The Federal Republic of Somalia

Puntland

Somaliland

National Strategic Plan for the Somali HIV and AIDS response 2015-2019

18th July 2014

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Foreword

The last Strategic Plan (SP) of HIV and AIDS for the Somali response was from 2009 to 2013 and is being used until the new plan is launched. A new National Strategic Plan has therefore been developed to cover the period 2015 to 2019. The Round 8 Global Fund HIV grant comes to an end in December 2014. Following declaration of eligibility by the Global Fund, a new HIV grant for the Somali response is under development for the period 2015 to 2017. A major requirement for the New Funding Model of the Global Fund is a comprehensive costed National Strategic Plan that has been developed with extensive country dialogue.

This Strategic Plan for the Somali AIDS Response 2015 to 2019 defines how we as Somali from all sectors of society and at all levels – are going to respond to HIV and AIDS in the next five years. There has been a shift in the planning paradigm from focusing on service delivery only, to understanding how service delivery efforts will lead to changes in the lives of the targeted audiences, and therefore impact on the epidemic itself. National and zonal priorities have been identified and the plan articulates targets (results) that all stakeholders will collectively contribute to. Gender and human rights are mainstreamed in the implementation, and monitoring and evaluation strategies.

HIV and AIDS remains a major development challenge as much as they are a health and human rights challenges. The planning for HIV and AIDS in the context of the NSP has taken cognizance of the development dimensions of the response and the need to align and harmonize the NSP with other national strategic policy frameworks such as New Deal and the Health Sector Strategic Plan at the national level. At the Global Level, the plan takes cognizance of the UN 2011 Political Declaration on HIV and AIDS, The UNAIDS Investment Framework, the Global Fund New Funding Model and the Gender Checklist developed by UNDP.

The planning of the NSP and the process of identifying national priorities and results has been informed by a wide range of studies and surveys that have provided the evidence required for the results based management of the response. Among the key studies include the Multiple Indicator Cluster Survey (MICS) of 2011, the Youth Behaviour Survey of 2011, the HIV ANC sentinel surveys of 2004, 2007, 2009 and 2011, Spectrum models of Estimates and Projections and the Integrated Bio-behavioural Survey of 2008 among others. The studies and surveys provided insights on the epidemic determinants for women and men, and the trends of new infections. Available data show that infections are not declining. .

The NSP describes results at three levels i.e. impact, outcome and output. These results are linked to key services that will be provided during the five year period. The NSP also provides detailed information on key strategies and priority actions. The operationalisation of the NSP is through the accompanying Zonal Operational Plans which are aligned to the NSP. The AIDS Commissions in collaboration with other development partners will continue to provide technical support to other stakeholders' in-order to ensure effective and efficient implementation of the proposed activities. All partners are urged to review and harmonise their strategic plans with the NSP.

The country dialogue during the development of the NSP was broad and participatory with multisectoral stakeholders. Government departments, civil society, religious leaders, PLHIV and their networks and

development partners among others participated in zonal and Somali wide consultations to conceptualise and develop the SP. This process has set the stage for consolidating the “Three Ones” principle of having one coordinating authority, one strategic plan and one M&E system. The NSP is a living strategy that will be reviewed annually with an extensive mid-term review in 2017. The guiding principles in this document provide us with last values in implementing the NSP.

We believe that the NSP provides a comprehensive strategy for cost-effective management and control of HIV and AIDS. We encourage all our partners to use it as their program and resource mobilization guide to support all HIV and AIDS work in Somalia.

Acknowledgements

The process of conceptualizing and developing the Strategic Plan for the Somali AIDS Response was commissioned during a meeting of stakeholders in Kampala in August 2013 attended by Government representation, AIDS Commissions and the Ministries of Health in collaboration with other stakeholders. The process started in December 2013 and was completed in June 2014. A key feature of the process was the meaningful involvement of all stakeholders. Over 100 people representing government, development partners, civil society, religious leaders, PLHIV and their networks participated in various ways in the development of the strategy. Stakeholder consultations were held at the zonal level with stake holders convening at Mogadishu and Baidoa for South Central Zone, at Garowe for Puntland. Subsequently, a validation workshop that brought together all key stakeholders from the 3 zones was held in Kampala.

We are grateful to all the development partners who provided financial and technical support. In particular, special appreciation goes to the Joint United Nations Team on AIDS (JUNTA) under the coordination of UNAIDS and the Global Fund to fight HIV/AIDS, Tuberculosis and Malaria (GFATM) without whose support the development of this strategy would not have been possible.

Special appreciation goes to the AIDS commission staff for organizing zonal level consultations. This was valuable in ensuring the NSP was comprehensive and represented the views of all stakeholders. The zonal consultations were critical in setting the stage for the national validation of the SP and operational plans.

Finally, we are grateful to all consultants for their dedicated effort during the development of the NSP.

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BCC	Behavior Change Communication
BMI	Body Mass Index
CIA	Central Intelligence Agency (CIA)
CMR	Clinical Management of Rape
CPT	Co-trimoxazole
CSW	Commercial Sex Worker
CEDAW	the Committee on the Elimination of Discrimination against Women
DOTS	Directly Observed Treatment (short course)
EID	Early Infant Diagnosis
EPP	Estimation and Projection Package
EPHS	Essential Package of Health Services (EPHS)
FSW	Female Sex Worker
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HSSP	Health Sector Strategic Plan
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
IBBS	Integrated Biological and Behavioral Survey
IPTCS	Integrated Prevention, Treatment, Care and Support
IEC	Information, Education and Communication
INH	Isoniazid
IPT	Isoniazid Preventive Therapy
JUNTA	Joint UN Team on HIV and AIDS
KABP	Knowledge Attitudes Behavior Practices
KAP	Key Affected Populations
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MDR-TB	Multi-Drug Resistance Tuberculosis
MICS	Multi-Indicator Cluster Survey
MIPA	Meaningful Involvement of People Living with HIV and AIDS
MoT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
MTR	Mid-Term Review

NGO	Non-Governmental Organization
NSP	National Strategic Plan
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counseling
PL	Puntland
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Services International
PwP	Prevention with Positives
SBCC	Social and Behavior Change Communication
SC	South Central
SL	Somaliland
SOPs	Standard Operating Procedures
SPA	Service Provision Assessment
SP	Strategic Plan
STI	Sexually Transmitted Infection
TB	Tuberculosis
UA	Universal Access
UN	United Nations
UNAIDS	Joint United Nations Program on HIV and AIDS
UNESCO	United Nations Educational, Science and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VAW/G	Violence Against Women and Girls
VL	Viral Load
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organisation
ZAC	Zonal AIDS Commission

Executive Summary

The Somali HIV and AIDS response has been guided by a strategic framework for 2008 to 2013 and funded majorly from the Round 8 Global Fund for HIV/AIDS, Tuberculosis and Malaria. The Somali republic has recently developed a Somali Compact, known as the New Deal that needs to be operationalized. As the strategic framework for the HIV and AIDS response expired and the major funding source from the Global Round 8 is due to end in December 2014, it was imperative that new planning instruments for the Somali HIV and AIDS response be prepared to guide the next phase ranging from 2015 to 2019. The new Strategic Plan would also be useful for resource mobilization as well as operationalizing the Somali Compact. It has also been aligned to the global commitments of the Somali republic.

Development of the Strategic Plan has been very consultative and participatory with active representation of government, development partners, civil society, religious leaders, PLHIV and their networks participated in various ways in the development of the strategy. Stakeholder consultations were held at the zonal and a validation was held during which strategic actions were prioritized. When compared to the previous strategic framework 2008 to 2013, there has been a paradigm shift in the development of the new strategy with emphasis on defined results, costing of strategic actions and prioritization. A dedicated prioritization process was undertaken and key priority strategic actions were listed.

The strategy has taken into account the federal and decentralized context providing operational plans for each of the zones. The first part of the strategy describes the profile of the Somali republic from a socio-economic and HIV epidemiological point of view. The 2012 Human Development Report estimates per capita GDP at US$284 - against a sub-Saharan Africa average of US$1,300 per capita. Nearly 75% of females between 15-24 years are illiterate, one of the world's highest levels of gender disparity. According to World Bank, Somali's health indicators are also among the worst in Africa. Access to health services is poor even by Sub-Saharan standards. Life expectancy at birth is 51 years and infant mortality rates are estimated to be 108 deaths per 1,000 live births i.e. one in every ten children dies in the first year (UNICEF).

The number of people living with HIV is estimated at 31,000 in 2013 (UNAIDS). The adult HIV prevalence rate in 2013 is 0.5%. However, integrated biobehaviour surveys conducted in Hargeisa found HIV prevalence of approximately 5% among sex workers in 2008 and 2014. The annual number of new infections is not reducing remaining at around 3,300 new infections since 2010 indicating that prevention efforts are not bearing impact. Similarly, annual AIDS deaths have remained at approximately 2,500 per year.

HIV testing rates amongst TB patients across all zones has increased. The percentage of TB patients tested for HIV in Somalia by zone in 2013 was 77.7% in Somaliland, 61.9% in Puntland and 59.2% in South Central.

The second part reviews the response during the last strategic framework. There was a three-fold increase in ART coverage from 569 in 2009 to 1,748 in 2013. However, there is still low coverage of ART (17% in adults and 10% in children) using the national eligibility criteria in 2013 translating to 6% adults and children receiving ART as a percentage of the total HIV population. At the outcome level, the ART program has achieved commendable retention rates linked to adherence and survival with 81.4% and 70.6% still alive on treatment at 12 and 24 months respectively.

There are has also been modest progress in HIV prevention. Integrated Bio-Behavioural Surveys of female sex workers conducted in 2008 and repeated in 2014 in Hargeisa revealed that nearly ten times (21.3%) more women had an HIV test in the last 12 months and received the results compared with in 2008 (2.4%). However, Only 9% of mothers received ARVs for PMTCT in 2013. Due to low coverage of PMTCT, the mother to child transmission rate (modelled) is estimated at 34% in 2013.

Stigma and discrimination is prevalent and impedes access to and utilization of prevention, treatment and care and support services for all Somalis, particularly those residing in rural areas and Key Affected Populations. Sexual and Gender based violence is also reported to be high.

The monitoring and the evaluation of the response still has challenges with regard to adequacy of skills of HIV program implementers in M&E with only 46% providing quality reports. In addition, most reported data does not have readily available sex disaggregation.

The response has been dependent on Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for over 85% of its HIV and AIDS related expenditure. Therefore the need to diversify funding sources including increasing domestic contribution is emphasized in the current NSP.

The third part of the strategy outlines the themes, strategies and actions for the 5 year period 2015 to 2019. Key strategic actions include: 1) strategic information generation to better target HIV interventions; 2) scale up of ART and PMTCT; 3) addressing the social barriers to prevention and treatment services and in particular stigma and discrimination and sexual and gender based violence; The NSP has identified gender and human rights strategic and prioritised interventions; and 4) strengthening Monitoring and Evaluation as well as Coordination and Management of the HIV and AIDS response.

Insecurity that affects large parts of the Somali republic is a great challenge to service delivery including for HIV and AIDS. This is compounded by the high transaction costs of program implementation. Mitigation measures for these risks are outlined in the NSP.

The total cost of the response for the 5 years (2015 to 2019) is estimated at US$ 57,893,235. Of these, the most (53%) is allocated to treatment, care and support.

1. Introduction

This document describes the Somali national strategy to respond to the continuing challenge of HIV and AIDS over the next five years (2015-2019). It builds on the achievements and lessons learnt from the implementation of the strategic framework for the Somali AIDS response 2009-2013.

Purpose of the National Strategic Plan (NSP)

The purpose of the National Strategic Plan for the Somali HIV and AIDS response 2015-2019 is to:

- Articulate a strategic framework for the implementation of the multi-sectoral HIV and AIDS response. It is based on the concept of the "Three Ones" principle of having one strategic framework, one coordinating authority, and one monitoring and evaluation framework;
- Identify and articulate priorities and results for the multi-sectoral HIV and AIDS response;
- Enable decentralised planning and implementation framework where zones and communities identify their strategic niche, design and implement appropriate evidence based and results focused interventions that contribute to results (targets). All stakeholders are expected to develop and align their HIV and AIDS strategic operational plans to the SP; and
- Provide a resource mobilisation tool for the HIV and AIDS response.

The content of the NSP was informed by an analysis of the current situation and epidemic trends and inputs gathered in consultations with a wide range of stakeholders. The stakeholder consultations included specially convened workshops in Baidoa, Garowe and Hargeisa that drew on the perspectives of the zonal AIDS commissions, zonal ministries of health, PLHIV, civil society and technical partners. The list of participants that attended these workshops is appended as Annex 1. Emerging ideas were tested at the consultations and refined accordingly. Subsequently, a validation workshop that brought together all key stakeholders from the 3 zones was held in Kampala (Annex 2).

Background Information

The National Strategic Plan for the Somali HIV and AIDS response 2015-2019 is a policy framework to guide all zones as to which HIV and AIDS programs they need to implement, for which target populations, in order to achieve which results. The NSP is a successor to the strategic framework for the Somali AIDS response 2009-2013.

The previous framework was not costed and did not articulate expected results. The focus of the SP 2015-19 is on achieving a set of quantifiable results – from service coverage targets to be achieved by zones and programs, to those outcomes and impacts that need to be evident in society as a result of programs implemented. The NSP has identified gender and human rights strategic and prioritised interventions.

The Country Context

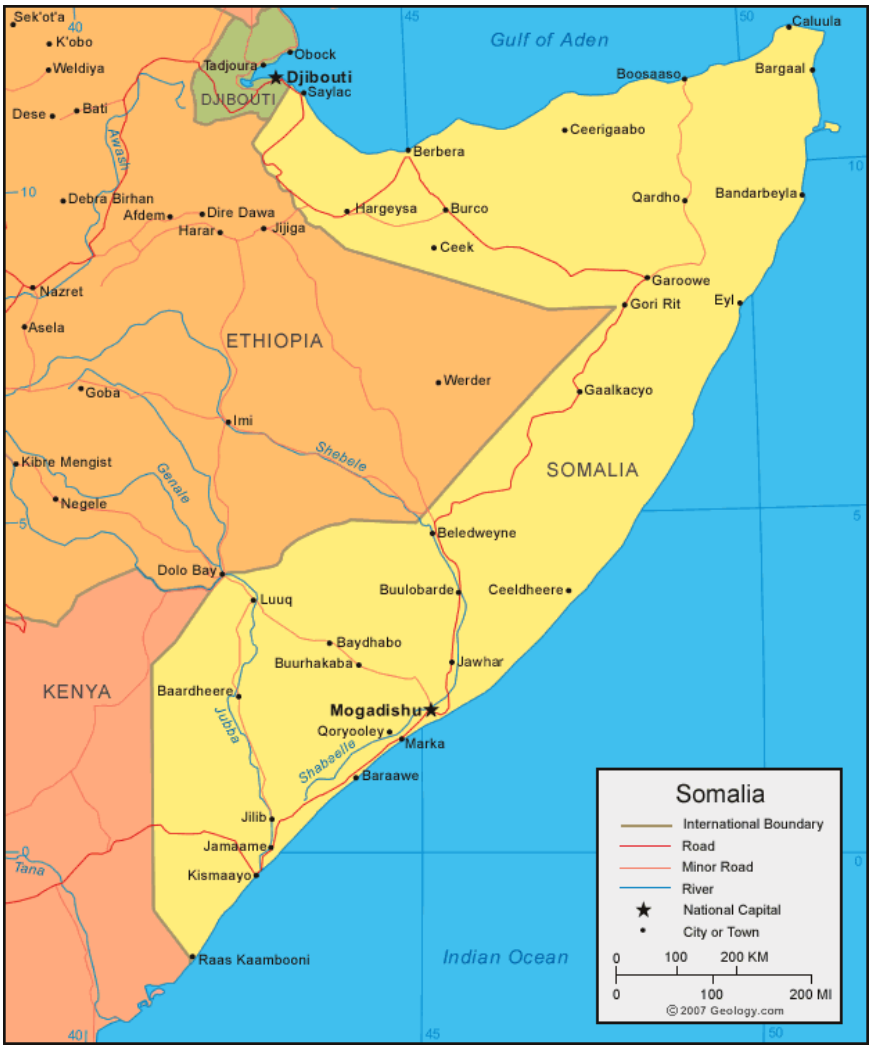
The Somali Republic is situated in the most eastern part of the Africa continent with what is commonly referred to as the "Horn of Africa" and has a surface area of 637,540 square kilometers (Figure 1). It is divided into 3 zones; South Central, Puntland and Somaliland. The total population is estimated to be 9, 331,000 according to a Somalia situation report for May to July 2013 by WHO. It is estimated 34% of the

population lives urban centres and that the urban population is rising at a rate of 5 to 8% per year. Forty four percent (44%) of the population is under the age of 15 years and with 2.6% of the population over the age of 65 (CIA World Factbook 2013).

Out of 170 countries, Somalia is among the five least developed as measured by the 2012 Human Development Index. The 2012 Human Development Report estimates per capita GDP at US$284 - against a sub-Saharan Africa average of US$1,300 per capita. Nearly 75% of females between 15-24 years are illiterate, one of the world's highest levels of gender disparity.

According to World Bank, Somali's health indicators are also among the worst in Africa. Access to health services is poor even by Sub-Saharan standards especially for areas out of the main towns and away from the main roads. Life expectancy at birth is 51 years and infant mortality rates are estimated to be 108 deaths per 1,000 live births i.e. one in every ten children dies in the first year (UNICEF).

Figure 1: Map of the Somali republic



The Somali Republic is emerging from fragility and the political reconstruction process and is being guided by the New Deal principles of fragile states that was agreed in Busan in 2011. A Somali compact has been adopted to address the political and socio-economic development process. The compact is in line with targets and commitments of the 2011 United Nations General Assembly Political Declaration on HIV/AIDS. In this regard, the compact aims at promoting the equitable distribution and access to basic services through the use of clear service delivery mechanisms and standards and addressing gender issues. It promotes a more gender responsive and accessible justice system that protects the human rights of all and provides for key priority laws in the legal framework, including the re-organisation of the judiciary and alignment with the Constitution and international standards.

A Health Sector Strategic Plan (HSSP) 2013-2016 has been developed and is being implemented using an Essential Package of Health Services (EPHS) that integrates HIV and AIDS into health services delivery.

While developing the strategy insecurity context was taken into account. It is expected that access should gradually improve and allow for increased access especially in the South Central zone. Related to insecurity, geopolitical context and the expanse of the country, transactional costs tend to be very high and this was reflected in the development of the strategy. Health systems were also severely affected by the long standing insecurity with HIV program units only being established over the last strategic framework. This has implications on the implementation and management capacity and therefore capacity building is key in the strategy.

Guiding principles

The strategy and its subsequent implementation will be guided by the following principles:

- Meaningful involvement of women and men Living with HIV (MIPA),
- Promotion and protection of human rights, alignment and harmonisation with the Somali compact, Health Sector Strategic Plan (HSSP) and other national and zonal development plans,
- Equity,
- Gender equity
- “Three ones principle”;
- Focusing on measurable results; and
- Grounding proposed actions in evidence and prioritizing what is more efficient and effective.
- Value for money
- Sustainability

Overview of the document

The Strategy is presented in seven parts that are preceded by this introduction (Part 1). Part 2 provides a situational assessment based on the most update to date epidemiological analysis of HIV and AIDS in the country. Part 3 provides an assessment of the Somali response to HIV and AIDS to date including achievements, challenges and key gaps in the response to HIV and AIDS to date. Part 4 constitutes the core of the strategy. It outlines the priority areas, strategic objectives for each priority area and specifies strategic actions for each objective. Details on expected results are also provided. Part 5 identifies key risks that may compromise the implementation of the strategic framework and articulates measures to mitigate those risks. Part 6 describes how monitoring and evaluation of this strategic framework will be undertaken, as well as providing information on the impact, outcome and output

level indicators that will be used to measure progress, the targets to be achieved and the systems that will be used to ensure data are collected. Part 7 provides a description of how the national response will be managed and coordinated. Part 8 summarizes costing information and presents the overall budget of the strategy. Part 9 lists strategic actions of top priority which should be supported at all costs that were derived as a consensus by stakeholders.

