

Somali HIV Epidemic and response 2013

March 19th, 2013

Table of Contents

| | |
|--|----|
| March 19 th , 2013 | 1 |
| List of Acronyms..... | 4 |
| The Country Context | 6 |
| 2. Overview of the Somali HIV and AIDS epidemic..... | 6 |
| 2.1 HIV prevalence and Incidence in Somalia | 7 |
| 2.2 Burden of HIV and AIDS in Somalia..... | 9 |
| 2.3 HIV and TB co-infection | 10 |
| 3. Assessment of the Somali response to HIV and AIDS (2009-2013) | 11 |
| 3.1 Prevention of new infections..... | 11 |
| 3.1.1 Social and Behavior Change Communication (SBCC)..... | 12 |
| 3.1.2 Prevention of Mother to child Transmission (PMTCT) | 12 |
| 3.1.3 Comprehensive condom programming | 15 |
| 3.1.4 Increasing availability and access to HIV Testing and Counseling (HTC) | 15 |
| 3.1.5 Increasing access to the management of Sexually Transmitted Infections (STIs) | 17 |
| 3.1.6 Universal precautions, blood safety and Provision of Post Exposure Prophylaxis (PEP).... | 18 |
| 3.2 Treatment, Care and Support for PLHIV | 18 |
| 3.2.1 Provision of Antiretroviral Therapy (ART)..... | 18 |
| 3.2.2 Pre-ART Care | 21 |
| 3.2.3 Diagnostic services for Treatment and care | 21 |
| 3.2.4 Prevention, care and management of TB/HIV co-infection..... | 22 |
| 3.2.5 Procurement and supply chain management..... | 23 |
| 3.2.6 Nutrition programming for adults and children living with HIV | 23 |
| 3.3 Strengthening Monitoring and Evaluation of the National response..... | 24 |

3.3 Creating an enabling environment for the national response to HIV and AIDS in Somalia 25

3.4 Strengthening management and coordination of the national response 26

3.5 Financing of the national response..... 27

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 |
| 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 Surveillance |
| 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 |
| 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 | United Nations Joint Programme on 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 |
| VL | Viral Load |
| VCT | Voluntary Counseling and Testing |
| WB | World Bank |
| WHO | World Health Organisation |
| ZAC | Zonal AIDS Commission |

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 (See Map). 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). The growth rate of population was estimated at 2.85% per year in 2006. The GDP per capita is estimated at \$600 in 2010 (World Bank).

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.

2. Overview of the Somali HIV and AIDS epidemic

The Somali HIV epidemic is heterogeneous and designing informed, prioritized, and effective responses necessitates 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

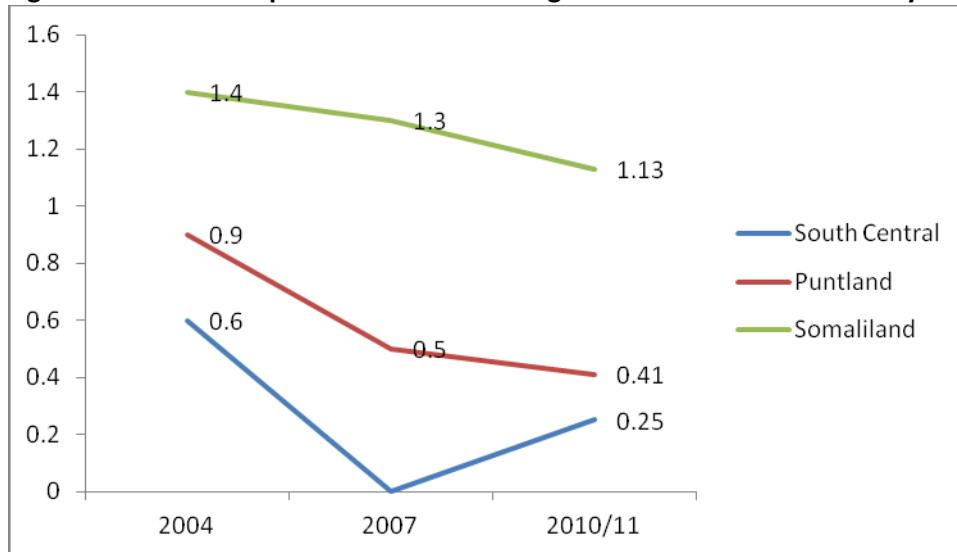
The Somali HIV and AIDS epidemic is characterized as geographically heterogeneous: low level in Puntland (PL) and South Central (SC), and concentrated in Somaliland (SL) with higher prevalence rates reported in locations of significant trade driven mobility across all zones. The most recent rounds (2011 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 respectively¹. The distribution of HIV positive testing findings among TB patients in Health Facilities as well as those tested through voluntary counseling and testing further corroborates the observation that the epidemic is more concentrated in Somaliland and Low level in South Central and Puntland.

