HIV/AIDS IN SOMALIA

HIV Epidemic and its Response 2003-2005

Joint United Nations Programme on HIV/AIDS

UNAIDS

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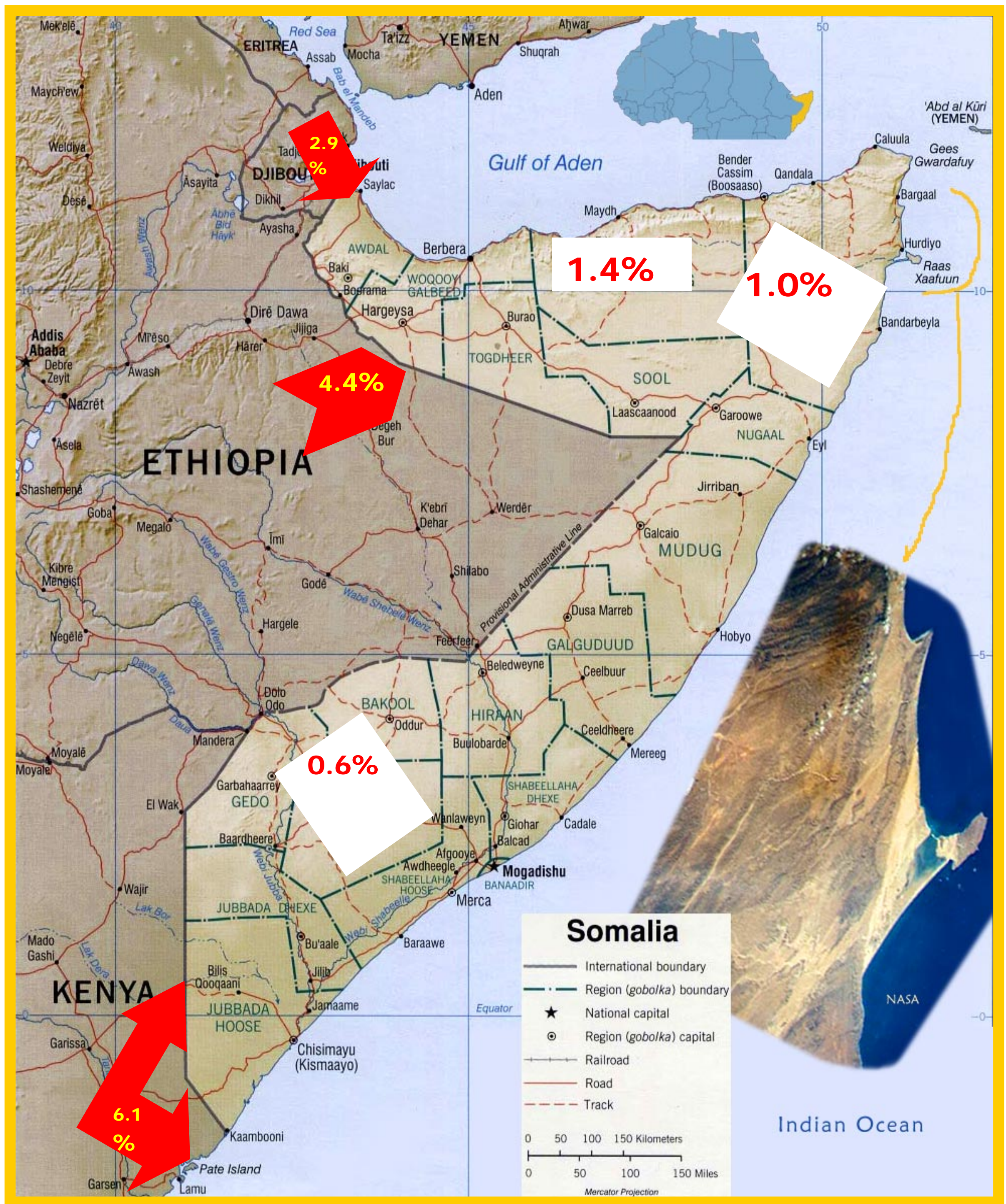
Draft Report

On the UNGASS Declaration of Commitment

December, 2005

Acronyms

1.	AIDS	Acquired Immune Deficiency Syndrome
2.	HIV	Human Immunodeficiency virus
3.	GFATM	Global fund on AIDS TB and Malaria
4.	DFID	Department for International Development (UK)
5.	UN	United Nations
6.	ARV	Anti-retroviral drugs
7.	IGAD	Inter-Governmental Authority for Development
8.	TNG	Transitional National Government
9.	TFG	Transitional Federal Government
10.	UNDP	United Nations development programme
11.	WHO	World Health Organization
12.	TB	Tuberculosis
13.	UNICEF	United Nations Children Fund
14.	UNAIDS	United Nations Joint HIV/AIDS Programme
15.	KABP	Knowledge Attitude Belief and Practice
16.	STD	Sexually Transmitted Disease
17.	ICD	International Cooperation Development
18.	MCH	Maternal Child Health
19.	PMTCT	Prevention of Mother to Child Transmission
20.	MSF	Medecines Sans Frontiers
21.	FGM	Female Genital Mutilation
22.	VCCT	Voluntary confidential counselling and testing
23.	CAP	Consolidated Appeal process
24.	IDP	Internally Displaced Persons
25.	IPTCS	Integrated Prevention Treatment Care and support
26.	UNISP	United Nations Implementation Support Plan
27.	PLHIV	People Living with HIV
28.	IEC	Information, Education and Communication
29.	BCC	Behavioural Change Communication
30.	GBV	Gender Based Violence



Source-WHO 2004 Advocacy Report

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Table 1: STATUS AT A GLANCE

NATIONAL COMMITMENT & ACTION

1. Amount of national funds disbursed by government.**(US$30,000 in Somaliland), Puntland (USD 10,000) (SOLNAC and PAC Report 2004)**
2. Percentage of schools with teachers who have been trained in life-skills-based education and who taught it during the last academic year: **No data**
3. Percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes: **No data**

GLOBAL COMMITMENT AND ACTION

4. Amount of bilateral and multilateral financial flow including GFATM, DFID, Regular UN Agency budget, International NGO. **$12,383,876. for 2004/2005 (UCC Report, 2004, UNICEF Report, 2005, Global Fund, 2005 DFID/UNDP Report)**

Knowledge and Behaviour

5. Percent of respondents 15-24 years of age who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or prevention: **Males – 12.5%, Females –7.9% (KABP Survey, UNICEF, 2004)**
6. Percent of people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner: **(No data)**
7. Percentage of [most-at-risk population(s)] who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. **No data**
8. Percentage of female and male sex workers reporting the use of a condom with their most recent client. **No data**
9. Percentage of men reporting use of a condom the last time they had anal sex with a male partner. **No data**
10. Percentage of injecting drug users who have adopted behaviours that reduce transmission of HIV, i.e., who avoid using non-sterile injecting equipment and use condoms, in the last 12 months. **No data**
11. Percentage of the population who have ever heard of HIV: **Males – 67.1%, Females – 57.1% (KABP Survey, UNICEF, 2004)**
12. Percentage of the population who have ever heard of AIDS: **Males – 79.6%, Females – 71.3% (KABP Survey, UNICEF, 2004)**
13. Percentage of the population who mention use of condom as a prevention tool (out of those who had ever heard of AIDS): **Males - 24.1%, Females – 11.4% (KABP Survey, UNICEF, 2004)**
14. Percentage of the population who have ever used condoms (out of those who have ever heard of condoms): **Males – 16.2%, Females – 8.7% (KABP Survey, UNICEF, 2004)**
15. Percentage of the population who have ever taken HIV test (out of those who had ever heard of AIDS): **Males – 4.8%, Females – 2.5% (KABP Survey, UNICEF, 2004)**
16. Number of people (VCT and STD patients) who have received HIV testing and know the results from 2004-2005). **500 (VCT programme monitoring report, 2004)**

Treatment, Care and Support

17. Percent of patients with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counselled: **No data**
18. Number of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission –**2 (Puntland Situation analysis Report)**
19. Number of people enrolled in treatment, care and support programme with access to ARV. **86 patients (ART Programme monitoring Report, 2005)**
20. Number of people with advanced HIV infection receiving ARV combination therapy: **45 patients (ART Programme monitoring Report, 2005)**
21. Number of adults and children with HIV still alive and known to be on treatment 6 months after initiation of antiretroviral therapy– **43 (ART Programme monitoring Report, 2005)**
22. Number of health facilities with the capacity to deliver appropriate care to PLHIV – **1 center ((ART Programme monitoring Report, 2005)**
23. Percentage of transfused blood units screened for HIV- **No data**

Impact alleviation

24. % of infants born to HIV infected mothers who are infected **No data**

Impact

25. HIV prevalence among pregnant women 15-49 years- **0.9% (WHO HIV surveillance Report, 2004)**
26. HIV prevalence among 15-24 years pregnant women- **0.9% (WHO HIV surveillance Report, 2004)**

1. Situation analysis

Political Environment

The UNDP Human Development Report for Somalia (2001)1 estimates the population at 6.3 million with an annual population growth rate of 2.7 percent.