2. Overview of the Somali HIV and AIDS epidemic

The Somali HIV epidemic is heterogeneous and therefore in order to design informed, prioritized, and effective responses, it necessitated an understanding of the epidemic's diversity between and within zones and particular populations. It is pertinent to note that some of the available epidemiological data is outdated and must therefore be interpreted with some caution. Investments to address data gaps and strengthen information systems are a priority of this strategy. The following section presents a characterization of Somalia's HIV and AIDS epidemic based on the limited epidemiological data available. Where available, data has been disaggregated by zone and by gender to the extent possible.

2.1 HIV prevalence and Incidence in Somalia

HIV prevalence

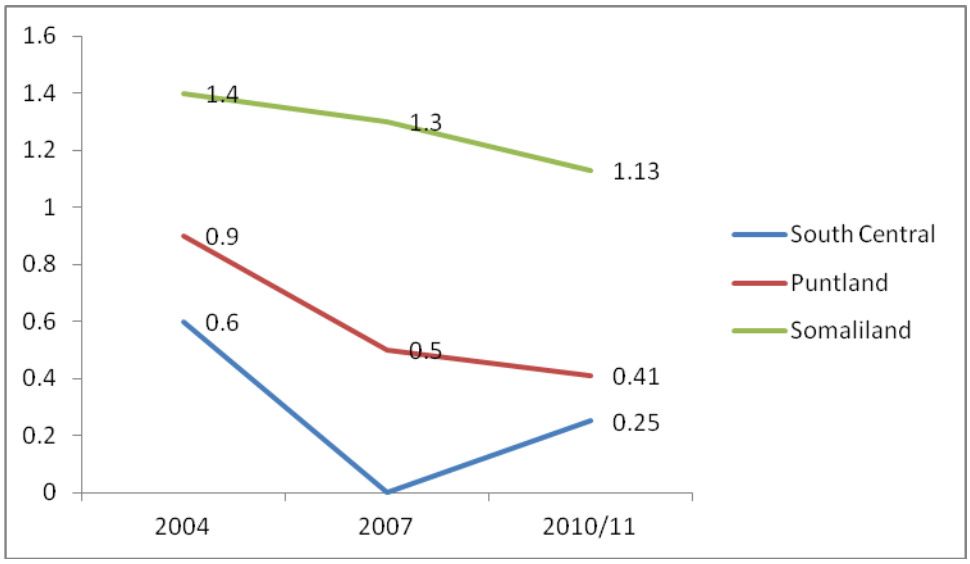
The Somali HIV and AIDS epidemic is characterized as geographically heterogeneous: low level in Puntland (PL) and South Central (SC), and generalised in Somaliland (SL) with higher prevalence rates reported in locations of significant trade driven mobility across all zones. The most recent rounds (2011 in the case of South Central and 2010 in the cases of Puntland and Somaliland) of Ante Natal Care (ANC) sentinel surveillance found median HIV prevalence rates of 1.13% in Somaliland and 0.41% and 0.25% in Puntland and South Central respectively[1]. Estimates of adult (15-49 years) HIV prevalence in 2012 in the general population using the UNAIDS Spectrum model was 0.54% for all zones (0.94 for Somaliland; 0.42 for South Central; and 0.55 for Puntland).

Although it would appear that HIV prevalence rates among ANC attendees declined between the period 2004 and 2010/11[2] as Figure 2 suggests, this reduction over time is not statistically significant. It is been suggested that the relatively higher HIV prevalence in Somaliland (three times higher than Puntland) may be related to substantial trade driven mobility and interaction with neighboring countries such as Kenya, Ethiopia and Djibouti which have higher HIV prevalence rates of ranging from 3 to 7 percent.

[1]Due to the low number of sentinel sites that participated in the survey (18 sites nationally: 8 in SC, 4 in PL and 6 in Somaliland), the rates reported need to be read with caution with respect to representativeness. There exists scope to increase the number of participating sites in future rounds

[2] Note that no survey was conducted in South Central in 2007

Figure 2: Median HIV prevalence rates among ANC attendees in Somalia by zone 2004-2007



Source: 2004, 2007 and 2010/2011 ANC survey reports.

To date, there has been no population based integrated bio-behavioral surveillance undertaken in Somalia. Indeed much of the surveillance undertaken has focused on knowledge, behaviors and practices. It is thus not possible to link the status or outcomes of various behaviors to the impact level indicator of HIV prevalence or to triangulate the sentinel biological data.

HIV prevalence amongst Key Affected Populations (KAPs)

Limited bio-behavioral surveillance of higher-risk (and often invisible) populations (called Key Affected Populations throughout this strategy document) has been conducted in recent years in Somalia. The last such survey conducted amongst Female Sex Workers (FSW) in 2008 in Hargeisa (Somaliland) reported prevalence rates of 5.2%. A second round of the survey in Hargeisa was recently completed (2014). In light of the fact that interventions to date focusing on FSW have not achieved sufficient coverage, intensity and duration to have public health impact, it is not surprising to find that preliminary findings from the second round of the survey indicate that that HIV prevalence rates have not changed from those reported in 2008. There have been no other epidemiological surveys conducted amongst the other KAPS prioritized and identified in the strategic framework 2009-2013[3].

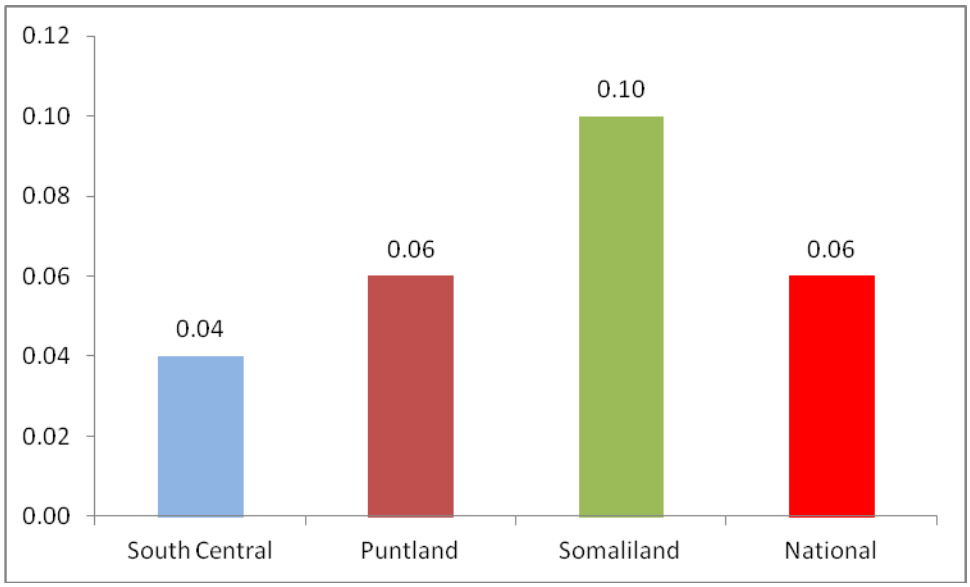
HIV incidence

It is estimated that in 2012, approximately 3, 351 new infections occurred in adults and children. Of these, 2, 616 were adults (aged 15 years plus) (1,313 females and 1,303 males) with an adult (15-49 years) incidence of 0.06% (Figure 3) and 735 new infections among children (aged 0-14 years. It is estimated that there is no significant difference in incidence among the sexes. However, sero-behavioural surveys among men are required to obtain a more precise sex disaggregation of incidence. Within these overall estimates however, South Central zone had the highest number of adult new

[3] The strategic framework identified the following additional KAPS: Prisoners, street children, uniformed personnel, militia, and mobile populations such as truckers, seafarers, port workers, internally displaced people, refugees and returnees

infections (1,434) followed by Somaliland (980). Puntland had the lowest estimate of 278 new infections. However, due to the populations of the zones, Somaliland had the highest adult HIV incidence of 0.1%, followed by Puntland with 0.06% and South Central with 0.04% (Figure 3).

Figure 3: HIV incidence (Adults 15-49 years) in Somalia by zone (2012)



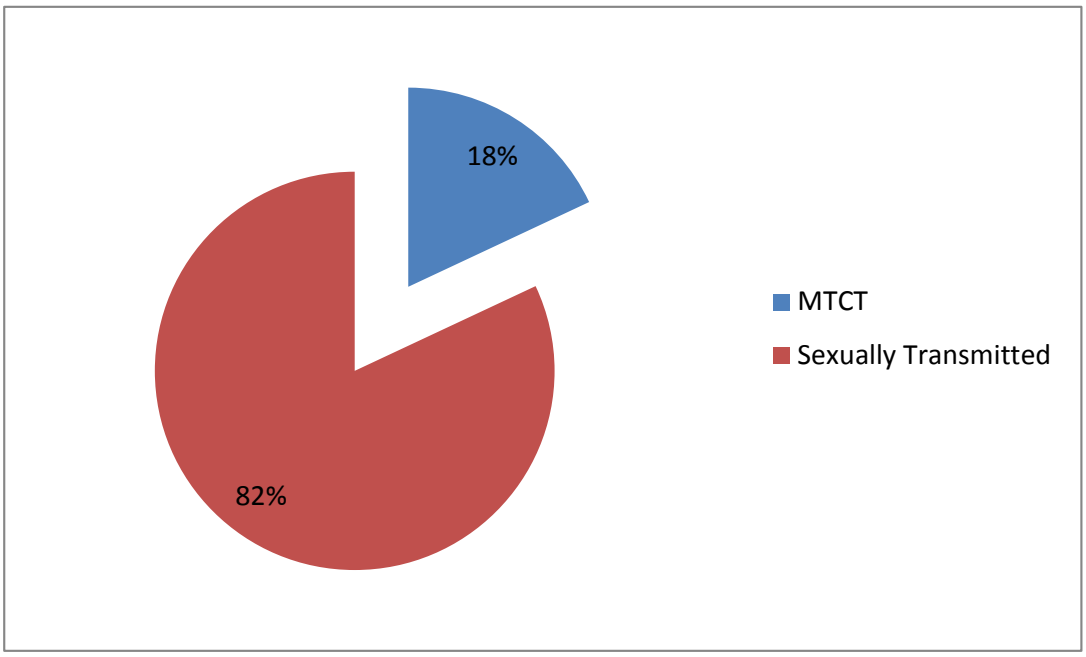
Source: Spectrum estimates for Somalia, 2013.

Modes of transmission (MOT)

In the absence of Modes of Transmission (MOT) and further studies, it is suggested that heterosexual transmission accounts for the majority of transmission of HIV in three zones, followed by perinatal transmission[4]. It is unclear as to the extent blood borne transmission of HIV as it became apparent during the development of this strategy that not all health facilities in the three zones consistently screen transfused blood for HIV prior to its use. In addition, the role of injecting drug use in HIV transmission is also unclear as no bio-behavioural assessments have been done among this population in Somalia, although a recent rapid assessment in Mogadishu reported the presence of injecting drug use amongst key affected populations that were the subject of the study[5]. From Spectrum modelling, it is estimated that 18% of the new infections were transmitted by mother to child transmission (MTCT) and the rest (82%) were most probably obtained sexually (Figure 4).

[4] Although there is no specific evidence to support this assertion
[5] IOM. HIV Rapid assessment among key and vulnerable populations in Mogadishu, 2013.

Figure 4: Modes of Transmission of HIV new infections, 2013

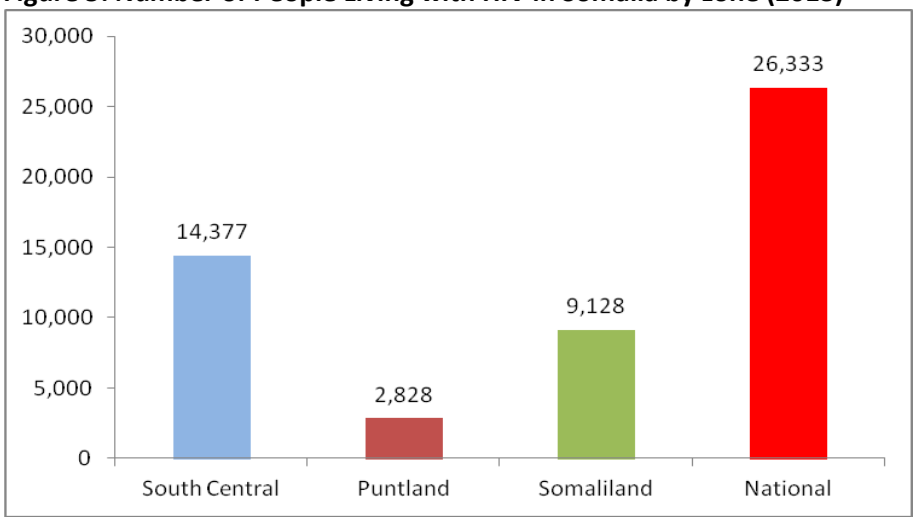


Source: Program reports/EPP Spectrum estimates (2013)

2.3 Burden of HIV and AIDS in Somalia

At the end of 2013, it was estimated that approximately 31,000 adults and children were living with HIV and AIDS in Somalia of whom 51% were women and 49% were men[6]. Figure 5 shows the distribution of the HIV burden in Somalia.

Figure 5: Number of People Living with HIV in Somalia by zone (2013)



Source: Spectrum estimates for Somalia, 2013.

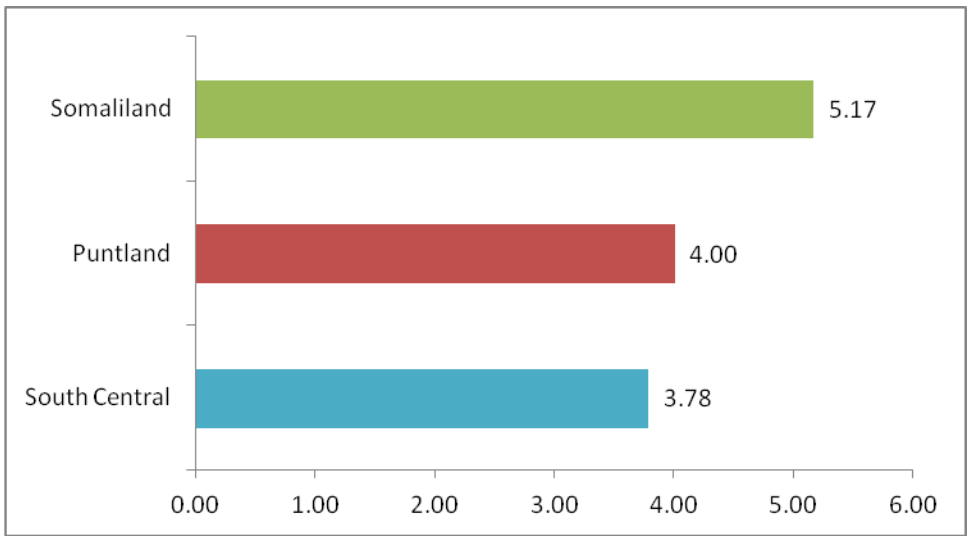
[6] The difference between the sexes is not statistically significant

As can be seen from Figure 5, the South Central zone accounts for a majority of the estimated burden of people living with HIV in Somalia (55%) followed by Somaliland (34%). Puntland (11%) has the lowest burden of HIV in the country.

2.4 HIV and TB co-infection

In Somalia, tuberculosis (TB) is a serious public health problem. The estimated incidence in 2011 was 300 cases per 100,000 persons, but fewer than half of the estimated cases are actually detected. Compared to other countries in the region, HIV-TB co-infection is estimated to be low and varies from 1 in 25 in South Central and Puntland and 1 in 20 in Somaliland (Figure 6).

Figure 6: Percentage of HIV patients with TB in Somalia by zone (2013)



Source: WHO Somalia reports to the Global Fund (2013)

2.5 Behavioural factors likely to contribute to HIV risk transmission in Somalia

One of the key limitations of behavioural data in Somalia is that much of the behavioural data is not linked to biological data, thus limiting the effective utility of the behavioural data in extrapolating the extent to which behavioural factors contribute to HIV risk transmission in the country. In addition, much of the available behavioural data is outdated, although recently, a rapid assessment was conducted in Mogadishu with IOM support[7]. The only bio-behavioural surveillance undertaken to date has been among sex workers in Somaliland in 2008 and in early 2014 during the period in which this strategy was being developed.

Preliminary data from the 2014 round of the survey amongst sex workers in Somaliland found that lack of comprehensive knowledge amongst them to be very low, with only 11.1% of those surveyed able to correctly identify ways of preventing transmission and reject major misconceptions. From the survey in Somaliland SGBV is an important behavioural factor with reports of forced sex.

The 2011 Multi-cluster Indicator survey (MICS), showed that comprehensive knowledge of HIV remains low with only 7% of young women aged 15-24 in Somaliland and only 10% in Puntland reporting comprehensive knowledge about HIV. No MICS survey was undertaken in South Central, but a 2011

[7] IOM. HIV Rapid assessment among key and vulnerable populations in Mogadishu, 2013.

youth behavioural survey indicates even lower levels of comprehensive knowledge with only 5.4% of males and 4.3% of females' aged 15-24 reporting comprehensive knowledge of HIV.

Somalia is a conservative society with strong religious beliefs that discourage the use of condoms. In addition, condoms are not widely availability. It is therefore not surprising given their limited availability as well as accessibility that condom use is low both in the general population as well as among key affected populations such as sex workers, truckers, fishermen, port workers and migrants. Preliminary data from the 2014 round of the bio-behavioural survey amongst sex workers in Somaliland indicate that only 59.4% of had ever heard of a condom, whilst only 34.6 % reported condom use at last sex. In the rapid assessment undertaken in Mogadishu, only 5% of truckers, 10% of fishermen and 7% of port workers reported having ever used male condoms. Although the sample size was low[8], only 35% of young men aged 15-24 in the Youth Behavioural Survey undertaken in 2012 who had had sexual intercourse with more than one partner in the previous 12 months, reported using condoms during their last sexual intercourse.

2.6 Structural barriers that impede access to HIV prevention, treatment and care services

As the epidemiological analysis of the HIV epidemic in Somalia has shown, Key affected populations, especially sex workers appear to be disproportionately affected by HIV and are susceptible to the adverse impacts of human rights barriers. As is the case elsewhere in many parts of Africa and the Middle East, sex work is criminalized in all 3 zones. Thus sex workers have been driven underground and avoid utilizing HIV prevention, treatment and care services in the country for fear of losing their livelihood and being imprisoned. The criminalization of sex work constitutes a serious constraint to an effective HIV response among this population.

Similarly as mentioned in section 2.3 above, Somalia is a conservative society with a strong religious culture that hinder condom promotion and distribution efforts in the country as consequence, access to condoms is severely constrained.

An estimated 80% of Somali's do not have access to basic health care and the delivery system for health care services is highly fragmented with public health service provision primarily concentrated in urban and insecure areas. It is also suggested that women would prefer female doctors and these are few. Indeed, the rate of access of health services by the urban population is 50% versus 15% for the rural population. Lack of accessibility to health services and infrastructure is thus a significant impediment to an effective response to HIV prevention, treatment and care services in Somalia.

Insecurity and instability as well as the high cost of program implementation in Somalia are other important barriers to access. A recent gender assessment of the Somali HIV response acknowledges sexual gender based violence as prevalent and therefore young girls are an important high risk group.

3. Assessment of the Somali response to HIV and AIDS (2009-2013)

The Somali response to HIV and AIDS has been guided by the strategic framework for the Somali AIDS response 2009-2013. The framework articulated four priority areas- prevention of new infections; treatment, care and support; strengthening monitoring and evaluation (M&E); and effective management and coordination of the HIV and AIDS response.