Although it would appear that HIV prevalence rates among ANC attendees declined between the period 2004 and 2010/11² as figure 1 below suggests, this reduction over time is not statistically significant. It is been postulated 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 Ethiopia with higher HIV prevalence.

¹Due 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 1: 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. However, the last such survey conducted amongst female sex workers in 2008 in Hargeisa in Somaliland reported prevalence rates of 5.2%. A second round of the survey in Hargeisa was in progress at the time of the development of this strategy. In light of the fact that interventions to date focusing on female sex workers (FSW) have not achieved sufficient coverage, intensity and duration to have public health impact, it is probable that HIV prevalence rates amongst them are not likely to have 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 2009-2013³.

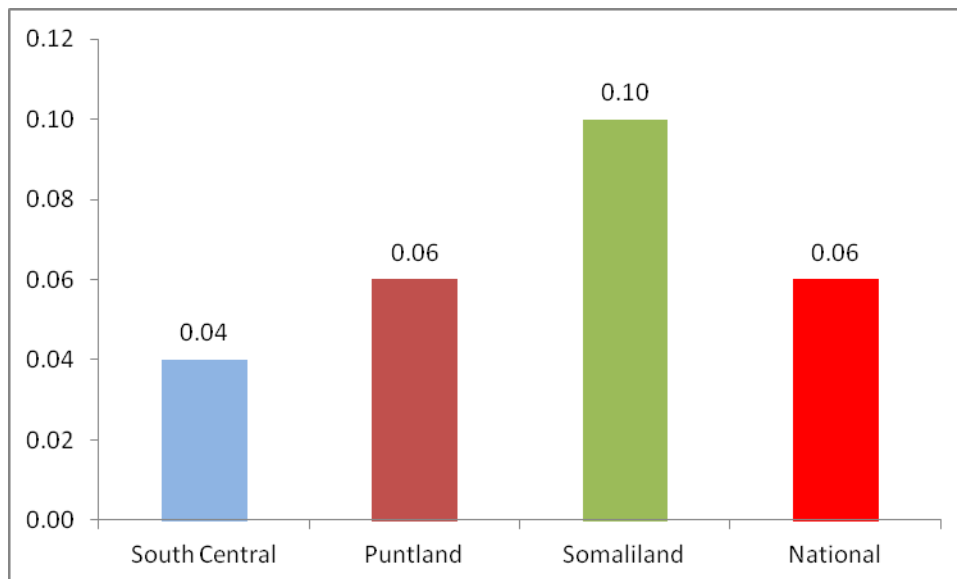
HIV incidence

It is estimated that in 2013, approximately 2, 691 Somalis were newly infected with HIV (1,350 females and 1,341 males). Within these overall estimates however, South Central zone had the highest number

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

of new infections (1,434) followed by Somaliland (980). Puntland had the lowest estimate of 278 new infections.

Figure 2: HIV incidence in Somalia by zone (2013)



Source: Spectrum/EPP 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 3 zones, followed by perinatal transmission⁴. 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 3 zones consistently screen transfused blood for HIV prior to its use. A recent rapid assessment in Mogadishu by IOM shows presence of injecting drug use.

