemented on the right scale.

Fig 3: Counseling and testing summary 2008/2009



Source: WHO database

The VCT program is focused on the general population but has been able to reach out to MARPS which include commercial sex workers and their clients, truck drivers, informal traders, cross border and other mobile populations among others. VCT programs in Somalia face various cultural barriers which influence; stigma and discrimination, attitudes, disclosure and discordance. At the program level, shortage of testing kits, staff turnover and infrastructure are some of the key limitations. There is no current population based studies to show the uptake of VCT in the general population. However, going by the 2004 KAPB study, which indicated that 5% of people were tested for HIV, this could have gone up slightly considering CT has been intensified over time. The IBSS survey among sex worker shows that HIV testing has made some inroads among the MARPs beyond the general population but in equally lower proportion.

- **Behavior Change Communication**

Somalia has no data on behavioral trends on which to scientifically attribute any behavior change. However, based on the project outputs at the facility and community based levels and small scale studies, there is significant positive change on general awareness and opening up of the society to the HIV debate. The scale and timing may not have been sustainable enough to bring changes in the outcomes level of behavior. Qualitative information has identified culture and related opinion as a

salient barrier to behavior change. Mobilizing communities for social and cultural change is a continuous time intensive activity that needs consistent implementation to be to be fully accomplished in the long term.

The behavior change component of the response in Somalia is implemented through the mass media, peer education and through IEC materials spearheaded by ZACs and members of the civil society. UNDP and the civil society takes the lead of the GFATM BCC component, which is divided into general population and key sub-populations such as; work with Most At Risk Populations (MARPs_ for example, TSW, Truck Drivers, PLHIV. The mass media campaign implemented by Health Unlimited (HU) in the three zones targeted; Uniformed service personnel, Sex workers, Long distance truck/Khat drivers, refugees and internally displaced persons, nomadic an sedentary populations and the youth. The program trained 30 media personnel to implement HIV radio program locally known as '***Badbado"*** which includes 15 minutes radio broadcast and 45-60 talk in sessions. The radio programs had uniform distribution in three zones through radio stations; (Radio Shabelle Merka, Radio Hargeisa, Radio Bay, Radio Daljir and Radio Galkaiyo. In all broadcasts special emphasis was placed on the roles of PLHIV in prevention as an effort to reduction of stigma. In 2008 these radio programs reached an estimated 1.9 million Somalis of various groups through various select messages.

The behavior change specific messages for various sub groups and the youth were developed and implemented in various other ways which included public awareness campaigns, outreach drama and HIV/AIDS health talks, songs and poems. Through these direct verbal communication messages, a total of 123,000 people were reached. In recognition of the special demands associated with communication among the youth, messages on HIV prevention and taking responsibility to entrench character formation were developed and implemented. The Youth messages directly reached 11,589 in 2008/2009.

In addition to the verbal messages, print materials of all forms were distributed to different Somali subgroups by through various programs. These include printed caps, T shirts; Flyers, fact sheets posters and banners at strategic points. Through direct distribution of IEC materials, approximately 528,000 people in the three zones were reached. Other BCC initiatives included capacity building of key stakeholders and community opinion shapers to provide leadership to various initiatives in different segments of the society.

Table 7: Summary of achievements of Behaviour change interventions

Intervention	**Number reached**		**Total reached**
	2008	**2009**	**2008/2009**
Estimated Number of people reached through radio messages	1250,000	625,000	**1,875,000**
Number IEC materials distributed	1,600,000	528,000	**2,128,000**
Number of HIV/AIDS radio/TV/Programs/Newspapers developed	50	21	**71**
Number of youth peer educators and teachers and religious providers trained to deliver HIV education	510	916	**1416**
Number of minority groups trained to support behavior change programs	86	435	**521**

Source: Program data

The BCC component of the response has made significant gains in general awareness and imparting knowledge in the general population and specific sub-groups. Despite this, cultural and religious aspects remained an important parameter drawing back various BCC efforts. Messages touching on specific aspects of prevention such as, condom use received varying perceptions and absorption in various subgroups. Cognizant of this, efforts have brought opinion leaders on board through various capacity building approaches and direct involvement in the BCC activities. UNDP and other stakeholders have been spearheading this initiative that target religious leaders, community leaders, uniformed officers and other opinion shapers in the community. Another challenge in the delivery of behavior change interventions includes; disjoint between high expectations by the programs and the services. To sustain behavior change, the Somalia ZACs will need to address cultural barriers and tailor messages to the context and epidemic realities and put more focus on stigma and discrimination reduction messages.

- **Distribution and Use of Condoms**

Male and female condoms are not available in most of the private pharmacies present in eight of the nine "priority geographic areas" designated for condom distribution in Somaliland and Puntland as per the Strategic Framework. The scale of condom distribution has been low due to low societal acceptance linked to socio-cultural barriers. Various prevention policies are yet to be endorsed and recognize condoms as a key intervention against HIV transmission. Condom use has not been publicly embraced in practice and use is collectively denied. Despite this, studies have shown that the demand for condoms is high in few existing distribution sites. Virtually all of the condoms now in circulation in Somaliland, Puntland, and South-Central Somalia come from one 2007 UNFPA donation, the distribution of which was managed by UNICEF. Additionally UNICEF directly supplied a large quantity of condoms to Puntland's VCT facilities in 2008[6]. The ZACs in Somalia and reproductive health departments have not developed systems for management of condoms as no policy on the same has been developed or endorsed. However, the ZACs in the country supported condom distribution initiatives through other programs as a preventative measure.

The survey conducted by PSI Somaliland on behalf of UNICEF in 2009 shows very low condom availability in a random sample of more than 70 MCH clinics and private pharmacies taken in late 2009 in 8 of the 9 "priority geographic areas. Less than 1 out of 8 outlets, on average, surveyed in Somaliland that could reasonably be expected to distribute or sell condoms actually do so. That suggests that a person in need of condoms will fail to find and obtain them more than 80% of the time, with more than likely, frustration – and unprotected sex – to follow as a result. Chances of finding a condom when needed appeared better in Puntland where 1 of every 4 outlets assessed sold them, but the sample – which did not include MCH or VCT centers - is very small.

There is an urgent need for increased, broader, more reliable, and sustained availability of male condoms in established public and private distribution points throughout Somalia. Mobilization of the existing private pharmacy network has been identified as the most efficient and cost effective way to do this and it has – at least in Somaliland and in a few places in Puntland. Condoms are available in some private pharmacies in Puntland and very scanty and risky to stock and access in South Central. The private

[6] A Condom Distribution Strategy for AIDS Control and Prevention in Somalia(CDSS-2009)

pharmacy sector affords government authorities a "low-visibility", relatively passive channel that will minimize offense to community and religious norms.

Available data shows that a total of 2.2 million condoms were distributed from 2005- 2008. In 2009 the number was 300,000. In Puntland a community based distribution system is adopted through various agencies that spearhead the prevention campaigns in 2009. In Somalia however, distribution of condoms may not translate into use due to various cultural stances. As a result, there is reduced communication about condoms and their use after acquisition may not be guaranteed. There is no recent national wide data to provide condom use in the general population. However the IBSS study in Somaliland showed that 24% FSWs had used a condom in their last encounter with a client. Considering Somali is a conservative society, this is stepping stone for condom use promotion using participatory approaches; such as positive deviance among others.

"…they include condoms and there's no clear policy from the government on how [or to whom] they should be distributed."- Extract from one respondent CDSS study-2008

Condoms use is critical in arresting the spread of HIV at this opportune moment. However, the commitment of agencies to confront various barriers to the intervention is lacking in momentum un-concerted and not fully coordinated. To scale up condom use, the Somalia response will need to address key challenges in a participatory manner with full involvement and engagement of various stakeholders in all zones. The challenges include; lack of comprehensive information on the availability and use, ignorance and absence of strategic information, widely disseminated, for evidence-informed decision making. In the entire country, limited mobilization of religious leaders from a collective stand point has been lacking until UNDP initiated programs targeting them. Considering over half of pharmacies indicated not stocking condoms for fear of religious victimization; makes its leadership a key determinant of the success of condom distribution. In all the regions, religious and community leaders have a role to play and their inclusion in the condom debate to get facts right is an important element of distribution strategy. Personal religious belief and/or religious "opposition" are the principal reasons why condoms are unavailable in service delivery. There is no policy backing of condom distribution and for this, the commitment of the government to have condoms available to users in the right place lacks and this increases their vulnerability to HIV transmission.

Table 8: Summary of condom distribution in Somaliland and Puntland 2009

Site	Number of sites distributing or selling condoms	% providing condoms	Total potential condom distribution sites	Total Pop. of Locality	Condom distribution Point catchment Pop
Berbera	1 MCH of 2 visited; 0 pharmacies of 4 visited	17%	10	69,373	69,373
Borama	1 MCH of 2; 2 pharmacies of 8	30%	85	236,319	78, 773
Burao	2 pharmacies of 14	14%	135	288,781	144,391
Togwachale	1 MCH of 1; 0 pharmacies of 7	13%	8	122,554	122,554
Hargeisa	2 MCH of 3; 2 pharmacies of 16	21%	261	488,702	122,175
Loiyado	0 MCH of 1	0%	3	25530	
Subtotal	**11 of 58**	**19%**	**500**	**1,231,259**	**537,266**
Bossaso	2 pharmacies of 6	33%	No data	955,000	
Garoowe	1 pharmacies of 7	13%	No data	33,700	
Gaalkacyo	not surveyed	No data	No data	545,000	
Sub total	**3 pharmacies of 13**	**23%**		**1,533,700**	

Source: A Condom Distribution Strategy for AIDS Control and Prevention in Somalia report

- **Prevention Programs for Most at Risk Populations (MARPS)**

Studies have consistently shown the possibility of concentration of HIV among commercial sex workers and persons with STI syndromes. VCT data has also confirmed that sub populations in select settings account for a significant HIV positive proportion of the total tested for HIV. The Somalia response is designed for a generalized epidemic and has not fully prioritized various sub populations for a focused intervention. However, in the last three years there have been substantial efforts by the civil society and UN agencies to map, and prioritize programming to hotspots in trade centers, cross borders, port cities and other high areas of concentration. Programming for commercial sex workers has been impeded by the concealed nature of the practice, denial and cultural barriers and not much has been done in this regard. Findings of hotspot mapping shows that commercial sex work thrives in the port cities of Berbera, Bosaso, Lowyado and Togowajale border towns between Somaliland and Ethiopia. Considering these were the only locations targeted by the assessments; the practice could be widespread along cross border towns and cities and therefore programs to reach out to these groups is quite low.