[8] 14/22

It is important to note that a major limitation of the strategic framework for 2009 to 2013 was that it did not articulate targets and expected results in each of the priority areas severely impeding the ability to objectively and transparently assess the response and its impact to date[9]. Secondly, it was not costed and therefore it was difficult to track expenditure against planned costs. Nevertheless, despite these limitations, the following section presents a summary of the results achieved, key challenges and gaps in the response to date. The section also articulates the policy and legal environment in which the national response is currently being implemented and managed.

There were some key achievements were realized under the last strategic framework through funding mainly sourced from the Global Fund Round 8. However, generally all responses were challenged by access issues due to insecurity and high transaction costs.

3.1 Prevention of new infections

The strategic framework for the Somali AIDS response 2009-2013 called for the following interventions to reduce new HIV infections: Social and Behavior Change Communication (SBCC), Prevention of Mother to Child Transmission (PMTCT), comprehensive condom programming, increasing availability and access to HIV testing and counseling (HTC), increasing access to management of Sexually Transmitted Infections (STIs) and improving blood safety, practice of universal precautions and post exposure prophylaxis. Available data from the 2013 HIV estimates using EPP/Spectrum suggests that annual HIV incidence rates have remained relatively stable across all 3 zones during the period in which the strategic framework was to be implemented.

The following section presents a summary of the results achieved, key challenges and gaps in the prevention response to date. Generally, further research is required for an effective prevention strategy to know which actions will best reduce new infections.

3.1.1 Social and Behavior Change Communication (SBCC)

A number of social and behavior change communication interventions targeting sex workers and other Key Affected Populations (KAPs), young people as well as the general population were implemented over the period of the current strategic framework by various actors primarily with funding from the Global Fund for HIV, TB and Malaria. These included community conversations in "hot spots" and the use of a BCC Toolkit to work with some high risk groups e.g. Truck drivers and sex workers. Prevention with positives (PwP) has been done with Talawadag Network of People Living with HIV rolling out Community Conversations on HIV in hotspots and training on 'Knowing Your Rights' which included topics such as Healthy Living and Leadership Training for PLHIV in all zones. School clubs for 10 secondary schools and 5 universities have been supported to organize HIV and AIDS debates on frequently asked questions on HIV. Twenty Community Owned Resource Persons were trained as trainers of trainers of community reproductive healths including HIV and 600 peer educators from Y-Peer network in Somalia have been trained on the Youth Peer education model that addresses HIV.

Key challenges and gaps in SBCC

- Although no evaluation has to date been undertaken to examine the efficacy and effectiveness of these interventions, analysis of program reports suggests that current and past SBCC interventions have not achieved sufficient coverage, intensity and duration to have public health impact.

[9] Neither the results framework (noted in the strategic framework) nor a Monitoring and Evaluation (M & E) framework were ever developed.

- There has been limited integration of SBCC interventions with other biomedical interventions such as HIV testing and counselling (HTC) and condom promotion and distribution. This is supported by preliminary results from the 2014 round of the IBBS survey in which only 29.5% of sex workers reported ever having an HIV test and whilst only 26.5% of them reported having had an HIV test in the last 12 months. Amongst key affected populations, similar results are reported, with only 10% of truckers, 36% of fishermen and 16% of port workers reporting having ever had an HIV test in the last 12 months in the rapid assessment undertaken in Mogadishu.
- Some of the current SBCC interventions have targeted the general population across all zones, whilst the limited bio-behavioural surveillance suggests that emphasis of SBCC interventions should primarily be focused on sex workers and their sexual partners such as truck drivers and uniformed personnel; Although there have been efforts to raise awareness of HIV, as previously noted in section 2.2 of this report, comprehensive knowledge of HIV remains low.
- HIV related stigma still deters many Somalis from utilizing prevention services or from being tested for HIV, severely limiting the efficacy of current SBCC interventions10; and
- Limited community outreach work to help increase awareness and uptake of HIV services
- Finally, prevention with positives (PwP) interventions were limited even though the evidence indicates that the adoption of healthy living and reduction in risk behaviours among HIV positive people leads to a substantial improvement in the quality of life and reduction in HIV transmission rates.
- HIV and AIDS and life skills education is not institutionalised

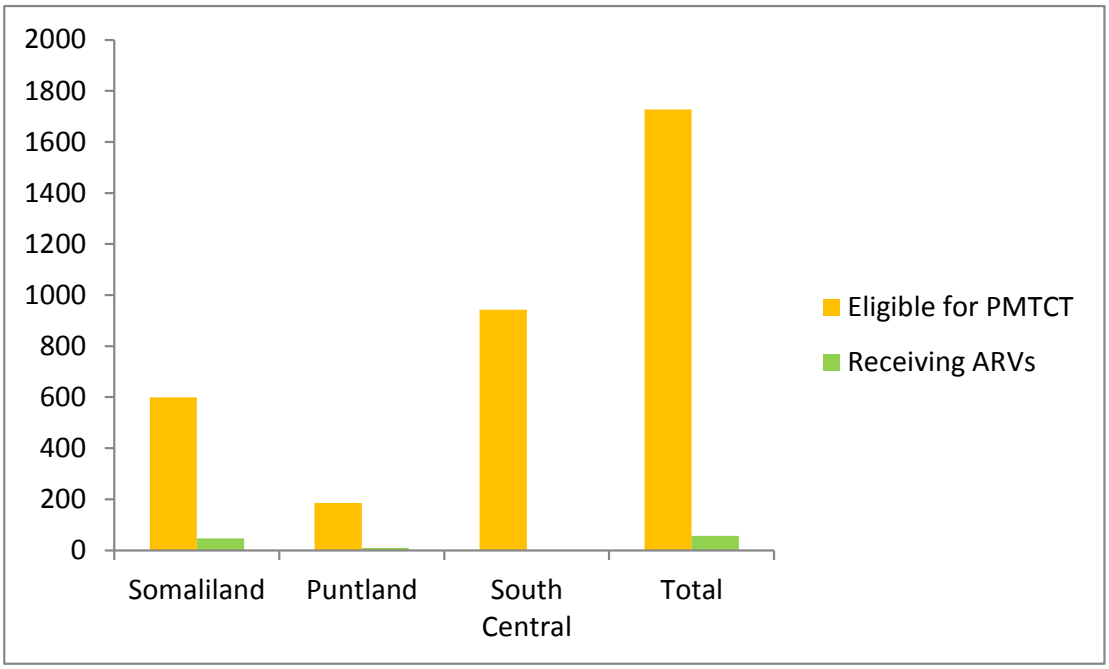
3.1.2 Prevention of Mother to child Transmission (PMTCT)

Virtually all HIV-infected children acquire the infection through MTCT, which can occur during pregnancy, labour and delivery, or through breastfeeding. In the absence of any intervention an estimated 15-35% of mothers with HIV infection will transmit the infection during pregnancy and delivery, and breastfeeding by an infected mother increases the risk by a further 5-20% to a total of 20-45%. Without treatment, most HIV-infected children experience severe morbidity and early death.

Access to services for preventing MTCT in Somalia only began to be provided in late 2010 in Somaliland and South Central and early 2011 in Puntland. Thus the provision of PMTCT services is still at a nascent stage with only 34 health facilities (8 in South central, 6 in Puntland and 20 in Somaliland) providing the full package of PMTCT services at the end of 2012. Health workers received capacity building on PMTCT.

[10] Only 9% of women aged 15-49 in Puntland and 8% in Somaliland expressed accepting attitudes towards PLHIV in the 2011 MICS survey.

Figure 7: Estimated coverage of PMTCT services in Somalia by zone (2013)



Source: Program reports/ Spectrum estimates (2013)

As Figure 7 indicates, with an estimated need of 1,728 for PMTCT at the end of 2013, only 56 (3.2%) had received ARVs. Due to low coverage of PMTCT, the mother to child transmission rate (modelled) is estimated at 34% in 2014.

Key challenges and gaps in the provision of PMTCT services

- Knowledge and awareness of PMTCT among Somali women is low as results from the 2011 round of the MICS indicate, with only 51% of women of reproductive age surveyed in Somaliland and only 44% in Puntland correctly able to identify all three means of mother to child transmission;
- Limited community outreach work to help increase awareness and uptake of PMTCT services
- In 2012, of the 39,543 women attending ANC services in facilities offering PMTCT services in Somaliland, only 9,101 (23%) were tested for HIV. In Puntland, during the same period, of the 10,936 attending ANC services in facilities offering PMTCT services only 4,737 (43%) were tested for HIV. In south central, of the 20,783 ANC attendees, only 8,171 (39%) were tested for HIV. These data indicate that HIV testing and counselling is a key constraint to improving coverage of PMTCT services in Somalia;
- In addition, the 2011 MICS reveals that ANC attendance by eligible Somali women is low, with less than 25% reporting receiving ANC services at least once by skilled personnel in both Puntland and Somaliland;
- As with the provision of SBCC interventions, pervasive HIV related stigma deters many Somali women from being tested for HIV; and
- As stated earlier only 34 health facilities across the three zones offer PMTCT services, limiting availability of services to those eligible women that may require them.
- Lack of integration with Reproductive, Neonatal, Mother and Child Health Services.

3.1.3 Comprehensive condom programming

The strategic framework 2008 to 2013 proposed the following actions in order to ensure comprehensive condom programming in Somalia: condom promotion and distribution through public sector and social marketing among young men and women, mobile and cross border populations and KAPs and operational research to explore and document community perceptions, identify gaps in knowledge, attitudes, and skills, and develop strategies to increase the correct and consistent use of condoms.

Although investments for condom promotion and distribution were made available from the Global Fund grant, the distribution of condoms and their promotion through the public sector was met with severe cultural and religious impediments in all three zones and presented a challenge to the implementation of integrated interventions. However, condoms appear to be available in private pharmacies as reported by Population Services International (PSI) in an assessment conducted in 2010. Due to the limited availability of condoms, pervasive cultural and religious impediments, it is therefore not surprising to note that only 37% of young people surveyed in the Youth Behavioral Survey (2012) reported that they were able to access condoms when they required them. In addition in the same survey, only 22% of young people reported using condoms at last sex act. In the survey conducted among sex workers in Somaliland in 2008, only 24% of sex workers reported using a condom in their last high risk sexual encounter. There is no data available on condom use among other KAPs identified in the strategic framework

Key challenges and gaps in comprehensive condom programming;

- Severely limited accessibility, affordability, availability (condoms are primarily found in the private sector with little or no condoms available in public health facilities) and utilization of condoms for both the general population and especially amongst Key Affected Populations (KAPS);
- There are no approaches for promoting condom use among PLHIV enrolled in Pre-ART and ART care;
- Pervasive stigma associated with use of condoms; and
- Strong cultural and religious barriers

3.1.4 Increasing availability and access to HIV Testing and Counseling (HTC)

The strategic framework proposed the following actions in order to increase availability and access to HIV testing: development of standardized Operating Procedures (SOPs) for the delivery of HTC; integrating diagnostic HTC amongst TB and other patients; training of service providers in HTC and establishment of at least 57 HTC sites (3 in each of the 19 regions) to deliver HIV testing and counseling. In addition, the strategic framework proposed actions to strengthen Somali CSO capacity for the delivery of HTC services.

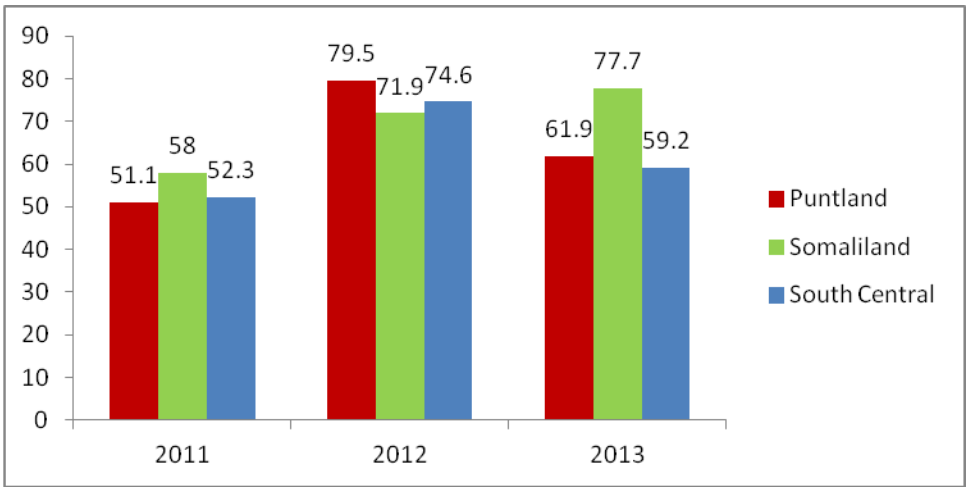
Standard Operating Procedures (SOPs) have been developed and are in place to guide the delivery of HTC services in all 3 zones VCT staff have undergone training in External Quality Assurance. In addition, access to HTC has increased significantly from only 13 facilities providing HTC to 51 at the end of June 2013 (89% of the minimum target identified in the strategic framework). Accordingly, coverage of HTC services has also increased from just 900 counseled and tested in 2005 when HIV testing and counseling was initiated to over 30,000 tested in 2012. Disaggregated by zone, 14,370 were counseled and tested in South Central (1.52% tested positive), 10,144 in Puntland (0.01% tested positive) and 5,869 in Somaliland (0.06% tested positive). The HIV prevalence results from the HIV testing and counseling services appear to corroborate ANC surveillance data for the 3 zones[11]. However, as previously stated,

[11] No gender disaggregated HTC data was available at the time of the development of this strategy

current coverage of HIV testing remains very low especially amongst sex workers and other key affected populations.

HIV testing amongst TB patients have also been initiated and HIV testing rates amongst TB patients across all zones has increased between the period 2011 and 2014 as Figure 8 indicates, although there remains clear scope for improvement particularly in South Central and Puntland.

Figure 8: Percentage of TB patients tested for HIV in Somalia by zone (2011-13)



Source: Program reports (2013)

Key challenges and gaps in the delivery of HTC services include;

- Approximately 89% of all Somalis infected with HIV remain undiagnosed. Identifying these individuals represents the biggest challenge for HIV control in Somalia and it would be fair to suggest that most HIV infections in the country are transmitted by people who are unaware of their HIV status;
- Although coverage of HTC services has increased, there remains additional scope to increase the number of facilities providing services as well as establish mobile testing services for hard to reach populations and in high risk transmission areas such as ports, borders and highway corridors across all zones;
- HIV related stigma and discrimination acts as a significant impediment to uptake of HTC services;
- Limited community outreach work to help increase awareness and uptake of HIV services
- Due to unforeseen increases in demand, stock outs of HIV test kits are quite pervasive across all three zones; and
- There remains further scope to strengthen HIV testing amongst TB patients;
- Severe lack of access by key populations especially sex workers and their clients as HTC is not customized to meet their needs especially due to the opening hours, location, and visibility.

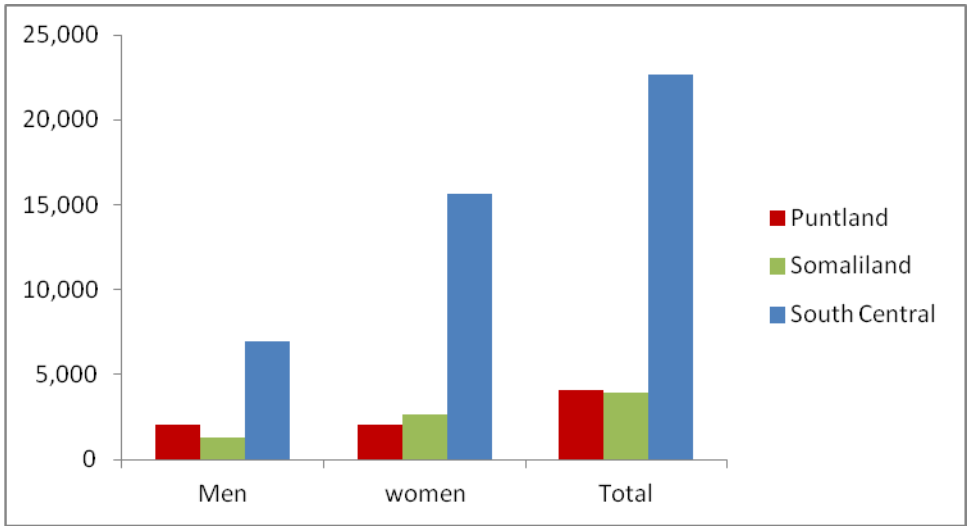
3.1.5 Increasing access to the management of Sexually Transmitted Infections (STIs)

The strategic framework proposed following actions in order to increase access to the management of Sexually Transmitted Infections (STIs): Syndromic management of STIs, training of services providers in

both the public and private sectors, and ensuring the availability of STI drugs, condoms and other related commodities. Health workers received capacity building on STI management.

Figure 9 below shows the number of cases diagnosed and treated for STIs in Somalia by zone at the end of 2012.

Figure 9: Number of cases diagnosed for STIs Somalia by zone (2012)



Source: Program reports (2013)

As Figure 9 indicates, diagnosed cases of STIs are quite high across the country with significantly higher cases diagnosed in South Central (22,647) followed by Puntland (4,087) and Somaliland (3,921). Reported cases of STIs diagnosed and treated are also significantly higher amongst women compared to men in all 3 zones. It was suggested during consultations that rates amongst women may be overstated due to poor diagnosis (as all abdominal pain is classified as an STI in Somalia) and that rates amongst men may be understated as asymptomatic sexually transmitted infections are not diagnosed with the current protocol in use. Prevalence rate of STIs amongst sex workers however remain very low (preliminary findings from the 2014 round of the bio-behavioural survey in Somaliland found prevalence rates of STIs to be less than 2%).

Key gaps and challenges identified in relation to the prevention and management of STIs include:

- Frequent stock outs of key STI drugs have been reported;
- Under reporting of asymptomatic sexually transmitted infections and a limited supply of accurate diagnostic tests that can diagnose asymptomatic;
- Non availability of rapid syphilis tests in MCH and HTC sites where a majority of the STI screening occurs; and
- Limited integration of STI treatment and management services with HTC and condom promotion and distribution
- Limited community outreach work to help increase awareness and uptake of STI services

3.1.6 Universal precautions, blood safety and Provision of Post Exposure Prophylaxis (PEP)

The strategic framework proposed the following actions: establishment and strengthening of blood transfusion centres; consistent screening of all blood transfusions; establishment of PEP services and utilization of universal precautions in all health facilities.

At the end of 2013, Somalia had 36 blood transfusion centres of which 13 (36%) are located in South Central. There is inadequate funding for blood screening reagents. Blood policy development is at different stages in each of the zone, and there remains a need to equip labs to adequately screen and prepare blood products, build the capacity of health workers to provide quality services, provide continuous supply of screening kits and consumables. Health workers were trained on Clinical Management of Rape and provided with PEP kits. However, even more health workers need to be trained.

Key gaps and challenges identified include:

- It is unclear as to the extent blood borne transmission of HIV as not all health facilities in the 3 zones consistently screen blood for HIV
- Blood screening reagent supply chain has been weak resulting in stock-outs;
- Blood bank infrastructure and equipment needs rehabilitation
- Weak integration between the national blood service and other services such as HIV testing and counseling services; and
- The provision of PEP and CMR is weak.
- Stigma and discrimination by health workers towards PLHIV

3.2 Treatment, Care and Support for PLHIV

With respect to treatment, care and support, the strategic framework for the Somali AIDS response 2009-2013 called for the following interventions: Increasing access to ART and management of opportunistic infections, strengthening linkages between HIV and TB care; improving care for the chronically ill; supporting children infected and affected by HIV and AIDS; and strengthening health care systems at facilities and community levels providing services for PLHIV. This section presents a summary of the results achieved, key challenges and gaps in the response to date.

3.2.1 Provision of Antiretroviral Therapy (ART)

The strategic framework proposed ART treatment targets similar to the Universal Access (UA) targets established at the time by UNGASS and to expand the number of sites offering ART services. During the period of the last strategic framework, the number of patients on ART was scaled up by threefold from 578 in 2009 to over 1,500 in 2013 as Table 1 indicates. However, there is still low coverage of ART (17% in adults and 10% in children) using the national eligibility criteria in 2013 translating to 6% adults and children receiving ART as a percentage of the total HIV population. Remarkable treatment outcomes have been realized, with 84% of patients alive 12 months after initiation of ART as a result of improvements in adherence and counseling. Somalia was assisted to adapt the WHO 2010 Anti-Retroviral Treatment guidelines.

