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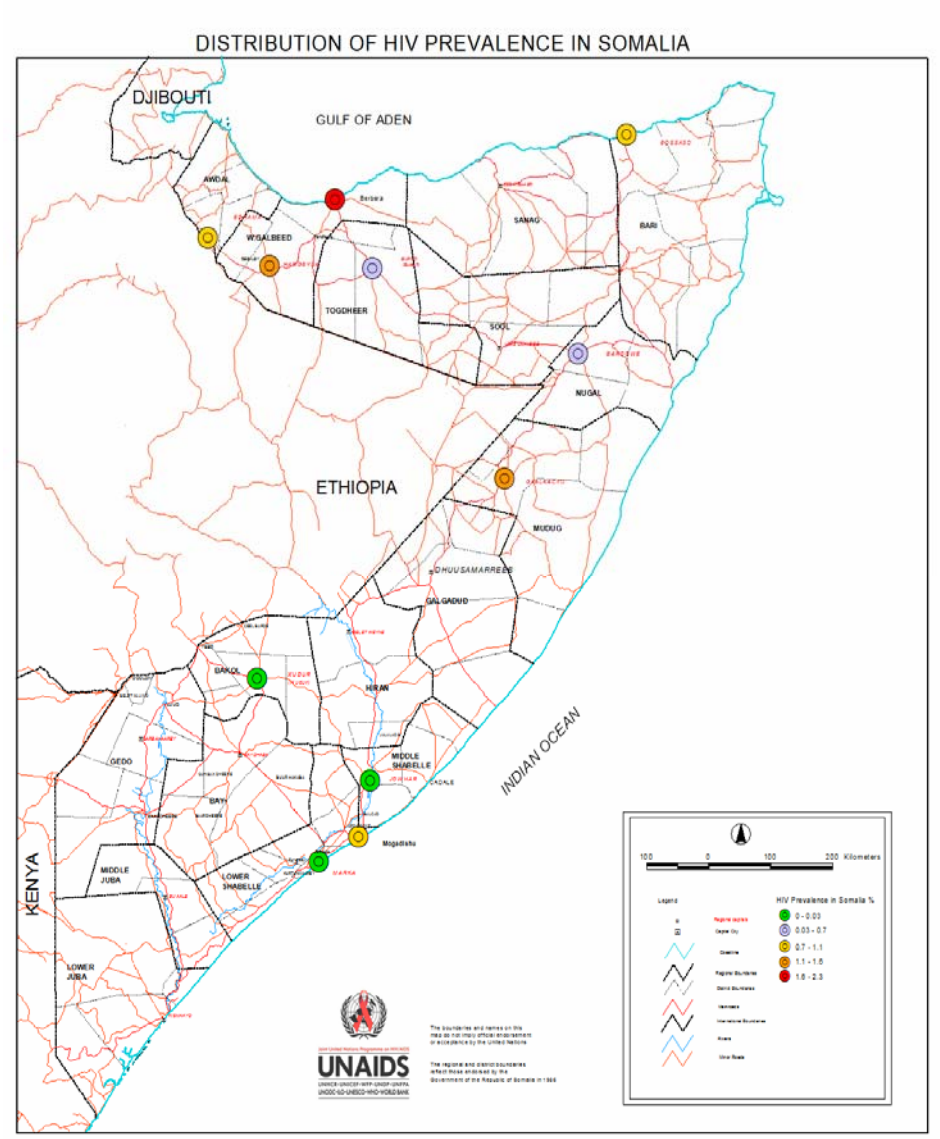
COUNTRY PROGRESS REPORT 2008

SOMALILAND, PUNTLAND and South Central SOMALIA

Narrative to Supplement CRIS Report – February 2008

Reporting Period: January 2006 – December 2007



Source: CRIS update - 2007

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To build consensus on the Somali UNGASS Report, the Joint UN Team on AIDS supported 4 workshops for various stakeholders in south Central, Puntland, Somaliland and Nairobi through which data was validated, consensus reached and the Report agreed upon.

The stakeholders who were involved in the development of the Somali UNGASS Report included: Non Governmental Organisations (NGOs), faith-based organizations (FBOs), People Living with HIV (PLHIV), Government ministries and departments in Somaliland, Puntland and South Central Somalia, the Joint UN Team on AIDS and other development partners. The following organizations and individuals are particularly thanked for their efforts:

- Executive Directors of South Central Somalia, Puntland and Somaliland AIDS Commissions.
- UNAIDS National Officers of South Central Somalia, Puntland and Somaliland.
- National M&E Officers of South Central Somalia, Puntland and Somaliland
- Line ministries representatives who deal with AIDS - Health, Finance, Planning, Education, Labour, Military/police, Women Affairs, etc.
- Representatives of Civil Society Organisations (CSOs): IFRC, COSV, CCM-Italy, Merlin, Oxfam Novib, Mercy USA, WV, OCHA, FAO etc and Networks like OSPAD, ARO, SORDSA and People living with HIV/AIDS (PLHIV)
- Representatives of Funding Agencies mainly UN partners: WHO, UNICEF, UNFPA, UNDP, DFID, UNESCO among others.
- Representatives or organizations working with Most At Risk Populations (Commercial Sex Workers, Injecting Drug Users, Drug Drivers, Internally Displaced persons etc.)

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CRIS	Country Response Information System
FAO	Food and Agricultural Organisation
FBO	Faith Based Organisation
GFTAM	Global Fund for Tuberculosis AIDS and Malaria
GBV	Gender Based Violence
HBC	Home-based Care
HIV	Human Immunodeficiency Virus
IASC	Inter Agency Steering Committee
ICC	Inter-agency Coordinating Committee (for HIV/AIDS)
IDP	Internally Displaced Person
IDU	Injecting Drug User
IEC	Information, Education and Communication
INGO	International Non-Governmental Organisation
IPTCS	Integrated Prevention Treatment Care and Support
JICC	Joint Inter-agency Coordinating Committee
KABP	Knowledge Attitude Behavior and Practice
M&E	Monitoring and Evaluation
MSM	Men who have sex with men
MTEF	Medium Term Expenditure Framework
NCPI	National Composite Policy Index
NGO	Non-governmental Organisation
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAC	Puntland AIDS Commission
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategic Plan
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
UCC	UNAIDS Country Coordinator
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nation Development Assistance Framework
UNICEF	United Nations Children's Fund
UNISP	United Nations Implementation Support Plan
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation
WFP	World Food Programme

1.0 STATUS AT A GLANCE

The Somali population is estimated at 8.1 million[1]; and over 50 percent of the population is under the age of 15 years. The population consists in its majority of pastoralist nomadic communities, with agricultural communities settlements in some parts; and is characterized by high mobility related to seasonal nomadic migration, and forced displacement due to the ongoing conflict. Population movement occurs within various parts of the three major regions, and also across the porous borders into Kenya, Ethiopia and Djibouti.

Political Environment

Somali populations have experienced political turmoil and conflict since the fall of central government in 1991. This has resulted in large scale under development, high levels of mortality and morbidity, large scale destruction of infrastructure including education and health facilities, and undermining economic activity and household livelihoods. Following the fall of the Said Barre regime, the government was decentralized to Zonal and Regional levels, operating under three entities in Somaliland, Puntland and currently the Transitional Federal Government in Central South Somalia. In 1991, Somaliland declared independence from Somalia and has experienced relative peace and stability under its own administration.

Conflict particularly since August 2007 has deepened disparities in gender relations, increasing vulnerability of women and children; the number of orphans due to all causes is estimated to be 630,000 (UNICEF). The conflict has undermined household livelihoods, with limited coping strategies for women and children. Additionally, the under five and maternal mortality rates are among the worst in the world, standing at 225 and 11-16 per 1,000 live births respectively[2]. The 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 have suffered Gender Based Violence (GBV) in the form of rape, torture, looting and forced displacement; which have been used widely in the conflict. In addition, women are excluded from decision making, access and control of resources.

The conflict has had dire humanitarian consequences throughout Somalia since the late 1980's. Particularly since early 2007, a new wave of displacement has forced over 600,000 people to flee bringing the overall number of IDPs in the country to 1 million people. There are now an estimated 1.8 million- 2 million vulnerable people, including rural populations, and new and protracted IDPs. This figure represents a 27% increase from 1.5 million during the previous six-month period. Worsening humanitarian conditions exacerbate the factors of conflict and effective responses can reduce tensions over basic means of survival.

AIDS Epidemic

The HIV and STI sero-prevalence survey conducted among Somalis in 2004, showed a mean HIV prevalence among pregnant women attending ante-natal clinics (ANC) of 0.9%.[3]. Based on the findings of the 2004 surveillance, the Somali epidemic is provisionally classified as a low-level epidemic. However, the new surveillance and mapping of most at risk populations suggest otherwise. This new evidence combined with anecdotal, M&E and programme implementation information suggest that Somalis may be suffering instead from a concentrated epidemic in urban and cross-border regions which host large numbers of sex workers, truck drivers, mobile and vulnerable populations. New HIV

[1] Somalia did not have a reliable census for over three decades; estimates are often contentious. The above reflects the figures adopted by the UN. (Population Estimates and Projections for Somalia 2005-2010).
[2] World Bank, Somalia: From Resilience Towards Recovery and Development
[3] 2004 HIV/AIDS and STI sero prevalence survey - ANC

data emerging from the 2007 ANC survey suggests that the Somali HIV epidemic remains a significant one with wide variations in prevalence between Somali regions.

The prevalence of HIV among neighboring countries (Kenya, Ethiopia and Djibouti) is relatively high ranging from two (2) to almost six (6) percent. This presents potential risk of spread along major routes of population movement and along porous borders, associated with seasonal migration and trade such as truck drivers and their passengers; and also among Internally Displaced Persons (IDPs).

Limited information is available on high risk and vulnerability factors that fuel the HIV epidemic in Somali populations. However, the available limited data indicates low awareness and access to information on HIV among all age groups; low risk perceptions; widespread sexual and gender-based violence; cultural norms and practices that increase vulnerability of women, such as FGM and GBV, polygamy, marriage before the age of 15 among girls, high illiteracy rates, poor access to basic health services due to destruction of health infrastructure; poor infection control, and poverty.

Response to AIDS epidemic

Recent qualitative research (IOM 2008) reported high HIV risk behaviors among transactional sex workers and their clients and PLWH. While quantitative data is still limited, if HIV is bridging into the general population, these risk behaviors will be significant contributors to the Somali HIV epidemic as demonstrated in other countries. Further HIV Behavioral Surveillance Surveys (BSS+) and operational research among most at risk populations are vital to understanding better the drivers of the epidemic and this is planned to begin soon.

Due to the existing political situation, the development partners working in the 3 Somali zones are operating under the zonal structures in North East (Puntland), North West (Somaliland) and Central South to support HIV response. The Transitional Federal Government and government in, Somaliland and Puntland continue to work together on the Somali AIDS response in spite of political divisions and conflict. The Somali AIDS response is based on the Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations June 2003 – June 2008 developed through the participation of all stakeholders. The Strategic Framework and its operational plan formed the basis for the development of the Round IV GFATM application and grant.