The IBBS study in Somaliland 2007 has shown that the prevalence of HIV among FSWS is 5.2% with higher STI incidence of 7.8%. Considering only 1 per very 4 FSWs has comprehensive information about HIV and only 24% used a condom in the last sexual intercourse with a client, the potential of HIV transmission toward the bridging population is very high. The drivers of the epidemic appear to be associated with these subgroup and underlying risk factors in the settings in which they live.

Apart from commercial sex workers, the country response has not made substantial efforts to map out other potential MARPS including; injectable drug users (IDU) and men having sex with men (MSM). In all three zones, sexual orientation is a serious cultural concern in that this would have an impact on any MSM programming initiatives. Considering that the proportion of MSM could be very negligible, focus of the response on this is not motivated. Hot spot mapping studies have however shown that MSM is a common practice along the Djibouti Somaliland border and is further associated with cross border trafficking. The assessment further revealed that MSM thrives among sexual acquaintances and transactional in a few.

The response has not focused on IDU programming in the three zones. In light of this, there is limited information on the practice, the scale and other related aspects of this subgroup. No study within the main stream response has documented the practice in any of the zones, but the scale of the problems seems to be very negligible. Khat has been used as a stimulant among the majority of Somalia Youth and the middle aged. Any potential IDU problem is reportedly associated with the South Central zone which has been embroiled in protracted conflict up to date.

So far, there is no structured mapping and prioritization of the response targeting sex workers. However, IOM and Handicap International have been working with transactional sex workers in Somaliland and Puntland but the total population of sex workers and target is widely unknown because of the concealed nature of the practice. Through hot spot mapping, IOM has identified 350 sex workers for behavioral mapping and programmatic response.

e) Rating of support to HIV prevention Programs in 2009

The Somalia zones have policies that promote information education and communication on HIV/AIDS in the general population. The policies cover the majority of preventive components but none of them target condom use. Similarly, all the zones lack a youth and reproductive health policy and sex health education in and out of school. There is no much policy focus on MARPS and substantial programmatic response to MARPS. In 2010, ZACs are reviewing policies that encompass all elements of HIV prevention to be endorsed for addressing all areas of the response.

In terms of implementation, there is no significant difference between 2009 and 2007 as the scale of preventive interventions remained same. So far, there is sufficient mass communication targeting the general population in the three entities, but subgroup specific behavior change communication needs to be intensified. So far, the response has not been able to overcome cultural and religious barriers to condoms distribution, resulting in widespread denial and non use. Design of more culturally appropriate and tested approaches to transform the opinion about condoms is recommended.

No formalized institutional extra-governmental mechanism to assure that condoms are regularly available and accessible (when needed) at the few places already distributing them. Condom distribution to-date in Somalia has been – and is – almost entirely donor-driven and largely ad hoc. There exists no sustainable mechanism in any of the three zones to regularly supply – and then monitor and re-supply – where the stock supplied to central distribution centers actually goes and in what quantities – or to

verify whether most condoms "distributed" have actually reached the intended beneficiaries. Therefore, the commitment of the response to this intervention has been lacking despite the central role that condoms play in young epidemics such as Somalia.

The review of progress on preventive interventions indicates that only a few preventive interventions have been implemented at acceptable scale. These include; HIV counseling and testing, reproductive health services and STI treatment. The scale of prevention interventions among the MARPs is low as preventive efforts have been targeting the general population.

Table 9 ; Rating of effort in implementation of HIV prevention Programs in 2009

	Poor										**Good**
2009	0	1	2	3	4	5	[6]	7	8	9	10
2007	0	1	2	3	4	5	[6]	7	8	9	10

As stated above; the rating for 2009 is not significantly different from 2007 as the scale of prevention efforts remained the same. However, efforts have been made to enlist religious and cultural leadership in BCC component of the response through social mobilization and capacity building. In Somaliland awareness has been intensified in the urban areas while in the rural areas community groups have been trained to spearhead BCC. Another justification of the rating is due to the fact that key opinion shapers leaders have not been fully integrated in prevention efforts, while the MARPS have not fully integrated in prevention programs. Furthermore, PMTCT services are no longer provided in any site and this makes HIV transmission in pregnancy a very high risk for the unborn children. The promotion and use of condoms is yet to be scaled up due to cultural stance on the intervention. More participatory approaches will be supported by ZACs and other stakeholders to ensure that such barriers are addressed adequately.

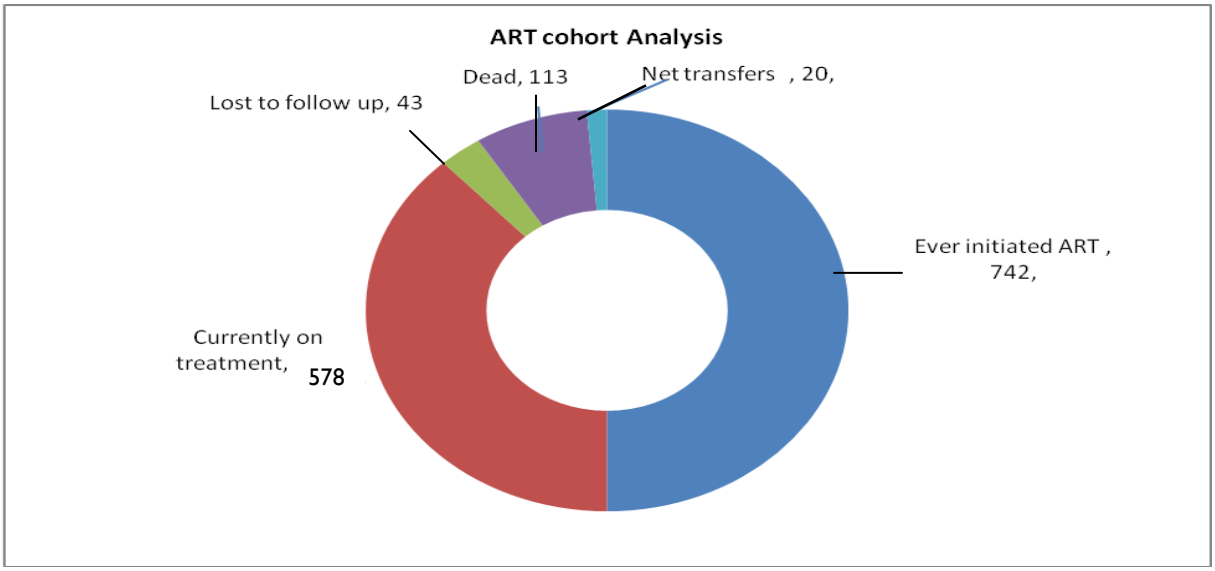
f) Treatment Care and Support

Treatment is one the areas of the response on which program delivery has been outpaced by growing needs of HIV positive clients who need to be initiated in the programs. As will be seen in the ensuing sections, projections clearly show a discrepancy between the demand for treatment and the current capacity of the response to provide the treatment services. Because of this disjoint, the response has not adequately addressed various care and support needs which are interlinked with treatment. Consequently, the scale of care and support interventions is equally low. It has not been possible to enlist all eligible patients into treatment and care due to limited community support and weak health facility coverage and community links. This has been confounded by stigma and discrimination that characterize health care seeking for HIV positive clients. This situation and other successful element of the treatment care and support component are detailed below.

i) Antiretroviral Treatment

Anti-retroviral treatment was initiated in 2005, but its progress though dependent on a number of factors has been outpaced by the demand. By the beginning of 2008, only [7]3% (211) of new eligible patients were put on anti –retroviral treatment. In line with universal access targets, the focus of treatment component was to scale up ART and initiate a complete package of prevention of mother to child transmission (PMTCT) in a network of integrated prevention and treatment centers. Since inception 742 HIV positive clients have been put on treatment. Every six months new cohorts of pre-ART patients have been initiated on treatment while there is slight censorship resulting from transfers, loss of follow up and recruitment into alternative treatment. Out of this, 113 patients on treatment have died (15.2%) implying survival rate of 84.8%. However, this is a cumulative proportion which only shows survival for the entire cohort. The Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti retroviral therapy (UNGASS) computed one year prior to the reporting period is 72.09%.

Fig 4: Anti-retroviral treatment- Cohort Analysis up to December 2009

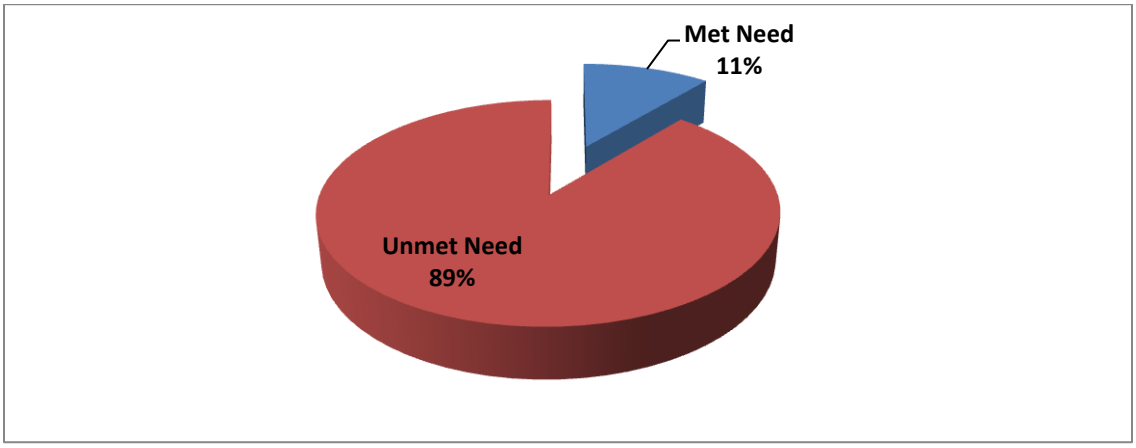


Source: WHO ART database

In 2008 and 2009, Anti-retroviral treatment has been provided in 8 centers. Due to expansive geographical spread, access has been very difficult hence increasing likelihood of missing referrals and loss of follow up pre-ART. Treatment has been implemented according to WHO clinical staging standards due to continuous outages of the CD4 machines and lack of technical capacity among the locals to manage basic technicalities of the equipment.