Somali populations have experienced ongoing decades of political turmoil and conflict resulting in large scale under development, high levels of mortality and morbidity, large scale destruction of infrastructure including education and health facilities, and lack of access to livelihoods and education. At the fall of the Said Barre regime, government was decentralized to Zonal and Regional levels, operating under three zonal structures in North West, North East and Central South. In 1991, the North West, declared independence from Somalia and has experienced relative peace and stability under its own administration since. Communities have been decimated either deliberately or as a by-product of conflict resulting in the displacement of a conservatively estimated 370,000 Somalis. There is also high mobility of Somalis within and outside.

A new Transitional Federal Government was formed in late 2004. A new President, Prime Minister and Parliament were elected to represent Somali people. Recently the government returned to Somalia.

The population is highly mobile, primarily due to nomadic life styles, mainly in the central and northern areas. Food shortages and clan warfare increase the mobility through displacement. No fully reliable health sector data exists in Somalia. Accurate figures on mortality and morbidity are also difficult to ascertain. However, there is a general consensus that Somalia ranks amongst the poorest countries in the world. Urbanization and uneven access to health services, poor quality of care due to limited knowledge, harmful traditional practices, inadequate training and the consequent mismanagement of medical cases all contribute to the declining health care status throughout Somalia.

As a result of the political situation of Somalia, development partners are working with three entities operating under three Zonal structures in North West, North East and Central South to support the HIV/AIDS response

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[1] UNDP Human Development Report 2001

2. The Impact of the Epidemic

The HIV/AIDS Epidemic

The prevalence of HIV among countries neighbouring Somalia, i.e Djibouti, Ethiopia and Kenya are 2.9%, 4.4% and 6.1%[2] respectively. In these countries, HIV is established in the general population. Somalia has close socio-economic links and population mobility with these countries is extensive.

The results of the WHO 2004 sentinel sero-surveillance survey showed a mean HIV prevalence of 0.9% in Somalia. HIV prevalence was also 0.9% among pregnant young women aged 15-19 years. HIV prevalence among the age group 15-24 is generally regarded as indicative of new infections in a population (incidence rate). In Somalia this indicator is 0.9%. Experience from Sub-Saharan countries showed that when the rate of HIV exceeds 1%, it could be doubled or tripled in 2-3 years. **(WHO HIV/AIDS Surveillance fact sheet - Somalia)**

Box 1: **An Awakening to AIDS (A life story)**

In the week of 8th August, 2005, a young woman, Asha, voluntarily presented at the Hargeisa Group Hospital antiretroviral treatment (ART) project in Somaliland, complaining of oral thrushes and other minor skin infections. She had previously tested HIV positive in Ethiopia. After clinical examination, appropriate counselling and laboratory testing by the attending physician, a provisional diagnosis of HIV related illness was made. She was classified as being in stage three of the disease according to the WHO case definition. She was then commenced on prophylactic cotrimoxazole, an antibiotic for the treatment of opportunistic infection. Asha was the youngest of three wives of Mohammed who died in 2002 from AIDS related illness. The two other widows of Mohammed are also in critical health situation related to advanced stage HIV related illness.

Asha recently remarried another man, Ibrahim, as the second wife. His first wife is Mariam, and has seven children. Ibrahim had refuted rumours about Asha's HIV status. Asha was also making deliberate efforts to dispel the rumours by hiding her HIV status from him. Mariam had confronted Asha, on several occasions - openly and violently – demanding that she left her husband alone.

Following counselling, Asha was able to disclose her HIV status to her husband only recently. But this effort has resulted in more violence from her family. At the moment, she is faced with family disintegration and neglect. Her husband has since abandoned her and has stopped his financial support for her. Recently, Asha visited the clinic with facial bruises, excoriations marks as a result of repeated assaults from co-wife, Mariam.

This story confirms the reality that HIV/AIDS is a real amongst Somalis even for married women and it is fuelled by fear, stigma, discrimination and gender based violence. So far eighty Somalis living with HIV in Somaliland have enrolled on ART.

Source: Draft ART case Study2004

[2] WHO 2004 Summary Report for Somalia on HIV Surveillance

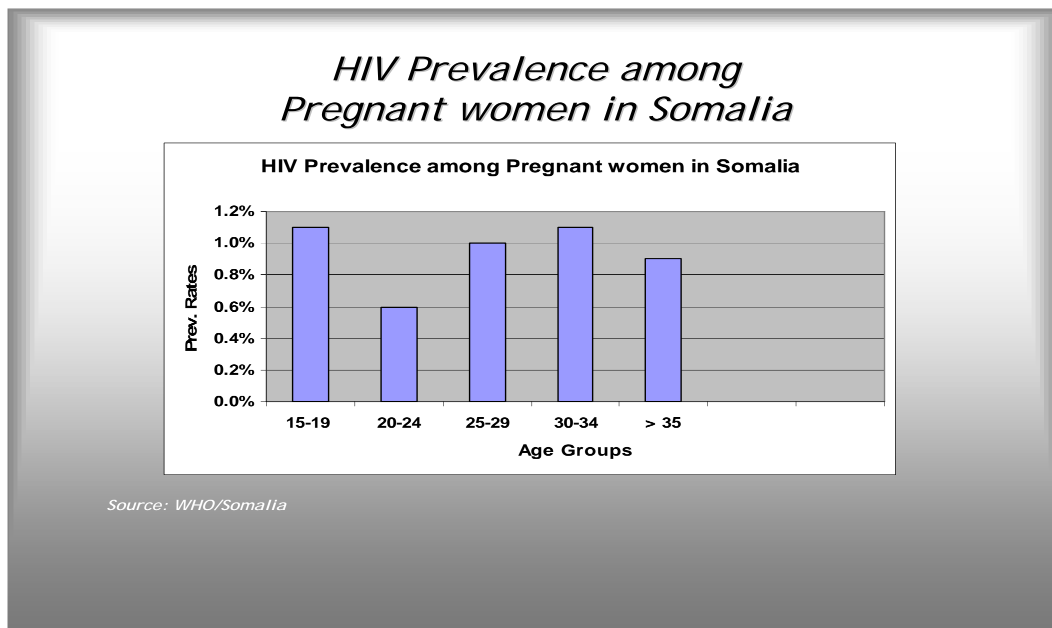
Box 2: Global Classification of HIV Epidemic

HIV epidemics are categorized into three stages; the generalized epidemic stage is characterized by an HIV prevalence that is consistently above 1% in pregnant women; in concentrated epidemics it is consistently >5% in at least one defined sub-population and is <1% in pregnant women in urban areas and in low level epidemic HIV prevalence has not consistently exceeded 5% in any defined subpopulation. In all countries, the HIV epidemic consists of multiple epidemics in various sub-populations that are due to variations in the behaviour in different geographical areas in the country. When the epidemic reaches higher levels within certain sub-populations, so-called bridging groups may transmit the virus more efficiently from sub-populations with higher rate of infection to the general population.

Source: UNAIDS/WHO Second Generation surveillance Guidelines 2002

At the moment, Somalia does not fit into any classification as only one round of sentinel surveillance has been undertaken. Provisionally, it may be classified as low-level epidemic until subsequent rounds find prevalence among pregnant women at over 1% or more detailed research identifies specific sub-populations where the rate is over 5%.

Figure 1: HIV Prevalence among pregnant mothers by age groups in Somalia, 2004



Wide variations in Epidemic Trends

Since the first Somali cases of HIV were diagnosed in 1991, it is estimated that about seventy thousand (70,000) people may have been infected based on the 2004 estimates from the WHO HIV Surveillance Report. From the WHO survey conducted almost all sites reported HIV infection except Merca as shown on table 1 below.