The resources of the GFATM, UN agency and other bilateral resources are coordinated through support of the Somali Support Secretariat AIDS related committees and working groups and the Joint UN Team on AIDS, to the three (3) multisectoral AIDS Commissions involving line ministries and civil society partners. Additional resources are being mobilized through evidence informed advocacy and through integration of the AIDS response into emergency interventions to target populations of humanitarian concern.

Partners have also gained more insight into the drivers of the HIV epidemic through improved behavioral and biological surveillance systems. Efforts underway to increase integration of the HIV response into humanitarian and emergency interventions, with populations of humanitarian concern targeted.

1.1 Stakeholders' Inclusiveness in the UNGASS 2008 Report Writing Process

The 2008 UNGASS reporting process took into consideration the representation of the three regions as separate entities with own implementation structures: South Central Somalia; Puntland (North East); and Somaliland (North West) respectively. Each of the three regional entities submits their M&E data in CRIS separately.

The processes applied for the UNGASS 2008 Somali reporting ensured comprehensive consultations and participation of all stakeholders involved in the multi-sectoral response

to HIV in each of the three regional entities. During the planning stage of the reporting process, extensive consultations were made by the three AIDS Commissions both in Nairobi and in-country to comprehensively identify stakeholders and partners, and ensure inclusiveness in the UNGASS 2008 reporting process.

Each of the three AIDS Secretariats (SCAC, PAC and SOLNAC) took the lead in the process in their respective regions, in planning and coordination of consultative meetings which involved participation of the following stakeholders and partners in contribution to the writing of the UNGASS report : Government line ministries (i.e. women, education, health, among others); Non Governmental Organisations (NGOs); Civil Society Organisations (Local NGOs, Faith Based Organisations, Community Based Organisations, Organisations working with PLHIV , and youth among others); and also representatives of UN organizations. Partners based in Nairobi contributed through interviews, review of relevant survey reports, and draft documents.

Initial consultative meetings were held with each of the three AIDS Commissions and their stakeholders/partners to comprehensively plan the 2008 UNGASS reporting process in adherence to the provided guidelines and requirements

Planning Stage:
During the planning stage, the three AIDS Commissions' Secretariats were contacted through the UNAIDS National Officer to organize a consultative meeting and make invitations for attendance of the following: i) Executive Director – NAC; ii)UNAIDS National Officer; iii) National M&E; iv) Representative of line ministries - Health, Finance, Education, Labour, Military/police, Women Affairs, People living with HIV (PLHIV) etc.; v) Representatives of CSOs - IFRC, COSV, CCM-Italy, Merlin, Oxfam, Novib, Mercy USA, WV, OCHA (OCHA is a UN organization not a CSO), FAO, IOM etc and Networks like OSPAD, ARO, SORDSA and other relevant partners; vi) Representatives of Funding Agencies mainly UN partners - WHO, UNICEF, UNFPA, UNDP, DFID, UNESCO and others; vii) Representatives of "Most At Risk Populations" i.e. organisations working with Commercial Sex Workers, Injecting Drug Users, Truck Drivers, Internally Displaced Persons etc.

The following documents were shared and guided the process for preparation of the UNGASS 2008 Somali Report: i) Guidelines on Construction of Core Indicators; ii) Matrix of Core Indicators for 2008 UNGASS reporting; iii) Assignment of roles and responsibilities; iv) Timeline; v) Key Informants Questionnaire; and vi) Roles and responsibilities of the local consultant.

Involvement of Civil Society Organisations
The consultative meetings held with AIDS Commissions of each zone identified the Regional Working Groups for Civil Society Organisations (CSOs) as the umbrella network that would coordinate Civil Society Organizations' participation and involvement in the UNGASS Reporting process. Specifically the following CSOs were charged with filling of the NCPI questionnaire: i) Human Rights - Representatives of CSOs dealing with human rights including People Living with HIV/AIDS (PLWHAs); ii) CSO Regional Working Groups; iii) CSOs and International NGOs dealing with prevention interventions; and iv) International NGOs dealing with Treatment, care and support.

There was no parallel process for Civil Society Organisations' reporting, they were fully involved and participated in the whole reporting process. Hence, there will be no shadow report.

Involvement of Government Line Ministries
The Director Generals of all the line ministries were contacted and they ensured their representation in the reporting process. The following ministries played specific key roles

in providing information for indicators and NCPI: Health, Education, Finance, Planning, Woman, and youth among others.

1.2 STATUS OF THE EPIDEMIC

HIV has emerged as a key development issue in Somali society. WHO's 2004 HIV and STI sero-surveillance survey showed a mean HIV prevalence of 0.9% in the 3 Somali zones. Of these, Central South Somalia had lower prevalence of 0.6%, Puntland 0.9% and Somaliland 1.4%. The HIV prevalence among STI and TB patients was 4.3% and 4.5% respectively. Based on the 2005 estimates for Somalis, the adult aged 15 years and above living with HIV was 40,000, new HIV infections was 4,200, deaths due to AIDS counted 3,300, while children (0-14) living with HIV are 3,900, children aged 0-14 years with new HIV infections are 1,300 and deaths due to AIDS was 970.

Refer to more detailed description of the epidemic including emerging 2007/2008 data on pages 15 – 17 of this report.

Table 1 below shows the variations in HIV prevalence in the various regional zones among adult population from the WHO 2004 HIV Surveillance Survey.

Table 1: The HIV Prevalence in 2004 - sentinel sites of the three regional zones

Region/zone and Sentinel Site	Number Tested	Number Positive	Percentage Positive
SOUTH CENTRAL			
Mogadishu	1232	11	0.89
Merca	350	0	0.00
Jowhar	351	1	0.28
Hudur	351	1	0.29
Mean - South Central	**2165**	**13**	**0.60**
Puntland			
Bossaso	324	3	0.93%
Galkaio	289	4	1.38%
Garowe	284	2	0.70
Mean – Puntland	**897**	**9**	**1.0**
Somaliland			
Hergeisa	499	8	1.6
Berbera	350	8	2.29
Borama	362	4	1.10
Burao	350	2	0.57
Mean – Somaliland	**1561**	**22**	**1.41**
Overall Mean	**4732**	**44**	**0.93**

Source: WHO 2004 HIV Surveillance Report

From the table above it can be seen that the rate of HIV positive cases among pregnant women was above 1% in five (5) out of thirteen sites. With Berbera's rate being the highest at 2.3%, this can be explained by its position as a very busy port serving Djibouti, Ethiopia and Somalia.

The survey results also showed an average HIV prevalence of 0.9% among pregnant young women aged 15-19 years. This prevalence is of concern to Somalis, given the past experience from other Sub-Saharan countries. And also the fact that the prevalence is verging on a generalized epidemic, portrays a risk of it doubling or tripling in 2-3 years.[4]

[4] WHO HIV Surveillance fact sheet - Somalia

KAPB surveys[5] have indicated a serious lack of understanding and awareness of basic information on HIV within the Somali population, including mechanisms for prevention. Other factors that increase HIV vulnerability include the ongoing complex emergency, the lack of adequate health facilities, widespread stigma and discrimination relating to HIV status, lack of confidentiality and partner disclosure, harmful cultural practices like FGM, gender inequalities and discrimination that increase vulnerability of women and girls, transfusion of unsafe blood, the widespread use of *Qat* (which could be associated with high risk behavior), transactional sex, long distance truck drivers and transporters[6].

It is difficult to assess epidemiological trends of HIV in Somali populations due to a lack of data on socio-behavioral determinants, HIV prevalence, and inadequate identification of at high risk population groups which may include but not limited to truck drivers, sex workers, most at risk adolescents, uniformed services and militias. Internally displaced populations, especially women and girls, border traders, fishing industry workers, seafarers, and irregular migrants may also be vulnerable to HIV.

New HIV data emerging from the 2007 ANC survey suggests that Somali HIV epidemic remains a significant one with wide variations in prevalence between Somali regions. Preliminary data in Somaliland from a survey conducted among 1766 young women aged 15-25 attending ANC recorded a HIV prevalence of 1.7%. Prevalence among patients with STD syndromes was 6.3% and was higher among males (7.4%) compared to the females at (5.4%). HIV prevalence ranged from 0.0% 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 has shown a steady increase in the trend of HIV infection: prevalence in 1999 was 0.0%; 2004 recorded prevalence of 2.3%; and in 2007 prevalence stood at 2.7% mark. **For detailed description of the AIDS epidemic refer to page 15-17 (overview of the epidemic).**

1.3 UNGASS Indicator Data

Table 2 below is a summary of the Somali's UNGASS m2008 indicators.

Table 2: SUMMARY INDICATOR TABLE

Indicator value 2006/2007
Indicator1 - Domestic and international AIDS spending by categories and financing sources: 2006 Amount of domestic public expenditure: **Somaliland – USD 60,000; Puntland – USD 30,000; *Global Commitment and Action (UN, Donors, International NGOs)* -** Total amount of AIDS expenditure in 2006: **USD12,202,916.81.** Source of data: **2006 Annual UNAIDS Country Report. The total funds mobilized for 2007 amounted to USD 10,436,051.**
Indicator 2 – National Composite Policy Index: **A trend analysis of efforts achieved in 2007 and in 2005 has been included in another section of this narrative report.**
Indicator 3 - Percentage of donated blood units screened for HIV in a quality assured manner: **Not able to report - the specified quality assurance requirements for reporting are not being met.**
Indicator 4 - Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy: **1/1/2006 – 12/31/2006: 2.3% (M=2%; F=3.1%)** **1/1/2007 – 12/31/2007: 6.11% (M=5.4% and F=6.7%)**
Indicator 5 - Percentage of HIV-positive pregnant women who received anti-retrovirals to reduce the risk of mother- to- child transmission: **PMTCT programme started in 2007: 0.4%**
Indicator 6 - Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: **2.4% - (M=1.4% and F=1.2%) Only Denominator not disaggregated by sex**
Indicator 7 - Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results: **Both M & F = 3.6% (M=4.8% and F=2.5%)**

5 UNICEF, 2004

6 Somali Joint Needs Assessment: Social Services and Protection of Vulnerable Groups Cluster, HIV/AIDS Sub Cluster (Draft) 2006

Indicators 8; 9;14; 18;19; 20; 21; 23 – These are indicators of the most at risk populations:
i) Indicator 8: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results;
ii) Indicator 9: Percentage of most-at risk populations reached with HIV/AIDS Programmes;
iii) Indicator 14: Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission;
iv) Indicator 18: Percentage of female and male sex workers reporting the use of a condom with their most recent client;
v) Indicator 19: Percentage of men reporting the use of a condom the last time they had anal sex with male partner;
vi) Indicator 20: Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected;
vii) Indicator 21: Percentage of injecting drug users who report the use of a condom at last sexual intercourse;
viii) Indicator 23: Percentage of most-at-risk populations who are HIV infected.
There has been no representative quantitative data captured on the above eight (8) indicators. Hence, due to data unavailability it will not be possible to report. However, there is a narrative on the qualitative IOM Somali HIV Hot Spot Mapping carried out among most at risk populations.