[7] In respect to universal access

Fig 5: ART coverage in respect to projections



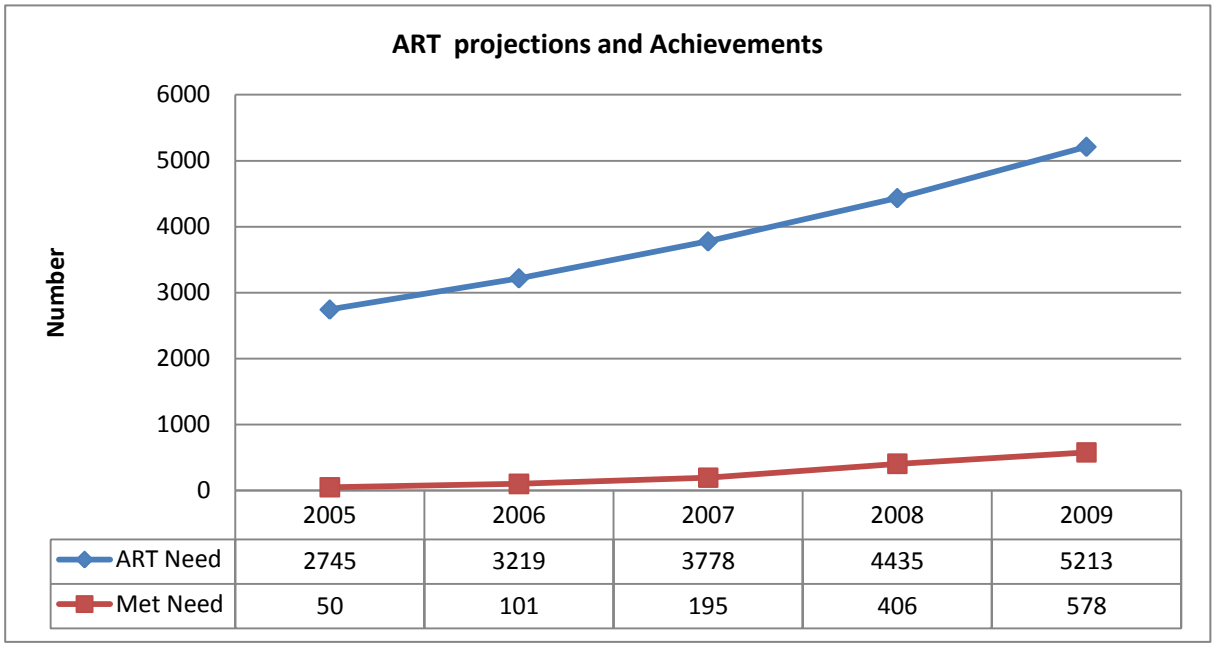
Source: WHO ART database

Projections continually reveal the massive scale of needs to be addressed and calls for additional attention to scale up in terms of services and equipping facilities to be able to identify and recommend patients for ART. By 2009, estimated eligible [8]5,213 HIV positive clients from three zones were in need of ART, so the response has been able to put only 11% on ART which implies that only one in eleven patients in need of treatment have been reached. Consequently, the unmet need for ART is likely to worsen due to imbalance between HIV transmission and existing treatment scale. This scenario is likely to put a strain on the already rudimentary health system and worsen AIDS related morbidity and mortality if treatment remains on the current scale. In a number of forums, PLHIV have expressed serious concerns about treatment among themselves and members of their networks indicating that the expansion of treatment at this time is very critical.

There is high discrepancy between number of people that test positive and those that are enlisted for treatment in all zones. VCT centers provide opportunities for recruiting clients for follow up and eventual initiation into treatment. However, this alone is not sufficient to bring treatment to the right scale. To achieve this, there is an urgent need to address barriers that prevent more people from testing in order to establish the status of as many and initiate them on treatment. Overall, the ZACs have indicated the need to review treatment through the existing coordination mechanism to allocate more resources and focus to treatment in respective zones with particular emphasis on South Central zone which is underserved. Since treatment has been successful in approach, efforts should be made to replicate it through an expanded system that identifies persons eligible for treatment through CT and making services available and accessible. Additionally, an enabling environment needs to be created for a conservative society that Somali is, to utilize services and make a difference.

[8] Spectral Projections for Somalia

Fig 6: Anti-retroviral treatment Achievement and Needs



Source: WHO ART database

ii) Prevention of Mother to Child Transmission (PMTCT)

PMTCT is an entry point in which key core PMTCT interventions are introduced (as a whole or in parts) within broader HIV/AIDS prevention, safe delivery, child survival, reproductive health, behavior change and other programs (psycho-social, economic and food security) to improve uptake and quality of comprehensive maternal and child health.

The SF and universal access programming recognizes PMTCT as key to reducing maternal transmission of HIV by 15-45%. Universal access targeted pregnant women and newborn babies with interventions that avert maternal to child transmission of HIV. Through the GFATM program, the response identified sites that would deliver PMTCT interventions. However, the universal access report of 2008 indicated that, only 0.4 %(6) of targeted women received PMTCT interventions in the second year of the program. In 2009, none of the targeted sites delivered a package of PMTCT intervention that include CT, ARV prophylaxis, ART, Cotrimoxazole prophylaxis , safe delivery and infant feeding support. A number of sites had counseling and testing, but there was no special consideration of other PMTCT interventions. A number of health workers have been trained on Safe delivery, but most sites lack equipment capacity to conduct safe deliveries while there is no package of PMTCT interventions for safe delivery alone to make an impact on reduction of HIV transmission. Considering the transmission potential from mother to child in absence of interventions is quite high. The 2010 programming has made PMTCT a priority in the three zones.

Globally, WHO has recommended a four pronged approach in PMTCT programs. The Somalia response has only been able to concentrate on one and the other three prongs that depend on the capacity of the

country in reproductive health programming are unlikely to get sufficient support. The forth prong that concentrates on the prevention of unwanted pregnancies also largely depends on the health systems which are in need of strengthening. From 2010 PMTCT programming should be revitalized in the sites that were earmarked for service delivery using the prong approach to make them more effective and sustainable. PMTCT programs have opportunity of integration the already existing IPTCs and can readily capture pregnant women from ANC sites for enlisting into other relevant interventions.

Table 10: PMTCT need projections and Achievements in 2008/2009

Year	Estimated HIV (+ve) pregnant women	Estimated Pregnant women in need of PMTCT	Women Received PMTCT
2005	1473	1252	0
2006	1983	1685	0
2007	2302	1957	0
2008	2667	2257	6
2009	**3087**	**2624**	**0**

Source: Spectra projections and program data

Like ART, PMTCT has failed to live up to the expectations of the response. PMTCT programming is an effective and cost effective measure that the Somali response needs to adopt to avert other health care demands resulting from transmission that could otherwise be avoided in pregnancy. With only 6 women ever initiated in PMTCT for 2 years now, it is obvious that the intervention has not received the attention that it deserves. In 2010, UNICEF through MOH has expressed commitment to revitalize PMTCT by increasing access to a fully integrated PMTCT service at IPTCs, MCHs and community level. The facility based component seeks to increase access to improved treatment, care and support opportunities for HIV+ pregnant women and their families. At the community level, the program will focus on engagement of various community level stakeholders for advocacy, leadership and providing the vital link between various individuals and the facilities. The selection of sites and partners for implementation has been done and supplies have been procured so far to initiate PMTCT services. The ZACs have indicated the need to hasten expansion of services to avert more cases of maternal to child transmission of HIV.

iii) Treatment of Opportunistic Infection

In the three zones treatment of opportunistic infection is provided in IPTCs and TB centers. In Somaliland and Puntland OI treatment is provided in 5 centers each. In South Central, 3 sites provide OI treatment. Compared to Antiretroviral treatment, more people have been reached through treatment of opportunistic infections which raises questions of stigma in utilization of Anti-retroviral treatment services. In 2008/2009 a total of 2,343 people were treated for various opportunistic infections in various centers. Treatment of opportunistic infections has been hampered by shortages and stock outs of high efficacy drugs and weakness of health systems to diagnose and refer eligible cases.

iv) Management of TB and HIV Co-infections

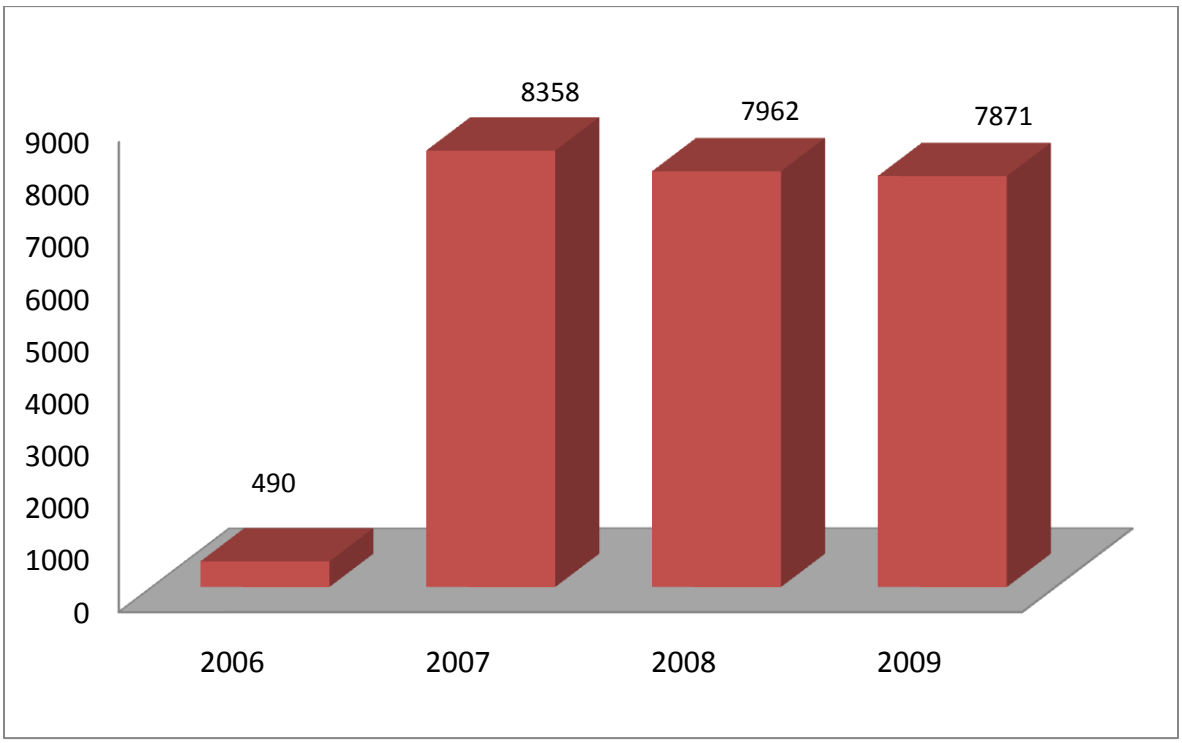
Somalia TB incident rates are estimated at 160/100,000. Comparatively, the incidence of TB in HIV is 5 times higher. In light of this, management of TB in HIV is very critical. For the last two years substantial progress has been made in case detection of TB and HIV. This has been facilitated, through 53 sites that were supported for TB case management in the three zones. Out of this, 9 sites are integrated TB and HIV management centers. This includes 5 sites in Somaliland and 2 each in Puntland and South central. A total of 310 TB patients were tested for HIV in TB centers out of which 70 (21%) were positive. All the TB HIV positive cases were referred for treatment at the IPTCS. TB detection in HIV and HIV detection in TB and reporting is complex. Referral systems for TB /HIV come from various facilities to the ART sites, but a vast majority is also lost in follow up. A dual approach is used in management of TB patients who are HIV +ve. Those that require treatment, are treated for TB at the TB centres and referred to the TB/HIV and ART sites for further management of HIV related conditions.