Table 1: Number of Somalis on ART during 2009-2013

Year	Number of People on ART
2009	569
2010	878
2011	1,139
2012	1,450
2013	1,748

Source: Program reports (2013)

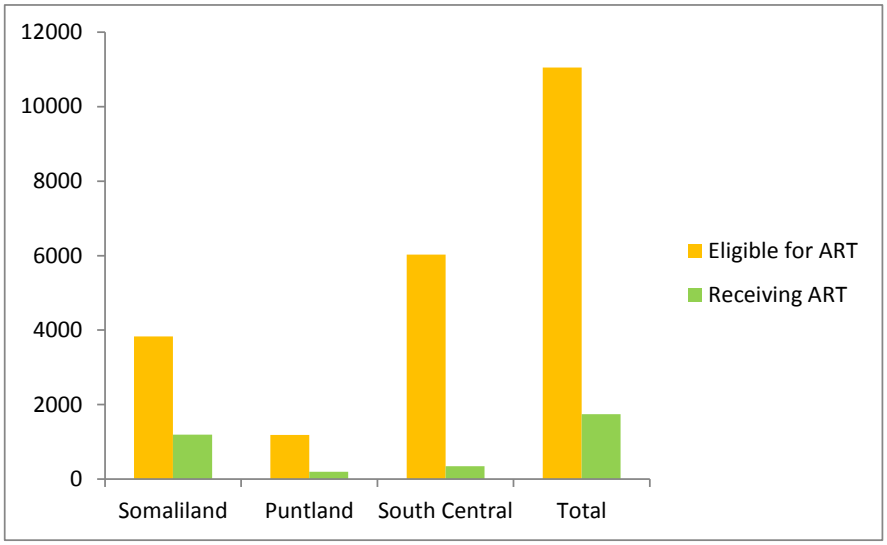
Table 2: Number of Somalis on ART disaggregated by zone, sex and age group

Zone	Total Number on ART			
	Female	Male	Total (Adults & Children)	Children
Puntland	120	80	200	5
South Central	200	152	352	14
Somaliland	777	419	1196	45
Total	1097 (63%)	651	1748	64 (6%)

Source: Program reports (2013)

Based on the context in which this program has been implemented, significant progress has been achieved. However, coverage is only 16% based on the new WHO eligibility requirements for the provision of ART (CD4 count eligibility of less than 500). Figure 10 shows ART coverage rates by zone at the end of 2013.

Figure 10: ART coverage in Somalia by Zone at the end of September 2013

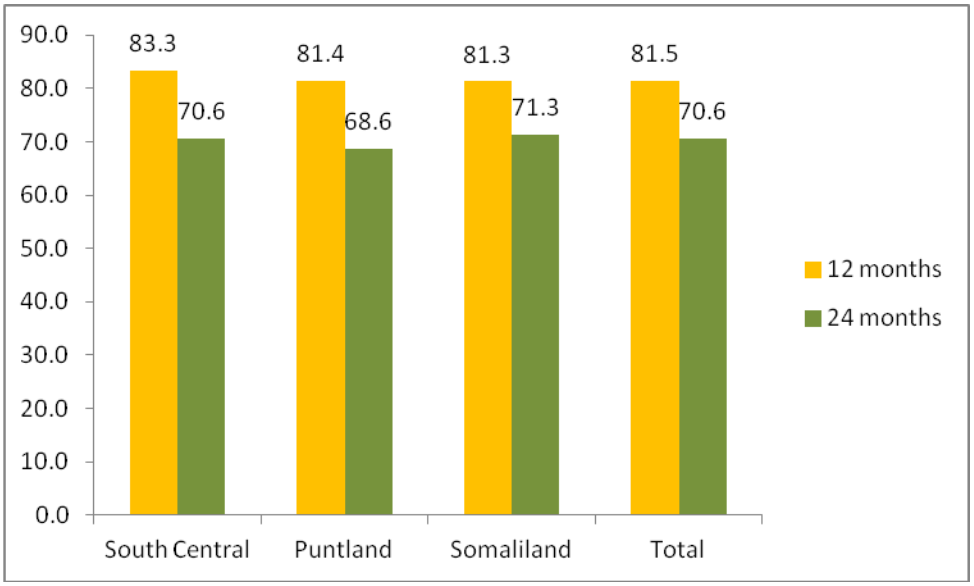


Source: program reports/Spectrum estimates 2013

As Figure 10 indicates, coverage is generally very low across the whole country, with coverage highest in Somaliland (31%) followed by Puntland (17%) and South Central with the lowest coverage at 6% reflecting the geographical challenges of accessibility to ART. Disaggregating the data, reveals that 63% were female and only 6% were children (Table 2). 11% were from Puntland, 18% from South Central and 71% from Somaliland. In order to ensure adequate access and coverage, there is a need to rapidly increase the number of ART centres from the current number of 11.

At the outcome level, the ART program has achieved commendable retention rates (comparable to those achieved amongst its neighbors) linked to adherence and survival as the Figure 11 illustrates:

Figure 11: Retention rates (still alive on treatment at 12 and 24 months) in Somalia by zone



Source: Program reports (2013)

The high adherence rates have been attributed to effective counseling approaches that have been adopted during the implementation of the current strategic framework. The adherence to counseling has also improved resulting in better outcomes to retention and other positive outcomes for ART program.

Key gaps and challenges relating to the provision of ART include

- Physicians are currently the only cadre allowed to initiate ART in Somalia. As a result of their shortage and their availability in major cities, expansion of ART services has been limited. Given that this shortage is expected to continue in the short to medium term, it has been acknowledged that tasks customarily performed by physicians will have to be shared and involve other health-care providers such as clinical officers and nurses, of whom there are greater numbers;
- There remain weaknesses in follow up in pre ART care, with disruptions in CD4 testing services and loss to follow up of some patients before ART is commenced;
- The quality of care is compromised by inadequate laboratory services (especially CD4) to monitor clients on OI/ART; moreover, viral load testing is not available;
- There is no virological testing (EID) for HIV exposed infant's resulting in many HIV positive infants unidentified in the postnatal period, thereby missing out on critical interventions;

- Coverage of cotrimoxozole prophylaxis remains low;
- Preventing unintended pregnancies among HIV positive women and women in general by increasing the voluntary use of contraception is low;
- Stigma and discrimination by health care professionals towards People Living With HIV (PLHIV); and
- Limited community outreach work to strengthen uptake of HIV services including ART.

3.2.2 Pre-ART Care

The role of Pre-ART and community systems was not explored in the previous strategic framework. These programs are essential in reducing default by providing strong follow-up mechanisms, increasing adherence by offering peer-to-peer psychosocial support and strengthening referral systems. There is a need to strengthen the national pre-ART program to ensure that people testing positive receive regular follow up care, receive Co-trimoxazole Prophylaxis Therapy (CPT) and monitored sufficiently so that when they are eligible for treatment, initiation is not delayed. A corollary effort in TB management for example, has helped drive results in narrowing gaps and unmet needs in TB-HIV co-infection management. In 2011 /2012, TB/HIV collaborative activities were strengthened and a total of 5,359 TB patients constituting to three quarters of those treated for TB were tested for HIV. In the same period over 700 PLHIV were tested for TB out of which 3.6 % tested positive for HIV. During 2013, the number of TB patients tested increased to 6,973 of whom 2.8% were HIV positive. The lower positivity rate could have had to do with extension of services to lower HIV prevalence sites, bringing down the overall yield of HIV positive cases

Key gaps and challenges relating to Pre-ART Care

- Weaknesses in the provision of a Pre-ART package – some patients are lost to follow up from HTC through to CD4 eligibility determination and onto ART;
- Lack of well-defined follow-up mechanisms, support and referrals at the community level;
- Distance to clinics is problematic and often contributes to late presentation. Information on how this differentially affects women and men needs to be determined.

3.2.3 Diagnostic services for Treatment and care

Diagnostic services play a vital role in the success of the national HIV and AIDS response. Laboratories play an essential role in diagnosing HIV infection, assessing the immune status of people living with HIV, formulation of treatment plans and in monitoring treatment outcomes such as adverse events and treatment failure. Key progress in diagnostic services includes the procurement, distribution and utilization of CD4, hematology and biochemistry machines in the public health facilities. The previous strategic framework envisaged strengthening diagnostic services as part of strengthening health systems; however although CD4, blood chemistry and haematology machines were procured for each of the hospitals hosting ART sites, supplies and consumables have been consistently available.

Key gaps and challenges relating to the provision of diagnostic services for HIV and AIDS include:

- Laboratory monitoring for Pre-ART and ART is largely non-existent; technicians and diagnostic services at the peripheral levels (particularly rural and remote areas) are severely lacking;
- Even with 11 ART across Somalia mainly in major cities, laboratory services haven't been offered consistently to all patients. The system for supplies management for laboratory activities is is inadequate to provide consistent diagnostic services for existing patients on Pre-ART and ART;

- Laboratory information and management systems (including stock management) are weak;
- Frequent stock outs of reagents and weak logistics systems for laboratory supplies have been reported;
- Electricity backup systems are inadequate;
- Support and supervision systems are inadequate;
- Frequent breakdown of existing CD4, chemistry and hematology machines couple with stock outs of reagents have been reported;
- EID and VL testing are virtually non-existent; and
- Insufficient cold-chain capacity for lab reagents.

3.2.4 Prevention, care and management of TB/HIV co-infection

ART is a high priority life-saving intervention for PLHIV. Studies and modeling efforts suggest that early initiation of ART for PLHIV who develop TB may lead to reduced mortality and incidence of TB[12]. Cotrimoxozole preventive therapy (CPT) has been proven to reduce morbidity and mortality among PLHIV and TB.

Out of 65 TB centres, 40 (62%) of them are providing HIV testing and counseling. During 2013, 7,252 TB patients tested for HIV, of TB patients were counseled and tested for HIV, 3% were HIV positive in all zones (4% in Somaliland; 4% in Puntland and 1% in South Central) (Table 3). They received treatment or were referred for treatment elsewhere. However, some planned activities, such as the provision of CPT or ART to HIV-positive TB patients, have been lagging, indicating a need for intensified training and supervision activities. While only 79% of HIV-TB patients were reported to have received cotrimoxozole in 2012, this proportion was even lower at 72.3% during 2013. It is therefore recommended that the TB-HIV collaborative activities be expanded gradually to reach the WHO target of counseling and testing every TB patient, and provision of HIV care to all TB patients found to be HIV positive. Case finding among PLHIV will be intensified. In order to build their capacity for creating TB community awareness among PLHIV and reduce TB stigma, peer educators will have to be trained.

Table 3: Number of TB patients tested for HIV and proportion that tested HIV positive

Zone	No. of Patients tested for HIV	TB/HIV+	%HIV+
Puntland	758	32	4%
Somaliland	3506	133	4%
South Central	2988	36	1%
Total	7252	201	3%

[12] Lawn SD, Churchyard G. Epidemiology of HIV-associated tuberculosis. Curr Opin HIV AIDS. 2009 Jul; 4(4):325-33.

Isoniazid preventive therapy (IPT) is approved as a national policy, guidelines were adapted and printed, but full roll out has been delayed by procurement difficulties, with the service only having been being initiated in one zone by the end of 2013.

There are regular TB HIV Coordination meetings in all three zones and joint supervision of HIV and TB service delivery is undertaken on occasion. Guidelines for TB infection control have been developed, and training undertaken, but there are no earmarked resources for undertaking layout and other improvements to enhance TB infection control. There is need for technical expertise to advice on these improvements starting at the higher volume TB sites.

Key gaps and challenges relating to the prevention, care and management of TB/HIV co-infection:

- Stock outs of Isoniazid;
- Isoniazid preventive therapy roll out has not proceeded as planned due to INH procurement constraints;
- Low uptake of ART for TB-HIV co-infected patients due to limited ART facility coverage r in comparison to the much wider TB facility distribution;
- HIV test kit supplies disruptions leading to suboptimal coverage of HIV testing for TB patients, even at sites where HTC is offered;
- TB infection control measures are equally important in settings providing health services, particularly to people living with HIV, but inadequacy of resources has limited the roll-out of infrastructure and lay out improvements in health facilities;
- The limited number of diagnostic services for TB (sputum examination and CXR) in health facilities has led to a delay in treatment of TB;
- There is still a need to strengthen integrated monitoring and evaluation systems to assess the progress and outcomes of collaborative HIV/TB interventions.

3.2.5 Procurement and supply chain management

The supply chain management systems were not addressed in the previous strategic framework. It is essential in the acquisition and distribution of inputs into the national response. Across the three zones, supply chain has been inadequate and this has often resulted in stock-outs of key pharmaceuticals and health products.

Key gaps and challenges relating to health procurement and supply chain management

- Procurement systems are ad hoc and reactive; the process is not driven by empirical data from the field based on actual consumption. Stock imbalances, stock-outs, expirations and unwanted formulations are common across all the interventions;
- Inadequate forecasting, quantification, inventory management, and reporting;
- A lack of an adequate Logistics Management Information and Monitoring Systems (LMIS);
- Long lead times indicating inadequate procurement capacity within the supply chain management structure;
- Given the absence of a logistics system design with no corresponding inventory control system and Logistics Management Information System (LMIS), the supply chain is unable to generate accurate and reliable data for decision making, with procurement being the hardest hit; and

- Vertical and parallel systems for PSM as well as lack of harmonisation and integration across all GF disease grants as well as to national systems

3.2.6 Nutrition and Economic status for adults and children living with HIV

It is widely accepted that nutritional health is essential for PLHIV to maximise the period of asymptomatic infection, to mount an effective immune response to fight OIs and to optimise benefits of antiretroviral therapy. Several programs have reported high mortality in the first 90 days of ART treatment correlated strongly with low body mass index (BMI<16) [13].

The World Food Program (WFP) has been providing food assistance for chronically ill patients and their families all ART sites as well as 19 TB centres. In 2013 WFP transitioned from relief food assistance to HIV and TB patients to a more targeted approach on malnourished HIV and TB patients. WFP's plan is to provide supplementary feeding to respond to specific nutritional needs of malnourished patients eligible for ART or DOTs. In 2011-2012, WFP Somalia undertook a "national nutrition and vulnerability profiling study of pre-ART, ART and TB-DOTS patients in the three regions to establish a baseline of the nutritional status and household food security situation. Prevalence of acute malnutrition (BMI<18.5) among HIV and TB patients in Somalia is 43.6%and the prevalence of severe malnutrition (BMI<16) is 17.6%. In addition, HIV and AIDS patients are severely hit by food insecurity with up to 70% of HIV/TB affected households having poor or borderline food consumption. The need for a nutrition care and treatment program for TB and HIV patients in Somalia is therefore paramount.

During the last strategic framework, economic strengthening interventions for PLHIV were implemented. Technical support, small grants and business skills training has been provided to less than 200 people living with HIV who received small grants to start their own business and there were over 7200 beneficiaries of this project, including family members and children.

Key gaps and challenges relating to nutrition programming for children and adults living with HIV

- Coverage of therapeutic feeding is low;
- National capacity to manage the nutrition is very limited resulting in Zonal AIDS Commissions and MOH/ relying on external parties to run the program;
- Nutrition counselling and assessment at facilities and in the community has been inadequate;
- The majority of the foods utilized to support therapeutic and supplementary feeding of children and adults living with HIV who are suffering from severe and moderate acute malnutrition are imported and are not sustainable in the long term;
- There is weak collaboration between the Nutrition and HIV programs;

3.3 Strengthening Monitoring and Evaluation of the National response

As noted in earlier sections of this strategy, one of the salient features of the Somalia epidemic is limited data in quality and quantity. The complex context, limited resources, and weaknesses in data collections systems have resulted in the lack of sufficient information to comprehensively and confidently characterize the epidemic, target groups and its drivers. Efforts to strengthen the surveillance system have been curtailed by these limitations and resources. For monitoring of the response the HIV Strategic Framework 2009-2013, as stated earlier both the results framework and the national M & E framework had yet to be developed at the time of the development of this strategy clearly understating the

[13] Greenaway K, 2009, No 2: Food by Prescription: A Landscape Paper, GAIN working paper series.

challenges in monitoring and evaluation prevalent at national and zonal levels. Several assessments undertaken during the implementation period of the strategy identified several gaps and challenges

Key gaps and challenges relating to monitoring and evaluation of the national response include:

- The ZACS, MOH/DOH, and TB unit do not have sufficient human and technical capacity to enable them to fulfil their role in coordinating M&E of the national response;
- HIV and AIDS data collection is frequently not sex disaggregated;
- Evidence based decision making is weak due to lack of strategic information from surveys and research studies;
- Routine HIV program monitoring is weak particularly for the non-health facility data collection;
- Surveillance is weak, non-comprehensive and sporadic especially for bio-behavioural surveillance of key affected populations;
- Surveys to characterize and quantify stigma and discrimination are limited.
- Zonal databases where available do not capture all data;
- Limited supportive supervision or auditing is conducted;
- Data dissemination and utilization is weak;
- Routine information systems are weak and data quality poor;
- Inordinate delays in approval of reports by the Zonal AIDS Commissions and other policy makers severely limits the ability of these reports to guide and inform programming and to be circulated to implementers that require them to inform their work
- With the exception of Youth Behavioural Survey (YBS) 2011, the other two sources of Knowledge Attitudes and behavioural data include; KAPB conducted in 2004 and Multiple Indicator Cluster Survey (MICS) 2006 and 2011. The MICS studies are designed for maternal and child indicators and only integrates HIV in one section on awareness. As a result, it is challenging to empirically link programmatic response to behavioural outcomes and establish their impact on the epidemic in the general population;
- For FSWs, the integrated biological and behavioural surveillance (IBBS 2008 and 2014) provided comprehensive testing for HIV and syphilis and behaviours of FSWs. However, the study only covered Hargeisa in Somaliland, which makes it difficult to generalize findings for the whole country; and
- Population size estimations of key populations such as sex workers, their clients including uniformed personnel, truck drivers, fishermen, port workers etc. has been undertaken once in two port cities of Berbera and Bosasso in 2011.
- Absence of collection of vital registration statistics
- HIV indicators not sufficiently integrated in HMIS

3.4 Creating an enabling environment for the national response to HIV and AIDS in Somalia

Participation and involvement of PLHIV at the community level in the national response has been establishment of organized groups in each zone attending planning and review meeting organized by the AIDS Commission. However the contribution by PLHIV and civil society in general to decision making is limited by their capacity to engage. Somalia is committed to fulfilling its international obligations as party to the UN 2011 Political Declaration on HIV and AIDS (UNGASS 2011), The UN Security Council Resolution 1983 (UNSCR 1983) which addresses HIV and sexual gender-based violence (SGBV) in conflict and post-conflict settings, The Abuja Declaration and Plan of Action (2001), the Maseru Declaration on HIV and AIDS, The Convention on the Elimination of all forms of Discrimination Against

Women (CEDAW) and the UN Convention of the Rights of the Child and the Universal Human Rights Declaration, and aiming to attain the Millennium Development Goals.

However despite the plethora of policy instruments, there are certain key aspects of the legal and regulatory environment that impede effective implementation of the national response. *National HIV and AIDS policy*: Somaliland has an HIV Policy that has been approved and finalised. Puntland and South Central have draft policies in place. Somaliland and Puntland also have Draft HIV Bills. However, they need to be reviewed and updated in light of new evidence and the evolving epidemic. Laws need to be enacted to protect the rights of PLHIV and enable effective programming for HIV and AIDS.

Gender policies for the zones have been developed. Although empirical data is limited, it is acknowledged that Gender Based Violence (GBV) and inequalities are common in Somalia and are further fueled by the conflict. The goal of the zonal gender policies is to promote gender equality and sustainable human development. Among other objectives, the policy seeks to improve equal access to HIV and AIDS information for prevention, treatment and care for women and men living with HIV and AIDS as well as to improve services for the management of cases of GBV.