Table 2: Variation in HIV Prevalence by Zones and Sentinel sites in 2004

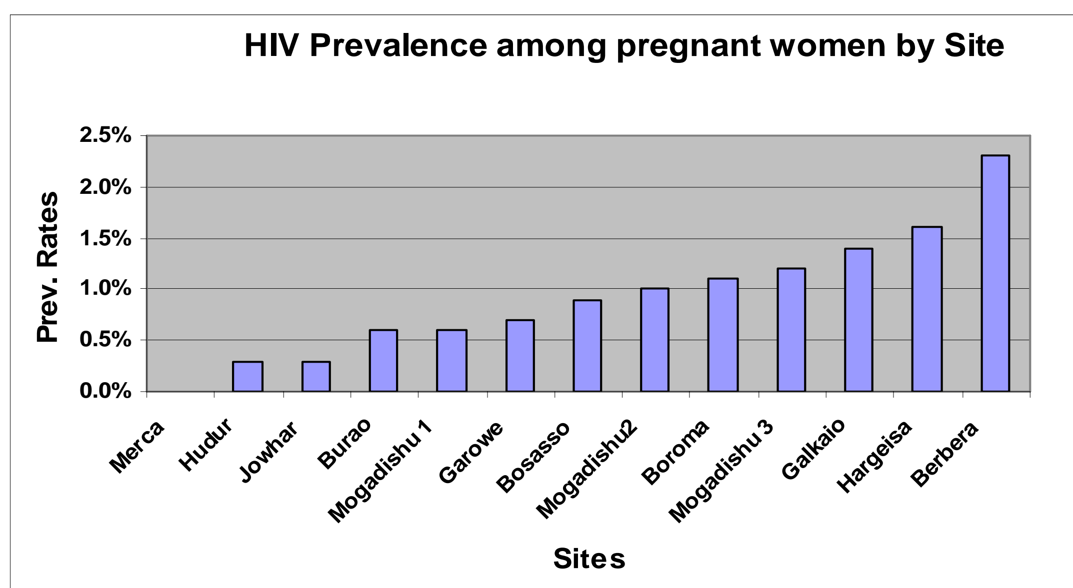
Name Region/Sentinel site	No tested	No Positive	Percentage Positive
Central South			
Mogadishu	1232	11	0.89%
Merca	350	0	0.00%
Jowhar	351	1	0.28%
Hudur	351	1	0.29%
Mean of Central and South	**2165**	**13**	**0.60%**
North East			
Bassaso	**324**	**3**	**0.93%**
Galkaio	**289**	**4**	**1.38%**
Garowe	**284**	**2**	**0.70%**
Mean of Puntland	**897**	**9**	**1.0%**
North West			
Hargeisa.	499	8	1.60%
Berbera.	**350**	8	2.29%
Borama.	**362**	4	1.10%
Burao	**350**	2	0.57%
Mean of Somaliland	**1561**	**22**	**1.41%**
Overall mean	**4732**	**44**	**0.93**

Source: WHO 2004 HIV Surveillance Report

In Somalia (6) out of the (13) sites where pregnant women were tested, the average rate of HIV positive cases was above 1%. Berbera (2.3%) stands out as the site with

the highest HIV rate in the country. This could be explained by the fact that Berbera is a very busy port serving Djbouti, Ethiopia and Somalia.

Figure 2: Geographical distribution of HIV Infection in Somalia, 2004



Source- WHO 2004 HIV Surveillance Report

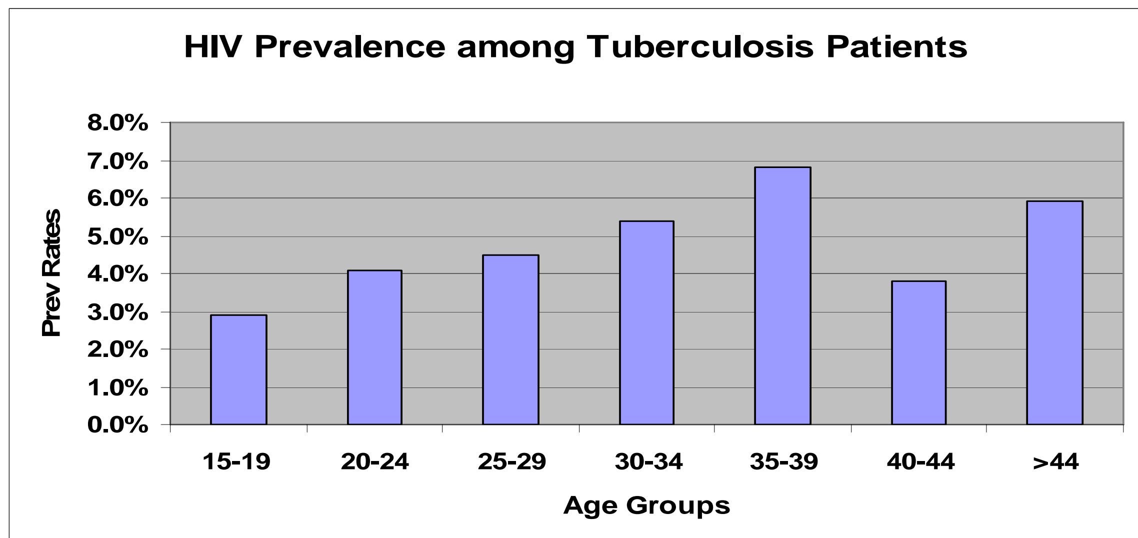
HIV Infection and the risk of Tuberculosis

HIV increases susceptibility to infection with M. tuberculosis. HIV increases the risk of progress of Mycobacteria tuberculosis infection to TB disease[3]. This risk increases with increasing immuno-suppression. It not only increases the risk but also the rate of progression of recent or latent Mycobacteria Tuberculosis to disease. It is estimated that while the life time risk of developing TB for a HIV negative individual is between 5 and 10%, the life time risk of developing TB for a HIV positive individual is 50%.

HIV among TB patients from Mogadishu, Bosaso and Hargeisa showed an average rate of 4.5%. HIV prevalence increased with age among the TB patients until about age 35-39 years as shown in figure 4. HIV prevalence among tuberculosis patients is an indicator of the level and maturity of the epidemic and hence the increasing burden of HIV-related disease in the health care services.

[3] WHO TB/HIV A clinical manual, second edition

Figure 3: HIV Prevalence by age groups among TB Sub-population Groups



Source: 2004 WHO HIV Report

TRANSMISSION OF HUMAN IMMUNODEFICIENCY VIRUS

Today, we know that both HIV-1 and HIV-2 are transmitted through three principal routes: sexual transmission, transfusion of blood and blood products and mother to child transmission. These routes include the four bodily fluids responsible for all HIV transmission:semen, vaginal fluids, blood and breast milk. In Somalia, there is dearth of data to confirm the major routes of transmission.

Heterosexual transmission is considered the dominant mode of HIV transmission in Somalia but there is little data to justify this argument, the only two widely quoted reports being the WHO surveillance survey and the UNICEF KABP study. Nevertheless, many risk factors that may facilitate the spread of HIV infection are prevalent in Somalia such as stigma, lack of information, mobility, displacement, conflict, harmful traditional practices including gender based violence, wife inheritance and unsafe medical practices such as unscreened blood transfusion and usage of unsterile instruments.

Sexually Transmitted Disease as a contributory factor to HIV Transmission

Sexually Transmitted Diseases are well documented a possible facilitating factor to the transmission of HIV infection as well as an indicator of high risk and vulnerability. STI patients among other sub-populations are one of the most well-known bridging groups in transmitting HIV to the general population. When examining the burden of curable STI (Gonorrhoea and Chlamydia) among pregnant women and STI patients in Mogadishu, Bosaso and Hargeisa, the results showed average rate of 2.5% among pregnant women.

Unpublished study report on STD prevalence in Galkayo town of Somalia indicated that 20% of people attending one of the private clinics in Galkayo suffer one or more STIs. Collaborative WHO and ICD study in 1999 showed that the prevalence of STI symptoms among antenatal attendees in Hargeisa, Borama, and Las-Anod MCH centres were 35%, 22.6%, and 34% respectively. The prevalence of STI symptoms among the men attending outpatients' clinics of the above hospitals was 12%. Even though these data are not

verifiable, if symptoms indicate infections, the rate of STIs among Somalis seems quite high.

The syphilis prevalence among pregnant women is still low 1.1%. It is more common among women living in urban than rural areas. The average rate of HIV infection among patients presenting with symptoms of sexually transmitted infections in Mogadishu, Bossaso and Hargeisa is 4.3%.

STI and HIV have similar mode of transmission and preventive measures hence clinical facilities can serve as important entry points for capturing both disease.

Blood Transmission as a possible Route of Infection in Somalia

HIV prevalence among blood donors in 15 hospitals in Somalia in 2003 was (1.1%) and in 2004 (0.9%). Also, WHO's blood-screening report from 1995-2002 showed that over 43,834 units of blood obtained from 18 health facilities was screened during the period and overall percentage of HIV prevalence was 0.9%[4]. However, there is no data to show the proportion of blood units that were screened before transfusion. See table below:

Table 3: Summary of the blood donors screening between 1995 – 2002[5].

Year	*Total No. of Blood Donors Tested*	*Blood Donors Tested Positive*	*%Positive*
1st June – 31st Dec. 1995	1564	12	0.8
1st Jan. – 31st Dec. 1996	2501	29	1.2
1st Jan. – 31st Dec. 1997	3803	32	0.8
1st Jan – 31st Dec. 1998	1551	17	1.1
1st Jan. – 31st Dec. 1999	6339	52	0.8
1st Jan. – 31st Dec. 2000	7598	62	0.8
1st Jan. – 31st Dec. 2001	8874	75	0.8
1st Jan. – 31st Dec. 2002	11604	98	0.8
Total	**43,834**	**377**	**0.9**

[4] WHO statistics report - 2003

[5] WHO statistics report - 2003

Transmission from mother to child

Based on the HIV sentinel surveillance report among pregnant women in the three zones of Somalia, there is evidence that mother to child transmission is a reality in Somalia. However, there is no structured study that has been carried out to ascertain the rate of transmission. Also HIV infections in infants have been recorded among patients recruited in the pilot ART project. It is propobable that there are numbers of pregnant mothers living with HIV infection with a possibility of mother to child transmission. If we compare the WHO 2004 HIV Surveillance Report among pregnant mothers in northwest regions with the another study carried out in 1999, it also confirm that the percent of pregnant mothers testing positive for HIV infection has increased from 0.9% to 1.4%.