During the reporting period, a total of 2,100 patients were eligible for TB/HIV treatment as shown from nation estimates. Due to challenges associated with health care seeking, detection and referral, only 59 were put on ART. This translates into only 2.8%, implying a big proportion of TB /HIV is yet to be initiated on ART. Despite this, the health system has been responsive to enlist into treatment those that are captured through testing and other areas.

v) Sexually Transmitted Infections (STI)

The morbidity of STIs has been increasing consistently for the last four years. Every year, health facilities have seen increased STI syndromes except 2009 which witnessed a slight reduction. This could be related to low condom use and a predictor of likely potential for HIV transmission. STI treatment is provided in all IPTCs and appears to be the main reason for seeking health care in IPTCs. Syndromic management approach is used to identify and treat the cases, while laboratory testing is available for confirmation. In 2008, 7,962 cases of STIs were treated in all sites, while in 2009 the number decreased slightly to 7,871. STI syndromes exhibited age differentials whereby in 2008 and 2009, youth aged 24 years and below accounted for 66% and 71% of all cases seen respectively. This is still another pointer of high levels of unprotected sex and equally high potential for HIV transmission among the youth.

Fig 7: STI syndromes seen at Health facilities from 2006-2009



Source: WHO database

d) Care and Support

Care and support for PLHIV has deep rooted stigma and discrimination that has led to adverse effects at the household and community level. In all zones, there has been a serious case of neglect of PLHIV which reportedly accelerates the progression of the disease resulting in eventual morbidity and mortality. This neglect has set a precedence of non disclosure among a big proportion of PLHIV who are eligible for care and support. To reduce stigma and impact of community level factors on care priorities should focus on, Correction of the myths and misconceptions about HIV/AIDS that fuels it through the use of community-based IEC initiatives, empowerment of PLHIV with life-skills, business, entrepreneurial and marketing skills; and linkages to credit and Creation of an enabling environment for the effective reduction of stigma and discrimination on PLHIV through policy influencing, advocacy.

i) Orphans and Vulnerable Children

Care and support has two components, one focuses on households of people who are chronically ill with AIDS and extends to households with orphans and vulnerable children. The scale of the support however remains low due to limited information on death reporting and controversy in the operational definition of Orphans and vulnerable children (OVC). In 2008, 329 households with OVC received basic standard household support, in 2009 the number increased to 495. The number is set to increase as more households get enlisted in the support programs. In the three entities, School enrolment has shown no significant difference between OVC and other children in terms of school attendance. It is likely that social /safety nets are available to manage some needs of OVC at household level. There are

zonal PLHIV networks that support their members but have not gained good ground in providing sufficient support to the affected through community based post test clubs and other related establishments. Through GIPA and with ZACs support, the response has started supporting the PLHIV network to advocate lobby and influence pre-legislative process in the zones and provide recommendations for the formulation of policies for PLHIV to ensure that the interests PLHIV are taken into consideration. Additionally, there are several civil society and support groups' networks that have continually provided support to HIV within the network. OVC programs are significantly absent in Puntland and more focus on this should be considered. In 2010, a survey of OVC has been planned through UNICEF/GFATM to establish the extent of OVC needs and come up with operationa,l definitions based on evidence.

ii) Home Based Care (HBC)

Home base care is provided through health facility catchments mainly by a number of GFATM sub recipients in all zones. Care is provided as a package of a home based care kits (HBC) and nutritional support is provided by World food program (WFP) in coordination with WHO through the same sites. In South Central, HBC is delivered through two hospitals supported by CISP and COSV. In Puntland the home based care program is delivered in three sites that include Bossaso Hospital, Garowe Hospital and Galkayio which are HBC catchments for each of the regions. Based on the likelihood of more number in need of care, Somaliland has more HBC centers which include regional sites of Boroma, Burao, Berbera and Hargeisa group hospital. The delivery of the HBC varies between regions with some hospitals, TB centers and VCT centers delivering the service depending on the context. Since the initiation of HBC, through the GFATM program, a total of 2,372 HBC kits have been provided. In 2009 alone 1,518 chronically ill patients received HBC kits.

iii) Life Based Skills Education

Majority of informal schools are providing life based education skills. In formal schools there are different curricula in use in the three zones and so far none has completely integrated life skills education skills for young people. Youth based interventions are integrated in ministries of Youth and sports and family welfare and several interventions have been delivered through this arrangement for the last two years. However, the current strategic framework has identified youth based skills education as an important element of the response and zonal operational plans for each of the three entities has given a chance to the zones to prioritize and highlight the modalities of delivering this youth based intervention.

iv) Rating of Treatment Care and Support

Table 11: Rating of efforts to implementation of HIV Treatment, Care and Support Programs

	Poor										**Good**
2009	0	1	2	3	4	[5]	6	7	8	9	10
2007	0	1	2	3	4	5	[6]	7	8	9	10

All the three zones have rudimentary policies and strategies and protocols for HIV treatment care and support. The general treatment needs have been identified through population based projections informed by empirical data on HIV prevalence in the three entities. However, the response has not been able to cater for most of the services in the treatment package. So far, a big proportion of the HIV infected population segment lacks ART, nutritional support, pediatric treatment, home based care, TB infection control and referral. However, progress has been made in STI management, management of TB co-infection, TB screening and treatment of opportunistic infections. One of the limitations of treatment is that the respective zones lack capacity and policy support to import drugs and supply chain. Considering the discrepancy between the existing needs, the epidemic has outpaced the response in terms of treatment. Overall, treatment has performed below expectation and warrants serious programmatic attention and prioritization at all levels. Mobilization of efforts and leverage of resource and participation of Somalis is crucial to accomplishing these recommendations.

e) Progress made in 2008 Recommendations

The 2008 UNGASS report identified policy and programmatic gaps that the response needed to address in the last two years. The previous report identified prevention as a salient component of policy and programmatic response and tailored recommendations around key prevention and related support activities. Other specific recommendations based on the gaps formed the basis of the work plans and progress and limitations of their implementation is as highlighted below.

Progress on Policy Support

Various initiatives were made to address vulnerable groups in all the three zones as per recommendations although there were no endorsements due to various legislative complexities. Additionally, policy revisions and amendments to include various clauses to prevention and human rights in the three states were made. In the end of 2009, mobilization of PLHIV efforts were made through GIPA to engage PLHIV in policy making process from a collective stand point.

Programmatic response to vulnerable and cross border populations

The last report recommended concerted programmatic response to sub populations which include; trafficking reservoirs, refugees, returnees, truckers, sex workers, nomadic, IDP, young people, women and girls, OVC, and armed forces; Through the IRAPP cross border initiative and Handicap International Programs, the response has addressed cross border mobile populations and their host communities and IDPs from South Central to Bosaso and other camps in other zones. The initiative is delivering a package of services that includes; Voluntary Counselling and Testing Program (VCT) including pregnant women; Management of Sexually Transmitted Infections (STIs); Clinical care of HIV patient (including ARV) and Treatment of opportunistic infections, including TB. Through the community component spearheaded by the civil society, IRAPP is reaching IDPs through; Social Communication; Peers education, Condom supply and promotion, Reference and link with health system, Home-based care and support of PLHIV (including OVC). The services are set to be expanded to new sites identified based on hot spot mapping reports which include, Mogadishu, Dolow in South Central; Togawajale, Lowyado and

Berbera in Somaliland and Galkaiao in Puntland. The sites are at the frontiers areas of the neighbouring countries.

Mainstreaming of HIV prevention into religious activities and uniformed services

The last report and studies have confirmed the importance of religious and cultural dimensions of HIV response and in turn recommend mainstreaming of religious leadership in BCC. In the same way, prioritization of uniformed forces and militia was seen as central in prevention HIV prevention efforts. So far, the response has integrated religious leadership in BCC efforts, right from general awareness in mosques, campaigns, world Aids day, and in various documentaries. As a result the, religious leaders and members of the uniformed forces been taken through holistic capacity building through trainings and mentorship to better spearhead their own behavior change interventions programs

Improved coordination

During the period under review the response has sufficiently resolved most of the coordination gaps recommended by the previous report and the country harmonization and alignment (CHAT) report. The formation of the steering committee was an effort to streamline coordination mechanisms to improve coordination at all levels including national, sub national and community based partners. The integration of key sub-populations into the response has been slow, but towards the end of 2009, substantial efforts have been made to improve PLHIV representation through their inclusion in various decision making forums, policy and legislative initiatives.