Indicator 10 - Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child: **This indicator should only be monitored in settings with high HIV prevalence (5% and greater). Therefore not currently relevant for Somalis.**

Indicator 11 - Percentage of schools that provided life skills-based HIV education in the last academic year: **Indicator relevant – however, it will not be possible to report for Life skills based HIV education has NOT yet commenced.**

Indicator 12 - . Current school attendance among orphans and among non-orphans aged 10-14: **- Indicator is relevant:**
A – (Attendance 25.4% - (Male=29.20%; Females=22.9%).
B- (Attendance 29.6% - (Male=30.2%; Females=27.9%
School attendance among orphans and non-orphans was almost the same.

Indicator 13 - Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: **Indicator relevant – but only data on women was captured by the UNICEF MICS 2006. (Percentage of women = 4.00%.)**

Indicator 15 - Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15: **There is no data available**

Indicator 16 - Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months: **Data not available**

Indicator 17 - Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse: **Data not available**

Indicator 22 - Percentage of young women and men aged 15-24 who are HIV infected: (**1.3%)**

Indicator 24 - Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy: **76%**

Indicator 25 - Percentage of infants born to HIV-infected mothers who are infected: **Countries are not required to submit any data for this indicator. Indicator will be modeled at UNAIDS HQ using data submitted in Country Progress Reports coverage of service (PMTCT)**

1.3 Programmatic Response

During the first half of the year 2003, a Strategic Framework for Prevention and Control of HIV/AIDS and STI within the Somali Populations was developed. This Strategic Framework is comprehensive in its vision, mission, broad goals and objectives.
In 2004, three Action Plans (2004-2006) for Somaliland, Puntland and South Central Somalia were developed as a basis for action and implementation of the Strategic Framework. They outlined target populations, expected outputs, indicators, responsible organisations, timelines, costs and the assumptions. The strategic framework is currently under review**.**

The following are the HIV/AIDS policies in place: i) Somaliland National Policy on HIV/AIDS and STI Prevention and Control; ii) National Policy on HIV/AIDS and Sexually Transmitted Infections (STI) Control for the Puntland state of Somalia, respectively.

i) A Joint UN Team on AIDS Workplan **(June 2007-December 2009)** - has been developed as part of the UN Transition Plan 2008/2009, which is the UN contribution to the first two years of the Reconstruction and Development Programme (RDP). The Joint Workplan is a result-based program that outlines inputs, activities, outputs, outcomes and measurable indicators for UN activity in the area of AIDS: a program that the UN and its constituent agencies and programs are accountable to deliver as part of a coordinated nationally owned response to HIV for all Somalis.

ii) Political Commitment and Governance

The Somali HIV response has gained momentum through highest level political leadership in Somaliland, Puntland and South Central Somalia as evidenced by involvement of the governments in the setting up and launching of the three AIDS Commissions. Furthermore, Somali entities have started to commit own resources from very limited budgets, to scale up the AIDS response. However there is still need to have continued advocacy for strengthening this commitment, given the challenge that the AIDS response is being implemented under situations of conflict and competing priorities. The strategic intent of the GFATM 5-year Grant, other funds and UN support was to build the Somali civil society and government capacity including that of the AIDS Commissions for provision of sustainable services.

iii) Gender and AIDS[7]

Empowerment of women and promotion of gender equality are critical to reducing vulnerability to HIV for women and girls. Somali women and girls have been survivors of larger conflict and anarchy as well as gender based violence (GBV). GBV in the form of rape, torture, looting and forced displacement has been used widely in the conflict. The GBV poses increased vulnerability to risk of HIV infection: additionally, lack of empowerment compromises the woman's ability to negotiate for safer sex and access to essential HIV/AIDS services. GBV is regarded as a private matter and many forms of violence (like physical and psychological violence) are not regarded as a violation by most of the people.

Somali women's NGOs have identified sexual harassment, abuse and exploitation as being prevalent. Additionally, polygamy and threat of abandonment affects a large number of women, including those in the civil services and NGOs. Polygamy is treated as a religious and cultural right of men. Female Genital Mutilation (FGM) remains widely prevalent despite advocacy and awareness by the women's organizations. The NGOs estimate the prevalence to be around 98%.

The United Nations through the support of their different agencies have embarked in the process of engendering the Somali response. Among other interventions, gender equality will be mainstreamed in the organizational and administrative culture of the AIDS Commission and in key sectors.

iv) The Most at Risk Populations[8]

The International Organization for Migration (IOM) has completed the first Somali HIV Hot-Spot Mapping of Most-At-Risk Populations. Existing information on the drivers of the Somali HIV epidemic were largely anecdotal or *ad hoc*. The mapping results provide a more accurate picture of potential drivers of the epidemic and have successfully identified effective, culturally appropriate methods of collecting HIV and sexual behavior data;

[7] Somali AIDS Response Newsletter – Issue n.5, January 2008 (UNAIDS)
[8] Somali HIV Hot Spot Mapping – by International Organization for Migration

defined the context of HIV risk and vulnerability among Most-At-Risk-Populations; established an evidence base for the development of the 2008 Somali National HIV Sero-Behavioral Survey.
The qualitative study covered sites across Puntland, Somaliland and South Central. Populations sampled included transactional sex workers, transactional sex clients, MSM and PLHIV. Sub-populations among the transactional sex workers and their clients include asylum seekers, refugees, internally displaced persons, uniformed services, militia, seafarers and truck drivers. The response rate of 93% was remarkable, given the cultural and religious challenges conducting sexual behavior research in the Somali context.

A key implication highlighted by these findings is the need to shift the Somali HIV & AIDS response from the general population to targeting Most-At-Risk Populations, many of who are mobile. Recommended approaches to achieving a targeted response include strengthening links with transactional sex work groups to develop effective interventions.[9]

v) Coordination, management, harmonization, and alignment

Based on the country harmonization and alignment tool (CHAT) developed by UNAIDS to track the Paris Declaration on coordination, harmonization and alignment, the Somali response was a selected pilot for the CHAT in 2006 due to its HIV coordination experience within the context of emergency humanitarian and post conflict situation. Based on the findings, it was shown that that the concept of "three ones" is functional to some extent but it was at a cross-road and needed realignment between the international partners and the national level structures. Additionally it was found that although the concept of "three ones" was being followed, operationally it was still functioning within 3 entities of Somaliland, Puntland, and South Central Somalia. This therefore means that there is still some work to be done in order to streamline the coordination mechanisms and structures for the Somali AIDS response.

Following lessons learned partners have made efforts to develop a roadmap to improve coordination of the Somali HIV response. The proposed coordination structure of the Roadmap should be adopted and tested without delay as it will go a long way to strengthening the coordination mechanisms that need to be in place at this point in time to scale up and monitor implementation of AIDS activities in line with Universal Access initiative.

vi) Programme implementation

With the support of the GFATM and other funders, partners have now achieved the first Universal Access target of providing access to prevention interventions on HIV awareness to one million Somalis in Puntland, Somaliland and South Central.
During the reporting period (between January 2006 and December 2007) the following was achieved: i) a total of 8,612 blood donors screened for HIV, Hepatitis B & C, and syphilis through 19 facilities; ii) 5,772 people counseled and tested for HIV iii) eight facilities provide interventions for Prevention of Mother to Child Transmission of HIV; and iv) 775,270 condoms distributed; v) establishment of 6 ART sites, 21 VCT centers, 19 STI centers, 8 integrated TB/HIV sites, 19 blood safety centers in hospitals and health centers, and 8 PMTCT sites. There are 142 integrated prevention, treatment, care and support (IPTCS) centers and 48 TB centers under Global fund TB programme, distributed evenly across South Central, Somaliland and Puntland. The progress in IPTCS programme is reflected in the case reporting, in which about 600 people are receiving HIV care and over 323 PLHIV are on anti-retroviral treatment.

A Behavior Change Communication Strategy was developed in 2006 which built on the 2003 Communication Framework developed by the World Bank and the UNICEF. UNDP also developed a behavior change communication toolkit for the Somali context using

[9] Somali HIV Hot Spot Mapping – by International Organization for Migration

John Hopkins University community entry facilitating tools. Over 380 peer educators from a range of different backgrounds have been trained on how to apply the toolkit within their communities. Also, 5185 persons from communities in all regions of Somaliland and Puntland have been reached. These have included members of the health service, members of the uniformed services, women groups, and youth, religious leaders, NGOs and other peer leaders.

Progress has also been made in addressing HIV/TB co-infection and collaboration and integration mechanisms and systems have been established. The main goal of the efforts has been to ensure that TB and HIV prevention and care interventions are mutually reinforcing with interventions to prevent HIV infection, prevent TB, provide care for PLHIV and provide care for people with TB at the primary health care delivery system level. [10]

vii) Harmonized Monitoring and Evaluation (M&E) Systems

Somalia has commenced implementation of a harmonized monitoring and evaluation framework and systems. The national monitoring and evaluation system was informed by the findings of the baseline assessment of the existing M&E needs and capacities on the ground. The major sources of funding for M&E so far has been from GFATM, DFID and UNAIDS cosponsors regular budget; however, technical support is provided by UNAIDS, CCM Italy, WHO, UNICEF, M&E references group.

About 12% of the HIV resources for the Somali response were spent on M&E support.

2.0 OVERVIEW OF THE AIDS EPIDEMIC

2.1 The AIDS Epidemic

The sero-surveillance surveys provides the best estimates of the HIV prevalence in the greater population in the case where no population based surveys such as Demographic Health Surveys has been carried out, as is the case in Somali. However, it is understood that rates of HIV infection in pregnant women are not expected to be the same as the rates for all adult women.

To date, there has not been a population based survey to determine HIV and other STIs sero-prevalence in Somali populations. Overall prevalence has been reported based on the sentinel surveillance survey among pregnant women in 2004. The HIV prevalence status as per the 2004 sentinel sero-surveillance survey indicated an epidemic at the verge of generalized epidemic with: about 40% of ANC sites being above 1%; 60% below 1%. At some of the sites, none of the pregnant women (0%) tested positive for HIV. The survey showed the following prevalence rates: an average HIV prevalence in Somali populations of 0.9%; prevalence rates of sentinel sites ranged from 0 to 2.6%: 1.4% in Somaliland, 1% in Puntland and 0.6% in South Central Somalia. Alarming is the high TB co-infection rate. Doubling worrying is the young age of the infected people.[11]

A repeat assessment was done in 2007 (Somaliland and Puntland), the survey in South Central is expected to be completed in early 2008. These contain prevalence rates by site and have provided data for the UNGASS indicators reporting. Preliminary data from the 2007 survey in Somaliland conducted among 1766 young women aged 15-25 attending ANC recorded a HIV prevalence of 1.7%. Prevalence among patients with STD syndromes was 6.3% and was higher among males (7.4%) compared to the females at (5.4%). HIV prevalence ranged from 0.0% 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 has shown a steady increase in the trend of HIV infection: prevalence in 1999 was 0.0%; 2004 recorded prevalence of 2.3% and in 2007; prevalence stood at 2.7% mark

[10] Mid Term Review Report 2007

[11] Somalia United Nations Transition Plan – Joint UN Team and AIDS Work Plan (June 2007 – December 2009)

Preliminary data in from a survey in Puntland conducted among 1884 clients attending ANC show variation in prevalence ranging from 0.0% in Lasanod to 1.6% in Bosaso Central MCH with a mean prevalence of 0.5% in the whole of Puntland. A mean prevalence of 0.9% and 2.2% was recorded among young women aged 15-24 years and patients with STD syndromes respectively. Amongst 15-19 women it was higher at 1.3%. Overall, HIV prevalence was higher among females (2.7%) than in males (1.5%). Syphilis prevalence among ANC attendees in Puntland was 1.9%. This is a very worrying situation and a great cause for concern.