Findings from an assessment showed the most commonly reported forms of SGBV in Somalia include rape, molestation, female genital cutting, and non-disclosure of positive HIV status.. Hospital records indicated an increase in reported SGBV cases between 2006 and 2008. Respondents indicated survivors of SGBV are highly stigmatized by the community and often discouraged from following judicial procedure through to their conclusions, in addition to a disconnection and inefficiency of traditional and formal judiciary procedures for perpetrators of SGBV, reducing willingness to report SGBV incidents. Therefore it is very important to work with traditional leaders as well as religious leaders to improve the enabling environment of HIV and AIDS services,

HIV and gender issues are often taboo topics. Community conversations, which identify and discuss social norms and values around HIV and gender, are spurring changes in social attitudes and behaviour. In 2013, 2,610 people – 77% of whom were female – shared that they had benefited from participating in 73 sessions held between Somaliland and Puntland. Somali women of all ages and backgrounds eagerly await these discussions so they can openly share their experiences for a change, and gain information on HIV and AIDS services, such as the Prevention of Mother to Child Transmission. Community conversations have provided a unique forum to discuss critical gender issues, including harmful traditional behaviour that can contribute to the spread of HIV, particularly in women who are vulnerable to HIV infection. In addition to raising awareness of human rights and discrimination, this dialogue has paved the way for people living with HIV and AIDS to access public services.

The Shari'a law is perceived to provide better protection for women who have suffered sexual and gender based violence than the traditional and contemporary law. These positive aspects need to be promoted. Working with and sensitizing religious leaders on women's empowerment and gender equality should be integral to the process. This should be accompanied with the use religious leaders to support with increasing the demand for HIV testing and treatment

To mainstream HIV and AIDS, 40 members of the Special Protection Unit of the Somali Police Force and 150 police women have received training on HIV and AIDS, An HIV Media project has worked with a nine local radio stations in Somaliland, Puntland and South Central Somalia in 2013. Local journalists have been trained in order to strengthen reporting on HIV and gender issues in Somalia, from a more human rights perspective.

Key gaps and challenges relating to the creating an enabling environment for the national response:

- Stigma (social, institutional and personal) remains the biggest barrier for PLHIV to effectively engage in the multisectoral response to HIV. This is combined with deep rooted cultural taboos that inhibit dialogue and communications on sexual and reproductive health issues;
- Although PLHIV are represented in key national meetings and consultations, effective engagement with the NAC and MOH has been limited by the fact that PLHIV representatives lack the resources to regularly communicate to their constituencies and to solicit ideas and feedback;
- High levels of poverty, further exacerbated by a conflict environment that may result in displacement and fragmentation of family units, increase vulnerability of communities, and women and girls in particular;
- Gender Based Violence (GBV) is high and it is often exacerbated by weak capacity and/or lack of commitment to address it;
- Weak legal framework for the protection of human rights, especially rights of people living with HIV as well as sex workers and other KAPS.

3.5 Strengthening management and coordination of the national response

Somalia's multisectoral response to HIV and AIDS is managed and coordinated by the AIDS Commissions of South Central Zone (SCAC), Puntland (PAC) and Somaliland (SOLNAC). The NACs have an executive secretariat, responsible for coordinating the response with particular focus on policy development, partnerships and resource mobilization, monitoring and evaluation and administration. During the last strategic framework period, All AIDS Commissions organized regular coordination meetings at zonal level. Joint planning and review processes for the national response to HIV and AIDS have been led by the AIDS Commissions.

Somalia's health sector response is coordinated by the HIV and AIDS programs of the zonal MOHs/DOH.TB-HIV activities are coordinated in partnership with the zonal TB programs.. Somalia adheres to the "Three Ones" principles: the existence of one national coordinating body, one strategic national plan of action and one national monitoring and evaluation framework. Decentralized coordination structures of the NAC include Regional IPTCS Groups, District HIV Committees, Service Delivery Points and Community Systems.

The HIV and AIDS programs and Zonal AIDS Commissions in the three zones have demonstrated commitment in various aspects but need continued capacity building. The coordination structures involved in the three zones demand more resources and effective logistics to deliver various interventions aspects of the response. There also needs to stronger coordination, clarify roles and responsibilities between the AIDS commissions and zonal ministries of health, which have not been clear and have been a continuing source of conflict.

The Somali response to the HIV and AIDS epidemic is almost entirely funded through donor funding and primarily by one donor - the Global Fund for AIDS, TB and Malaria. The dependency on the Global Fund has the potential to severely compromise the implementation and sustainability of the response if the Fund was to withdraw assistance or to decrease funding for the response significantly.

Key gaps and challenges relating to management and coordination of the national response to HIV and AIDS

Key gaps and challenges that hinder the effective management and coordination of the national response to HIV and AIDS include:

- The teams of AIDS programs in the MoHs are quite new and thus need further capacity building support;
- There is inadequate capacity and experience in operational planning;
- There is paucity of required zonal disaggregated data on infections and risk to adequately inform management and coordination decisions;
- There seems to be limited understanding between the Zonal AIDS Commissions and their MOH counterparts on their respective roles and responsibilities vis-a-vis coordination of the national AIDS response
- Capacity for coordinating the mobilisation and strategic allocation of financing to different areas of the national HIV and AIDS response has been limited
- Support to coordination mechanisms have been focused at higher level, with limited or no investment to strengthen or create structures for effective coordination, mobilization and leadership at regional and district levels.
- Reliance almost exclusively on one external funder to fund the response to HIV and AIDS.

3.6 Financing of the national response

The Somali response to HIV and AIDS is funded almost entirely by the Global Fund and since March 2009, the Fund had disbursed over $43,365,731[14] to support the Somali response to HIV and AIDS. It is widely acknowledged by stakeholders inside and outside the country that this is unsustainable and that a more diversified financing base is required, including significant domestic commitments by the Governments of the respective zones. As the strategic framework 2009-2013 was not costed, it has not been possible to provide an analysis of the expenditure to date.

4. The Somali National Strategic Plan for the response to HIV and AIDS 2015 - 2019

The Strategic framework for the national response 2009-2013 provided a framework within which sectoral and civil society-led strategies, plans and budgets could be formulated and implemented. However, a key weakness of the framework was that it was not robust i.e. it was not prioritized nor was it results focused as reflected in the lack of a results framework or clearly articulated targets. In addition, the framework was never costed and did not have detailed operational plans at the decentralized (zonal) level.

A key feature of the Somali National Strategic Plan for HIV and AIDS 2015 - 2019 (NSP 2015-2019) therefore, is a results framework that starts with evidence and baselines and articulates specific measurable results. Secondly, interventions proposed in the framework are prioritized based on consultations at decentralized and national levels and taking into account the UNAIDS Investment Framework. HIV services have been targeted based on the observed distribution of the disease with ART sites for scale up guided by the burden in these health facilities. Similarly, HIV prevention interventions are designed to respond to the epidemiological and geographical context such as refugees returning from and mobile populations from countries with high HIV prevalence.

[14] As at 22 October 2013 (Round 4 and Round 8 HIV grants)

Integration of HIV and AIDS into other health services delivery is a key feature of the NSP. In this regard, the EPHS delivery mechanism for health services will be applied by including HIV and AIDS in the package. Capacity building efforts will be integrated by application of integrated health training curricula that include HIV and AIDS and targeted health infrastructure development around "hot spots".

Goal and Impacts of the NSP 2015-2019

The goal of the NSP is to reduce HIV infections and HIV related mortality and morbidity among Somalis. Reflecting a commitment to achieving an impact within the population, the NSP 2015-2019 is structured around achieving the following expected impact level results:

Impact Result 1: Reduction in new infections by 30% by 2019

It is estimated that in 2013 about 3,247 new HIV infections (2,691 in adults 15+ and 556 in children ≤ 15 years) occurred in the Somali republic. The estimates do not indicate a significant difference by sex, however, more HIV prevalence studies on men are need to confirm this. In order to maintain a low HIV prevalence, the country must reduce annual new infections to 2,273 by 2019.

Achieving this result will require HIV prevention interventions to target key populations in order to have the greatest impact on the incidence of new infections.

Impact Result 2: Reduction in mortality among men, women and children living with HIV by 30% by 2019

It is estimated that in 2013 currently about 2,591 people (2,179 in adults 15+ and 412 in children ≤ 15 years) living with HIV die annually in the Somali republic. This is due to the fact that only 15% of them have access to life saving ART by 2013. The estimates do not indicate a significant difference by sex. This strategic plan has defined ambitious strategies for scaling up HIV treatment services in order to keep more women, men and children living with HIV alive

In order to achieve the above impacts, the following five priority thematic areas have been agreed upon:

1. Prevent new HIV infections especially among key populations such as sex workers and their clients through combination HIV Prevention interventions;
2. Increase access to and utilization of optimally efficient, effective and integrated treatment, care and support services;
3. Strengthen monitoring and evaluation of the response;
4. Ensure an enabling environment for the response; and
5. Strengthen management and coordination of the response

The specific prioritized interventions under each of the five priority areas, the expected results as well as the strategic objectives and priority actions to achieve those results are described in the sections that follow.

4.1 Preventing new HIV infections

Somalia has prioritised prevention in order to reduce the annual number of new infections from 3,247 in 2013 to 2,273 by 2019 and an estimated adult HIV incidence of HIV from 0.06% in 2013 to 0.04% by 2019. To achieve this aim, the NSP articulates strategies of combination prevention that will focus on the most effective biomedical and social behavioural interventions and that will target those likely to

contribute disproportionately to HIV transmission including female sex workers and their clients. The combination prevention interventions will focus on reducing the risk of HIV transmission through changes in sexual behaviour and through biomedical interventions. The NSP therefore proposes four interrelated strategic objectives (in order of priority) to reduce the risk of HIV transmission:

1. Reduce sexually acquired HIV infections;
2. Reduce Mother to Child Transmission (MTCT) (See section 4.2.2).
3. Reduce morbidity of other Sexually Transmitted infections;
4. Reduce the transmission of HIV through blood, occupational and non-occupational exposure

The ensuing sections articulate the prioritized strategic actions for each of the three strategic objectives as well as the expected results if these strategic actions are undertaken

4.1.1 Reduce sexually acquired HIV infections through the following strategic actions (in order of priority):

- Implement Combination HIV Prevention[15] by tailoring and coordinating biomedical, behavioural and structural strategies, for key populations such as sex workers and their clients including truck drivers, port workers, fishermen, etc.[16] across all three zones;
- Scale up Prevention with Positives (PwP) interventions across all zones targeted at known PLHIV[17] and those identified as HIV positive through HIV Testing and Counselling (HTC). 'Know Your Rights' and Leadership training for PLHIV can support this work.
- Improve and scale up condom use (especially among female sex workers and their clients as well as PLHIV) through implementing the UNFPA 10 step approach to comprehensive programming;
- Support private sector condom promotion;
- Expand access to Social and behaviour change communications and increase awareness of HIV in the general population with a special focus on populations at higher risk such mobile populations, uniformed services, youth especially young girls, etc; and
- Deliver prevention through education interventions with a focus on young girls and boys in schools

4.1.2 Reduce the prevalence of and Morbidity from STIs through the following priority strategic actions:

- Ensuring an adequate supply of STI diagnostics and drugs in order address the frequent stock outs identified in the gaps and challenges. This will be complemented by training service providers in STI case management according to national protocols; and
- Strengthening quality assurance (QA) for STI management through regular supervision of services as well as service provision assessments
- Training of staff in Syndromic management protocols and guidelines
- Procure rapid tests for syphilis
- Strengthen laboratory diagnosis of STIs where lab capacity exists

4.1.3 Reduce the transmission of HIV through blood, occupational and non-occupational exposure through the following priority strategic actions:

[15] http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/JC2007_Combination_Prevention_paper_en.pdf

[16] Uniformed personnel (especially in South Central), truck drivers

[17] Those on Pre-ART and ART programmes

- Develop and implement blood transfusion strategy across all zones;
- Ensure adequate screening of transfused blood through the procurement of required reagents; and
- Ensure the availability of post-exposure prophylaxis for those occupationally and non-occupationally exposed to HIV
- Quality assurance and supervision of non-public health sector
- Address traditional practices

The following table outlines the key results during the period of this strategic plan to achieve the objectives of preventing new infections:

Expected Results	Prevention with Positives (PwP)	• **More PLHIV adopt key HIV prevention behaviours**: The percentage of PLHIV who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months is not less than 80% annually • **More PLHIV disclose their HIV status to their sexual partners:** The percentage of PLHIV newly tested who reported having disclosed their HIV status to their sexual partners in the last 12 months is increased by at least 50% in 2017 and 80% by 2019
	Integrated Social Behavioural Change Communication (ISBCC) for female sex workers and their clients	• **Less female sex workers are infected with HIV:** The percentage of female sex workers who are infected with HIV is reduced from 5.2% in 2008 to 3.6% by 2019 • **More sex workers are knowledgeable about HIV prevention:** The percentage of female sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from 6.9% in 2008 to 80% by 2019
	ISBCC and HIV awareness raising for young people and the general population	• **Young men and women are more knowledgeable about how to prevent HIV:** The 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 is increased from 8.7% among men and 13.4% among women in 2012 to 50% by 2019 • **More young people have acquired comprehensive knowledge on HIV:** The percentage of young people with comprehensive knowledge increases from 5.4% males and 4.3% females to 50% males and 50% females by 2019.
	Condom programming	• **More female sex workers use condoms with their clients**: The percentage of female sex workers reporting the use of a condom with the most recent client is increased from 24% in 2008 to 60% by 2019 • **More young men are able to get access to condoms:** The percentage of young men aged 15-24 who report they could get condoms every

		time it is needed is increased from 37% in 2012 to 74% by 2019
	STI management and treatment	• **The number of Somalis who access syndromic STI management is increased**: The number of STI cases treated by the syndromic case management approach is increased by 50% by 2017 and 80% by 2019. • **STI diagnosis and treatment is available for all who require it:** The percentage of health facilities providing syndromic STIprovide regular reports and experienced no stock-outs of STI drugs in the last 12 months is increased to 90% by 2019
	Blood safety and exposure	• **All blood donated for transfusion is properly screened for HIV and other transmissible infections, according to national screening and quality assurance standards**: The Percentage of donated blood units screened for HIV in a quality assured manner is maintained at 100% by 2019 • **More health facilities provide PEP:** The Number of health facilities with HIV post-exposure prophylaxis (PEP) available is increased from 11 in 2013 to 50 by 2019. • **PEP is available for all who require it:** The percentage of health facilities providing PEP that experienced no stock-outs of PEP in the last 12 months is no less than 85% annually

4.2 Increasing access to and utilization of optimally efficient, effective and integrated treatment, care and support services

Universal access to and utilization of optimally efficient, effective and integrated treatment care and support services for PLHIV remains a major component of the Somali response to HIV and AIDS in order to reduce HIV associated mortality and morbidity. However, as previously mentioned, most of Somalis infected with HIV remain undiagnosed. Identifying these individuals' represents the biggest challenge for HIV prevention and treatment, care and support in Somalia. The NSP therefore seeks to address this challenge through the delivery HIV testing and counseling (HTC) services that target those populations likely to be at high risk for HIV including STI patients and their partners, TB patients, female sex workers and their clients as well as other potential or known key affected populations. It is acknowledged that a universal approach to HTC may not be cost effective in terms of yield in light of low HIV prevalence rates.

Somalia has agreed over the implementation period of this NSP to adopt Option B+ in which all pregnant women living with HIV are offered life-long ART, regardless of their CD4 count. It is recognised that the implementation of Option B+ will require that some HTC, ART and PMTCT services are co-located (which is not current practice)

In addition to the implementation of Option B+, Somalia also intends to adopt the "Test and Treat Strategy". The SP also seeks to significantly expand the coverage of pediatric and adult pre-ART and ART services, reduce the burden of TB associated HIV and ameliorate severe malnutrition among PLHIV on

pre-ART and ART in order to improve case fatality. These activities will need to be supported by strengthened laboratory and diagnostics services for ART, TB and PMTCT as well as pharmaceutical and health product management in order to achieve outcomes proposed.

The NSP therefore proposes eight strategic objectives to increase access to and utilization of quality integrated treatment, care and support services:

1. Increasing the availability and coverage of HIV Testing and counselling (HTC);
2. Scaling up the availability of high quality paediatric and adult ART and PMTCT services;
3. Strengthening Pre-ART services;
4. Reducing the burden of HIV associated Tuberculosis;
5. Improving the nutritional and economic status of PLHIV
6. Strengthening laboratory and diagnostic services for ART, TB and PMTCT delivery; and
7. Strengthening procurement and supply chain management capacity for HIV and TB related pharmaceuticals and health products.
8. Scale up community outreach work to support access and uptake of HIV treatment, care and support services

The following sub- sections articulate the strategic actions for each of them;

4.2.1 Increase the availability and coverage of HIV Testing and Counseling (HTC) services through the following priority strategic actions

- Develop and implement Provider Initiated Testing and Counselling (PITC) services with an emphasis on STI patients, Maternal and Child Health (MCH) attendees, TB patients and those attending health facilities;
- Increase the number of mobile HTC services customized and targeted at Key Affected populations (as a part of Combination HIV Prevention activities) which are integrated in healthcare services;
- Ensure the availability of HTC commodities;
- Strengthen HTC supervision; and
- Continue external quality assurance through proficiency testing.

4.2.2 Scale -up the availability of high quality adult and pediatric ART and PMTCT Services through the following priority strategic actions

- Adopt “Test and Treat” and PMTCT (Option B+) guidelines;
- Expand HIV testing and counselling services to more facilities;
- Increase the number of facilities offering ART services
- Promote the use of contraceptives among PLHIV to prevent unintended pregnancies
- Community engagement and mobilization to increase demand for and utilization of ANC, HIV and PMTCT services; and
- Strengthen private sector engagement in the delivery of ART and PMTCT services

4.2.3 Strengthen Laboratory and Diagnostic Services for ART, TB and PMTCT Delivery through the following priority strategic actions;

- Establish and scale up Early Infant Diagnosis (EID);
- Strengthen and scale up CD4 Testing;

- Strengthen and scale up Viral Load (VL) Testing;
- Procure and supply laboratory and diagnostic reagents for ART, TB; and
- Undertaking regular quality assurance of laboratory and diagnostic services

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4.2.4 Reduce the Burden of HIV-Associated Tuberculosis (TB) through the following priority strategic actions;

- Expand HIV testing among TB patients to additional TB sites;
- Increase coverage of co-trimoxazole for HIV positive TB patients;
- Scale up access to ART for HIV positive TB patients;
- Scale up TB screening among people living with HIV;
- Scale up access to IPT among people living with HIV and who do not have active TB; and
- Coordinate national efforts to reduce the burden of HIV associated TB

4.2.5 Strengthen procurement and supply chain management capacity for HIV and TB related pharmaceuticals and health products through the following priority strategic actions;

- Strengthen forecasting and quantification HIV and TB related pharmaceuticals and health products;
- Strengthen Procurement systems and planning;
- Strengthen receipt, storage and inventory management of HIV and TB related pharmaceuticals and health products
- Strengthen distribution and Logistics Management Information System (LMIS);
- Improve quality assurance for HIV and TB related pharmaceuticals and health products; and
- Address PSM (integration of supply chains across all 3 grants and within the MOH)

4.2.6 Improve the nutritional and economic status of PLHIV through the following priority strategic actions;

- Scale up nutrition care, support & treatment at ART sites for eligible PLHIV;
- Mitigate the socio-economic impact of HIV among PLHIV through income generating activities; and
- Implement food security activities for vulnerable PLHIV

4.2.7 Strengthen Pre-ART Services through the following priority strategic actions;

- Scale up access to CPT for HIV positive TB patients;
- Scale up access to IPT among people living with HIV and who do not have active TB; and
- Improve treatment retention and strengthen referral/linkages from HTC to pre-ART care.