Increased civil society involvement and participation

The country harmonization and alignment report indicated that representation of the civil society in critical decisions regarding HIV in Somalia was limited in the last 3 years. The country harmonization recommended augmentation of the civil society involvement and redefined mechanisms to ensure this achieved to improve implementation and service delivery and accountability in which the civil society is lead. Due to this and other concerns on the working groups and coordination mechanisms, the civil society representation in the steering committee which has now the overall mandate of the country response. Additionally, all HIV working groups and committees have civil society representation form bulk of the GFATM sub-recipients under the leadership of UNICEF. The role of the civil society will continue to be strengthened in key decision making levels by at the steering committee levels and their representation in ZACs.

V. Best Practices

The Somalia ZACs in the three zones have identified evidence based, innovative approaches and practices that have been applied successfully and maximized effectiveness in the national response. Based on lessons learned in coordination, planning and various components of the response, some of the key practices are highlighted as follows;

a) Coordination Planning and Policy

i) Political Support

Despite the ongoing conflict associated political differences between the three zones the leadership in the three zones has approached the response from a collective stand point. The political leadership has put their differences aside and supported a harmonized response through a signing and steadfast implementation of MOU and endorsement of the steering committee for Somali response (SCSAR). The SCSAR will provide strategic direction and leadership for the HIV response and ensure participation of Somalis and civil society organizations at all levels of decision making. This is an important step towards promotion of "three ones" and a show of solidarity in HIV response and its elevation to a matter of national importance.

HIV/AIDS response in Somalia remains a living example due to the harmony and teamwork that has been demonstrated within the national AIDS commissions and their working synergies. The response benefits from consultations between the three entities and this has cultivated motivation and a sense of responsibility and learning that has deepened the collective HIV response in the three zones.

ii) Supportive Policy Environment

Efforts have been made to bring into force various legislation focused on rights based programming of HIV which has been elusive for some time now. Towards the end of the period under review, the ZACs have been supported UNDP and UNAIDS to bring together associations of people living with HIV from respective zones through umbrella organizations Somaliland, Puntland and South Central respectively. This was intended to engage the groups in the legislative process through their participation in identifying key areas of support and rights that respective parliaments would debate and support for endorsement. Despite this, there is limited progress on endorsement of various pieces of legislation due the fact that HIV is not yet fully prioritized among other aspects of legislations in the three zones.

The Somali HIV response has multi-sectoral support and is coordinated at the Nairobi and zonal levels. At the Nairobi level, the response is coordinated through the Coordination of International Support for Somalia (CISS) which is further supported by a secretariat. The Health Sector Committee has been the main coordinating body for the response acting as a bridge between international and zonal level coordination mechanisms through meeting and various focused working groups. Most working groups are open to all organizations working in the HIV/AIDS response. In addition to this the UN theme working group and Joint Team on AIDS, funds and programs remain committed to these meetings and

provided their inputs to shape the HIV response in Somalia. The implementation coordination has been well done, but the forum is not fully empowered to cultivate responsibility that holds members to account.

The Zonal level coordination is led by respective AIDS commissions which are established and comprised of government line ministries representing key sectors, civil society organizations , PLHIV, religious groups and community leaders. Previously, the zonal AIDS commissions used to coordinate and oversee response in respective zones and embody one coordination authority; but in 2009 all of them have been brought together to one structured coordination body through the national steering committee. The commissions have continued to receive support from the subsidiaries of various technical working groups including M&E technical working group, Gender and HIV working group, IPTCs among others. During the period under review, the national AIDS commissions have continued to support forums and initiatives of these working groups and provided leadership for their recommendations. There are varying perceptions about the ZACs, some pointing out those commissions are government driven challenging their civil society inclusion and raising questions about representation. The Executive Directors have continued to lobby for greater participation of various stakeholders including civil society and PLWA, women, community and religious leaders. This is mainly seen as a vehicle to identify and prioritize emerging issues within broader representation and influence policy direction at the zonal level. So far, there is negligible political commitment on this issue.

iii) Coordination

In the country context the "three ones" have unique construction to take into account political realities in Somaliland, Puntland and South Central. The zonal AIDS commissions have been established in administrative structures of the three entities. Despite this, ZACs have collectively endorsed the strategic framework which informs and guides overall response across the three zones with differentiated zonal operational plans reflecting their different realities. Collective HIV/AIDS response has remained a living example for promoting peace and regional integration among the three zones and the neighboring countries**.** The leadership and coordination of the Somali response has over time thrived on the good will of three zonal entities and collaboration in most of the aspects of the response. In 2009, their further efforts and support for "three ones" was manifested in their support to the formation of the steering committee drawing membership from the government, the civil society and UN agencies. The steering committee will provide oversight to the response at all levels by increasing civil society participation and ownership of the response to all Somalis hence improving accountability and transparency in all aspects of the response. The model has been acknowledged by the UN country team and other sectors have been encouraged to develop such structures. The consensus surrounding the process in the establishment of the committee is an innovative approach that can be replicated in other programs.

iv) Functional Program delivery and M&E Working groups

Despite limited local capacity for technical areas of program delivery**,** various working groups have made significant contribution to program monitoring and exchange of information through networks and

indeed improved the quality of program delivery. These working groups have adhered to various schedules including; meetings and have backstopped a number of initiatives collectively. Additionally, through working groups some marginalized groups such PLHIV, gender and other areas deemed cross cutting with no one's responsibility have found a voice.

v) Coordination and collaboration between civil society agencies and government partners

The success of various interventions and the overall HIV response can be partially attributed to the harmony working relationship between various stakeholders between themselves and in linkages to the ZACs and key line ministries. This approach has been extended in program, planning, implementation, monitoring and evaluation and this has reinforced participation and ownership of the response by all.

b) Prevention

Support of religious and community based leadership and integration of preventive response

Due to the cultural dimension of some risky behaviors and potential to adverse effects on the epidemic, the opinion of the leaders and input to the BCC component is very crucial. In the period under review, the response has achieved milestones in integration of the prevention component of the response to community structures, religious leadership and other cultural institutions. This has improved absorption of the messages, hence reducing underlying stigma that has been previously high. So far, there is BCC component spearheaded by UNDP through the GFATM and its initiatives have recorded significant support at all levels. This approach needs to be documented and replicated everywhere for its relevance and efficacy.

c) Treatment care and support

There is an imbalance between actual need for ART compared to the current treatment levels. The response has delivered this service on a low scale but the implementation approach in terms of management of cohort has been successful. The treatment component has witnessed low proportions of drop out and high levels of treatment adherence and efficacy and a success rate of 100%. As a result, there has been increased quality of life and survival. This approach should be embraced in scaling up future treatment services to reach the segment of the population that is living with the virus and yet to be identified and who are yet to be introduced to treatment through the clinical staging process.

Treatment adherence as shown by cohort survival - augmentation of STI and Opportunistic infections

Although, treatment scale has been low, WHO recommendations for clinical staging and follow up has been observed. The proportion of patients surviving after one year of ART is 72.6%. Overall, the delivery of ART has recorded some success with only 15% deaths and no drop outs in the last three years. This approach should be replicated for 2010 scale up plans to other sites. Treatment of STIs and OI has improved over time and slight reductions have been documented.

Prioritization of HIV response at all levels – Including integration in all programs

Initial efforts have been made to integrate HIV in other sectoral programs including primary health care, water and sanitation, food security and livelihood. It is important that government and the donors support scale up of the initiatives to not only reinforce multi-sectoral approach, but also leverage to scale up response and reach out the underserved and marginalized population through other sectors work. UNAIDS and ZACs have included various line ministries in operational planning and engaged them in identifying and prioritizing various aspects of the response.

Support of regional initiatives

In addition to the mainstream programs and the strategies, the Somalia response continued to expand to the regional initiatives that target various vulnerable sub-populations in the region. The aim of these initiatives is to address the challenges posed by vulnerability driven by cross border mobility in terms of HIV transmission. Through this, the response becomes party to the collective regional efforts on HIV/AIDS response and promotes regional integration. A case in point is the IGAD Regional AIDS partnership program (IRAPP) which is a regional HIV program intended to strengthen regional collaboration in addressing impact of the epidemic among refugees, IDPs , cross border and mobile populations in the seven member states of IGAD which include; Djibouti, Uganda , Eritrea, Somalia , Kenya , Ethiopia and Sudan. So far, implementation of IRAPP is ongoing in 4 cross border sites, 3 in Somaliland, and 2 in Puntland and 1 in South Central. Two more sites in Puntland and Somaliland are in the process of mapping and subsequent assessments to pave way for implementation. The program addresses the three components including prevention, treatment care and support through partnership between UNAIDS, WHO the national AIDS commissions and select civil society organizations implementing activities in these sites. Through this program, the response has made efforts to address these populations that have previously not been prioritized in the response and further extends to mitigate HIV transmission from other countries in which there are generalized epidemics.

d) Monitoring and Evaluation

Reinforcing the role of ZACs in strategic information and operational research studies

The findings of a number of studies have previously faced stiff resistance from the ZACs due to lack of their involvement from the design and implementation. HIV projections have elicited a lot of debate but due to involvement of all stakeholders, the figures have been agreed and ratified after discussions. The participation of ZACs has increased ownership of strategic information from projections, hotspot mapping and surveys and this should be replicated in all. The engagement of ZACs in understanding of various processes involved in generating strategic information at enhances interpretation and has programming and ownership implications.

VI. Challenges and Remedial Actions

Though foundation has been laid towards comprehensive HIV /AIDS response, several challenges remain in the way of efforts to scale up the response and target its drivers in the country. These constraints of programmatic and contextual decent have been addressed to the limit of the response capacity. However, some of the key challenges are outlined below.

Socio-Economic Environment

The outcomes of the response are influenced by the external characteristics of the program. The ongoing conflict has led to increased poverty, fragmentation of family units and sexual networks and gender based violence and other outcomes that have a bearing on the epidemic and interventionist measures. Additionally, the context has deep rooted taboos which inhibit open dialogue on sexual reproductive matters, which seriously undermines HIV/AIDS response.

Program Delivery - Weak Health systems

The 2008 report noted inequities and limited responsiveness of the existing heath systems to deliver comprehensive HIV/AIDS services. An essential service package of HIV prevention, treatment and care services was recommended for integration to a number of sites to increase availability of and accessibility to quality comprehensive HIV services. Delivery of select HIV interventions has been seriously undermined by periodic shortage of supplies, equipment and shortage of qualified staff. As a result coverage of some services and actual delivery has been seriously undermined. Equipment such as CD4 machines, blood safety and delivery has not been consistently available in sites earmarked for the delivery of related services.