The ANC surveillance in South Central zone is underway and the preliminary data outlined above needs to be collated with the south central data before a verified picture of the Somali epidemic can be articulated Clearly however, the epidemic is heterosexually driven and great cause for concern especially amongst young people.

Availability of data is still limited and a challenge. Data available is on pregnant women, patients with STIs and TB, and some behavioral data. A Second Generation Surveillance Plan is in place – the stage of the Somali epidemic has not been established since the ANC survey second round is not complete and there is lack of data and strategic information on most vulnerable/at risk populations. There is a possibility of existence of concentrated/low prevalence epidemic among vulnerable/at risk populations such as sex workers, MSM, truckers and cross-border and other mobile populations.[12]

The following are the prevalence rates showed by the 2004 sero surveillance survey done among ANC clients, TB and STI patients, for each of the regions:

- In South Central - a median HIV prevalence of 0.6% among pregnant women attending ANC and of 2.4% among TB patients. Prevalence of STIs was as follows: 1.2% syphilis; 0.4% gonorrhea; and 1.4% chlamydia – this shows evidence of STDs as a driving factor of the HIV prevalence. The median prevalence of HIV in south Central was 0.9%.[13]

- In Puntland - a median HIV prevalence of 1.7 % among women attending ANC; 5.6% among TB patients. The prevalence of STDs was as follows: 1.3% for syphilis, 1.1 -1.4 for gonorrhea and 1.2-1.4 for Chlamydia. Pockets of sentinel sites are already in generalized epidemic with HIV prevalence above 1%. The trend in HIV infection in Puntland is on sharp increase.[14]

- In Somaliland - a median prevalence of 1.4% among women attending ANC, 5.6% among TB patients. Prevalence of STDs was as follows: 1.3% syphilis.

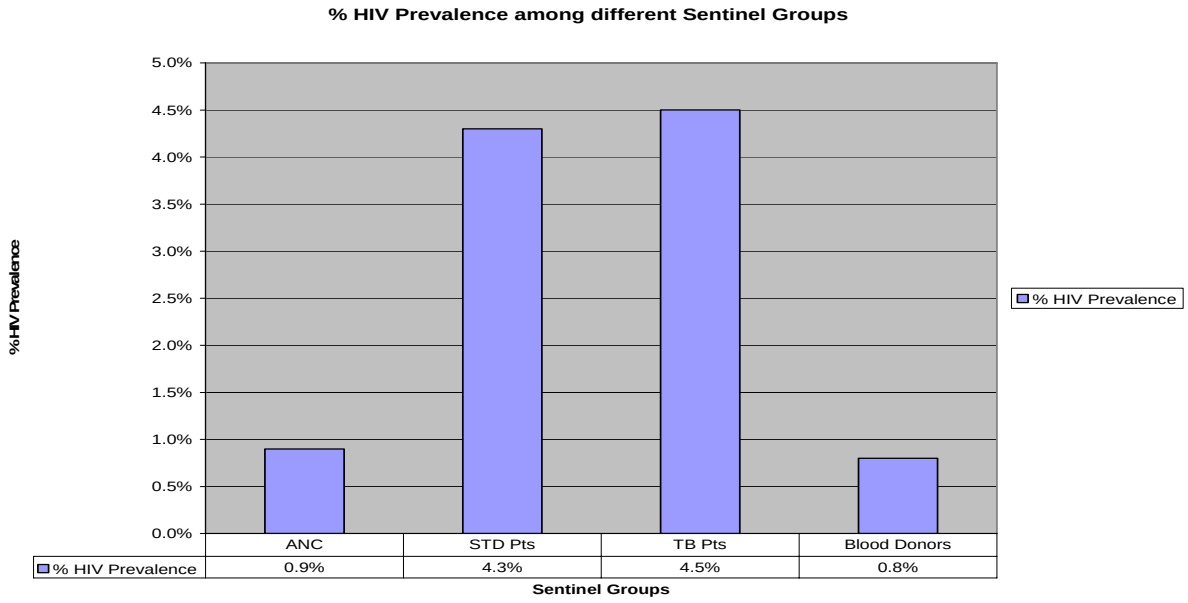
The figure 1 below shows HIV prevalence among different sentinel groups as per the 2004 sero surveillance survey.

[12] Somalia United Nations Transition Plan – Joint UN Team and AIDS Work Plan (June 2007 – December 2009)

[13] South Central Technical Report: 2004 First National Second Generation HIV/AIDS/STI Sentinel Surveillance survey among pregnant women attending Ante-natal clinics, tuberculosis and STD patients – by WHO

[14] Puntland Technical Report: 2004 First National Second Generation HIV/AIDS/STI Sentinel Surveillance survey among pregnant women attending Ante-natal clinics, tuberculosis and STD patients – by WHO

Fig 1: HIV PREVALENCE AMONG DIFFERENT SENTINEL GROUPS



Source: CRIS update 2007

HIV prevalence among different sentinel groups is more meaningful in comparison over time.

The 2007 sero Surveillance survey has not been finalized; therefore it will not be possible to make any meaningful comparisons. The 2007 sero surveillance survey is not yet published; however, the available findings are presented below for Puntland and Somaliland:

a) *Puntland* :–

Table3: Distribution of HIV prevalence among ANC attendants 2007

Age Group	No. Tested	No. HIV Positive	% HIV Positive
15-19	300	4	1.3%
20-24	582	4	0.7%
25 -29	404	0	0.0%
30-34	230	0	0.0%
35-49	189	1	0.5%
Total	1705	9	0.5%

Source: WHO – 2007 Sero surveillance survey

Table 4: HIV and Syphilis prevalence by site – Puntland 2007

Site	No. of Samples	No. HIV positive	% HIV Positive	No. Syphilis	% syphilis
Bosaso Central MCH	386	6	1.6%	9	2.3%
Bosaso IDP - MCH	276	0	0.0	12	4.3%
Bosaso STD	179	4	2.2%	0	0.0%
Garowe	345	2	0.6%	6	1.7%
Galkaio	350	1	0.3%	3	0.9%
Lasanod	348	0	0.0%	2	0.6%
total	1884	13	0.7%	32	1.7%

Source: WHO – 2007 Sero surveillance survey

In summary the 2007 sero-surveillance survey has shown the following findings for Puntland:

- HIV mean prevalence ranged from 0.0% in Lasanod MCH to 1.6% in Bosaso Central MCH with a mean prevalence of 0.5% in Puntland.
- Among young women aged 15-24 years the mean prevalence is 0.9% (2007).
- There was an increase in the mean prevalence in Bosaso Central MCH from 0.9% in 2004 to 1.6% in 2007.
- In STD patients, HIV mean prevalence increased from 0.8% in 2004 to 2.2% in 2007.
- Syphilis Prevalence ranged from 0% in Bosaso STD to 4.3% in Bosaso IDP MCH (2007).
- Syphilis prevalence among ANC attendants in Puntland is 1.9% (2007) and 0.2% (2004).

b) *Somaliland: –*

Table 5: Distribution of HIV Prevalence among different sites - 2007

Site	No. of samples	No. HIV Positive	% HIV Positive
Berbera	222	6	2.7%
Borana	358	0	0.0%
Burao	235	3	1.3%
Daami IDP Camp	450	10	2.2%
Hergesia MCH	499	4	0.8%
Total	**1764**	**23**	**1.3%**

Source: WHO – 2007 Sero surveillance survey

Since there are only two data points (2004 and 2007), no meaningful trend analysis could be done. The HIV prevalence in 2004 among young pregnant women was 1.2%; this went up in 2007 to 1.7% with no statistical significance difference.

The available data indicates a significant TB/HIV co-infection problem. Even though a second generation surveillance plan is in place, still little data exists on young people, IDPs, returnees, refugees and other mobile populations - notably, cross border populations and pastoralists. The bordering with higher prevalence countries, increasing displacement, conflict mobility and porous borders are all a major determinant of the future course of the epidemic for Somalis[15].

[15] 2006 country report

3.0 SOMALI RESPONSE TO THE AIDS EPIDEMIC

The Somali AIDS response is being implemented within a humanitarian and emergency setting, albeit for the South West zone (Somaliland) which is in post conflict situation and the response is developmentally oriented. Most areas are plagued by prolonged insecurity, categorized as Phases 4 and 5 security situations by UNDSS. This severely constrains humanitarian access, and challenges achievement of planned response. However, through the collaboration between government, development partners, and civil society organizations, the AIDS response is integrated into humanitarian and emergency operations for systematic delivery of interventions. Some of the key achievements include development of strategic framework to coordinate and guide the response; promote partnership, resources mobilization, leadership commitment, and local ownership, establishment of coordination of multiple structures and capacity building efforts, and making sustained progress towards the achievement of the Universal Access targets.

The implementation of the Strategic Framework for the Prevention and control of HIV and STIs in Somali Populations (2003-2008) has achieved significant progress in scaling up the response towards achieving Universal Access Targets. The approach at the outset was to address a generalized epidemic – intensify prevention activities with immediate focus on establishing response management capacity, political support, strategic information and community advocacy and engagement. However, response is still in its early days.

The NCPI indicated the following ratings of strategy planning efforts in the HIV and AIDS programs in 2007 and in 2005 are shown in table 6 below:

Table 6: Rating of Strategy Planning Efforts in 2007 and 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

From the table above, there is has been a significant improvement in the strategy planning efforts in 2007 as compared to 2005. This is being attributed to GFATM monitoring which has helped focus on strategic planning. New data generated is the basis for the 2007/2008 review of the strategic framework and development of a costed action plan towards Universal Access. The Joint Needs assessment, Reconstruction and Development Plan, UNTP and the development of Joint UN Team work plans; part of the UNTP has systematically bolstered strategic planning.

A comparative rating of the political support for the HIV and AIDS programs in 2007 and in 2005 is as shown in the table 7 below:

Table 7: Rating of Political Support for the HIV and AIDS programs in 2007 and 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The improved rating achieved in 2007, has been due to the following: Joint UN Team, AIDS Commissions, and GFATM resources since mid 2005. The three Somali entities have continued to work together above politics inspite of conflict and political divisions between them. The political commitment has remained high because major resources for the response have been secured and because visible access to IPTCS has materialized.