In early October 2005, five HIV positive women who were pregnant sought PMTCT services at Galkayo and Garowe hospitals respectively. Unfortunately, none of these hospitals were in a position to help these women because PMTCT services were not operational. In Puntland, the Ministry of Health of Puntland and local organizations jointly appealed to various development partners for support for ART drugs and MSF-Holland supported the Galkayo Regional Hospital the essential ART drugs enough for 100 pregnant women and children. Two pregnant mothers benefited from the ARV drugs that were donated, even though we don't know the HIV status of their babies. Niverapine is currently available at Galkayo, Garowe and Bossaso hospitals for the purpose of PMCT.

However, one of the greatest challenges of providing PMCT in Puntland is that there is no institutionalized PMTCT programme beyond the availability of ART drugs. Consequently, while the ARV drugs were made available at the health facility, three pregnant mothers delivered at home and neither the women nor their babies received ARV drugs to prevent the transmission. Considering that there could be more pregnant mothers with HIV infection seeking care at major health facilities, it is imperative to initiate interventions on prevention of maternal and child transmission in Somalia. However, efforts have reached advance stage to commence a sustainable PMTCT programme in Somalia by local authorities and development partners taking into consideration the existing challenges and experiences.

Behavioural determinants of HIV Transmission in Somalia

Some of the high risk and vulnerability factors influencing the HIV epidemic in Somalia include low awareness and access to information on HIV/AIDS; high mobility of people across the country due to civil unrest; negative cultural practices such as FGM and GBV, low education levels; poor infection control, polygamy, early marriages for young girls and poverty.

Knowledge and HIV awareness

The 2000 and 2004 qualitative study on communication channels in Somalia[6] conducted in the three zones by UNICEF found that most study subjects have heard about HIV/AIDS being a killer disease. Another UNICEF KABP survey in 2003 showed that 79.6% and 71.3% of men and women respectively had "ever heard about AIDS". Another KAP survey conducted by Health unlimited in 2000 indicated that knowledge of correct methods of HIV transmission was relatively low, while beliefs in incorrect transmission methods such as

[6] KABP survey in Somalia by UNICEF 2000

mosquito bites, use of public toilets, touching someone infected with AIDS and sharing food with HIV infected persons were higher[7].

Attitudes and behaviours

In 2000 and 2003 UNICEF's KABP survey in Somalia revealed that abstinence and faithfulness are the most known and religiously and culturally acceptable means of HIV prevention. However, the 2003 study indicated that the proportion of people that cited use of condoms as an HIV preventive measure was very low (24%). Alarming misconceptions exist - even among the well educated and it is important to note that both of the above studies reported that Somalis consider HIV/AIDS as a disease of non-Muslims. Islam, they opinionated, if properly followed, protects one from HIV/AIDS, and the disease is inflicted as punishment against non-believers.

Knowledge of one's own HIV sero-status and fear of dying from the infection seem to be one of the major factors preventing people from taking a test. In 2000, WHO study[8] reported that less than 6% of study participants have ever taken an HIV test; this value was also confirmed in another UNICEF study in 2003. Both studies reported that higher number of Somalis indicated willingness to care for persons living with the virus, in their families or communities.

Stigma and discrimination

Contrary to the above findings in regard to the tolerance and willingness to care for HIV persons, health care workers have a tendency to discharge AIDS patients from the hospital, while relatives of AIDS patients tend to isolate them and violate their rights. A woman who is HIV positive is more likely to be divorced and separated from her children than HIV negative women in Somalia[9]. Stigma and discrimination against people living with HIV/AIDS is very common and is associated with denial and secrecy about HIV/AIDS, which in turn leads to discrimination – people are treated unfairly because of their sero-status. Thus, people are blamed and victimized; social exclusion and divisions are reinforced and HIV infections continue to emerge. A member of Somali parliament once said that "HIV/AIDS is not a problem in Somali, people are dying from Malaria and TB". The greater the silence surrounding HIV, the more the stigma and discrimination is directed towards people living with HIV.

Gender Dimensions including Gender based violence

Gender plays a role in vulnerability to HIV/AIDS infection. Different socio-economic contexts expose people to different infection risks. Similarly, the socio-cultural context that assigns certain roles, including the care roles to different groups often creates a situation in which one gender bears the greater burden. The UNIFEM study on Gender dimension of HIV/AIDS in regard to care and support found that women are the predominant care providers for the sick people, especially with regard to intimate personal care of patients.

The following determinants constitute the main gender considerations regarding the spread of HIV infection[10]:

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[7] UNICEF KABP survey in 2003

[8] Knowledge, Attitude and Practice in Northwest and Northeast Somalia by WHO 2000.

[9] UNIFEM Study on Gender dimensions and HIV, 2003.

[10] UNIFEM Study on Gender dimensions and HIV, 2003.

- " Social construction of gender and socialization process places greater peer pressure on men than on women to engage in sexual activity.
- " Lack of gender disaggregated data results in limited knowledge, especially of female Sexual behavior
- Negotiation power in sexual relations.
- " Certain aspects of sexual activity are taboo, which results in weak laws on and low public awareness/acknowledgment of rape as well as other forms of sexual violence and sex work.
- " Limited access of girls to education results in low literacy levels and exposure to HIV/AIDS information, fewer career opportunities and economic dependence on men.
- " Due to lack of gender sensitivity in social institutions, including families, women tend to be less assertive about their sexuality and find it difficult to seek advice on ailments related to sexuality or preventive commodities, i.e. condoms.
- In case of a divorce, the unequal social status attached to divorced women and men often limits the options of women even further.
- " Some prevalent practices such as FGM and related complications as well as wife inheritance potentially increase exposure of women to HIV infection.

HIV and Conflict

A recent report by United States Institute of Peace indicated that the relationship of the AIDS epidemic to violent conflict in Africa is far too complex to be expressed in simple cause-effect terms[11]. But no one denies the role of conflict in the spread of HIV, because it creates ideal conditions which includes; poverty, famine, collapse of health, large population movement, and breakdown of family units, increased women's vulnerability, and others. Somali's longstanding civil conflict and lack of central government could have contributed to the rise in HIV infection. Due to increased militia movement during conflict and the breakdown of judicial system that protect women and children's rights, vulnerability of women to rape, sexual violence and other gender related abuses have increased. These will likely increase the number of HIV infected women.

HIV/AIDS and Mobility

Urban labor migration is a significant factor in transmission[12]. The migration has been perpetuated in recent times by urban industries that provide much needed employment opportunities. Lack of food security in rural communities has also resulted in migration into urban areas, especially in times of severe drought. Based on available HIV statistics, towns with high concentrations of people, coupled with high levels of poverty and marginalized populations are particularly vulnerable to the spread of the epidemic.

Population groups whose mobility relates to economic activity are perceived to be particularly vulnerable. They spend long periods of time away from their families and, if travels take them outside Somalia, engagement in high-risk behaviors is aggravated by the higher HIV prevalence rates in the surrounding countries. Truck drivers, traders, domestic workers employed in neighboring countries as well as students in overseas institutions belong to this set of potentially vulnerable populations.

Cultural and societal factors

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[11] Special report on AIDS and violence in Africa, United States Institute of Peace, 2001.

[12] Somali Strategic Framework 2003-2008

Cultural norms and practices that subjugate women are considered to be important determinants in the spread of HIV/AIDS. In Somalia, these include wife inheritance, remarriage to the same family ('dumaal'), polygamy and female genital mutilation (FGM).

However, culture is by no means static and whereas some traditional practices need to be seriously evaluated as contributors to the spread HIV/AIDS, the Somali culture provides rich forms of artistic expression such as poetry, drama and song that are crucial in spreading HIV prevention information about the epidemic. Education, the mass media and the modern global economy have had a profound effect on norms and practices in Somalia and should not be overlooked as potential platforms for raising the issue of HIV/AIDS.

3. Response to the HIV/AIDS epidemic

Lessons from the past showed that national Programs grappled with the HIV epidemic as a behavioral issue that could be fixed by promoting safer sex. Governments in most African countries underestimated the roles that migration, poverty, gender inequality, war and conflict play in the spread of HIV. The approaches ranged from promotion of behavioral change to essentially switching from health sector response to a multi-sectoral approach. According to Barnet and Whiteside, the national response should take guidance from six conceptual phases: timing and targeting, information, observation, or instruction; advocacy and ownership, process versus product, scaling up and sustainability; and the myth of coping.