Overall, the last two years focused on strengthening of the elements of the health system in addition to expanding the scope of services. Some progress has been made in some of the health system recommendations, but access to some services such as ART is limited by geographical distance and shortage of service delivery equipments. VCT sites have been consistently functional most of the time but stock outs have been experienced. PMTCT services were only provided in 2008, but no single facility has either maternal or child has comprehensive PMTCT interventions. Substantial efforts have been made in training of health workers who deliver various services hence. Despite this, the capacity of health workers to deliver some technical interventions such as lab based skills and equipment handling will require more attention if effective service delivery is to be realized. More efforts should focused on shaping facilities to be friendly to positively influence health seeking behavior and enlist more clients in prevention, treatment and care programs

Research and evidence- Strategic information Limitations

Operational research and studies for evidence based decision making was identified as a critical step in guiding policy and programming as recommended in the previous report and prioritized in the strategic framework. In 2008, IBBS was conducted among FSWs. The national second generation surveillance has

been hampered by various contextual limitations and likely impact of political realignments regarding dissemination of results for one country in which there are three different entities. Even with limitations of national wide studies, there hasn't been substantial effort in strengthening behavioral and sentinel surveillance at the zonal level. Other small scale behavioral, gender based, MARPS and mapping studies have been done for programmatic baselines and to guide priorities of populations and geographical scope of various interventions. Comparatively, more operational research studies than second generation surveillance with behavioral component have been done. With this, the existing information is fragmented to be generalized which makes tracking various aspects of the epidemic and its drivers very difficult. This warrants concerted efforts to ensure that the response has sufficient data of all forms in order to effectively inform policy and programmatic decisions. The M&E framework development is ongoing and will be completed in 2010. With this, strategic information is envisaged to improve in quality and uniformity.

Vulnerability, stigma and discrimination

Stigma discrimination and vulnerability has been a key barrier in the overall HIV/AIDS response. Cognizant of this, advocacy and social mobilization has been intensified among key community, religious leaders, parents' opinions and service provider's capacity to create a safety net for most at risk populations. Through the GFATM, UNDP and ZACs has supported religious leaders and community capacity building programs which has engaged and shaped opinions and attitudes towards HIV response. This component also focused on involvement and public support of PLHIV to underscore the importance of stigma and discrimination reduction in the HIV response. In response to the gender dimensions of the epidemic, efforts have been made to identify and document gender vulnerabilities that expose women to risky sexual behaviors, exploitation, abuse and potential linkages with HIV and STIs. Vulnerability related to displacement and exploitation in IDPs camps has also received significant attention by various stakeholders among the UN and the civil society. The response need to focus on consistently creating a more enabling environment through general and specific stigma reduction measures to establish a broad base for preventive strategies as highlighted on the SF.

Life skills education for young people;

Compared to other areas of HIV response, less progress has been made in imparting life based education among the youth. There has been more focus on general awareness with no special attention on life based skills. There are a number of curricula in schools but none has so far integrated life skills. Youth based interventions are integrated in ministries of 'Youth' and supports and 'Family Welfare' and some have been delivered through this arrangement for the last two years. The current SF has identified youth based skills education as an important element of the response and zonal operational plans will prioritize and highlight the modalities of delivering youth based interventions.

Context Prevailing Security

Somaliland and Puntland enjoys relative stability; however, violence has escalated in South central for the last two years. Access to provide technical support, routine monitoring and other activities has been restricted to non warzones. Displacement has put a strain on health systems and necessitated change in approach to humanitarian focus for the vulnerable and mobile populations.

VII. Support by the Development Partners

a) Funding

Based current state of the economy, Somalia has very few resources to contribute to a meaningful HIV/AIDS response. The GFATM is the most important funding mechanism for the Somali AIDS response, and has sustained the Somali AIDS response for the past 4 years, ensuring an ongoing, stable funding environment. The reliance on one main funding source constitutes a weakness in itself, as cessation of this source would entail serious disruptions in the delivery of services. However, since 2007, the funding base for the response has diversified, with a sizeable proportion of the available funds for HIV-related activities are currently derived from other donors. The source of these funds consists of contributions made by the Joint UN Team on AIDS, DFID, World Bank and other UN – agencies/programmes. Central Government funding is practically non-existent in the Somali context and little resource-mobilization is carried out by the AIDS Commissions Local government and community-based funds largely raised by implementing partners, i.e. local NGOs with no GFATM funding, who rely on private donations and voluntarism to implement their activities.

The National AIDS Spending Assessment (NASA) shows that Somalia has spent an estimated US$10,502,830 on HIV and AIDS between 2008 and 2009. The proportion of the Global Fund to fight AIDS, Tuberculosis and Malaria expenditure on HIV and AIDS was 84% during the reporting period. The proportion of highest spending during the reporting period went to program management and administration (39%) and care and treatment (27%). The analysis shows that despite the human resource constraints in the health sector, only 8% of the resources have been spent on human resources strengthening. Further, only 6% of the resources have been spent on an enabling environment despite human rights, policy and legal frameworks on HIV and AIDS being weak in Somalia. The GFATM grant is managed by the Principal Recipient (PR), UNICEF, who reports to the HSC as the acting CCM. Sub-recipients are selected by the PR based on submitted project proposals and funds are channeled from the PR in Nairobi to implementing partners in the field through consultations with the ministries of health and briefing of ZACs. However, limited involvement of Somalis has raised some concern among stakeholders regarding the decision-making process. The national steering committee established in 2009 empowers Somalis to be part of the strategic leadership in all areas of response including representation in key coordination and funding decisions.

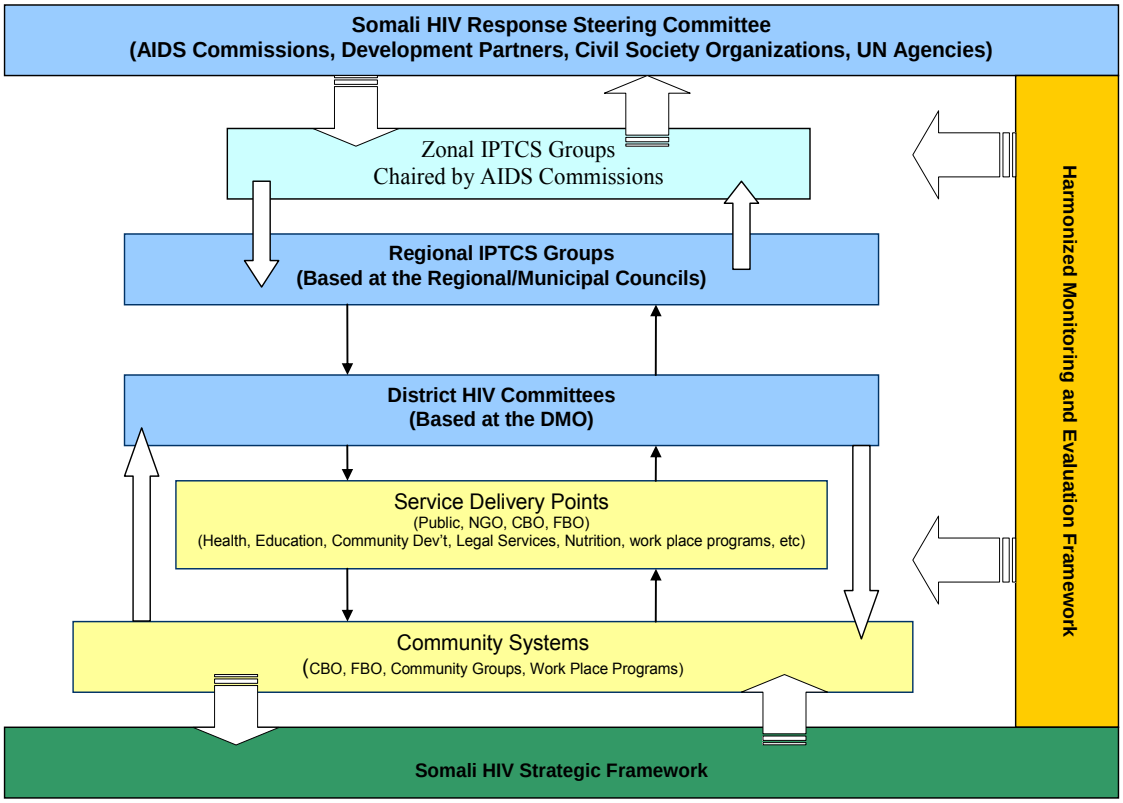
Key recommendations of National AIDS Spending Assessment (NASA) include the need to allocate more resources to the enabling environment in order to strengthen local capacity and human rights and to have more Somali ownership and decision-making in the HIV/AIDS response. Additionally, more resources allocated to human capital in the health sector in order to deliver quality and comprehensive HIV /AIDS care. The findings lay emphasis to strengthening of local systems including the Universities to manage strategic information in order to have a better understanding of the response, programs and resource needs.

b) Coordination

The overall multi-sectoral international support to Somalia (not only HIV/AIDS) is coordinated through the Coordination of International Support to Somalis (CISS) and supported by the Somalia Support

Secretariat (SSS). The Health Sector Committee (HSC) is the main coordinating body for the AIDS response, and acts as a bridge between international/donor and Somali coordination mechanisms, primarily through the Health sector committee (HSC) open meetings and the HIV working group. The HSC also plays the role of acting CCM (non-CCM) for the GFATM grant. A large number of committees, working groups, reference groups and taskforces have been set up under the aegis of the HSC, such as the HIV Working Group, the M&E reference group and the IPTCS (Integrated Prevention, Treatment, Care and Support) Task Force. The forums are open to all partners interested in HIV/AIDS issues. Many different stakeholders take part in these coordination mechanisms, including the UN Theme Group (UNTG), the Joint UN Team on AIDS, individual UN agencies, funds and programmes, bilateral and multilateral donors, international NGOs, Somali NGOs, sub-recipients of the GFATM and effectively monitor various aspects of the response through these meetings. So far, the coordination mechanism has not been able to provide leadership of the response to scale up of program delivery which is urgently needed in the three zones. The ZACs have raised various issues of concern and have been supportive establishment of other coordination mechanisms with clear mandate and focus on accountability and elimination of any conflict of interest. The coordination structure below has been ratified by government in the three zones and will be implemented with a few amendments as agreed with other stakeholders during the first meeting. This is a good practice that will increase civil society participation and Somali ownership of the response which has been for long elusive.