3.1 Universal Access

Notably, the AIDS response has been the first sector to bring the three (3) Somali entities together in a common struggle to avert the threat of a major epidemic. The three AIDS

Table 8: Achievements of Universal Access Indicators Targets

Prevention targets				
Target 1	% of general population or populations most at risk who received an HIV test in the past 12 months and informed of results			
Baseline	2006	2007	Target Achieved	Remarks
2.50% (2004 KAPB Survey) = 202	3%	5%	4%	This data is based on the UNICEF KAPB survey of 2004. With greater awareness among the Somalis, any new survey conducted will reflect a higher percentage of those who have tested for HIV.
Target 2	% of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT			
Baseline	2006	2007	Target Achieved	
0 (Somali PMTCT program data. 11 out of the estimated 2,865 HIV+ women	0.3	0.4	**0.4%**	PMTCT Program started in 2007.
Target 3	Number of condoms distributed annually by the public sector and the private sector			
Baseline	2006	2007	Target Achieved	
300,000 Global Fund program monitoring report 2007	545,000	1,000,000	**775,270**	This is the Total number of condoms distributed as at December 2007. Largely funded through Global Fund. Plans by UNFPA condom strategy will boost the number of condoms issued.
Target 4	% of young people (15-24) or "at risk" groups who correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions (GIRLS)			
Baseline	2006	2007	Target Achieved	
2006 MICS Report Total = 4766, Age 15-19=1706 , 20-25=3060	8%	8%	**4%**	Target achieved (Use of old data 2006 MICS)
Target 5	% of young people (15-24) or "at risk" groups who correctly identify ways of preventing sexual transmission (BOYS)			
Baseline	2006	2007	Target Achieved	
	13%	13%	**No Data available**	-----
Target 6	number of populations most at risk reached by prevention programs			
Baseline	2006	2007		
0	-	-	-	IOM Hot-Spot mapping will capture the qualitative data in the UNGASS 2008 narrative. This lays foundation for a BSS+ for MARP for Somalis
Treatment targets				
Target 7	% women, men and children with advanced HIV infection receiving ARV combination treatment			
Baseline	2006	2007	Target Achieved	
1.6 %. Program monitoring - ART Registers and ANC Surveillance and 2007 estimates	2%	3%	**6.11%**	Double target achieved (exceeded by 3.11%)
Target 8	% people with advanced HIV infection still alive 12 months after initiating ARV therapy			
Baseline	2006	2007	Target Achieved	
Total 12 month Cohort =115. Alive = 87 From ART Program monitoring data	78%	80%	**76%**	Target not achieved by 2007 The Somali ART program was started in Hargeisa and was mainly targeting refugees who were very sick already. Majority of them died in the first month of starting the ARV treatment.
Care and support targets				
Target 9	% of OVC who received a basic external support package			
Baseline	2006	2007		**This indicator should only be monitored in settings with high HIV prevalence (5% or greater)**
MICS 2006 report estimate OVC population at 18,884	-	153	0.8%	
National commitment targets				
Target 10	Amount of national funds distributed by governments			
2005 baseline	2006	2007		
Puntland, Somaliland & South Central	132,500	None	N/A	No figures have been provide for 2007
Partners in AIDS Response	12,362576	10,436,051	N/A	

Commissions are working together to scale up a comprehensive and integrated services in prevention, treatment, care and support within the context of a multi-sectoral HIV response; this efforts are aligned with the broader humanitarian assistance, and the UN Transition Plan, outlined in the Reconstruction and Development Program for Somali populations. The table below shows the achieved progress towards meeting the set Universal Access Indicators targets *(see next page).*

During the reporting period (2006/7), access to ART, VCT and other services have improved, even though, critical capacity gaps in implementation capacities remain. Universal access to services for Somalis will require much more work on engaging most-at-risk populations in planning and execution of interventions, promoting community dialogue at various levels, targeting youth, expansion of PMTCT and services for OVCs, uniformed services, public sector and religious leaders.

3.2 Existing Implementation Frameworks

The Somali AIDS response is based on the Strategic Framework developed in 2003 through the participation of all stakeholders. The *strategic Framework for the Prevention and Control of HIV and STIs in Somali Populations (2003-2008)*, ends in June 2008. In addition, the *Strategic Framework* has been developed into three zonal action plans. The Strategic Framework and its operational plans formed the basis for the development of the Round IV GFATM application and grant**.**

One harmonized ME framework for Somalis is currently being adapted into three zonal ME framework. The one M&E Framework with common reporting tools and a Country Response Information System (CRIS) data base for all the three regional entities has been established through participatory approach.

3.3 HIV Response Coordination

The overall coordination of the response is managed through the three AIDS Secretariats in partnership with the SSS HIV Working Group and associated taskforces which includes the Joint UN Team and AIDS partners. As the response has been scaled up, a review of these structures is currently underway to strengthen and enhance the coordination and management.

Line ministries and civil society including religious leaders have continued building partnerships in all regions to avert a major epidemic. However, participation of women and women's organizations should be improved. The establishment of AIDS Commissions and Secretariats in each region offers the possibility for all Somalis to coordinate their efforts on AIDS. Somalis already have one agreed strategic framework and are working on one integrated prevention, treatment, care and support guided by one harmonized monitoring & evaluation framework.

Table 9 below shows the rating of the efforts to increase civil society participation in 2007 and in 2005.

Table 9: Rating of the efforts to increase civil society participation in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

There is great progress in achievement of increased civil society participation in 2007, this is explained by the following: GFATM since mid 2005; and all development and humanitarian instruments have civil society strengthening strongly incorporated.

Examples of this can be seen in the Consolidated Appeals Process (CAP), United Nations Transitional Plan (UNTP), Reconstruction and Development Plan (RDP), Joint Needs Assessment (JNA), and Joint UN Team and AIDS Workplan. Civil Society has been the major providers of services over the past 16 years in the absence of functioning governmental structure. This is less the case in Somaliland although civil society has been a major service provider too.

3.4 Existing HIV Policies and Programme Linkages

Implementation of Somali AIDS response has involved linkage with the humanitarian plan/strategy which has a budget line on HIV/AIDS, and has HIV/AIDS-related indicators included. This strategy has addressed linkages between the humanitarian situation and HIV/AIDS.

The AIDS Action Framework include programs for: Youth; Women and girls; Uniformed services; Strengthening health systems for provision of AIDS treatment and care; collaborative tuberculosis/HIV activities to reduce tuberculosis among people living with HIV; actions related to conflict-affected, disaster-affected areas and/or other humanitarian settings (e.g. AIDS related services to refugees, internally displaced people); Mobile populations; Prison populations; Orphans and other vulnerable children. Missing out are programs on the following: Men who have sex with men; Injecting drug users; and Sex workers.

i) Laws and Regulations that Protect People Living with HIV against Discrimination

Puntland and Somaliland have embarked on policy development which addresses to an extent discrimination of people living with HIV. Implementation has been through the following frameworks: i) Somaliland National Policy on HIV/AIDS and STI Prevention and Control; ii) National Policy on HIV/AIDS and Sexually Transmitted Infections (STI) Control for the Puntland state of Somalia.

ii) Laws, regulations and Policies that Present Obstacles to Effective HIV Prevention, Treatment, Care and Support for Vulnerable Sub-Populations

There is no independent national institution for promotion and protection of human rights that covers AIDS (e.g. a human rights commission, law reform commissions, or ombudsperson). This is explained by the fact that Somali is a very conservative Islamic country, and sex and condoms are not openly discussed. In many parts, especially in South Central Somalia and with the rise of the Islamic Courts Union, even the issue of girls in school (let alone getting life skills education) has been contentious. Transactional and survival sex is common but is not able to be addressed because officially it does not exist, similarly for Men who have Sex with Men (MSM) despite the IOM Hot-Spot Mapping confirming the existence of these populations and HIV risk behaviors.

Table 10 below shows the rating of the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005.

Table 10: rating of the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The overall rating of the effort to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in 2007 and in 2005 is shown in table 11 below.

Table 11: rating of the effort to enforce the existing policies, laws and regulations in relation to human rights and HIV and AIDS in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The progress is still low in the improvement of rating of the policies, laws and regulations in place to promote and protect human rights. However, there has been some achievements: i) since inception of the 3 AIDS Commissions there is great human rights focus; ii) the GFATM grant in 2004 gave greater impetus to human rights programs; and iii) in 2007, the UN Transitional Plan placed major emphasis on Human Rights and especially women's rights.

3.5 Resources for Somali AIDS Response

The AIDS Action Framework and the operational plan (annual priority action plan) is the basis for the AIDS program and resources mobilized from The Global Fund and other contributions from external partners. Multiple financial resources have been secured which include the GFATM, bilateral and UN funding to implement a comprehensive response. Still new additional resources are needed in order to stay in course towards the UA targets.

Development of human resources has been a key priority for 2007, where capacities have been built for the AIDS Commissions to play a more prominent role in the strategic management of the HIV response for Somalis. Another area in which foundations have been laid and the UN is strongly committed is gender parity in the Commissions themselves, the first step of which will be the inclusion of a Gender Officer in SCAC, PAC and SOLNAC. However, there is a strong need to build gender capacity and skills among the staff of the Commissions and all those involved in the response, since gender equality has to be mainstreamed in the response in order to reduce the vulnerability of Somali women and girls to HIV infection and the impact of AIDS.

The current Strategic Framework on HIV/AIDS and the GFATM resources are not sufficient for the next five years and nor are they targeted at addressing these most at risk populations. If the Somali AIDS response is to avert an escalation in prevalence there is an urgent need to energize the current revision of the Strategic Framework (which expires in 2008) and put commensurate resources in place to address drivers of the epidemic. These plans and resources need to (inter alia):

- Better target most at risk populations;
- Strengthen health systems to ensure that adequate services can be provided to ensure that the response can be scaled up to meet the Universal Access targets which have been set.

For an overview of funding, please refer to page 33

i) Building institutional capacity among government and civil society partners

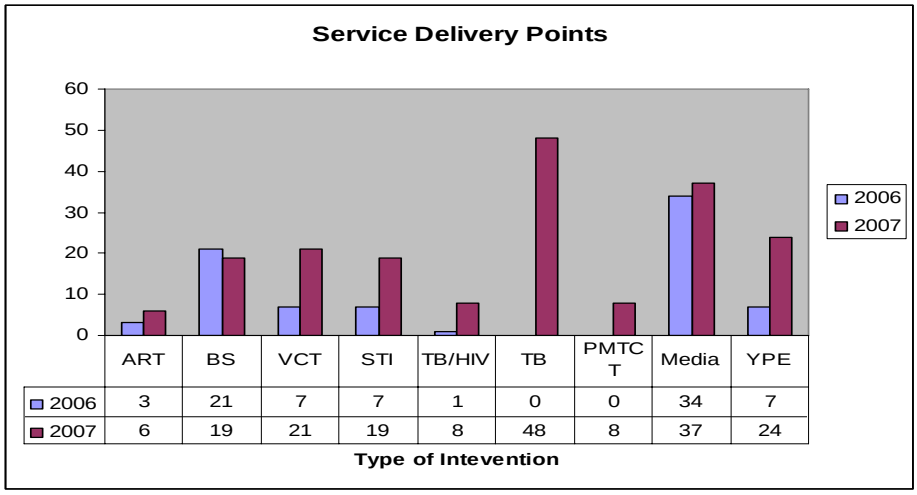
Two HIV units were set up in the Ministry for Family Affairs and Social Development in Somaliland and in the Ministry of Women's Development and Family Affairs in Puntland. This included the technical training of key staff and technical support in developing terms of reference and workplans to integrate HIV prevention into social service planning and delivery. During 2007, UNICEF provided institutional capacity building support to eight NGOs, three line ministries, nine HIV regional working groups in South Central Somalia and one media house.