The following table outlines the key results during the period of this strategic plan to achieve the three objectives above:

Expected Results	HTC	• **More sex workers are aware of their HIV status**: The percentage of female sex workers who received an HIV test in the last 12 months and who know the results is increased from 26.5% in 2014 to 40% in 2017 and 80% by 2019
		• **More TB patients are aware of their HIV status**:
		  • The percentage of TB patients who know their HIV status is increased from 61.9% in Puntland in 2013 to 75.7% by 2017 and 85% by 2019
		  • The percentage of TB patients who know their HIV status is increased from 44.1% in South Central in 2013 to 68.7% by 2017 and 85% by 2019
		  • The percentage of TB patients who know their HIV status is increased from 74.3% in Somaliland in 2013 to 80.9 % by 2017 and 85% by 2019
		• **The HIV status of increased numbers of infants born to HIV positive is known within six weeks of birth**: The percentage of infants born to HIV positive women who received a virological test within six weeks of birth is increased no less than 80% annually
		• **More health facilities offer HIV testing and counselling services:** The number of health facilities that offer HIV testing and counselling services is increased from 51 in 2013 to 99 by 2017 and 130 by 2019
		• **More Maternal and Child health facilities offer HIV testing and counselling to mothers:** The percentage of MCH facilities that offer HIV testing and counselling services is 80% by 2019
		• **More pregnant women attending ANC services are tested for HIV:** The percentage of pregnant women attending ANC services who were tested for HIV and know their results is no less than 60% annually
		• **More TB facilities offer HIV testing and counselling**: The percentage of health facilities that provide TB services that offer HIV testing and counselling is increased from 46% in 2013 to 80% by 2019

	Pediatric and adult ART and PMTCT	• **More HIV positive pregnant mothers are provided with life-saving ART to protect them and their unborn child**: Percentage of HIV-positive pregnant women receiving antiretroviral therapy is no less than 80% annually • **More adults and children receive ARTs:** The number of adults and children with advanced HIV infection receiving antiretroviral therapy is increased from 1,748 in 2013 to 2,995 by 2017 and 4,000 by 2019 • **More health facilities offer ART services**: The number of health

		facilities that provide ART services is increased from 11 in 2013 to 29 (10 SCZ, 9 Puntland and 10 Somaliland) by 2017 and 32 (12 SCZ, 10 Puntland and 12 Somaliland) by 2019 • **More PLHIV on treatment are alive longer:** The percentage of adults and children known to be alive on treatment 24 months after initiation of ART is increased from 70.2% in 2013 to 71.3% in 2017 and 72% by 2019
	Pre-ART care	• **More health facilities offer Pre-ART care to eligible PLHIV:** The number of health facilities that offer Pre-ART care is increased from 21 in 2013 to 29 by 2019
	Nutrition and economic status of PLHIV	• **All clinically malnourished PLHIV are provided with therapeutic food:** The percentage of PLHIV in HIV care who received therapeutic or supplementary food in the last three months. • **All PLHIV enrolled in Pre-ART and ART care benefit from economic strengthening services:** The Number of HIV positive adults provided with funds for starting income generation is 2,995 by 2017 and 4,000 by 2019
	HIV Associated TB	• **HIV positive TB patients are provided CPT:** The percentage of HIV positive patients receiving CPT is increased from 72.3% in 2013 and maintained at >90% from 2017-2019 • **All HIV positive patients are screened for TB and status recorded and reported**: The percentage of HIV-positive patients who were screened for TB is increased from 65% in 2013 to >95%% in 2017 and maintained at >95% from 2017-2019 • **All eligible HIV positive individuals are provided INH prophylaxis**: Percentage of new HIV-positive patients starting Isoniazid Preventive Therapy (IPT) during the reporting period is increased to >80% by 2019.
	Laboratory and diagnostic services	• **Virological testing for infants is widely available**: The percentage of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants, on site or through Dried Blood Spots (DBS) is increased to 100% of all PMTCT sites by 2019 • **All ART facilities offer CD4 testing** The percentage of facilities providing ART using CD4 monitoring in line with national guidelines/policies on site or through referral is increased to 100% of ART sites by 2019
	Procurement and Supply chain Management	• **ART drugs are available to all that require them**: The percentage of health facilities providing ART that reported no stock-outs of ARV drugs lasting more than 1 week during the last 12 months is no less

	(PSM)	than 85% annually • **STI drugs are available to all that require them:** The percentage of health facilities providing STI diagnosis and treatment that reported no stock-outs of STI drugs lasting more than 1 week during the last 12 months is no less than 85% annually • **TB drugs are available to all that require them:** The percentage of health facilities providing TB drugs that reported no stock-outs of TB drugs lasting more than 1 week during the last 12 months is no less than 85% annually • **HIV test kits are available to all that require them:** The percentage of health facilities providing HTC that reported no stock-outs of HIV test kits lasting more than 1 week during the last 12 months is no less than 85% annually

4.3 Strengthen monitoring and evaluation (M & E) of the Somali response to HIV and AIDS

Monitoring and evaluation of the Somali response to HIV and AIDS is essential in order to: establish performance incentives for program implementers; to detect and address problems so that program redesign and improvement become standard operating procedures; provide early evidence of program effectiveness; and communicate to those infected and affected by HIV and AIDS in transparent and objective ways the efforts being made to improve prevention, care, treatment and mitigation programs. Monitoring and evaluation must be relevant, objective, transparent, and most importantly with its outputs as (i) a source of information on performance for the public and for donors; and (ii) a management tool for implementation agencies.

As previously mentioned, there has been insufficient monitoring and evaluation of the response to HIV and AIDS in Somalia. The strategic objective for this priority area is therefore that a functional M & E system is developed and in place.

In order to achieve the M&E objective, the following priority strategic actions are proposed:

- Continue biennial sentinel surveillance among pregnant women, STI patients and possibly TB patients
- Conduct integrated bio-behavioural surveys for sex workers and other Key Affected populations including IDUs followed by a Modes of Transmission study (MOT);
- Provide tailored training in M&E for implementers of HIV programs including the AIDS Commissions, MoHs and civil society;
- Provide technical assistance and mentorship for M&E coordination;
- Regularise on-site data verifications and data quality assurance
- Institutionalise data management, dissemination and use;
- Undertake regularly planned program assessment, reviews and Evaluations; and
- Strengthen supportive supervision
- Conduct PLHIV stigma index determination and survey of health workers attitudes towards HIV
- Compile a National Commitments and Policy Instrument (NCPI) report

- Strengthen vital registration
- Integrate HIV core indicators into HMIS

The table below outlines the key results during the period of this strategic plan to achieve the three objectives above:

Expected results	Monitoring and evaluation	• **Data quality is assured**: The percentage of HIV response implementing partners submitting timely, accurate and complete reports increased from 46% in 2013 to 70% in 2017 and 90% in 2019 • **The M & E system is fully functional and able to provide gender disaggregated data required to monitor the response**: Zonal M & E systems provide 100% indicator values (due) for the for the strategic framework results indicators annually • **Reviews of the response are undertaken annually :** 100% of Zonal AIDS Commissions have undertaken annual reviews of the zonal response to HIV and AIDS • **All planned M & E activities in plans are implemented**: 100% of the activities in the annual zonal M & E plans are implemented

4.4 Strengthen enabling environment

It is acknowledged that stigma and discrimination is prevalent and impedes access to and utilization of prevention, treatment and care and support services for all Somalis, particularly those residing in rural areas and Key Affected Populations. In order to create an enabling environment for the delivery of HIV and AIDS services in the country, this strategic framework emphasizes engagement with community, political, religious and media leaders to challenge and address HIV related stigma and discrimination and fight increase HIV knowledge stigma so that individuals find it easier to access services. Addressing HIV related stigma and discrimination is best led by PLHIV and therefore this strategic framework also emphasizes the engagement of these populations in challenging and addressing HIV related stigma. In addition, it is important to ensure that a policy and regulatory environment that enables an effective response to HIV and AIDS is created. Insufficient attention has been focused in this area during the life of the previous strategic framework and will be prioritized in the course of this Strategy.

There is growing recognition that women and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities - violence against them in particular. A gender assessment of the Somali HIV and AIDS response indicates that a substantial proportion of Somali women women have experienced violence in some form or another at some point in their life. In addition, like elsewhere social norms tend to be biased against the Somali women. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not. The NSP 2015-2019 therefore prioritises reduction of gender violence and gender inequality.

The Civil Society in the zones lack the capacity to engage meaningfully and to advocate for equitable and effective HIV and AIDS services and the rights of the people affected and infected.

The strategic objective for this priority area is improve the enabling environment for the delivery of HIV and AIDS services in Somalia. In order to achieve this objective, the following priority strategic actions are proposed:

- Sensitize and dialogue with religious, political, community leaders and the media to address HIV-related stigma, discrimination, GBV and gender inequality;
- Sensitize and dialogue with religious, cultural, political and other leaders on the importance of effective interventions among key affected populations such as FSWs and the role of condoms;
- Support the development and adoption of policies and laws that improve equitable and affordable access prevention, treatment, care and support services;
- Strengthen and support networks of PLHIV associations and CSOs to advocate successfully and sustainably for the adoption of supportive policies and to challenge and address HIV related stigma and discrimination within the health sector and in the community;
- Mainstream HIV into other Ministry/ sectoral strategies e.g. agriculture, health, education, Justice, interior (defence and police), labour and social affairs, youth, religion, information, women and human rights;
- Integrate HIV into all GBV action plans of the Ministries responsible for Women and Gender;
- Empower young girls and women as drivers for change in the areas of HIV prevention, care and support through innovative actions such as women support groups;
- Use promising approaches in the Shar'ia law to protect victims and survivors of sexual and gender based violence;
- Strengthen the legal and policy framework to address gender related barriers that impact on women, girls and other vulnerable groups from accessing comprehensive HIV prevention information and services;
- Strengthen religious leaders networks and recruit religious leaders as champions to address and challenge stigma and social norms that are biased against the female gender;
- Training of health care providers on human rights and medical ethics related to HIV to reduce stigma and discrimination in the health care settings;
- Tailor interventions that address stigma to each constituency to include children and other voiceless;
- Sensitize law enforcement and law makers and law enforcers understand well what are the HIV related legal issues and the rights of PLHIV and women sexually abused so that they do protect them.

The table below outlines the key results during the period of this strategic plan to achieve the three objectives above:

Expected results	Enabling environment	• **Intimate partner violence is reduced.** The reported intimate partner violence is reduced by 50% by 2017 and 80% by 2019. • **Services for victims of VAW/G are readily available.** The number of health facilities providing services for VAW/G increases by 50% by 2017 and 80% by 2019. • **Improved legal and policy environment as reported in the National**

		Commitments and Policy Instruments (NCPI) HIV policies are adopted: At least 3 zonal HIV and AIDS policy are developed and adopted by 2015 • **HIV related stigma is reduced amongst health workers:** The percentage of health workers who express accepting attitudes toward PLHIV is increased to 80% in 2015 and 85% or higher from 2016-2019 • **HIV related stigma is reduced in Somaliland:** The percentage of women aged 15-49 in Somaliland with accepting attitudes towards PLHIV is increased from 8.3% in 2011 to 85% by 2019 • **HIV related stigma is reduced in Puntland:** The percentage of men aged 15-49 in Puntland with accepting attitudes towards PLHIV is increased from 9.6% in 2011 to 85% by 2019 • **HIV related stigma is reduced in South Central:** The percentage of men aged 15-49 in South Central with accepting attitudes towards PLHIV is no less than 85% by 2019 • **CSO capacity for HIV and AIDS advocacy and service delivery is increased.** The percentage of registered HIV and AIDS CSOs that have received capacity building support is not less than 70% by 2019

4.5 Strengthen management and coordination of the response to HIV and AIDS

The Global fund to fight AIDS Tuberculosis and Malaria (GFATM) is the main source of funding for Somalia covering almost all of its HIV-related needs. The current gains could be threatened without sustainable funding that is guaranteed. Recently, the national response has witnessed funding cuts in crucial areas such as prevention which is a key pillar of programming given the characteristics of the epidemic. There might be a need to review these spending cuts and either source for alternative resources or re-program existing resource to mitigate the shortfalls. Sustaining of the gains and addressing new challenges should form the core efforts in addressing the epidemic which will continue to pose a serious health challenge in all parts of the country.

The strategic objective for this priority area is to strengthen management and coordination of the response to HIV and AIDS. This will be achieved through the following 4 priority strategic actions:

- Secure both domestic and external funding to implement the national response;
- Diversify funding sources and increase domestic expenditure to improve sustainability
- Strengthening the institutional capacity of the Zonal AIDS Commissions to coordinate multi-sectoral response; and
- Strengthening the institutional capacity of the Zonal Ministries of Health to coordinate the heath sector response to HIV and AIDS;
- Mainstream HIV in zonal development and Ministry/sector plans especially of Ministry of Health, Ministry of Women and Gender; Ministry of Justice, Ministries working with uniformed services (police and military) and Ministry of Education.

The table below outlines the key results during the period of this strategic plan to achieve the objective above:

Expected results	Management and coordination of the response	• 100% of the resources required to implement the strategic framework are mobilized by 2019 • The percentage of annual expenditure on HIV and AIDS that is domestic is no less than 9% by 2017 and no less than 15% by 2019 • 100% of activities in zonal operational plans have been implemented by 2017 and 2019 • HIV has been mainstreamed in the National Development Plans • HIV has been mainstreamed in all mandated ministries/sector plans

5. Risk and Mitigation strategies

In developing the strategic framework 2015-2019, a number risks that may affect its implementation have been identified. These potential risks and proposed risk mitigation strategies are described in the table 3 below. The following risk rating codes are used: **H** (high risk), **S** (substantial risk), **M** (Medium Risk), **L** (Low risk) and N (Negligible risk)

Risk	Risk Rating	**Proposed mitigations**	**Residual risk**
Sustainability may be jeopardized by continued reliance on one major funding source and without significant domestic contribution	**H**	Diversify funding sources beyond the Global Fund and increase domestic contribution by government.	**M**
Transaction costs of program implementation may affect efficiency and effectiveness of service delivery.	**H**	Increase domestic capacity for program management and implementation	**M**
Political and economic instability may limit the measurable effectiveness of proposed interventions in short and medium term	**H**	Lessons learnt during the past instability in Somalia and elsewhere have been well documented and will be used to guide HIV interventions in emergency and avoid disruptions in services	**S**
Policy, regulatory and legislative constraints may impede the achievement of key results especially in relation to interventions for sex workers (sex work is illegal and taboo and condoms religiously and culturally shunned in Somalia) and their clients	**H**	The strategy proposes legislative, policy and regulatory reforms in key areas as well as advocacy activities with key stakeholders and policy makers	**S**
Rapid scale-up of ART and PMTCT is central to this plan. Weak systems, capacity, infrastructure and HR availability may impede the achievement of key results	**H**	Technical assistance will also be provided to the zonal health ministries and implementers to ensure that implementation is not impeded	**L**
HIV and TB related stigma and discrimination will impedes utilization of HIV services proposed in this plan	**S**	The strategy proposes robust strategies and interventions to challenge and address HIV related stigma and discrimination at all levels	**M**
Limited health sector experience in enabling service delivery to Key Affected Populations such as Sex Workers	**M**	Sharing of experiences and or approaches from other national programs and technical capacity from partners on programming as well as implementing interventions to address HIV related stigma	**L**

Risk	Risk Rating	**Proposed mitigations**	**Residual risk**
		amongst health providers	
Weak health system with challenges of access to some locations make measurement of theeffectiveness of proposed health sector interventions difficult.	**H**	Resources have been committed to support health systems strengthening initiatives	**H**
Implementing partners (governments, private sector and communities) have limited capacity to implement interventions proposed	**H**	Capacity building of all implementing partners will be scaled up	**M**
If the Zonal AIDS commissions fails in their key role, coordinating and holding partners accountable for the implementation of Strategic framework 2015-2019, especially as it relates to reporting, implementation will suffer	**H**	Strengthening Zonal AIDS Commissions on their M&E functions and closely linking that with policy and coordination to ensure evidence is leading the implementation of interventions in the HIV national response	**M**
Weak capacity to develop and implement operational plans for the strategy that will guide results-oriented actions will may limit ability to achieve proposed results	**H**	Technical support will be sourced to build national capacity in action planning and implementation	**L**

6. Monitoring and Evaluation (M & E)

Monitoring and evaluation of NSP 2009-2013 was identified as a key challenge in the situation and response analysis. The plan did not include a monitoring and evaluation framework that identified for all expected results, the performance targets of indicators that would be used to assess progress.

A detailed M & E plan and costed action plan to accompany this strategy had been developed separately. For each core indicator, it outlines the definition, what it measures, method of determination, the baseline, targets, responsible body, data source, frequency of data collection limitations and where indicated, disaggregation by sex, age, zone. It will also presents a calendar of important M&E events during the strategy period as well as a list of important operational research studies and surveys to be conducted.

A midterm and end-of-term NSP evaluation will be conducted. The midterm evaluation will focus on achievements, challenges, emerging issues and recommendations for the remaining half of the NSP, and will take place in 2017. In addition to the midterm evaluation, joint annual program reviews will be conducted. This will require multi-sectoral stakeholders to come together at the end of each implementation year to review progress and challenges. The final NSP evaluation will be conducted in 2019 to provide the evidence base for the next strategic plan. Independent evaluators will carry out the midterm and end-term evaluations. *Performance evaluations* will be conducted at midterm (2017) and end term 2019 to address the question:

- "Are interventions working/making a difference?"

Impact evaluation will be conducted at end-term (2019) to address the question:

- "Are collective efforts being implemented on a large enough scale to impact the epidemic?"

6.1 Priority research studies and surveys

The following research studies and surveys have been prioritized during the NSP 2015-2019:

1) Integrated Bio-Behavioural Surveys of Key Populations
2) MoT Study
3) HIV risk and migrant populations
4) HIV risk and trade routes
5) PLHIV Stigma Index
6) ART Cohort analyses
7) Youth Behavioural Surveys

Table 4 articulates the baselines and expected targets of core indicators for the NSP 2015-2019.

Table 4: Baselines and expected targets of core indicators, 2015 to 2019

Indicators	Expected Results							Data compilation and Reporting	
	Baseline	2015	2016	2017	2018	2019	Data source	Institutional responsibility	Reporting Frequency
1. Preventing new infections									
Impact Indicators									
Estimated HIV incidence	0.06			0.05		0.04	Spectrum	Zonal AIDS Commission	Annual
% of female sex workers who are HIV infected	5.2			4.8		4.6	IBBS	Zonal AIDS Commission, Zonal MoH	Biennial
% of infants born to HIV infected mothers who are HIV infected	34			25		20	Spectrum and program reports	Zonal AIDS Commission, Zonal MoH	Annual
% of pregnant women aged 15-24 who are HIV infected									
-All 3 zones	0.34		0.34		0.34		ANC surveillance	Zonal MOH	Biennial
Somaliland	0.94		0.94		0.94		ANC surveillance	Zonal MOH	Biennial
Puntland	0.25		0.25		0.25		ANC surveillance	Zonal MOH	Biennial
South Central	0.17		0.17		0.17		ANC surveillance	Zonal MOH	Biennial
Outcome indicators									
BCC: % of young women aged 15–24 in who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission									
Somaliland	7			30		50	MICS	Zonal MoH	Every 3-5 years

Puntland	10			30		50	MICS	Zonal MoH	Every 3-5 years
South Central	4.3			30		50	MICS	Zonal MoH	Every 3-5 years
PMTCT : % of infants born to HIV positive women who received a virologic test within 6 weeks of birth	TBC	20	30	40	50	70	Program reports	Zonal MOH	Annual
PwP: % of PLHIV who reported having adopted and adhered to at least 2 key HIV prevention behaviours in the last 12 months		40	50	60	70	80	Survey among PLHIV enrolled in Pre-ART and ART program	Zonal MOH	Biennial
Key Populations: % of female sex workers who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	6.9			60		80	IBBS	Zonal AIDS Commission, Zonal MoH	Biennial
Key Populations: % of female sex workers reporting the use of a condom with their most recent client	24			48		72	IBBS	Zonal AIDS Commissions, Zonal MoH	Biennial
Youth: % of young men aged 15-24 who report they could get condoms every time it is needed	37					74	Youth Behavioral Survey	Zonal AIDS Commission, Zonal MoH	Every 3-5 years
Output Indicators									
BCC: Number of individuals from the targeted audience reached through community outreaches with at least one HIV information, education, communication or behaviour change communication (cumulative annually)[18]									
All Zones	3,915	7,200	10,000	13,000	16,000	19,000	Program reports	Zonal AIDS Commission	Annual

[18] This GF Top Ten indicator measures the number of individuals (key priority population) who attended community outreach activities focused on creating awareness on how to prevent HIV and decrease HIV and AIDS stigma against specific key populations and vulnerable groups.Community awareness is targeting: vulnerable people, IDPs, truck drivers, sex workers, migrants, khat sellers.