Fig 8: Proposed Coordination Structure for HIV /AIDS response



c) Support Required from Development Partners

So far, development partners have provided reasonable resources for the HIV /AIDS response based on the magnitude of the epidemic and associated factors. Projections indicate that the programmatic needs will increase as the epidemic changes in patterns and target populations. In light of this, leverage of resources to support all components of the response will be required. The response programming has been overtaken by the demands of the epidemic partially due to leadership gaps at the coordination level. The ZACs have indicated that all stakeholders will need to promote accountability in program delivery and support generation of strategic information for decision making on key aspects of the epidemic and response. Capacity building support and involvement of Somalis in generation of strategic information and planning will along way into scaling up all areas of the response.

The ZACs have indicated need to reduce the partner's approach that compels them to implement their agenda, when locally grown solutions could be feasible. Apart from increasing resources for the response ZACs looks upon partners to support the steering committee efforts to engage Somalis in key aspects of the response. Additionally, capacity building efforts for technical, program management and M&E require more specialized attention from development partners in order to ensure that Somalis can fully participate in management of the response at all levels.

VIII. Monitoring and Evaluation Environment

a) Overview of the current monitoring and Evaluation System

The development of harmonized M&E frame work for the Somali response in line with the "three ones" principle of a common monitoring and evaluation framework to track progress and performance in various aspects of the response is ongoing. The framework will be rolled out together with zonal operational plans for the strategic plan 2009-2013 whose finalization is also ongoing.

The M&E framework was established for the purpose of all reporting needs of the response but most tools for HIV/AIDS data are largely responsive to the GFATM requirements. A NGO sub- recipient has been implementing the M&E GFATM component tasked with conducting independent M&E of the response through the GFATM round 4 grants. The M&E framework was rolled out through 3 national M&E coordinators for each zone and 10 regional officers for each respective region in the three zones. The M&E officers work through the ZACs secretariats to further facilitate reporting function to the zonal M&E units. M&E capacity building is a part of the package that has been provided to the M&E officers and included collaboration with UNAIDS in CRIS training in 2008. In 2009 M&E capacity building focused on the job training to M&E officers provided by mentors as a transition measure which saw final handing over of responsibility to the national AIDS commissions.

So far, all partners involved in the implementation of the various elements of the Somali HIV response, reported progress within this framework, despite absence of standardized reporting formats and timelines. In the three zones there are different pathways of data flow from the service delivery points to district regions and to the ministries of health (MOH) and ZACs. The other data flows from the sites to the sub-recipients ZACs and Principal Recipient for the GFATM reporting. There is data sharing between the ZACs and various sector leads including reporting relationship but there is rarely any structured feedback at whatever level. Management of prevention and awareness community based data is disjointed and so far non-systematic at the community level. The lead agencies have however managed to capture data as output of their interventions comprehensively. In number of cases the awareness data is captured through 'working groups' updates which are monthly; M&E working groups, gender and HIV IEC working group attend meetings, whereby information and data is exchanged. At the ZAC level, the GFATM tools and formats were used for reporting prevention based interventions. Overall there is no unified reporting system. M&E reporting formats and databases are disjointed in the three zones.

Apart from CRIS, there has been no other uniformed database that brings together data for all indicators in standard electronic format since 2008. There are different formats in the three zones basically tailored for data storage and retrieval with little flexibility for any disaggregation and analysis. The reporting formats are based on the ZACs data requirements and lack uniformity and are not flexible to aggregation between the zones as they are disjointed in several ways. CRIS remains a definitive tool but has not been configured to reflect various political alignments and subsequent regions and thus not been effective in the management of the data at zonal level. Apart from this, various

stakeholders lack infrastructure to facilitate use of CRIS on the ground and this accounts for a sizeable proportion of output data generated from various interventions.

The evaluation component of the M&E framework meant to provide data on the progress of various indicators through household surveys and surveillance has not received much attention in the reporting period. The current framework stipulated various aspects of impact and outcome measurement, but this has been limited to zonal level studies on which no national conclusions can be made. For the last two years, there has been no nationally representative impact level study but the ZACs and newly established steering committee is likely to intervene in response to promote one national M&E framework.

The M&E working group supports a consultative process for periodic monitoring by implementing partners at district, regional and zonal levels updating information on activities and other M&E functions of the response. Through these meeting, aspects of M&E activities and progress of interventions is shared and discussed along with challenges in the response from M&E perspectives.

b) Challenges faced in the implementation of a Comprehensive M&E system

All stakeholders in Somalia HIV/AIDS response have indicated that M&E has not been fully prioritized in the response but there is an improvement from previous absence of the function programming. It has taken efforts of each to cultivate M&E culture through support of various initiatives that have been highlighted. The CHAT assessment indicated that CRIS had significantly harmonized reporting and a precursor of the M&E system. Despite this, there are various aspects of M&E that have remained as challenges and will need to be addressed in the coming years.

i) Limited ownership of the national M&E Framework

M&E has received signification attention at the national level but the process has not been fully owned at the regional levels. Due to limited understanding of the concepts M&E officers mandate has similarly suffered low acceptance. Due to this, the country response has not fully utilized data generated from the sites for reporting into the country response information system (CRIS) and universal access reporting. One of the key findings of the M&E systems strengthening workshop was limited involvement of the health sector in the data collection, reporting at district, regional and zonal levels in Somaliland, Puntland, and South Central Somalia. UNAIDS and the PR will take the opportunity provided by the existing M&E manpower, civil society, zonal AIDS commissions and the ministry of health to work collectively towards improvement of the current routine monitoring through engagement, ownership and capacity building in a decentralized approach. This will improve the existing levels of low public sector involvement.

The current version of CRIS will be configured to allow data entry for each specific program and the contribution to the whole. Therefore program level monitoring plans and reporting continues to demand additional effort to maximize collection of data and decision making from the regions to the facility levels. To ensure that ownership, sustainability and successful implementation of M&E activities work, full involvement and partnership of the programs with the zonal commissions, the MOH and the civil society is critical.

ii) Data quality and flow limitations

The data quality assessments and evidence from CRIS databases and universal access reports indicate that data collection at the facilities and districts is fragmented and usually incomplete. This is confirmed by the findings of the M&E strengthening workshop conducted in 2008 which addressed general and specific elements of the M&E system.

To fully utilize of high quality data in various programming decisions, unification of reporting and oversight of various routine monitoring, supervisory support and mentorship is crucial at the regional level. Through the GFATM routine monitoring activities, significant efforts have been made to closely follow implementation of various discreet interventions at the programs level, but data collection and supportive monitoring systems has not be fully functional.

iii) Lack of uniformity data management and reporting systems

Various programs led interventions have created multiple M&E structures to support their specific elements of the response and this resulted to parallel reporting systems. There is no centralized reporting system where complete data for the response can be accessed as neither ZACs nor the principal recipient receives reports from all agencies and no standard database captures reports from all ZACs. Some substantial members of the civil society adhere to reporting requirements of their respective donors and in some instances the reports are not accessed for inclusion in the national response. There are several tools and formats in use and several database formats in three zones. This not only hinders data capture, aggregation and analysis, but discourages structured feedback that would be acceptable to all.

iv) Geographical Spread and Limitations of the Context

Most of the M&E challenges are related to the context and the spread on which few M&E staff has to cover to deliver what is expected of them. Due to these factors there has been limited routine monitoring and supervision and the vital technical M&E backstopping support. The few M&E officers are contracted by various specific agreements under ZACs and lacking in most sites resulting in weak systems.

v) Limited M&E capacity at all levels

Some of the weaknesses identified by the partners during the M& E systems strengthening workshop are cross cutting and need to be addressed through a comprehensive capacity building approach. Similarly through the NCPI, ZACs have identified the areas of M&E strengthening in the short and long-term. The M&E framework has attempted to address various M&E gaps in print but additional capacity building and technical support will be required to actualize the implementation of effective changes to the overall system.

Through GFATM, and UNAIDS support, national and regional level staff have been trained in M&E , but due to staff turnover and lack of structured follow up, capacity has not improved to desired standards. Apart from this, M&E has not been fully embraced by the members of the civil society through prioritization of resource allocation qualified staffing and capacity building has not been done.

c) Remedial Actions and M&E Technical Support Required

Somalia conducted an M&E strengthening workshop in 2007 and identified a specific weakness that forms the basis of M&E strategy development and implementation. The weakness is mainly in cross-cutting issues which working groups are trying to resolve through capacity building. However, there is no comprehensive capacity building plan and ZACs are of the opinion that this should be put into consideration. There are key capacity building features related to weaknesses of M&E staff to concepts and practice of M&E at all levels.

i) Promotion and adoption of one multi-sectoral M& E system for the Somali HIV response

The Somalia response will work under the auspices of the national steering committee to develop a M&E framework that clearly defines the indicators for specific HIV intervention areas, sources of data, frequency of data collection, responsible body for data collection and the method of measurement. This will be informed by the current framework and tailored for the multi-sectoral response. This framework will further prioritize impact level population based data collection through special surveys, like Behavioral Surveillance Surveys, Sentinel Surveillance Surveys, Blood Bank Data, Health facility surveys, routine data collected through projects and service delivery points. The implementation of the system will engage all stakeholders and will be simplified for use at all levels of the HIV response.

ii) Strengthen systems for routine tracking of the HIV response, at all levels.