3.6 Prevention, Care and Support Response Interventions

HIV/AIDS response strategies have focused on implementation of service delivery mainly targeting the vulnerable groups and high risk populations as well as those situated at high exposure points; as well as provision of care and support for PLHIV.

The figure 2 below shows the current service delivery points in Somali.

Fig 2: Number of Service delivery points in Somali



Source: CRIS update January 2008

3.7.1 Prevention

The following are the efforts made in HIV prevention during the period 2006/7: Situation analysis of the vulnerable groups in Somalia; Behavior Change communication; Mass Media; Voluntary counseling and testing in ten centers; Community mobilization and awareness raising; starting off of PMTCT services planned for ten centers; Gender, women and girls; establishment of HIV/AIDS Multipurpose youth centers, Peer Education programme for young people; An assessment and analysis of the underlying drivers of the epidemic in Somali populations is a key priority, for it will inform the ongoing review, and development of a revised strategic framework that will be more focused and targeted to halt and reverse the spread of the epidemic. The assessment will also inform development of appropriate delivery strategies for interventions that are proven to be effective.

Table 12 below shows the rating of the efforts in the implementation of HIV prevention programs in 2007 and in 2005.

Table 12: Rating of the Efforts in the Implementation of HIV Prevention Programs in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The above progress in the rating was made since GFATM grant began implementation in mid 2005. The Joint UN Team was formed in 2006 and the Joint Work plan implemented in mid 2007.

i) HIV prevention among young people

UNICEF supported the development of two critical strategy documents: a) the life skills implementation strategy and b) the programming strategy for adolescents most at risk.

Both pieces of work were completed based on operational research with young people, using participatory methods and peer reviews by UN, government and NGO partners. The strategies were necessary to guide and target programming better, not just for HIV prevention, but for a generally improved adolescent programming approach in the Somali context. In Somaliland, 1,500 adolescents were reached through interactive drama with information on HIV, drug abuse, sanitation and youth development. 10,000 copies of KOOR magazine carrying HIV information developed by young people for young people were distributed to young people across all administrative zones.

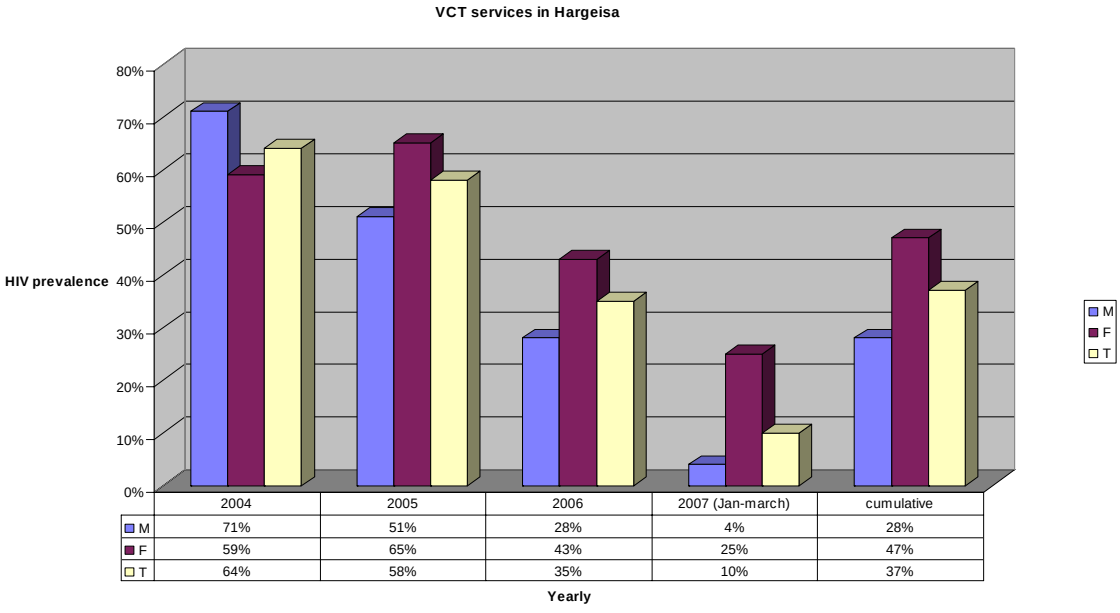
To-date there is no national task force on HIV prevention in Somali. This function is carried out by the Joint UN Team on AIDS in collaboration with the AIDS-related working groups in the Somali Support Secretariat and the Health Sector Committee – which also acts as the GFATM CCM

3.7.2 Voluntary Counselling and Testing:

With the low prevalence among ANC and high stigma, it could be explained that those who considered themselves with high risk behavior hoping to benefit from the ART programme are the main clients for the VCT services in Somalia.

The Figure 3 below shows the number of clients who had used VCT services in Hargeisa Somaliland.

Fig 3: Use of VCT Services in Hergeisa Somaliland



Source: CRIS update 2007

3.7.3 Care and Treatment

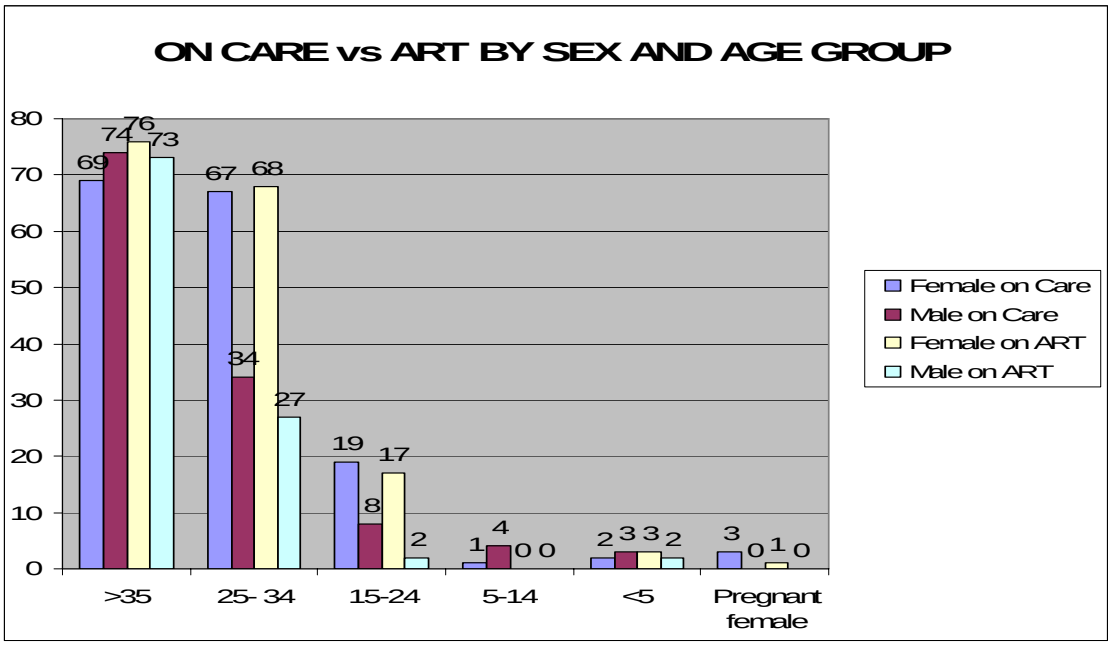
i) Greater Involvement of People living with HIV

During 2007, UNICEF conducted participatory research in all three administrative zones with PLHIV, government and NGO partners and developed a strategy for the greater involvement of people living with HIV (GIPA). The strategy was reviewed and will be launched in 2008 as the basis to scale up GIPA among Somalis. In Puntland, support was

provided to HOPE, a local NGO, to set up two support groups for PLHIV, one in Bosaso and one in Garowe. This included organizational management and technical training for the NGO. The peer support groups are linked to the local hospitals to access medical services. As part of the GIPA initiative, 18 nurse students and 27 health workers were trained in HIV prevention, treatment and care and support for PLHIV. In turn, the nurse students and health workers have conducted neighborhood meetings on HIV prevention and greater care and support for PLHIV.

Figure 4 below shows People on Care and ART as from June 2005 to December 2007[16]:

Fig 4: People on Care and ART - June 2005 to December 2007



Source: CRIS update 2007

Table 13: Rating of the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	■	□	□	□	□
2005	■	□	□	□	□	□	□	□	□	□	□

The above improved rating of the efforts in the implementation of HIV treatment, care and support services has been achieved since GFATM grant operationalization in mid 2005.

3.8 National Commitment to HIV/AIDS financing:

Somalis remain in state of conflict and particularly in the south, are in an on-going emergency humanitarian crisis. However, there is the highest political commitment and goodwill towards HIV/AIDS response interventions. The government is constrained by lack of basic infrastructures such as offices among others. There is significant financial support

coming from the Diaspora, however, there is no documentation available to enable its quantification.
It has also not been possible to track all HIV/AIDS funds flowing into the Somali response through the NGOs and Civil Society Organisations. Due to the above limitations it will not possible to report detailed AIDS spending by funding source using the "National Funding Matrix – 2008." However, please refer to page 33 for an overview of major resource flows into the response.

3.9 Blood Safety:

WHO Somalia is taking the lead in ensuring that quality assurance procedures are followed during blood screening. A total of 8,612 units of blood were donated and screened for HIV, Hepatitis B & C, and for syphilis through 19 health facilities that are known to provide blood transfusion services in Somaliland, Puntland and South Central Somalia. It has been reported that the facilities have trained personnel, and written Standard Operating Procedures exist and are readily accessible to staff. However, universal screening of blood is still under development, and external quality assurance scheme has yet to be established to support the facilities, and therefore, none of the facilities or laboratories participate in an External Quality Assessment Scheme for HIV screening"

3.10 Prevention of Mother to Child Transmission of HIV (PMTCT):

The HIV/AIDS/STI Sentinel surveillance survey of 2004 showed that HIV prevalence among Somali pregnant women was as follows: South Central – 0.6%; Puntland – 1.0%; and Somaliland – 1.4%. With the overall prevalence among pregnant women at 0.93%, this is a clear indication that transmission of HIV infection from mother to child is a reality, and hence need to establish PMTCT services in all the three regional entities.