The response is still at advocating for ownership by Somalis in Somaliland, Puntland and Central South and ownership in the response. From 1991- 2004, Somali people have painfully passed through a period of long denial. Many senior political leaders in Somalia remain detached from the response to HIV/AIDS.

Public Sector Response

In terms of structures, the public sector's response to HIV epidemic in Somalia began in 2003 with the development of the Strategic Framework and peaked in 2004/5 with the approval of the GFATM resources. Since then, the public sector was able to institute structures to ensure that there was strategic vision, coordination bodies, safety of blood and blood products, establishment and strengthening of epidemiological surveillance for HIV and other STIs and promotion of syndromic management of STIs.

Strategic Framework

The overall goals of the Strategic Framework are to prevent the spread of the HIV/AIDS epidemic within Somali populations (containment below epidemic level); and to prevent and reduce the prevalence of other Sexually Transmitted Infections within Somali populations.

Within the developed Strategic Framework (2003-2008) which guides the national response, HIV/AIDS has been integrated into existing development plans-Consolidated Appeal Process (CAP), United Nations Implementation Support Plan, the UN Transitional Plan and the Joint Needs Assessment process. Civil society organizations were fully engaged in the process of formulation of the framework. The strategic framework promotes a multi-sectoral response to combat HIV/AIDS. The following sectors are included in the response-Health, Education, Civil Society Organizations, People living with HIV, Religious leaders and Women. It recommends interventions such as –comprehensive prevention including Voluntary Confidential Counselling and Testing (VCCT), STI prevention and treatment, blood safety, prevention of mother to child transmission and integration of prevention into Treatment, Care and Support. The target populations recommended are the general population, youths and people living with HIV. The strategic framework and its actions plans have been used as tools to secure GFATM and DFID resources as well as UN Agencies regular budgets.

The Strategic framework however has some specific limitations and gaps. It does not give specific focus pertinent sectors such as labour, transport, military, women and girls, IDP, refugees and returnees. This implies that issues of vulnerability, multiple vulnerabilities of women and girls, humanitarian response and protection did not receive adequate attention whereas they are important in a situation such as in Somalia. There is need to include intervention areas related to HIV/AIDS impact mitigation, reduction of gender inequalities, human rights and HIV/AIDS, uniformed services, reduction of income inequalities and multiple vulnerability issues of women and girls. The operational plan requires a review of its programme goals. There is minimal information on condom promotion and distribution, breastfeeding and mitigation. It also does not address issues related to interventions and monitoring of high risk population groups.

Rating of Strategy planning Efforts in the HIV/AIDS Programme

The improvement in rating between 2003 and 2005 rating is as a result of the global fund process, DFID proposal, UNISP, CAP and IPTCS Plan. Between 2003 and 2005, increased resources, expanded partnerships and mutisectoral policy development and implementation were observed in the response.

Table 4: Rating of Strategic planning efforts from 2003-2005

2005									
Poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
poor									Good
1	2	3	4	5	6	7	8	9	10

Political Support and interest

There has been a visible interest and political support at the highest level of leadership on HIV/AIDS Response in Somalia. There is remarkable public discussion taking place on HIV/AIDS by top government officials-President and Head of Government ad other high officials. Somaliland and Puntland launched their multi sectoral HIV/AIDS management and coordination body in 2005. Somaliland established its commission in September, 2005 while Puntland in 15th October, 2005. Central South is in the process of strengthening its HIV Committees and upgrading it into a commission as well through the support of the Transitional Federal Government (TFG) and a roadmap is under construction for one Somali tripartite HIV/AIDS Coordinating body. The commissions have clear terms of reference and defined membership including civil society and people living with HIV or AIDS. The private sector however is not represented in the commissions. Both commissions have action plans and functional secretariats. The last meeting of the secretariat was in November, 2005 while preparing for the World AIDS Day Campaign. The commissions promote interaction between government, PLHIV and the civil society for implementing HIV/AIDS strategies, programme and service delivery at the community levels.

In Somalia, the HIV response has moved from a health sector response to a multi-sectoral response – developing closer cooperation between Ministries of Religion, Education, Health, Information, Culture, Family Welfare and Social Development etc., with civil society organizations including women's and youth groups, media, and people living with HIV/AIDS.

The improvement in rating between 2003 and 2005 rating was as a result of the visible political commitment through launching of the HIV/AIDS commission by the Presidents of Somaliland and Puntland as well as provision of seed funds and free office accommodation to jump start the commission secretariats.

Table 5: rating of Improvement in Political support in 2003 and 2005

2005									
Poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
Poor									Good
1	2	3	4	5	6	7	8	9	10

Human rights support

The promotion and protection of human rights is explicitly mentioned in the HIV/AIDS policy and strategy. Existing Cultural and religious values and practices promote equal access between men and women to prevention and care intervention but there are no written laws supporting these norms. Somaliland has a National HIV policy and decrees that:

- Will protect people living with HIV/AIDS against discrimination;
- Ensure non-discrimination laws or regulations with specific protections for certain group of people identified as being especially vulnerable to HIV/AIDS discrimination.
- Ensure written laws or regulations that present obstacles to effective HIV prevention and care for most-at-risk populations.
- Prohibit HIV screening for general employment purposes

However, the policy has the following weakness within the framework of HIV/AIDS and Human right practices:

- Absence of ethical committees to review and approve research protocols involving human subjects. Although, the UN has the statistical reference group that looks at UN specific studies and its protocols.
- It does not also have a monitoring and enforcement mechanisms for the collection of information on human rights and HIV/AIDS and the use of this information in policy and programme development. Although, there is religious protection against such incidence.
- No focal points within government health and other departments to monitor HIV-related human rights abuses
- There are also no performance indicators or benchmarks for compliance with human rights
- No policy to ensure equal access to prevention and care for most at risk populations

- So far no training has taken place among members of the judiciary in Somaliland and Puntland on HIV/AIDS and human rights issues. Also, there are no legal aid systems for HIV/AIDS

In the last few months, efforts have been made to train people living with HIV (PLHIV) and their rights in Algeria during a UNAIDS Supported regional meeting of networks of people living with HIV/AIDS.

At the conclusion of an 11-day mission[13] to Somalia and the region in 2005, the UN Independent Expert on the Situation of Human Rights in Somalia, Dr. Ghanim Alnajjar concluded with the following points[14]:

- **Women:** Applauded the initiative and persistence of countless Somali women who are showing leadership in a wide variety of fields such as education, development and, in particular, the demobilization of militia in Mogadishu**.**
- **Establishment of independent human rights institutions**: He welcomed the commitment by TFG Prime Minister Ali Mohamed Gedi to include the establishment of an Independent National Human Rights Commission as an agenda item to be discussed in the next meeting of the TFG Cabinet. In Somaliland, an independent human rights institution is in the final stages of establishment, with the assistance of UNDP's Rule of Law and Security Programme
- **Internal Displaced Persons (IDP)**: There are approximately 370,000 Internally Displaced Persons (IDPs) in Somalia and Somaliland and he recommends that attention should be drawn to the desperate conditions under which they live.
- **Children**: He was particularly concerned about many Somali childrens' lack of access to primary and secondary education. With an estimated enrolment rate of 19.9%, efforts to ensure the basic right to education of these children should be stepped up.
- **Minorities**: Minority groups continue to be marginalized and discriminated against. In Somaliland, representatives of some of these groups requested that the UN Special Envoy support them in raising their concerns with the Somaliland authorities and the three main political parties, and stressed their desire to be included in the political process.
- **Prison conditions:** Prisons in Somalia remain unacceptable and much below international human rights standards mainly due to lack of funding and management know-how.

Rating of Policies, Laws and regulations and enforcements

There has been minimal improvement in existing policies and regulations with respect to HIV/AIDS and Human right but with little enforcements as shown on table 6 and 7.

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[13] **Press Release of Human Right Envoy, Dr Graham Alnajjar to Somalia, September, 2005**

[14] Briefing Notes of UN Special Envoy on Human Right to Somalia, September, 2005

Table 6: Rating of existing policies, laws and regulations

2005									
poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
poor									Good
1	2	3	4	5	6	7	8	9	10

Table 7: Rating of efforts to enforce the existing policies, laws and regulations

2005									
poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
poor									Good
1	2	3	4	5	6	7	8	9	10

Civil Society Engagement

Civil society organizations have played significant and impressive role and contributions to strengthening the existing political commitment of top leaders as well as policy formulation in Puntland, Somaliland and Central/South. They were at the fore front of in-country consultation during the formulation of the Strategic Framework and GFATM proposal development processes. As a result, the Government has included them as members of the AIDS commissions in Somaliland and Puntland. Over the years, civil society organizations remain the major implementing agents of prevention interventions which include training, sensitization and community mobilization. There are plans to include the civil society in the planned midterm review of the strategic Framework in 2006. The harmonized monitoring and evaluation framework of Somaliland clearly state the critical role of the civil society organization in community monitoring and feedback.