In order to facilitate data flow, support will be provided to AIDS Commissions to implement the Country Response Information Systems (CRIS) in the three zones. CRIS will be configured to enhance data entry and reporting requirements at regional and national levels and considerations will be made to pilot a mobile phone electronic reporting system to break contextual, geographical and security related barriers that hinder timely and complete reporting.

iii) Establishment of operations research framework to determine the drivers of the epidemic

There needs to be a continuous focus on research and systematic population based data collection that can be used to identify trends of the epidemic and dynamics of various risk factors. This is not only important for understanding of these variables but also important for prioritization of the response. In addition to this, data to inform interventions in specific most- at- risk sub-populations where the epidemic is concentrated including mapping and prioritization is crucial for more effective programming. So far, there is limited quantitative bio-behavioral data on specific populations, including most-at-risk populations, to evaluate the status of the epidemic and risk behaviors in these groups. In view of the

mobile life style of the general population across borders, displacement and disintegration of family units, increased vulnerability of women and girls due to gender inequalities exacerbated by the ongoing conflict, major trucking operations associated with trade and humanitarian emergency services, uniformed services and other armed groups, IDPs and refugees. It is therefore critical to systematically monitor the HIV prevalence through a combination of population based surveys and targeted 2nd generation surveillance surveys that capture behavioral and epidemiological trends across the general population and most-at-risk populations in priority geographical settings.

iv) Increased dissemination and utilization of HIV information and feedback at all levels

Apart from CRIS updates there has been very little attempt to systematically disseminate response information while there has been minimal feedback of service statistics data from the rudimentary databases to the regions and sites. Information sharing and feedback has been known to not only motivate service delivery but extends further attention to intensification of efforts to various components of the M&E system. The ZACs will work with all stakeholders to strengthen skills for data collection, analysis and decision making at all levels and create systems for information sharing promoted at district and Zonal levels through CRIS, due to its capacity to guarantee wider dissemination at all levels.

To enhance quality of service and data generated from such interventions, the response warrants continued improvement of data management through harmonization of various tools and processes through capacity building and increased stakeholder involvement. This is in line with the finding of the M&E systems strengthening work shop conducted in 2007.

v) Building M&E capacity at all levels

The ZACs have indicated the need to build the capacity of their staff at all levels to have a common understanding of M&E concepts and practice. One of the priorities identified is to provide full training and refresher training through partnerships between renowned institutions for technical support and local universities for routine backstopping. Apart from M&E human resources capacity, provision of financial support for establishment of fully functional M&E units has been recommended.

Rating of M&E Efforts of the HIV/AIDS programmes in 2009

Table12: Rating of M&E Efforts of the HIV programmes in 2009

	Poor										Good
2009	0	1	2	3	4	**5**	6	7	8	9	10
2007	0	1	2	3	4	5	6	**7**	8	9	10

Somali's M&E framework development is ongoing. The last two years have not seen systematic management of program data while only one IBBS study targeting MARPS was done once again

underscoring limitations of population based epidemiological data. Similarly, the response still lacks recent nationally representative study for understanding the behavioral aspects of the epidemic. Compared to 2007, the M&E framework has not evolved in line with the response; however the M&E framework is expected to strengthen M&E in light of these gaps. M&E capacity building has been done at the zonal and regional levels, but the existing capacity still remains low. Due to lack of functional M&E units in each of the zones, data management and reporting lacks uniformity. On a positive note there is a budget committed to continuous strengthening of the M&E system.

Annex 1: Additional Comments Received From Principal Recipient of the GFATM for HIV/AIDS Response After Validation Workshop

My general comment is that the overall report is structured in a way that it does not reflect the real situation of HIV program in Somalia because it is too much focused on challenges and "un met" targets without underlying enough the achievements reached up to now. The comprehensive HIV programme including prevention, treatment, and care and support interventions targeting all regions of Somalia is a relative new program, started in 2005 with the support of GFATM. Moreover, despite a very challenging context, the current programme has significantly contributed to strengthening national human resources capacities and coordination structures; a framework for tracking the status of the epidemic and the progress in the response has also been successfully set up; most importantly, access to prevention, treatment and care/support services was established for the first time and significantly scaled up across all Somalia. It is important to highlight that within the context of this programme sustained efforts are being made by all partners to support the scaling-up of services that are:

- **Equitable** – information and services are available for all (rich and poor, women and men, young and old, and vulnerable groups, including now sex workers).
- **Accessible** – relevant information and services are available locally; however, it is acknowledged that additional efforts are required to further reduce prejudice and discrimination.
- **Affordable** – free HIV services in terms of medicines (e.g. ART, OI prophylaxis and treatment, STI treatments), diagnostics (e.g. HIV testing, blood exams, CD4 count), commodities (e.g. condoms) and support (e.g. HBC) are provided to all in need of them.
- **Comprehensive** – services are planned and delivered in close collaboration with local NGOs, partners and government. There is still a need to strengthen involvement of people living with HIV. Further efforts are also required to ensure greater involvement of the private sector.
- **Sustainable** – HIV services are not one-off intervention but an entry point to strengthen the overall national health system (in the GF HIV round 8 there is a component to support Health system).

Suggested changes to be done in the report:

1. Missing acknowledgement to UNICEF and GFATM!

2. *Paragraph "iv) UNGASS data overview" page 13:* all the zero (0) are to be reported as "no data" and not zero (0) because according to the remarks no appropriate studies were done to give value to the indicators. *Remarks of the National program indicators 3:* change the remarks in "blood screening is done in all referral hospital following the standard procedures but external quality assurance not yet done".

3. *Paragraph c) Universal Access page 26*: there are already two studies done by IOM (see introduction) that have shown which are the MARPs to be targeted. Moreover, also the National HIV strategic plan has clearly stated which are the targets of the Somali HIV epidemic.

4. *Paragraph "blood safety" page 27*: as we discussed in the workshop in Naivasha, it is important to add which criteria of set standard for the intervention are not met because the blood screening is done and 100% of the blood is screened before been transfused to the patients folowing standard procedures. What is still missing in the blood safety program in Somalia is that the routine external quality assurance requested by the criteria is not yet in place. Moreover, quality assurance will be one of the main activities in GFATM HIV grant round 8 started in 2010.

5. *Paragraph f) treatment care and support page 34*: the second sentence " as will be seen in the ensuing sessions [....] to provide the tretment services" is not exactly correct. It is true that the AR coverage is still

low (11%) if we use as denominator the estimated number of HIV infected people eligible for ART. But the performance ART program indicators are going quite well: out of the 2,178 HIV positive clients (detected at VCCT), 1,182 (54%) were enrolled in pre-ART. Out of the 1,182 pre-ART clients, 742 (62%) are on ART. 72% of people on treatment are currently on ART at 12 months (UA target was >70%). Morover, from 2 sites in 2005, now we have 8 sites (3 in Somaliland, 3 in Puntland and 2 in Central-South) by end 2009. Therefore, the major weakness of HIV program in Somalia is not the treatment component. The main reasons of having a low coverage, in addition to the ones mentioned in the paragraph, are that the HIV (especially ART) program is still young and implemented in a very challenging socio-cultural and political context with consequences on access and service seeking from the population. It's true that we have to improve the coverage of ART and strengthening the pre-ART services but most important is to scale up the VCCT service (increasing number of sites and outreaches and targeting MARPS) in order to detected more people living with HIV to be able to enroll them in the pre-ART and ART services as it is shown by statistics: out of the estimated 23,480 HIV positive people, only 2,178 (9%) were detected at the VCCT despite 24,284 people were tested and counseled for HIV in 20 VCT sites.

6. *Paragraph i) antiretroviral Treatment at page 35*: the statement "by the beginning of 2008, 3% (211) of eligible patients were put on ART...." is not correct because 211 are ONLY the new clients started on ART in 2008/2009. We have to take in account also the clients started on ART before and still (currently) on ART during 2008/2009. Therefore, if we use the denominator of "numb of estimated HIV clients eligible for ART" (5,213) we have to use as numerator the "current clients on ART (742: new plus the one alive on ART). Percentage is 14.2% (reported wrongly also at page 36). Moreover, see what I mentioned before at point 5.

7. *Paragraph iii) page 39*: numb of OI treatment is higher of ART because of the following reasons: 1. Patients can come more than one time for recurrent OI infections (re-attendance), therefore one clients can be counted more than one time; 2. In this number are counted also the clients that are receiving only CTX prophylaxis; 3. Only 20% of the HIV positive clients are eligible for ART. You can use the following statistics: Out of the 1,182 pre-ART clients, 742 (62%) are on ART. The pre-ART indicator shows the NEW HIV positive clients receiving CTX prophylaxis and OI treatment, therfore it is the more indicated denominator to be used.

8. *Paragraph v) page 39*: please, see comments raised during the workshop. Moreover, I cannot understand why you were not able to collect data according to diagnosis, age and sex because these data are available at health facility level.

9. *Paragraph d) page 40*: is it possible to know from where you have found this statement? It's true that there is need to scale up the care and support services but I was not aware of such high level of stigma among the community. Moreover, there are existing and well accepted PLHIV network in all the three zones that are now opening and participating to coordination meeting and awareness campaigns.

10. *Paragraph iv) Rating of treatment Care and Support page 41-42*: *my final comment.* Since the beginning of this programme, access to ART, VCT and other services has indeed improved; however, it must be acknowledged there are still major gaps in implementation capacities which surely hinder the ART rollout. New approaches may need to be devised to increase the impact of interventions on the ground in an effort to boost treatment numbers. This may include, further engaging most-at risk populations in planning and execution of interventions, including youth groups; investing more in promoting community dialogue at various levels, including with religious leaders; supporting expansion of PMTCT and care and support services for OVCs,. Some of these approaches are already being promoted within the activities. Moreover, it is accepted there is a need to improve the integration and scaling up of access and utilization of services,

to foster empowerment of local institutions and communities, to develop a surveillance system and undertake more research on barriers to access. The escalating conflict and subsequent levels of insecurity have indeed severely affected households stability,, further exacerbated disparities in gender relations thus increasing the overall vulnerability of women and children to all forms of violence and abuse, and created an environment where human rights violations are committed on a large scale and with impunity. All these factors directly contribute in increasing the population's overall vulnerability to HIV. Despite these difficulties, delivery of HIV services to Somali people is still possible. In Somaliland and in Puntland HIV response has to be systematically integrated into the recovery and reconstruction efforts, through a strategy that brings together both international and local partners, with the aim of sustaining and further scaling up HIV services in identified priority areas. HIV interventions in South-Central zone need to be conceived and delivered as an integral part of the humanitarian response. In this respect, some partners are already exploring opportunities for the integration of a minimum package of HIV interventions into the humanitarian response to maintain existing HIV services (e.g. ART), and possibly scaling up, with the presence of dedicated local staff and/or direct involvement of patients in HIV activities. Moreover, there is need to review and set more achievable universal access for Somalia due to the very challenging context.

11. Page 46: see comments of point 4-7.

12. Page 48: according to partners reports there was not out of stock of supplies in 2008/2009!

Annex 2 : Somali HIV/AIDS Response Partners Consultative and UNGASS 2010 Report Validation Workshop 6/5/2010 – Naivasha Kenya				
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