Somaliland	2,473	3,200	4,000	5,000	6,000	7,000	Program reports	Zonal AIDS Commission	Annual
Puntland	1,226	2,000	3,000	4,000	5,000	6,000	Program reports	Zonal AIDS Commission	Annual
South Central Zone	216	2,000	3,000	4,000	5,000	6,000	Program reports	Zonal AIDS Commission	Annual
HTC: Number of health facilities that offer HIV testing and counseling services	51	67	83	99	115	130	Program reports	Zonal MOH	Annual
HTC: Number of people who received testing and counseling services and have received their test results (cumulative annually)									
All Zones	27,234	31,000	38,000	46,000	57,000	70,000	Program reports	Zonal MOH	Annual
Somaliland	6,472	8,000	10,000	12,500	15,500	19,000	Program reports	Zonal MOH	Annual
Puntland	6,098	7,000	8,000	9,500	12,500	16,000	Program reports	Zonal MOH	Annual
South Central Zone	14,644	16,000	20,000	24,000	29,000	35,000	Program reports	Zonal MOH	Annual
HTC:% of female sex workers who received an HIV test in the last 12 months and who know the results	0			40		80	IBBS	Zonal AIDS Commission, Zonal MoH	Biennial
PMTCT: Number of pregnant women who were tested for HIV in MCH settings and who know their results (cumulative annually)									
All Zones	37,592	48,000	61,000	74,000	87,000	100,000	Program reports	Zonal MOH	Annual
Somaliland	10,229	14,000	18,000	22,000	26,000	30,000	Program reports	Zonal MOH	Annual
Puntland	11,800	15,000	19,000	23,000	27,000	31,000	Program reports	Zonal MOH	Annual

South Central Zone	15,563	19,000	24,000	29,000	34,000	39,000	Program reports	Zonal MOH	Annual
PMTCT: Number of HIV pregnant women who received antiretroviral to reduce the risk of MTCT (cumulative annually)									
All Zones	56	210	315	420	525	630	Program reports	Zonal MOH	Annual
Somaliland	46	110	165	220	275	330	Program reports	Zonal MOH	Annual
Puntland	9	40	60	80	100	120	Program reports	Zonal MOH	Annual
South Central Zone	1	60	90	120	150	180	Program reports	Zonal MOH	Annual
PMTCT: Number of health facilities that offer PMTCT	34	38	42	46	48	50	Program reports	Zonal MOH	Annual
Youth: Number of young people aged 10-24 reached by life skills-based HIV education									
All Zones	1,323	4,600	7,000	10,000	13,000	16,000	Program reports	Zonal AIDS Commission, MoE	Annual
Somaliland	559	1,600	2,000	3,000	4,000	5,000	Program reports	Zonal AIDS Commission, MoE	Annual
Puntland	0	1,000	2,000	3,000	4,000	5,000	Program reports	Zonal AIDS Commission, MoE	Annual
South Central Zone	764	2,000	3,000	4,000	5,000	6,000	Program reports	Zonal AIDS Commission, MoE	Annual
STI: Number of cases treated for STIs and referred for VCT (cumulative annually)									
All Zones	23,245	24,000	24,000	24,000	24,000	24,000	Program reports	Zonal MOH	Annual
Somaliland	2,897	3,000	3,000	3,000	3,000	3,000	Program reports	Zonal MOH	Annual

Puntland	4,837	5,000	5,000	5,000	5,000	5,000	Program reports	Zonal MOH	Annual
South Central Zone	15,511	16,000	16,000	16,000	16,000	16,000	Program reports	Zonal MOH	Annual
STI: % of health facilities providing STI diagnosis and treatment who reported no stock outs of STI drugs last more than 1 week in the last 12 months	TBD	100	100	100	100	100	Program reports	Zonal MOH	Annual
Blood screening: % of donated blood unit screened for HIV in a quality assured manner	99.4	100	100	100	100	100	Program reports	Zonal MOH	Annual
PEP: Number of health facilities offering HIV post exposure prophylaxis (PEP)	11	14	18	22	26	29	Program reports	Zonal MOH	Annual
PEP:% of health facilities offering PEP that experienced no stock out of PEP lasting more than 1 week in the last 12 months	TBD	100	100	100	100	100	Program reports	Zonal MOH	Annual
Number of health facilities that provide virological testing services for infant diagnosis for HIV exposed infants on site or through DBS	0	5	14	18	22	25	Program reports	Zonal MOH	Annual
Treatment, care and support									
Impact Indicators									
Estimated annual number of deaths due to AIDS	2,179	2,092	2,005	1,918	1,831	1,744	Spectrum	Zonal AIDS Commission	Annual
Outcome indicators									
ART: % of adults and children known to be alive and on treatment **12** months after initiation of antiretroviral therapy	79.2	80.0	80.5	81.0	81.5	82.0	Cohort analysis report	Zonal MoH	Annual
ART: % of adults and children known to be alive and on treatment **24** months after initiation of antiretroviral therapy	70.2	70.6	71.0.	71.3.	71..6	72.0	Cohort analysis report	Zonal MOH	Annual

ART: % of adults and children known to be alive and on treatment **36** months after initiation of antiretroviral therapy	66.0	66,3	66.8	67.0	67.3	67.5	Cohort analysis report	Zonal MOH	Annual
TB/HIV: % of TB patients who know their HIV status									
Combined target all 3 zones	52.4	55.0	58.0	62.0	66.0	70.0	Program reports	Zonal MOH	Annual
Puntland	48.0	53.0	60.0	70.0	80.0	90.0	Program reports	Zonal MOH	Annual
South Central	38.6	42.0	46.0	50.0	55.0	60.0	Program reports	Zonal MOH	Annual
Somaliland	74.9	80.0	84.0	88.0	92.0	95	Program reports	Zonal MOH	Annual
Output indicators									
ART: Number of Adults and children with advanced HIV infection (currently) receiving antiretroviral therapy (in accordance w/ the nationally approved treatment protocol)									
All Zones	1,748	3,021	3,657	4,293	4,929	5,565	Program reports	Zonal MOH	Annual
Somaliland	1,196	1,855	2,185	2,515	2,845	3,175	Program reports	Zonal MOH	Annual
Puntland	200	460	590	720	850	980	Program reports	Zonal MOH	Annual
South Central Zone	352	706	882	1,058	1,234	1,410	Program reports	Zonal MOH	Annual
ART: Number of health facilities providing ART using CD4 Monitoring in line with national guidelines on site or through referral	TBC	18	23	29	31	32	Program reports	Zonal MOH	Annual
ART: Number of health facilities that offer ART	11	18	23	29	31	32	Program reports	Zonal MOH	Annual

ART: % of health facilities offering ART that experienced no stock out of ARVs lasting more than 1 week in the last 12 months	TBC	100	100	100	100	100	Program reports	Zonal MOH	Annual
Pre-ART: % of HIV positive persons on Pre-ART or ART receiving CPT	TBC	100	100	100	100	100	Program reports	Zonal MOH	Annual
Pre-ART: Number of health facilities that offer pre-ART care	21	29	36	43	51	58	program reports	Zonal MOH	Annual
Care: % of pre-ART and ART facilities that offer CPT that reported no stock outs of CPT lasting more than 1 week during the last 12 months	TBC	100	100	100	100	100	Program reports	Zonal MOH	Annual
TB/HIV: Number of TB facilities that provide TB services that offer HIV Testing and counseling	36	38	42	44	48	52	Program reports	Zonal MOH	Annual
TB/HIV: % of HIV positive patients who were screened for TB	65	100	100	100	100	100	Program reports	Zonal MOH	Annual
TB/HIV: Number and percentage of new HIV-positive patients starting IPT during the reporting period	20 22.2%	50 42.7%	70 50.0%	80 55.0%	90 60.0%	100 65.0%	Program reports	Zonal MOH	Annual
TB/HIV: Number of TB patients counselled and tested for HIV									
All Zones	6,568	8,000	10,000	12,000	14,000	16,000	Program reports	Zonal MOH	Annual
Somaliland	2,853	3,200	3,800	4,500	5,200	5,900	Program reports	Zonal MOH	Annual
Puntland	792	1,200	1,900	2,500	3,200	3,800	Program reports	Zonal MOH	Annual
South Central Zone	2,923	3,600	4,300	5,000	5,600	6,300	Program reports	Zonal MOH	Annual

Nutrition: Number of HIV positive clinically malnourished clients receiving therapeutic or supplementary food	TBC	838	1,048	1,258	1,468	1,680	Program reports	Zonal MOH	Annual
Economic strengthening: Number of HIV positive adults provided with economic strengthening services	120	1,995	2,495	2,995	3,495	4,000	Program reports	Zonal MOH	Annual
Monitoring and Evaluation									
Output indicators									
% of HIV response implementing partners submitting timely and complete reports	46	75	80	85	90	100	Annual ZAC reports	Zonal AIDS commission	Annual
Number of Zonal AIDS commissions that have undertaken annual reviews of the zonal response to HIV and AIDS	0	3	3	3	3	3	Program reports	Zonal AIDS commission	Annual
% of activities in zonal M & E plan implemented	0	100	100	100	100	100	Annual M & E report	Zonal AIDS commission	Annual
Enabling environment									
Outcome indicators									
% of health providers who express accepting attitudes towards PLHIV	TBD	80		85		85	Health provider stigma survey report	Zonal AIDS commission	Every 3 to 5 years
Gender: Prevalence of recent intimate partner violence (IPV)				50		30	Population Based Survey	Zonal Ministry for Gender	Every 3 to 5 years
Stigma & Discrimination: % of women aged 15-49 in Somalia with accepting attitudes towards PLHIV									
Puntland	8.3					85	MICS	Zonal MoH	Every 3-5 years
South Central	9.6					85	MICS	Zonal MoH	Every 3-5 years

Somaliland	TBD					85	MICS	Zonal MoH	Every 3-5 years
Output indicators									
Gender: Proportion of health units that have commodities for the clinical management of VAW/G		30	35	40	45	50	Program reports	Zonal MoH	Annual
Policies: Number of zonal AIDS policies adopted by zonal government	1	3	3	3	3	3	Annual ZAC report	Zonal AIDS commission	Annual
Stigma & Gender: Number of leaders (Men and Women) sensitized on addressing HIV related stigma, discrimination, gender inequality and SGBV	TBD	90	90	90	90	90	Annual ZAC report	Zonal AIDS commission	Annual
Policies: National Commitments and Policy Instrument (NCPI) reports	1	1		1		1	NCPI report	Zonal AIDS commission	Annual
Management and coordination									
Output indicators									
Resource mobilization: % of strategic plan resource costs that are mobilized	0	80	90	100	100	100	Annual ZAC report	Zonal AIDS commission	Annual
Sustainability: % of expenditure on HIV and AIDS that is domestic	0	3	6	9	12	15	Annual ZAC report	Zonal AIDS commission	Annual
Implementation: % of activities in zonal operational plan implemented	0	60	70	80	90	100	Annual ZAC report	Zonal AIDS commission	Annual
Coordination: Number of HIV coordination meetings held per zone	4	4	4	4	4	4	Annual ZAC report	Zonal AIDS commission	Annual

7. Implementation arrangements

The effective implementation of this NSP will depend on the technical, material and financial support from the Somali Government and development partners. It will also rely on commitment from stakeholders at various levels.

The zonal AIDS Commissions will lobby and source various forms of support towards implementation of the strategy. The process will require building capacity of stakeholders so that they have requisite knowledge and skills to plan, implement and monitor prevention interventions. The Government through the Zonal AIDS Commissions will also work with key lead agencies and other coordinating organisations so that they continue to provide technical directions in HIV prevention programming. During the course of implementation, special attention will be paid to emerging issues so that they are incorporated and addressed depending on the evidence.

For accountability purposes and at the same time adhering to the 'Three Ones principle', the Zonal AIDS Commissions will provide leadership and coordinate the implementation of the strategy in the three zones. However, implementation of various components of the strategy will be housed to mandated line government ministries and coordinating organisations.

Integration: The Essential Package of Health Services (EPHS), Somalia's newly adopted framework for primary health care services will be used for the delivery of health sector HIV and AIDS services at ART, PMTCT and HTC accredited facilities.

The NSP seeks to simplify implementation arrangements where possible and to further strengthen integration of HIV and AIDS into the health and development.
The table below outlines the respective roles and responsibilities of key entities involved in supporting the Somali response to HIV and AIDS

Entity	**Role**
Organisations of People Living with HIV	• Voice and accountability activities • Meaningful representation of PLHIV in all relevant coordination, planning and monitoring structures • Participation in all design, planning , implementation and monitoring of the HIV and AIDS response
Zonal AIDS Commissions (ZAC)	• Coordination of the multisectoral response to HIV and AIDS in the zones • Guide the development and review of zonal multisectoral strategic frameworks and operational plans for HIV and AIDS • Facilitate HIV and AIDS multisectoral policy and bill development, adoption, dissemination and periodic review; • Identify obstacles to AIDS control policy and program implementation; • Ensure implementation and attainment of program activities and targets;

Entity	Role
	• Lead resource mobilization allocation and tracking of effective utilization; • Collect and collate aggregated data from regions, ministries and other partners ; and • Disseminate information on HIV and AIDS and its consequences • Monitor and evaluate the overall zonal response to HIV and AIDS
Zonal Ministries of Health	• Guide the development and review of zonal Health sector strategic plans for HIV and AIDS • Develop and review policy guidelines for the health sector HIV response • Ensure implementation and attainment of Health sector HIV program activities and targets respectively; • Collect and collate HIV aggregated data from health sector; • Monitor and evaluate the overall health sector response to HIV and AIDS • Integrate HIV and AIDS services into health systems
Mandated Ministries	• HIV and AIDS services delivery and program implementation within their mandates • Review of Ministry plans and policies impacting on the AIDS response. • Monitor and evaluate of the Ministry HIV and HIV programs • Mainstream HIV and AIDS in their core business • Workplace policies and programs with the Ministry
Joint UN team on HIV and AIDS (JUNTA)	• Facilitate timely access by national partners to the collective technical support within the UN system and outside; • Support the design, development, implementation, monitoring and evaluation of the national HIV strategy and zonal operational plans; • Support the design, development, implementation, monitoring and evaluation of major grant proposals; and • Mobilize resources for technical assistance
Civil Society organisations	• Advocacy • Service delivery based on expertise and comparative advantage • Participate in decision making platforms for the response e.g. review meetings

8. Cost of implementing the Strategic Plan for 2015-19

The cost of delivering the targets set out in this strategic plan was conducted through an activity based costing methodology. Budgeting was done on an input cost basis. It was developed by examining all the elements of the various activities and interventions vis-a-vis the inputs that were the cost drivers for the various strategies recommended in the NSP.

This section provides a summary of the costing while the detailed cost estimates by Zone are contained the workplans.

The total resource needs for the strategic plan from 2015 to 2019 are estimated at USD$ 57,885,563. A detailed summary of the resource needs for 2015-2019, costed by thematic and program areas, is presented section 10.

Based on this costing, Somalia, through this strategic plan, will allocate about 53% of its resources to HIV treatment, care and support, 14% to prevention of new HIV infections, 15% to strengthening management and coordination, 8% to Monitoring and Evaluation and 10% to the creation of an enabling environment for the Somali response to HIV.

9. Prioritization of the Strategic Plan for 2015-19

The following prioritization criteria of strategic actions were agreed upon and used for ranking:

- Clear evidence that the proposed strategic action matches current patterns of HIV transmission
- Clear evidence that the proposed strategic action has public health benefits in terms of reducing the onward transmission of HIV
- Strategic actions that need to continue because of their importance in sustaining the gains already gained in prevention
- Clear evidence that proposed strategic action reduces the incidence of AIDS related Tuberculosis
- Clear evidence that the proposed strategic action is an essential (absolutely necessary) enabler that creates an environments conducive to rational HIV responses

Using the criteria above, the following strategic actions were ranked of highest priority and should be supported at all costs:

Under reduce sexual transmission of HIV:

- Implement integrated Social Behavior Change Communication (iSBCC) interventions for Uniformed Personnel, fisherman, truck drivers, khat sellers
- Implement Combination HIV Prevention interventions for Sex Workers and their clients
- Improve and scale-up targeted condom use focused on KAP
- Ensure adequate supply of STI diagnostics and drugs
- Ensure adequate screening of blood
- Infection Control and Post-Exposure Prophylaxis (PEP)

Under treatment, care and support and PMTCT:

- Increasing the number of mobile HTC sites targeted at Key Populations Most at Risk (KPRs) (FSWs, truck drivers, port workers, fishermen, migrants etc)
- Ensure the availability of HTC commodities (test kits, gloves, condoms, etc.)
- Adopt the new WHO ART (CD4 500) and PMTCT (Option B+) guidelines
- Increase demand for ANC, HIV and PMTCT through community mobilization
- Procure & supply ARV drugs
- Establish and scale up Early Infant Diagnosis (EID)
- Strengthen and scale up CD4 Testing
- Strengthen and scale up Viral Load (VL) Testing
- Procure and supply lab and diagnostic reagents for ART, TB
- QA for Lab Services
- Expand and improve HIV-TB co-infection management
- Strengthen forecasting and quantification HIV &TB products and pharmaceuticals
- QA for health products and commodities
- Scale up access to HIV testing among TB patients
- Scale up access to CPT for HIV positive patients
- Scale up access to ART for positive TB patients
- Scale IPT for TB negative HIV positive patients
- Scale up TB screening among PLHIV
- Scale up nutrition care, support & treatment at ART sites
- Mitigate the impact of HIV among PLHIV
- Scale-up CPT for PLHIV
- Improve treatment retention and strengthen referral/linkages from HTC to pre-ART care

Under Monitoring and Evaluation:

- Strengthen HIV surveillance
- Strengthen supportive supervision
- Strengthen HR capacity for M&E
- Strengthen M&E coordination
- Strengthen routine program monitoring
- Strengthen data management, dissemination and use
- Undertake regularly planned program assessment and reviews

Under enabling environment:

- Strengthen networks of religious leaders and women groups to address HIV-related stigma, discrimination, gender inequality and GBV
- Sensitization of religious, political and community leaders to address HIV-related stigma, discrimination, gender inequality and GBV
- Capacity building of networks of PLHIV associations and CSOs working on HIV and AIDS