Global best practice has been recognized in Somaliland and Puntland, with PLHIV being identified as crucial in the planning and management of the HIV/AIDS response. PLHIV from Somaliland, Puntland and central south participated in network training and advocacy workshops in Algeria and Cairo, supported by UNAIDS and UNDP in 2005. This is part of capacity building efforts by development partners to increase the greater participation of PLHIV in the country.

Formal religious leaders network named 'RAHMA' (Mercy), made up of 15 sheiks in Somaliland and AL-IHSSAN", (Charity), in Puntland have also been formed among the Somali population. Two members each from South Central, Somaliland and Puntland were participants in a capacity building workshop in September, 2005 in Yemen where religious leaders of the region met. The UN Theme Group on HIV/AIDS is planning to launch a key initiative to support all Somali religious leaders

through a strategic planning exercise in early 2006 and then support for religious leaders in their efforts to prevent HIV/AIDS.

The key challenge is to engage religious leaders on condom supply and promotion. Many prominent religious figures are favorable to support for abstinence and avoidance of extramarital relationships. The fear of losing the support of powerful religious leaders is a major impediment to prevention efforts by the local authorities or communities. In the past, experience of condom burning and condom myths of distributing male and female condoms infected with HIV was observed.

The high level of political support to address HIV/AIDS is significant; however, there remain numerous constraints to the effective implementation of HIV/AIDS response. Major obstacles that hinder the capacity to perform effectively are the shortage of lack of technical, human and financial resources. Skills in planning and management are scarce in Somalia. Furthermore, due to lack of national policy, the sectoral obligations outside the Ministry of Health are not clearly defined. The role of civil society organizations in HIV/AIDS response is very weak and their overall capacity to undertake effective interventions is considered inadequate.

Involvement of Bilateral, Multilateral and Donor Agencies

The major funding agencies of HIV/AIDS programmes and activities in Somalia are GFATM, DFID, USAID, World Bank as well as UN agencies and international NGOs. The major focus areas of funding include HIV/AIDS advocacy, prevention and treatment; as well as programmatic areas of monitoring and evaluation, capacity building and awareness creation.

In total six donor countries and organisations have provided financial commitment and actually disbursed funds through UN agencies and international NGO to support the HIV response in 2004. The majority of support focused on HIV prevention interventions.

United Nations Implementation Support Plan for the Strategic Framework.

- ❖ An important element of UN Reform is the expectation for UN agencies and national stakeholders to work together in planning, implementing, financing and technically supporting joint programmes. In early 2005, UNAIDS and the UN Country Team identified the need for a UN Implementation Support Plan for Somalia

The emphasis of the UNISP is on monitoring and evaluation of collective key results and outcomes over and above individual agency activities. The following UN agencies were involved in the development and monitoring of the UNISP. There are only four UN agencies with full time staff while two others have consultants to support the strategic framework implementation in Somalia as shown below.

- **FAO-** No full time HIV staff
- **ILO-** No full time HIV staff
- **OCHA-**No full time HIV staff
- **UNAIDS-**Four fixed term, three national focal points and one consultant on HIV
- **UNDP-** Three full time staff, one full time consultant
- **UNESCO-** One full time HIV consultant
- **UNFPA-** One fixed term HIV staff

- **UNHCR-** No full time HIV staff
- **UNICEF/GFATM-**Six fixed term HIV staff and three consultants
- **UNIFEM-** One full HIV consultant
- **WFP-**No full time HIV staff
- **WHO-**Five full time HIV staff
- **World Bank-**No full time HIV Staff

The milestones achieved through the collective actions by two or more UN agencies are summarized below in the collective outcome areas:

- **Outcome 1.** Effective policy frameworks will be in place for multi-sectoral HIV/AIDS response and adequate technical and financial capacity of key stakeholders to ensure harmonised and results-based execution of priority interventions.

Collective Outputs:

1. **Harmonised HIV/AIDS Support Plans implemented**
    - UNISP
    - Draft IPTCS Plan
    - M&E Framework for Somaliland

2. **Adequate resources mobilised for the HIV response**
    - DFID Funds mobilized
        1. to commence PMTCT and Condoms programming,
        2. support STD and opportunistic infection drugs for the ART project,
        3. Support the procurement of blood safety equipment and test kits
        4. support the ART drugs
    - GFATM resources mobilized to boost response
    - CAP resources mobilized to commence the ART Project

3. **Somali leaders demonstrate greater commitment to HIV/AIDS**
    - Three Joint missions to top officials
    - Support for Religious leaders capacity
    - UNICEF leadership advocacy on multi-sectoral response

4. **Coordination and Management Capacity Enhanced.**
    - Two coordination structures established in Somaliland and Puntland

5. **Increased role of women and women's groups in the HIV response**
    - No joint approach (UNIFEM)

6. **HIV/AIDS policies established**
    - 1 policy in Somaliland
    - 2 HIV/AIDS Decrees published signed by the President

- **Outcome 2. Communities throughout Somalia have increased access to gender-sensitive information on HIV/AIDS, are effectively mobilised to collectively engage in preventing the spread and stigma attached to HIV/AIDS, and improved care and support.**

Collective Outputs:

7. HIV/AIDS communication activities are more effectively coordinated and effectively sound

- Collaboration has commenced
- Draft Communication strategy in progress

8. Risk behaviours are more effectively targeted by behaviour change communication approaches

- Feasibility study done
- Still have a long way to go to make vulnerable the focus of the response-IDP, Sex workers, women and girls etc
- Resources mobilized for WHO and UNICEF on surveillance

9 Broadcast and print media have increased capacity to deliver appropriate HIV/AIDS messages

- Communication strategy in progress
- Health Unlimited being supported to deliver messages by different UN agencies

10. Public and private partners have capacity to support and implement community awareness raising and mobilisation

- Not done yet

11. Target communities are consulted and actively engaged in awareness, prevention and de-stigmatisation activities.

- Target communities are continually more involved in HIV/AIDS response

- **Outcome 3. All men, women, boys and girls living in Somalia have access to appropriate quality services within both the private and public health and social service systems.**

Collective Outputs:

12. Integrated Prevention, Treatment, Care and Support Plan developed and endorsed

- Draft plan exists but needs leadership

13. Institutional and human resource capacity of health and community structures providing IPTCS strengthened

- Promotes local capacity building
- Three UNAIDS Focal Points
- NAC M&E Officers in process
- WHO 3x5 and three GFATM coordinators are in progress

14. A minimum of 3 pilot IPTCS sites and satellite services are more functional

- 1 ART Site operational

15. Safety of blood transfusion systems strengthened

- Not done collectively but supported by WHO

- **Outcome 4. Improved health status and quality of life for all aged people living with and affected by HIV.**

Collective Outputs:

16. Increased access to psycho-social support and nutrients/vitamins/sanitary supplies to PLWHA at TB hospitals and other access points

- Nutrition available for PLWHIV in ART site
- Scale up in process

17. Improved protection of HIV/AIDS infected and affected children

- Not done

18. PLWHA accepted as constructive members of the community

- Some efforts including participating in the blue print-Algerian declaration

- **Outcome 5.** Partners have increased access to strategic information and are undertaking more informed evidence based programming in HIV responses.

Collective Outputs:

19. Recommendations of the Strategic information review endorsed and adopted

- In progress

20. Surveillance systems are functional

- WHO led HIV Surveillance among sentinel groups done

21. HIV/AIDS vulnerability factors for Somali populations identified and understood

- UNAIDS led feasibility study completed

22. Consolidated M&E plan endorsed for Somalia

- M&E Taskforce functional in Somaliland and Nairobi
- Draft Somaliland M&E framework done
- M&E needs assessment in Puntland and Somaliland completed
- CRIS training
- Draft common tools done for Somaliland

23. Access to strategic information is improved

- Significantly improved
- Monthly updates
- First bimonthly news letter
- OCHA HIV fact sheet

NATIONAL PROGRAMMES AND BEHAVIOUR

Prevention policies and strategies

Somalia has a draft strategy that promotes information, education and communication (IEC) on HIV/AIDS to the general population. In the last year, a lot of efforts were put in place to implement active programmes to promote accurate HIV/AIDS reporting by the media including media training on HIV/AIDS. The strategy is far from active implementation in relation to sexual and reproductive health education for young men and women. Also, there is clearly no strategy promoting IEC and other preventive health interventions. However, a feasibility study had just been completed to inform a programming for high risk and vulnerable sub-population groups.

The outcome of the feasibility study will inform the development of harmonized strategies to expand access to most at risk populations to essential preventive services such as VCT, condoms and STD drugs. There is a blood safety programme but no programme on social marketing for condoms, safe injections in health care settings and antenatal syphilis screening. At the moment, there is advocacy process ongoing to fill these gaps.

Table 8: Summary of ratings of prevention policies and interventions in 2003 and 2005

2005									
Poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
Poor									Good
1	2	3	4	5	6	7	8	9	10

We have only moved forward a little in the provision of active prevention services in the country.