Introduction of Prevention of Mother-To-Child Transmission of HIV (PMTCT) in Somalia

UNICEF has supported the building of national capacity for the implementation of the prevention of mother to child transmission of HIV (PMTCT) in Somali. The process started in January 2006 with the adaptation of a national policy and guidelines, the training of 15 national trainers and 47 service providers on PMTCT in the three zones. From June 2007 PMTCT was introduced in six sites - two in Somaliland (Hargeisa Group Hospital and Hawadle MCH) and four in Puntland (Bosaso Hospital Maternity Ward, Ugaas Yasin MCH, Garowe Hospital Maternity Ward and Wabeeri MCH). As by November 2007 a total of 1,757 pregnant women had been counseled and 1,375 tested for HIV, an overall uptake of 78%. Out of the 1,375 pregnant women so far tested, 11 were found to be HIV positive (0.8%) and have benefited from the PMTCT package. As part of the roll-out process, two more sites in Somaliland will become operational in December 2007 - Edna Aden Maternity Hospital and Guriasamo MCH - bringing the total number of functional PMTCT sites to eight. Somalia is the 26th out of 46 countries in Sub-Saharan Africa to introduce services for the prevention of mother-to-child transmission of HIV.[17]

3.11 Tuberculosis:

The 2004 Sero- Surveillance surveys showed that HIV among TB patients from Mogadishu, Bossaso and Hargeisa was on average 4.5%. Significant activities have been carried out to address tuberculosis among people living with HIV during the reporting period (2006/7). Activities to address the burden of tuberculosis among people living with HIV/AIDS have been included in the annual joint UN Team on AIDS work plan.
About 33% of the financial resources for the annual HIV/AIDS work Plan are for TB-HIV issues. Through these resources the following has been achieved: i) Two members of staff have been trained to provide technical support on HIV/AIDS Collaborating activities at

[17] Somali AIDS Response Newsletter – Issue n.5, January 2008

the WHO Training center in Italy; ii) In-country sensitization workshop on HIV/TB collaboration; iii) Development of HIV/AIDS Collaboration guidelines; iv) Situation analysis on HIV/TB surveillance carried and operation plan developed; v) HIV/TB surveillance protocol developed; vi) Joint TB/HIV collaboration team established; and vii) Five TB/HIV collaboration centers identified.

3.12 Knowledge and HIV Awareness

The UNICEF KABP survey of 2004 on knowledge and awareness showed that 79.6% and 71.3% of men and women respectively had "ever heard about AIDS". On attitude and behavior, the survey revealed that abstinence and faithfulness are the most known, and are the religiously and culturally acceptable means of HIV prevention (this is the expected given the Somali Islamic society). Also, the survey indicated the proportion of people that cited use of condoms as an HIV preventive measure was very low (24%).[18]

3.13 Orphaned and Vulnerable Children (OVC)

The MICS 2006 indicated that the HIV related orphanhood is not widespread in Somali populations. The current levels are explained more by poor parental health status and the effects of conflict/ displacement rather than the impact of HIV/AIDS. Just over 1% of Somali children have lost both parents and 9.5% have lost one parent. The MICS found no large disadvantage between double orphans to non-orphaned children when it comes to school attendance.

The table 14 below shows the rating of the efforts to meet the needs of orphans and other vulnerable children.

Table 14: Rating of the efforts to meet the needs of orphans and other vulnerable children

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The minimal achievement in the efforts to meet the needs of orphans and other vulnerable children is explained by lack of an OVC strategy. However, it is currently being developed. And in addition, efforts to identify the OVC population are underway. At the moment about 153 identified orphans receive free external support, education, medical psychosocial, food and any other support. This has been implemented under the GFATM OVC programme.

3.14 The Most At Risk Indicators

The UNGASS Indicators 8, 9, 14, 18, 19, 20, 21, and 23 have not been reported in CRIS due to unavailability of data. The IOM Somali HIV Hot Spot Mapping provides information on the Most-At-risk populations, which is reported below in a narrative format.

The IOM Somali HIV Hot-Spot Mapping is a qualitative study among Most-At-Risk Populations. Owing to the qualitative methodology and purposive sampling no information on population sizes or denominators can be determined, and these data are not representative of the general population. The main benefit of these data is to confirm the existence of Most-At-Risk populations and frequently reported HIV risk behaviors in Puntland, Somaliland and South Central Somalia.

The table below is a narrative on the indicators listed above:

[18] The UNICEF KABP survey in 2003

Table 15: Narrative on indicators 8, 9, 14, 18, 19, 20, 21 and 23

UNGASS Indicator	Narrative
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	**Transactional Sex Workers:** Almost one-half of transactional sex workers reported taking an HIV test, and those who knew their result reported a negative result except one individual. The main reasons for not taking a test were no access to VCT and not being sick. One female sex worker reported she was HIV+ but was not always successful persuading clients to use condoms. **Transactional Sex Clients:** Less than one-third of transactional sex clients had ever taken an HIV test, and those who knew their result reported a negative result. The main reason given for not having an HIV test was that participants did not feel sick. **Street Children:** No street children reported taking an HIV test, including those involved in transactional sex.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	**Transactional Sex Workers & Clients:** Most transactional sex workers and clients spontaneously identified condom use as a means of sexual HIV transmission. A minority of transactional sex workers and clients spontaneously reported HIV transmission misconceptions including: • Condoms do not effectively prevent HIV transmission • Condoms contain the HIV virus and infects users Using condoms with oil-based lubricants is safe (MSM)
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	**Transactional Sex Workers:** **Female:** Most female sex workers reported no or inconsistent condom use with clients. Principal barriers to condom use were client refusal, clients paying more for sex without a condom, condom prices being high and sex workers' unwillingness to use condoms. **Male:** Only 2 male sex workers were interviewed. Both reported always using condoms with clients. However condom use was often accompanied by oil-based lubricants due to lack of knowledge of the corroding effect.
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**Transactional Sex Workers:** Two male sex workers reported always using condoms with clients for receptive and active anal sex. However this was frequently accompanied by oil-based lubricants. MSM sex workers and clients reported both receptive and active anal sex with consistent condom use. However, condom use was frequently accompanied by use of oil-based lubricants such as hand lotion, hair lotion or vegetable oil. **Street Children:** 2/3 male street children reported anal sex with multiple partners including both adult transactional sex partners and older street children. They reported never having used a condom.
21. Percentage of injecting drug users who report the use of a condom at last sexual intercourse	There were no reports of injecting drug use among any participants: transactional sex workers and clients (truck drivers, seafarers, uniformed services, and militia). However, unconfirmed key informant reports suggested there were incidents of injecting drug use in Mogadishu.
23. Percentage of most-at-risk populations who are HIV infected	One HIV+ woman was a sex worker at the time of interview. She reported trying to negotiate condom use with clients, which was not always successful resulting in potential onward transmission to clients.

Source: IOM Hot Spot Mapping survey

4.0 BEST PRACTICES

The HIV response in Somali has become a building block in reconciliation processes for it has elevated a development response to a technical level above politics.

The three regional entities have managed to lay aside their political differences and have come together during three occasions of international meetings which has demonstrated the possibility to collaborate on the national "three ones principles."

The success of the special Somali response established by the UN and their partners is a case of the evolution of an HIV response in an Islamic country rocked by conflict and natural disasters, with some of the worst human development indicators on earth.[19]

The following are some of the lessons learned in the Somali response which can be adapted as best practices:

- The ART programme has been a cornerstone of scaling up prevention, treatment, care and support, for example: the existence of ART encourages people to access counselling and testing services; and provision of ART can help open up discussion on HIV within a community and presents an opportunity to reduce stigma and discrimination.
- The joint partnership between UN Agencies, government, international agencies, non-government organizations, and community leaders has been possible despite political divisions between the North West (Somaliland), North East (Puntland) and Central South zones.
- VCT, provision of prophylaxis of cotrimoxazole and nutritional supplements can serve as effective entry points for comprehensive ART interventions.
- Resource mobilization though difficult in conflict setting, is possible through the humanitarian vehicle.
- It is feasible to identify and engage Most-At-Risk Populations in HIV research including male and female transactional sex workers, transactional sex clients from a variety of mobile groups (truck drivers, uniformed services, militia etc.), MSM and PLWHA.

A key priority for the future is to provide Somalis with assistance to collate evidence and best practice on Islam, conflict and HIV/AIDS.

5.0 MAJOR CHALLENGES AND REMEDIAL ACTIONS

Key challenges and emerging issues encountered by stakeholders and partners during the reporting period 2006/7 were as follows:

- Somalis are faced with the challenge of highly mobile populations that threatens the achievement of halting and reversing the spread of HIV. The address of cross-border vulnerability requires collaboration of the National Aids Commissions of neighboring countries to jointly respond to HIV vulnerability among mobile populations and the host populations with whom they interact.
- A major challenge for the national response is building the capacities of the AIDS Commission to better manage the response strategically and financially. Systematic address of lack of capacities in a climate of violence and change has proved unsustainable because of the shifting political and security situation.
- Almost all Somali girls undergo FGM. Sexual and gender-based violence is widespread, and in Somali society, not actually considered as a violation of women's rights – with the exception of rape. Fundamental religious and cultural values make it difficult to address the drivers of the epidemic concerned with sex work and women's disempowered societal status.
- Lack of access to deliver interventions, and political and clan divisions, coupled with phase 4 and 5 security situations, make it difficult to build a culture of human rights amongst Somalis.

[19] Country Report 2006

- The three (3) Somali entities make it impossible to develop "national" policies, priorities and goals for all Somalis for any emergency humanitarian, early recovery or development.

5.1 Remedial Actions

To address the identified policy issues and gaps, plans are underway to revise the Policies in Somaliland and to develop policy in South Central. And also the following policy gaps will require address in order to scale up prevention activities: i) Institutionalization of cross border HIV programming interventions to address vulnerability groups, human trafficking reservoirs, refugees, returnees, truckers, sex workers, nomadic, IDP, young people, women and girls, OVC, and armed forces; ii) Mainstreaming of HIV into religious activities and uniformed services; iii) Life skills education for young people; iv) Provision of paediatric ART; and v) Universal access to integrated prevention, treatment, care and support services.

Key strategic actions and targets have been set based on core intervention areas and indicators identified to overcome the existing obstacles in order to scale-up the response towards universal access.

Given 14 years of collapsed statehood, Somalis are reinventing the role of civil society and government and struggling to ameliorate the lawlessness which prevailed in a climate of violence. Regional and global action will need to help solve the political, humanitarian and emergency challenges concurrently with addressing the obstacles to universal access.

6.0 SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

This section provides: i) information on the key support received from the development partners; ii) an outline of actions that need to be taken by development partners to ensure achievement of the UNGASS targets.