Under Management and Coordination

- Secure funding to implement national response

10. Five year annualized budget for the strategy by theme, strategy and strategic actions

	BUDGET - SOMALI 3 ZONES - cost summary by theme, strategy and strategic action (USD)	2015	2016	2017	2018-PRJ	2019-PRJ	5-YR TOTAL-PRJ
	TOTAL PROGRAM COST	**9,496,016**	**12,355,704**	**12,581,938**	**11,527,995**	**11,923,910**	**57,885,563**
1.0	**PREVENTION**	**1,434,945**	**1,644,207**	**1,817,037**	**1,686,776**	**1,734,640**	**8,317,605**
1.1	**Reduce Sexually Acquired Infections**	**1,065,193**	**1,326,503**	**1,444,691**	**1,266,564**	**1,266,564**	**6,369,514**
1.1.1	Develop and implement prevention with Positives (PwP) interventions	98,110	115,525	146,013	146,013	146,013	651,673
1.1.2	Implement integrated Social Behavior Change Communication (iSBCC) interventions for Uniformed Personnel	34,952	7,800	7,875	7,875	7,875	66,377
1.1.3	Implement Combination HIV Prevention interventions for Sex Workers and their clients	205,722	271,350	351,921	351,921	351,921	1,532,836
1.1.4	Expand access to SBCC and increase HIV awareness in the general population	156,000	156,000	156,000	156,000	156,000	780,000
1.1.5	Expand access to SBCC and increase HIV awareness among the youth	510,306	723,352	688,432	510,306	510,306	2,942,701
1.1.6	Improve and scale-up condom use by implementing the 10-step strategic approach to comprehensive condom programming (CCP)	60,103	52,475	94,450	94,450	94,450	395,928
1.2	**Reduce Prevalence of and Morbidity from STI**	**187,089**	**224,130**	**262,430**	**297,699**	**332,969**	**1,304,318**
1.2.1	Ensure adequate supply of STI diagnostics and drugs	162,729	199,770	238,070	273,339	308,609	1,182,518
1.2.2	Improve Quality Assurance (QA) for STI management	24,360	24,360	24,360	24,360	24,360	121,800

1.3	**Prevent HIV Transmission through Blood, Blood Products and Invasive Procedures**	**182,663**	**93,574**	**109,917**	**122,512**	**135,107**	**643,773**
1.3.1	Develop and implement blood transfusion strategy	10,337	3,000	3,000	3,000	3,000	22,337
1.3.2	Ensure adequate screening of blood	159,488	73,206	85,018	97,613	110,208	525,533
1.3.3	Infection Control and Post-Exposure Prophylaxis (PEP)	12,837	17,368	21,899	21,899	21,899	95,903
2.0	**TREATMENT, CARE and SUPPORT**	**4,693,640**	**5,737,223**	**6,965,623**	**6,351,214**	**6,775,686**	**30,523,387**
2.1	**Increase Availability and Coverage of HIV Testing and Counselling (HTC)**	**542,309**	**653,461**	**769,032**	**710,439**	**753,928**	**3,429,170**
2.1.1	Develop and Implement Provider-Initiated Testing and Counselling (PITC)	71,376	79,039	91,121	79,039	79,039	399,612
2.1.2	Increasing the number of mobile HTC sites targeted at Key Populations Most at Risk (KPRs)	240,000	300,000	360,000	270,000	270,000	1,440,000
2.1.3	Ensure the availability of HTC commodities (test kits, gloves, condoms, etc.)	206,573	250,062	293,552	337,041	380,530	1,467,758
2.1.4	Strengthen HTC QA and supervision	24,360	24,360	24,360	24,360	24,360	121,800
2.2	**Scale-Up Availability of High Quality Adult and Pediatric ART and PMTCT Services**	**2,480,790**	**3,237,424**	**4,013,436**	**3,673,849**	**3,933,241**	**17,338,739**
2.2.1	Adopt the new WHO ART (CD4 500) and PMTCT (Option B+) guidelines	432,513	562,606	823,979	225,000	225,000	2,269,098
2.2.2	Prevent unintended pregnancies among PLHIV	27,962	57,546	91,793	91,793	91,793	360,887
2.2.3	Increase demand for ANC, HIV and PMTCT through community mobilization	223,006	381,088	420,088	420,088	420,088	1,864,358
2.2.4	Procure & supply ARV drugs	1,232,111	1,491,503	1,750,895	2,010,287	2,269,678	8,754,474
2.2.5	Strengthen existing ART facilities, QA and supervision	542,544	722,027	904,027	904,027	904,027	3,976,650
2.2.6	Strengthen Private Sector engagement in the delivery of ART/PMTCT services to expand treatment options	22,654	22,654	22,654	22,654	22,654	113,272

2.3	**Strengthen Laboratory and Diagnostics Services for ART, TB and PMTCT Delivery**	**838,535**	**894,011**	**1,131,366**	**860,909**	**928,272**	**4,653,092**
2.3.1	Strengthen and scale up Early Infant Diagnosis (EID)	15,355	21,144	25,675	25,675	25,675	113,523
2.3.2	Strengthen and scale up CD4 Testing	362,834	474,738	607,819	270,000	270,000	1,985,391
2.3.3	Strengthen and scale up Viral Load (VL) Testing	185,163	46,079	43,174	43,174	43,174	360,765
2.3.4	Procure and supply lab and diagnostic reagents for ART, TB	275,183	352,050	454,697	522,060	589,422	2,193,413
2.3.5	QA for Lab Services	-	-	-	-	-	-
2.4	**Reduce the Burden of HIV-Associated Tuberculosis (TB)**	**87,014**	**148,303**	**172,775**	**172,775**	**172,775**	**753,641**
2.4.1	Expand and improve HIV-TB co-infection management	87,014	148,303	172,775	172,775	172,775	753,641
2.5	**Strengthen Health Procurement and Supply Chain Management Capacity for Health Products and Pharmaceuticals**	**224,366**	**216,738**	**220,161**	**220,161**	**220,161**	**1,101,586**
2.5.1	Strengthen forecasting and quantification HIV &TB products and pharmaceuticals	55,875	55,875	55,875	55,875	55,875	279,375
2.5.2	Procurement systems and planning	-	-	-	-	-	-
2.5.3	Strengthening receipt, storage & inventory management	72,000	72,000	72,000	72,000	72,000	360,000
2.5.4	Strengthen distribution and Logistics Management Information System (LMIS)	12,098	9,549	11,558	11,558	11,558	56,320
2.5.5	QA for health products and commodities	84,393	79,313	80,728	80,728	80,728	405,890
2.6	**Improve nutritional and economic status of PLHIV**	**382,827**	**420,478**	**463,034**	**488,252**	**513,470**	**2,268,061**
2.6.1	Scale up nutrition care, support & treatment at ART sites	90,012	127,663	170,219	195,437	220,655	803,986
2.6.2	Mitigate the impact of HIV among PLHIV	292,815	292,815	292,815	292,815	292,815	1,464,075
2.7	**Strengthen Pre-ART Services**	**137,799**	**166,809**	**195,819**	**224,830**	**253,840**	**979,097**
2.7.1	Scale-up CPT for PLHIV	137,799	166,809	195,819	224,830	253,840	979,097

2.7.2	Improve treatment retention and strengthen referral/linkages from HTC to pre-ART care	-	-	-	-	-	-
3.0	**MONITORING and EVALUATION**	**564,867**	**2,082,994**	**759,936**	**600,186**	**600,186**	**4,608,168**
3.1	**Effectively Monitor and Evaluate the National Response to HIV**	**564,867**	**2,082,994**	**759,936**	**600,186**	**600,186**	**4,608,168**
3.1.1	Strengthen HIV surveillance	13,920	1,504,329	13,920	13,920	13,920	1,560,009
3.1.2	Strengthen supportive supervision	196,220	252,519	254,559	254,559	254,559	1,212,415
3.1.3	Strengthen HR capacity for M&E	111,875	111,875	111,875	111,875	111,875	559,375
3.1.4	Strengthen M&E coordination	24,165	24,165	24,165	24,165	24,165	120,823
3.1.5	Strengthen routine program monitoring	35,880	42,100	47,660	47,660	47,660	220,960
3.1.6	Strengthen data management, dissemination and use	101,601	66,801	66,801	66,801	66,801	368,807
3.1.7	Undertake regularly planned program assessment and reviews	81,206	81,206	240,956	81,206	81,206	565,779
4.0	**ENABLING ENVIRONMENT**	**1,195,804**	**1,159,004**	**1,157,544**	**1,157,544**	**1,081,123**	**5,751,020**
4.1	**Improved Enabling Environment for the Delivery of HIV and AIDS Services**	**1,195,804**	**1,159,004**	**1,157,544**	**1,157,544**	**1,081,123**	**5,751,020**
4.1.1	Sensitization of religious, political, media and community leaders to address HIV-related stigma and discrimination	923,763	923,763	923,763	923,763	923,763	4,618,815
4.1.2	Strengthen networks of PLHIV associations	102,166	89,706	89,706	89,706	89,706	460,990
4.1.3	Design, review, finalization and operationalization of policies and laws	102,221	77,881	76,421	76,421	-	332,944
4.1.4	Mainstreaming HIV into other strategies	67,654	67,654	67,654	67,654	67,654	338,272
5.0	**MANAGEMENT and COORDINATION**	**1,606,760**	**1,732,275**	**1,881,798**	**1,732,275**	**1,732,275**	**8,685,384**
5.1	**Improve Program Management & Coordination for HIV**	**1,606,760**	**1,732,275**	**1,881,798**	**1,732,275**	**1,732,275**	**8,685,384**
5.1.1	Secure funding to implement national response	7,551	7,551	146,301	7,551	7,551	176,507

5.1.2	Strengthen the institutional capacity of the NAC to coordinate multi-sectoral national response	693,772	693,772	693,772	693,772	693,772	3,468,860
5.1.3	Strengthen the institutional capacity of the MOH to coordinate the heath sector response to HIV and AIDS	391,411	391,411	391,411	391,411	391,411	1,957,055
5.1.4	Strengthen the coordination in national response to HIV and AIDS among the Somali Zones	514,025	639,541	650,314	639,541	639,541	3,082,962

11. Annexes

Annex 1- List of participants and stakeholders attending zonal strategy and operational planning and development workshops in Somaliland, Puntland and South Central in January and February 2014

Somaliland participants

Name	Organisation/Constituency
Abdulkhadir Hussien Rabile	SOLNAC
Aden Ismail Gedi	SOYVO
Abdiqadir Mohamed Ali	YOVENCO
Abdillahi Abdirehman Moge	SOLNAC
Abdirehmand Hassan Yusuf	Ministry of Religion and Endowment
Amran Hassan	PLHIV
Abdillahi Elmi Ali	anppcan-som
Abdulqadir Hussein Rabile	SOLNAC
Abdirashid Hashi Abdi	UNICEF
Adan Ismail	SOYVO
Ahmed Omar Mohamed	SAHAN
Ahmed Yusuf Mire	SOLNAC
Ahmed Abdi Muse	HPA
Adam H Farah	UNFPA
Abdullahi Elmi Ali	ANPPCAN Som
Abdulaziz Saed Saleh	YOVENCO
Abdillahi Abdirehman	Ministry of Religion and Endowment
Abdiqadir Hassain Ali	Ministry of Religion and Endowment
Abdala Saed Abdi	SOLNAC
Abdi Ali Jama	SOLNAC
Abdi Khadar mohamed	YOVENCO
Abdikariim Mohamed Muse	Ministry of Religion and Endowment
Abdikarim ibrahim Mayagaag	SOS
Abdikarim M Yusuf	HAVOYOCO
Abdikarim mohamed	Ministry of Religion and Endowment
Abdillahgi Elmi Ali	anppcan-Som
Abdillahi Abdirehman	SOLNAC
Amren Yasin	UNDP
Anab Gulaid	Volunteer
Anwar Warsame	SAHAN
Binit Jamaa Ahmed	Ministry of Health
Deq Said Jama	WHO

Name	Organisation/Constituency
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Dr. Adam Habibeh Farah	UNFPA
Dr. Deq Said Jama	WHO
Dr. Mohamed Hamud Ahmed	COOPI
Foosiya mohamed	Alraxma/PLHIV
Gulaid Osman	TALOWADAG
Hassan Adan Ali	SOLNAC Consultant
Hassan Ahmed Saled	SOLNAC
Hassan Omar	Ministry of Health
Ibrahim Hussien Ali	UNDP
Ismail Khalif Adan	SOLNAC
Kaise Hassan Absiye	SDF
Kayse Mohamed Abdi	SOLNAC
Koos Mohamed	Alraxma/PLHIV
Liban Ahmed Bile	SOYVO
Madhi Ismail	PLHIV
Mahdi Hussien Saleeban	CCS
Mahdi Ismail	PLHIV
Mahdi Jama Nur	SOLNAC Consultant
Martin Odiit	UNAIDS
Mohamed Abdi Ali	SAHAN
Mohamed Abdillahi Jama	Mercy USA
Mohamed Ali	SAHAN
Mohamed Ibrahim Qalinle	WVI
Mohamed Osman Abdiilahi	SOLNAC/Volunteer
Mohamed Said Abdiqani	
Mohamoud Mohamed	Ministry of Religion and Endowment
Mowlid Osman	UNFPA
Mubarag Hassan Saban	SOLNAC
Mubarak Mohamoud	IOM
Mubarik Hassan	SOLNAC
Mubarik Mohamoud	IOM
Omar Abdi Ismail	SOLNAC
Richard Matikanya	KPMG
Ruth Pfleiderer	UNDP
Sahra Gulaid	SOLNAC
Sh. Abdirehman Sh. Farah	Ministry of Religion and Endowment
Sh. Mohamed Sh. Ismail	Ministry of Religion and Endowment
Sh. Abdirahman Hassan	Ministry of Religion and Endowment
Thomas Kisimbi	KPMG

Name	Organisation/Constituency
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South-Central Somalia participants

Name of participant	Organization/Constituency
Mohamed A. Mahdi	IPA
Thomas Kisimbi	KPMG
Idow Sheikh Ali	IPA
Abdulahi Jama Hassan	Sophpa
Mohamed Abdurahman Mohamud	SCAC
Hassan Warsame Nur	SCAC
Abdulahi Osman Ali	Wesin Gutb
Hussein Mohamed Ibrahim	Baidoa Model school
Abdullahinur Sheikh Kassim	IOM
Hussein Hassan Abdullahi	Ksiwara
Abdi Aim M. Guled	Ministry of information
Yasin Mohamed Ibrahim	BWHG
Yassin Ali Mohamed	SWHG
Abdulkadir Abukar Abdullahi	OSPad
Sadia Alsamad	MOH
Safuju Sheikh Abdullahi	Mercy USA
Amina Abdi Isman	IIDA
Mohamed Said Shire	PLHIV. Net
Abdulrahman Ibrahim Ada	COCO
Mohamed Mohamoud Osman	SCAC
Hussein Sheikh Abdik.	Office of the Prime Minister
Mohamed Osman Ahmed	President office

Name of participant	Organization/Constituency
Luul Iftin Mohamed	AWC
Fatuma Muhumed	UNFPA
Abdikarim Mohamed Sharif	AAWDO
Martin Odiit	UNAIDS
Ruth Pfleiderer	UNDP
Sadad Mohamed Nur	Ministry of Gender
Ibrahim Hussein Ali	UNDP
Ahmed Mohamed Jimaale	SCAC
Rukia Ibrahim Abdullahi	SCAC
Abdirahman Abdullah	MOH Somalia
Abdiaziz Omar	HDC

Puntland participants

Name of Participant	Organization/constituency
Alwali M. Adam	MOH
Sh. Abdirizak Hussein Isse	Religious Leader
Suliman Said Noor	MOICCH (Ministry of Information)
Ali Farah Samatar	TIDES
Abdinaasir Mohamed Osman	Gardo/ VCT
Abdalle Mohamed Muse	PLHIV
Adam Abdulkadir Mohamed	Galkaio Medical Center
Dr. Ahmed Bulhan	Bossaso VCT/ART center
Abdirahman Aden	WFP
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Name of Participant	Organization/constituency
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Mohamoud Warsame Maxamed	PLHIV
Fadumo Adan Ali	PAC RM&E-Gardo
Safia Jama Gayre	MOWFSA (Ministry of Women, Family and Social Affairs)
Mohamed Abdulahi Mohamoud	PAC RM&E-Bosaso
Faadumo Ahmed Yussuf	PAC RM&E-Baran
Abubakar Sheikh Ahmed	WHO
Sharmake Abdi Elmi	PAC NM&E
Abdikadir Mohamud Abdi	PAC RM&E- Galkaio
Abdihakim Noor Khalif	Y - PEER
Abdirashid Ismail Xasan	PLHIV
Salebaan Mohamed Ismail	MOLYS (Ministry of Youth and Labour)
Adnan Ahmed Said	MOH – NTP (National TB Program)
Mohamed Duale Ahmed	MOJRA (Ministry of Justice and Religious Affairs)
Zainab Osman Mohamud	PUNCHAD
Zahra Abdi Mohamoud	UNFPA
Zam Zam Osman Ibrahim Xsan	Y – Peer
Nawal Abdi Mohmood	Personal
Abdiqafar Abdirahan	Kaalo
Abdirahmaan Haji Abdi	SOMDA
Faiza Abdirashid	UNICEF
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Saadiq Hirsi Saman	PAC – RM&E-Garowe

Name of Participant	Organization/constituency
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Mohamed Musse Mohamed	TIDES
Hawo Yusuf Osman	MOH / PMTCT
Dr. Maymun Farah Samatar	Galkaio VCT/ART center
Bahsan Hassan Mohamed	Badbaado
Dr Ahmed Ismail Jama	Local NSP Consultant
Thomas Kisimbi	International Consultant
Dr Martin Odiit	UNAIDS
Dr Abdisalam M. Hersi	MoH
Ahmed Dahir Warsame	MOH
Hamdi Ahmed Said	RDI
Maxmud Said Maxed	DMO Roko
Ruth Pfleiderer	UNDP
Fatuma Muhumed	UNFPA
Mohamed Abdulkadir	WHO
Said Mohamed Jama	WHO
Bahsan Ahmed Said	UNFPA
Habubo Nuh	Garowe VCT/ART
Dr Idil Mohamud	PAC/Garowe Hospital

Annex 2- List of participants and stakeholders attending the joint zonal stakeholders Strategic Plan validation workshop in Kampala, from 16th to 18th April 2014

Somaliland

Name	Organisation
Prof.Abdi Ali Jama	SOLNAC
Sarah Aden Guled	SOLNAC
Faiza Ahmed Ibrahim	MOH
Khadra Mohamed Ibrahim	MOH
Abdirahman Abdillahi Mohamed	INGO Progressio
Mr Yasin Qalinle Kahin	LNGO
Miss Amran Hassan Ahmed	PLHIV
Abdiaziz Mohamed Ali	MARPs CSO
Cris Batista	INGO Progressio

Puntland

Name	Organisation
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Mohamed Shire Abdi	PAC
Dr. Abdisalam Mohamed Hirzi	MOH
Dr. Abdirahman Mohamed Abdi	INGO SCF-UK
Abdi Ibrahim Hassan	LNGO TIDES
Abdala Mohamed Muse	PLHIV
Bahsan Hassan Mohamed	MARPs Badbaado CSO
Sharmake Abdi	UNDP

South-Central

Name	Organisation
Ahmed Mohamed Jimale	SCAC
Abdullahi Hashi Hassan	SCAC
Dr. Abdirizaak Yusuf Ahmed	MOH
Dr. Saadia Abdisamad Abdullahi	MOH
Safia Aheikh Abdullahi	INGO - Mercy USA
Abdirahman Ibrahim Adam	LNGO- COCO
Mohammed Said Shire	PLHIV network
Abdiaziz Adam Omar	MARPs - HDC-CSO
Ibrahim Ali	UNDP

Partners

Name	Organisation
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Richard Matikanya	KPMG-Consultant

Thomas Kisimbi	KPMG-Consultant
Martin Odiit	UNAIDS
Betty Oloo	WHO HSC Liaison
Rogers Busulwa	WHO
Vianney Rusagara	World Vision International/ TB GFATM Grant Principal Recipient
Salma Taher	IOM
Jane Kamau	UNESCO
Chiara Pierotti	UNICEF/HIV GFATM Grant Principal Recipient
Dr. Innocent Mwesigye	IGAD
Dr. Elduma Mohammed	IGAD
Afework Kassa	IGAD
Fatuma Muhumed	UNFPA
Robert Basil	FAO
Walter Mukwana	LFA
Amy Clancy	GFATM
Carin-Marie La Cock	GFATM
Patrick Manyange Osoro	GFATM
Derek Sedlacek	USAID