Implementation of Prevention activities

Implementation of HIV/AIDS prevention interventions in Somalia consists largely of awareness campaigns conducted by local non-governmental organisations working in collaboration with international governmental organisations and some United Nations Agencies. Other activities address the intersection between gender-based violence and HIV/AIDS risks using organised women's groups as the channels for outreach. UNICEF's approach involves building the capacity of school teachers to provide life-skills education.

See some examples below:

1. Woman to Woman Initiative

Women are in a unique position to address a wide variety of issues related to HIV and AIDS such as awareness, community and home-based care, gender-based vulnerabilities and solutions, health promotion and education and family wellbeing. It is essential that the resourcefulness of women and their ability to act as conduits for information dissemination and change be fully utilized. As institutional capacities for HIV and AIDS -related care and support are quite low in most parts of Somalia, and in recognition of a) the role of women as caregivers b) the specific vulnerabilities of women to HIV globally, and c) the potential influence that women have on their families and communities, partnerships with leading women's groups have been forged for mobilization of women to act as grassroots communicators and caregivers, activities vital to addressing HIV infection and care and support for those affected.

EDUCATION AND HIV/AIDS

2. Youth Peer Education (YPE)

55 youths were trained as Youth Peer Educators who in turn trained 2,000 youth. The YPE training has facilitated youth-to youth education in topics ranging from sexuality, female genital mutilation and HIV/AIDS. The training also imparted key life skills to young people aimed at reducing their vulnerability to HIV/AIDS infections. These 2,000 youth have developed youth peer education action plans to guide them in accessing other youth within their community with these life skills. Youth Peer Educators organized and carried out sensitization activities during Youth and HIV/AIDS week leading up to World AIDS Day. Activities included communication competitions, quizzes on HIV/AIDS, marathons, development of Information Education Communication (IEC) materials and marches. Whilst there is an emerging education sector strategy for the three zones of Somalia there is not a strategy for systematic development of life-skills based education for in and out of school setting. Some work has been done on school curricula but it is not systematic. Teacher training and materials development needs to ensue that it is cultural sensitive and applicable to the Somali context.

3. KOOR Magazine (An example of engaging young people)

Somalia offers a very challenging environment limiting space for adolescents and youth to participate in key development activities including those directly affecting them. KOOR magazine was designed to address issues related to HIV/AIDS and youth. In 2005, UNICEF took deliberate efforts to expand KOOR magazine into a national youth magazine produced by youth for youth. Through an extensive process of review and reorientation the need to involve the youth in the collection of articles, designing the magazine and circulation was highlighted. During this review, young editors from across Somalia were selected whose responsibilities included the collection of articles from young people across Somalia. Regular features include Dr. KOOR Answers aimed at addressing questions on HIV/AIDS posed by Somali youth, reporting on youth events on HIV/AIDS prevention, and stories targeting younger children. Cost sharing with a private printing company, GESKA Printing Agency, was negotiated to ensure a high quality product attractive to Somalia's youth. The first revised KOOR edition was launched in November, 2005.

4. Other Behavioural Change Interventions

BCC activities in Puntland included the procurement of over 10,000 stickers, 2 classic video cassettes, 10,000 flier, 6000 caps and t-shirts, 10,000 posters, 2000

annual calendars, over 45 bill boards on HIV/AIDS and printing a Youth magazine on HIV/AIDS

In Somaliland, there are over 20 bill boards and sign post promoting HIV/AIDS prevention. There is also a community radio programme which provides awareness on HIV/AIDS and FGM-SAXAN SIXON. STI management and prevention is being carried out in six centers. Somaliland has current two major network of women groups, and numerous youth and human right groups. One religious leader had been trained on Faith-base response over the years. There are efforts to coordinate NGO activities and structures through SAHAN HIV/SAIDS Network.

5. Leadership Advocacy Training

Leadership advocacy training was held for local and religious leaders in Somalia outlining their roles in HIV/AIDS awareness and advocacy in line with the teachings of the Qur'an as religious leaders have been identified as key in promoting behaviour change in Somalia. The toolkit includes an Islamic perspective in the prevention of the HIV/AIDS pandemic. An additional 70 leaders were trained in Somalia in 2005. As a result, trained religious leaders have ensured HIV/AIDS prevention is a regular topic during Friday prayers and during religious teachings and community events.

6. Youth friendly services (Youth Multi-purpose Centers)

UNICEF has completed the rehabilitation, equipment, and furnishing of 4 youth multi purpose centres (YMPC) and rehabilitation efforts on the fifth are underway. The YMPC's have sports facilities which continue to be utilised by both boys and girls.

Voluntary Counselling and testing services

A pool of health professionals were trained in advanced Voluntary Counselling and Testing. About 100 community members drawn from religious groups, women groups and community elders have also been trained in providing counselling support as part of their daily work.

In whole of Somaliland, there is only one VCT centre. So far 500 persons Somaliland have gone through voluntary counselling. Strategies for incorporating reproductive health services including VCT and general counselling support have been developed. Management and advisory structures have also been established including fund raising responsibilities. However, much more strategic work needs to follow to ensure sustainable VCCT in prevention, treatment, care and support plans.

Prevention of Mother to child Transmission

There is no single specific intervention on prevention of mother to child transmission in Puntland and Somaliland. However, efforts have reached advance stage to mobilize resources and commence implementation of interventions. There is an urgent need to bring together PMTCT, VCCT and ART within the MCH services.

Control of Sexually transmitted Disease

Somalia has strategies and interventions related to prevention and control of STIs, mainly built on the syndromic management approach. This initiative was pilot tested in thirteen secondary health facilities in 2002. There is very little data on STI available to understand the burden of the problem and the role it plays in HIV/AIDS transmission.

It is thus recommended that there is need to establish coordination office for STD among the UN bodies, establish a common basket for STD funds or divide responsibilities among the UN bodies. There are areas which need immediate attention: streamlining of data collection, STD case definition/diagnosis, rigorous active promotion of the application of the Syndromic approach guidelines, policy on HIV testing and validation of the Syndromic management approaches. Currently there are plans to revise the syndromic management protocols.

Blood safety Centres and infection control

All public hospitals screen for HIV before blood transfusion as a government policy but this is currently but it is not clear whether this policy is adhered to at all times. Thirty health workers have been trained on infection control so far by WHO.

Summary of Prevention activities in 2003 and 2005

See below the summary of the milestones made on prevention activities made so far.

Table 9: list of Prevention Interventions in Somalia

		2003	2005
a.	A programme to promote accurate HIV/AIDS reporting by the media.		X
b.	A social marketing programme for condoms		
c.	School-based AIDS education for youth		X
d.	Behaviour change communications	X	XX
e.	Voluntary counselling and testing	X	XX
f.	Programmes for sex workers		
g.	Programmes for men who have sex with men		
h.	Programmes for injecting drug users, if applicable		
i.	Programmes for other most-at-risk populations		
j.	Blood safety	XX	XXX
k.	Programmes to prevent mother-to-child transmission of HIV		
l.	Programmes to ensure universal precautions in health care settings	X	XX

Table 10: rating of Progress made in implementing prevention interventions

2005									
Poor									Good
1	2	3	4	5	6	7	8	9	10
2003									
Poor									Good
1	2	3	4	5	6	7	8	9	10

From table above, it showed that there increase in number and intensity of prevention activities from 2003 to 2005. These were mainly in the areas of HIV/AIDS and media, school based education for youths, behavioural change communication, blood safety and universal safety precautions in health care settings.

Real gaps in prevention exist in voluntary counselling and testing, prevention of mother to child transmission of HIV and control and prevention of sexually transmitted infections (STI) services, which are still very limited. Blood safety standards are observed in all the health facilities, courtesy of technical support of the WHO. Voluntary counselling and testing is presently available only at Hargeisa Group Hospital. There is need for systematic life skill development intervention especially for young people.

Implementation of Treatment, Care and Support

Somalia has a comprehensive HIV/AIDS care and support plan- Integrated prevention, treatment, care and support plan. It promotes VCT, psychological care, access to medicines, home and community based care.

When the antiretroviral treatment (ART) program implementation commenced in Hargeisa, Somaliland in June 2005, it initially catered for around 50 patients. It was planned as a pilot project to be sustained through resources from the Global Fund for AIDS, Tuberculosis (TB) and Malaria (GFATM, funds from the Department for International Development (DFID) and regular budgets of United Nations (UN) Agencies including the 3x5 Initiative. The Project is being implemented by the Ministry of Health in partnerships with development partners.