6.1 UN Partners in Somali HIV Response

The on-going humanitarian crisis, conflict and emergencies have necessitated decentralization of the UCC office through national officers in Puntland, Somaliland and Mogadishu for south central Somalia. This has been crucial to UNAIDS support to AIDS Commissions secretariats in the three entities. It has contributed to: i) strengthened systems, structures and mechanisms for local HIV response coordination and management; ii) harmonized M&E and improved mechanisms for information sharing between partners; iii) provided technical support to the young AIDS Commissions and their secretariats (especially Executive Directors) – by building leadership alongside a multi-sectoral response; iv) ensured systematic data collection and strategic information; and v) built integrated prevention, treatment, care and support services in line with Universal Access.

The overall objective of the Somali UNCT is to scale-up integrated prevention, treatment and care services in line with universal access and GFATM targets whose indicators have been aligned to UNGASS reporting.

6.2 Financial Support Received from Development Partners

The financial resources that were received and spent in AIDS response are detailed below for the year 2006 and 2007 respectively.

Total amount of AIDS expenditures in 2006 was 12,202,916.81, with most of the external funding largely received from five donors as indicated below.

- The first largest donor was GFATM with the amount spent in 2006 at $5,733,179.18
- Second largest was Italian Cooperation with amount spent at $3,074,435.56: 29.4% Prevention; 9% treatment and care, 33% governance and Coordination.
- Third largest donor was UNICEF with amount spent in 2006 at $2,855,529.58
- Fourth largest donor UNDP with amount spent at $1,438,000
- Fifth largest donor UNAIDS/DFID with amount spent at $617,862.67

Table 16: The total received from external funding for AIDS in 2007 and spent

Source of Funding	*Total Budget (US$)*	*Total Spent (US$)*
Government Funding	Somaliland, Puntland, South Central (Implement GF money and respective governments provided needed support)	
GFATM	**5,872,881** (IPTCS)	5,872,881
UNICEF (CHEP) see **CPP**	**1,029,206** (Prevention)	1,029,206
UNFPA	**1,025,000** (Prevention)	1,025,000
UNDP	**1,034,553-343,000 (GF)= 691,553** (Prevention)	691,553
WHO	**753,716-168,346** (GF sentinel surveillance) **= 565,370**	753,716
UNAIDS	**531,929** (Includes PAF/PSF and other funds for the Joint UN Team work plan)	372,850
UNOCHA (funds to UNFPA)	**249,275**	249,275
UNOCHA (funds to IMC	**85, 337**	85, 337
IOM	**125,000** (Hot spot zapping)	125,000
World Bank	**100,000** (ASAP)	100,000
FAO	**20,500**	20,500
UNICEF (PMTCT)	Prevention of Mother to Child Transmission of HIV	
UNIFEM	Includes AIDS in gender activities with media	
WFP	Pay for food for ART patients	
UNHCR	Contributing regionally through support to IDPs, returnees and refugees	
World Vision	Not reported specifically on AIDS; part of TB activities	
TOTAL	**US$ 10,436,051**	**US$ 9,811,603**

There were significant efforts put in place during 2006/7 to meet targets on number of people on ART, number of persons on comprehensive STI management, and number of people accessing VCT services.

The National AIDS Spending Assessment or Country Resource Needs Estimate has not been developed in Somali, however, it is planned to be developed in the future. Up to date there are no "unit costs" of AIDS activities available in the country.

6.3 The Role of the UN in Somali HIV/AIDS National Response

- The UN is a building block to effective response – it has demonstrated strength in acceleration of effective and efficient response in Somali; for there is high commitment to ensure that Somali becomes the first country in Africa to stop the HIV epidemic at an early stage of infection

7.0 MONITORING AND EVALUATION ENVIRONMENT

Key strategic achievements of the Somali M&E system include development of partnerships on M&E, mobilizatioon of M&E resources, establishment of M&E infrastructures, building of core M&E capacities; and development of strategic instruments, tools and strategies using the harmonized M&E Framework and commencement of systematic data collection. M&E data will be utilised in the development of New Strategic Framework in 2008, GFATM round 8 proposal, implementation of BSS+ and ANC Surveillance plan and development of integrated prevention, treatment, care and support (IPTCS) plan.

Table 16 below shows the rating of M&E efforts of the AIDS programme in 2007 and in 2005

Table 16: Rating of M&E efforts of the AIDS programme in 2007 and in 2005

	Poor										Good
	0	1	2	3	4	5	6	7	8	9	10
2007	□	□	□	□	□	□	□	□	□	□	□
2005	□	□	□	□	□	□	□	□	□	□	□

The achievement in the M&E efforts of the AIDS programme shown in the table above has been realised since GFATM grants became operationalised in mid 2005. UNAIDS developed a harmonized M&E Framework but this has yet to gain traction. M&E tools were developed by WHO and UNAIDS but these are yet to be universally used in all facilties. Training of M&E Officers is carried out regularly in the three entities, and has included use of CRIS.

However, the M&E system is still at a crucial stage of development and needs improvement and scale-up. There is need of developing gender indicators on the epidemic and for IPTCS, in order to better direct the response. Also M&E system now needs to refocus on identifying the HIV transmission routes and exposures patterns and groups including the major drivers. [20]

7.1 Technical support for M&E

The following technical support has been provided by partners to ensure the development and implementation of a single and coherent M&E system: i) conducted an M&E needs and capacity assessment; ii) development of harmonized M&E Framework for all partners including the GFATM and DFID; iii) Development of Harmonized data collection tools; iv) establishment of systematic data collection through the AIDS Commissions; v) Capacity building through development of M&E training modules and its implementation; vi) Resource mobilization to strengthen the Human resource capacity to 13 M&E officers at the central and regional level; vii) promotion of CRIS as the central database through the AIDS Commissions; and vii) establishment of

[20] Mid Term Review Report 2007

national M&E Reference Groups to coordinate M&E technical support and implementation of M&E Framework.

7.2 Existing Challenges, constraints and Gaps

The existing mechanisms to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit/Department, are only partially working. This is explained by the sub-recipients not being fully aware of the M&E system and also there are challenges in data transmission.

The data available from the M&E reporting in most instances does not meet the requirements for the UNGASS indicators reporting. There is need to align the M&E reporting to UNGASS indicators requirements.

8.0 CONCLUSIONS

8.1 Key Strategic Considerations and Areas of Focus 2009 – 2013

The Somali HIV Hot Spot Mapping done in 2007 has provided the background for a more intensive BSS+ for most-at-risk groups that will be carried out later in 2008. This BSS+ will be a follow up to mapping of most-at-risk groups and their clients/host communities.

The review of the Strategic Framework for the Prevention and Control of HIV and STIs in Somali Populations (2003-2008) is underway. The review process and development of the new strategic framework, and CHAT review of coordination, will be more inclusive of Somali's in contributions and decision making. The review, BSS+, the second round sero Surveillance Survey (2007), mapping of most-at-risk, among others; will inform the development of the new strategic plan which will in addition address the drivers of the epidemic.

A new M&E framework and costed action plan will be developed in tandem with the development of the new strategic framework. The expected new GFATM resources will fund these Somali AIDS implementation frameworks

The challenge of cross-border vulnerability will be addressed through collaboration of the National Aids Commissions of neighboring countries to jointly respond to HIV vulnerability among mobile populations and the host populations with whom they interact.

The current Strategic Framework on HIV/AIDS and the GFATM resources are not sufficient for the next 5 years and nor are they targeted at addressing these most at risk populations. If the Somali AIDS response is to avert an escalation in prevalence there is an urgent need to energize the current revision of the Strategic Framework (which expires in 2008) and put commensurate resources in place address the drivers of the epidemic. The revised Strategic Framework and resources need to better target most at risk populations, and strengthen health systems to ensure that adequate services can be provided to ensure that the response can be scaled up to meet the Universal Access targets which have been set

The overall goal of the Somali AIDS Response in the coming five years will remain focused on reducing the transmission and halting and reversing the spread of the HIV epidemic in Somali populations by 2015. Priority interventions will focus on addressing two main areas: 1) reducing risk among key populations with high risk behavior and/or in high risk settings; 2) strengthening selected elements of the health systems strengthening to enable effective delivery of HIV related services and interventions. The response will focus on the following four objectives:

- **Research and evidence:** This will focus on strengthening surveillance (biological and behavioral) and operational research among key populations with high risk behaviors and/or in risk settings to guide policy and programming.

- **Improved access to and use of quality comprehensive services:** An essential package of HIV prevention, care and treatment services needs to be more effectively integrated into the health system at primary, secondary and tertiary levels. This requires strengthening of the specific elements of the health system. It includes improving the health information management system, human resource development for delivery of HIV interventions, management and supervision and supply management structures. This component will fill gaps and be complementary to the HSS work supported with grants from the EC, the GFATM for Malaria and other donors. The component will look at strengthening and where necessary expanding services for, STI (incl. syphilis), HIV testing and counseling, post exposure prophylaxis (PEP), sexual and reproductive health, blood safety and availability and use of male condoms. PMTCT + services will be strengthened as part of a larger approach to improve maternal and child health services, including human resource development, and improved supervision. Special approaches to health service delivery for marginalized and most at risk populations to overcome barriers to accessing health services will need to be developed. Well developed behavior change communication efforts will be used to positively influence health care seeking behaviors and to increase uptake of services, especially among key populations. Services must be non-judgmental, confidential, adolescent friendly and free of charge.

- **Reduce vulnerability, stigma and discrimination:** This component will look at increased advocacy and social mobilization to develop community, religious leaders, parents, opinion leaders and service providers' capacity to create a protective environment for most at risk populations. This will ensure that stigma and discrimination among key populations will be reduced and increase their access to information and use of services. This component will also look at increasing the involvement of PLWH into the HIV response and providing support to people who are affected or infected, including children affected by AIDS. Strategies will look at ensuring that key populations are participating in the AIDS response, including most at risk adolescents, and that gender inequality is pro-actively being addressed as a cross cutting issue. Life skills among key populations will be built to reduce vulnerability and risk. Behavior development (and maintenance) communication efforts will underpin the interventions. Strong links will be built to increase the social protection of vulnerable groups. This will include addressing sexual violence, including intimate partner violence which is wide spread.

- **Improved coordination**: This will include improved coordination at National, sub national and importantly with community based partners. It will also look at improved involvement of key populations into the response.

8.2 Epidemiological, population and geographical focus

Interventions will be based on HIV prevalence and tailored to the specific contexts in the three administrative zones. Efforts in Central Southern part of Somalia will have a strong emergency and humanitarian character, including engaging peace keeping forces in HIV prevention, care and treatment efforts. The interventions in the Northern Zones will be more developmentally oriented and with a stronger focus on health systems strengthening - though this will also be endeavored to be achieved in the South - to reach the Universal Access targets. All strategies and interventions will be in line with the

new Strategic Framework on HIV among Somalis and build on previous investments made.

The AIDS response will address the needs of key populations with high risk behaviors and/or living in high risk settings based on HIV background prevalence. This will include women and men who are engaged in commercial and transactional sex, men who have sex with men, adolescents most at risk and especially vulnerable young people, mobile populations (truck drivers, uniformed services, seafarers, and returnees, migrant and seasonal laborers) and internally displaced people. Strategies will be scaled out in phases based on lessons learned, new evidence and strategic information.