Box 3: Progress on the ART Project M&E indicators (June to December, 2005)

- *12 health workers trained on ART*
- *15 doctors trained on STD management*
- *Number of patients enrolled in ART programme; 86 patients*
- *Number of patients now on ART : 45 from launching*

Source- ART Project monitoring report

See below budget breakdown including associated cost and contributions from partners as shown in table 1 below:

Table 11: Estimated Cost of Pilot ART project

Budget description	Estimated Costs ($)	Partners contributions

Initial procurement for 50 patients for three months	8,985.34	UNOCHA
Second procurement of drugs and equipment for additional six months	17,820.68	DFID
Provision of food ration for 50 patients	1000.00	WFP
Managed cost by clinician	9000.00	ICD
Development of IPTC Plan	6,500.00	UNAIDS/WHO
Cost of M&E system	1500.00	UNAIDS/WHO
Estimated cost of ART drug procurement additional 12 months	35,941.36	UNICEF/GFATM
Cost of provision of STI drugs for 12 months	100,000.00	DFID
Cost of provision of Condoms for 12 months	10,000.00	DFID
Cost of Cotrimoxazole for 50 patients for 12 months	3000.00	DFID
Estimated total cost for one year for 50 patients on ART	**193,747.38**	

Source-Draft ART case study, 2005

The average estimate cost of provision of ART care and support for the selected 50 patients is $323 per year per patient and $27/month per patient. The total cost of providing comprehensive access to treatment, care and support for additional 50 patients will be $200,000.00.

Key challenges facing the project include issues related to sustainability and future scale-up. Others include:

- Need to build human capacity
- Availability of drugs for sexually transmitted infections and opportunistic infections
- Integration of the prevention of mother to child transmission services and pediatric ART
- Need to build community based support interventions including literacy education, community mobilization and encourage partner disclosure of status
- Increasing desire to integrate prevention, treatment, care and support services in Somaliland

The ART program has demonstrated that when humanitarian and development agencies commit themselves to a collaborative effort in partnership with national authorities, results obtained demonstrate that even in a context as Somaliland where no care and support programs really exist, extraordinary results are achievable. Such an initiative, initially led by humanitarian concern, has now been demonstrated as a proved being the basis for the accelerated development of a comprehensive approach to HIV/AIDS.

At the moment, there is no provision of ART intervention in Puntland. Seven sites drawn from the three zones are being assessed for health systems strengthening by ICD and COOPI Consortium with support from GFATM Training has been provided for some health workers on ART and treatment protocols exist in Puntland to start the 3x5 Universal Access programme.

See summary activities implemented under treatment care and support strategies on HIV/AIDS as shown below:

Table 12: Comparison of Treatment, Care and Support activities implemented between 2003 and 2005,

	2003	2005
HIV screening of blood transfusion	*X*	*XX*
Universal precautions	*X*	*XX*
Treatment of opportunistic infections (OI)	*X*	*XX*
Antiretroviral therapy (ART)		*X*
Nutritional care		*X*
STI care	*XXX*	*X*
Family planning services	XX	XX
Psychosocial support for PLHIV and their families		*X*
Home-based care		*X*
Palliative care and treatment of common HIV-related infections: pneumonia, oral thrush, vaginal candidiasis and pulmonary TB (DOTS)		*XX*
Cotrimoxazole prophylaxis among HIV-infected people		*X*
Post exposure prophylaxis (e.g. occupational exposures to HIV, rape)		
Other: (*please specify*)		

Rating of the milestones made on treatment, care and support are as follows.

Table 13: Rating of Progress made in Treatment, Care and Support interventions

2005									
Poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
Poor									Good
1	2	3	4	5	6	7	8	9	10

4. MONITORING AND EVALUATION ENVIRONMENT

Efforts have commenced in the building of a harmonized monitoring and evaluation system in Somalia. So far an M&E technical working group has been formed in Somaliland and Puntland - integrated into the PAC and SOLNAC.. Draft harmonized M&E indicators and infrastructure are currently being built in Somalia.

The development of a harmonized Monitoring and Evaluation Framework is in progress. There is also an M&E reference group at Nairobi. The framework is being developed in consultation with civil society organizations and other key partners. It was preceded by an elaborate M&E needs and capacity assessment. Some of the key findings from the assessment are summarized in table below:

Table 14 : Ranking of the current situation of the M&E system in Somaliland

	Ranking of Current Status		
	High	**Moderate**	**Poor**
• Perception/value	*		
• Institutional support		*	
• M&E activities		*	
• Infrastructure			*
• Workforce development			*
• Professional development			*
• Human Resources			*
• Financial Resources	*		
• Constructive use of Strategic Information			*

Source-Draft M&E Needs assessment Report, 2005

The draft M&E framework has section covering data collection, analysis, reporting and information feedback, well defined standardized set of indicators, data management plan. The plan is hoped to be budgeted and funded. We already have secured funding from GFATM, DFID and UN Agency regular budgets.

There is proposed monitoring and evaluation units at the commissions in Puntland and Somaliland, the Ministry of Health whilst UNAIDS, UNDP, WHO and UNICEF have functional M&E units. The monitoring and evaluation framework is promoting central reporting system to the commissions. There are full time monitoring and evaluation officers at, UNAIDS, UNDP and WHO. The harmonized monitoring and evaluation system is coordinated through a working group that meets monthly and it covers HIV surveillance issues. Civil society organizations are well represented in the working group.

There is high degree of M&E results among UN, bilateral and government partners. The UNISP was developed to promote harmonized M&E indicators. The ministry of healthy also has a function health information system but with minimal indicators on HIV/AIDS. Although a review process is currently ongoing to include HIV/AIDS data. The health information system is also found at the sub national levels respectively.

There is plan to publish at least once a year evaluation report on HIV/AIDS. The latest HIV surveillance report was done in 2004. Strategic information is fairly used for planning and implementation. We have reviewed the strategic information generated in the response and also produce monthly updates and bimonthly newsletter on the response.

Training on M&E has been conducted focusing initially on the country response information system for 32 Somalia from the national, sub-national and civil society organization.

Table 15: Rating of M&E programmes

2005									
poor									Good
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	10
2003									
poor									Good
1	2	3	4	5	6	7	8	9	10

5. Major challenges faced and actions needed

The need for a consolidated monitoring and evaluation system cannot be over emphasized. HIV/AIDS interventions should be prioritized based on human, institutional capacity as well as the security situation of the country. Implementation of programmes must be based on dynamics of the epidemic in terms of risk factors and vulnerable groups as wee as the existing humanitarian and emergency context.

While there is emerging better understanding of the epidemic and progress in care plus treatment, there is a significant need to strengthen and broaden HIV prevention and life skills education. Progress needs to be made to reduce stigma, increase promotion of safer practices, encourage HIV confidential counselling and testing, and establish youth friendly health and other services.

One of the greatest challenges is the need for large-scale institutional and human resource capacity-building and strengthened coordination mechanisms to support an integrated comprehensive response. Above all, the response needs to be tailored to an ongoing emergency and humanitarian crisis setting. In such a setting, the most vulnerable face higher risk of HIV infection and its effects. Women and girls are particularly vulnerable, especially those in IDP settings, and the response needs to address these vulnerabilities as a matter of urgency.

The action needed to improve the HIV response include refocusing on most vulnerable groups, addressing issues related to multiple vulnerability of women and girls, involvement of religious groups and integrating HIV/AIDS into emergency settings.

Other existing challenges in the response to HIV/AIDS in Somalia include limited institutional and human capacity, high security phases, high mobility of people and limited capacity to carry out financial monitoring.,

Support required from development partners

Principal areas where support from development partners are required include provision of institutional and human capacity development, mentorship of the coordination bodies, monitoring and evaluation of the response and regular generation of strategic information to inform re-planning and re-programming of interventions. Somalia also needs support in implementing universal access to prevention, treatment, care and support interventions on the ground by Somalis.

BIBLIOGRAPHY

1 UNDP Human Development Report

2 WHO Summary Report for Somalia on HIV Surveillance, 2004

3 WHO TB/HIV Clinical manual, 2nd edition

4 WHO Statistical Report, 2003

6 Knowledge, attitudes, practice and behaviour survey, UNICEF, 2000

7 Knowledge, attitudes, practice and behaviour survey, UNICEF, 2004

8 Knowledge, attitudes and practice in NW and NE Somalia, WHO, 2000

9 National Strategic Framework, 2003-2008

10 Special Report on AIDS and Violence in Africa, United States Institute of Peace, 2001

11 Somali Strategic Framework, 2003-2008

12 Bernett T, Whiteside A. AIDS in the twenty-first Century: disease and globalization, New York: Palgrave Macmillan 2002:316

13 Press Release of Human Rights Envoy, Dr Graham Alnajjir, September, 2005

14 Briefing notes of Human Rights Envoy, Dr Graham Alnajjir, September, 2005

15 Evaluation of STD Syndromic Management Report

16. ART Programme Monitoring Report, 2005

17. WHO 2004 Summary Report/Fact sheet

18. WHO TB/HIV Clinical manual, 2nd edition

19 WHO KAP, 2000

20. UNAIDS/WHO second generation surveillance Guideline Report, 2002

21. Draft ART case study in Hargesia, Somaliland, 2004

22. STI Management through Syndromic Approach in Galkayo Hospital, 2002

23. Draft Monitoring and Evaluation Assessment Report in Somaliland, 2005

24. UNIFEM study on Gender Dimensions of HIV/AIDS, 2003

25. WHO KAP in North west and North East in 2000

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