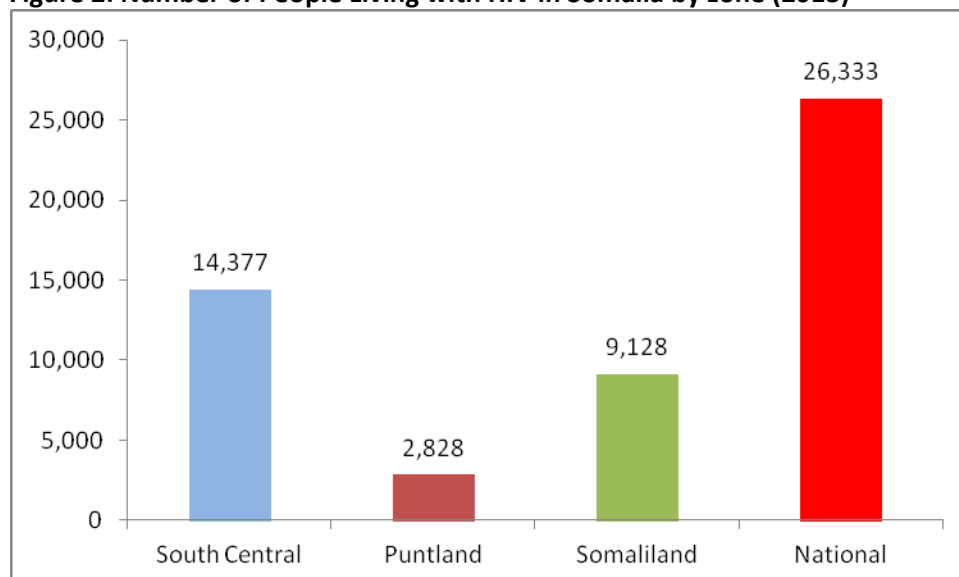
2.2 Burden of HIV and AIDS in Somalia

At the end of 2013, it was estimated that approximately 26, 000 adults and children were living with HIV and AIDS in Somalia of whom 51% were women and 49% were men⁵. Figure 1 below shows the distribution of the HIV burden in Somalia.

⁴ Although there is no specific evidence to support this assertion

⁵ The difference between the sexes is not statistically significant

Figure 2: Number of People Living with HIV in Somalia by zone (2013)



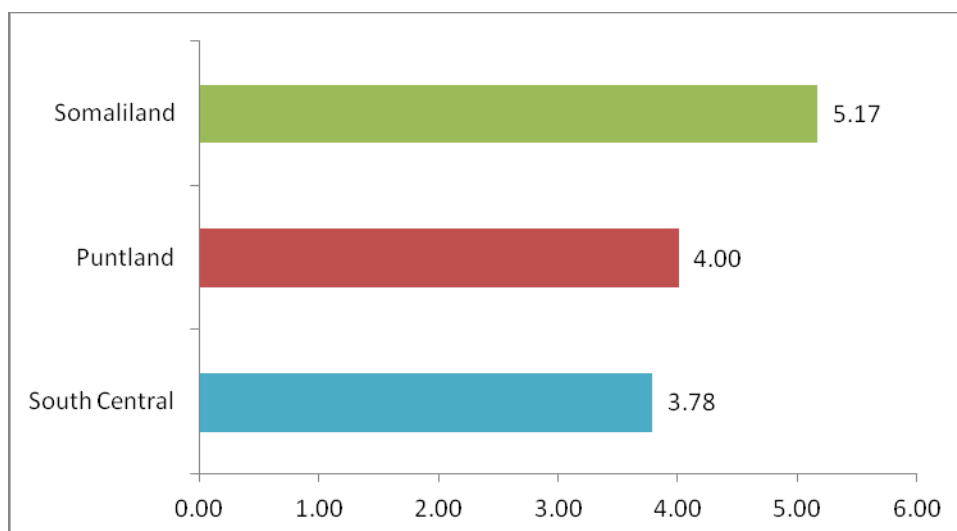
Source: Spectrum/EPP estimates for Somalia, 2013.

As can be seen from the table above, 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.

2.3 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 low and varies from 1 in 25 in South Central and Puntland and 1 in 20 in Somaliland.

Figure 4: % of HIV patients with TB in Somalia by zone (2013)



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

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.

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 date⁶. Secondly, it was not costed and therefore it was difficult to track expenditure against planned costs. e. 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

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.

The following section presents a summary of the results achieved, key challenges and gaps in the response to date.

⁶ Neither the results framework (noted in the strategic framework) nor a Monitoring and Evaluation (M & E) framework were ever developed.

3.1.1 Social and Behavior Change Communication (SBCC)

HIV incidence is the gold standard for assessing whether or not interventions undertaken have led to a reduction in the number of new infections over the past 5 years in which the strategic framework was being implemented. 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.

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 have been implemented over the period of the current strategic framework. No evaluation has to date been undertaken to establish the efficacy and effectiveness of these interventions.

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 programme reports suggests that current and past SBCC interventions have not achieved sufficient coverage, intensity and duration to have public health impact.
- There has been limited integration of SBCC interventions with other biomedical interventions such as HIV testing and counselling (HTC) and condom promotion and distribution.
- 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, 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 youth behavioural survey indicates even lower levels of comprehensive knowledge with only 5.4% of males and 4.3% of females reporting comprehensive knowledge of HIV.
- HIV related stigma still deters many Somalis from utilizing prevention services or from being tested for HIV, severely limiting the efficacy of current SBCC interventions⁷; and
- Finally, there has been no prevention with positives (PwP) interventions implemented, 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.

3.1.2 Prevention of Mother to child Transmission (PMTCT)

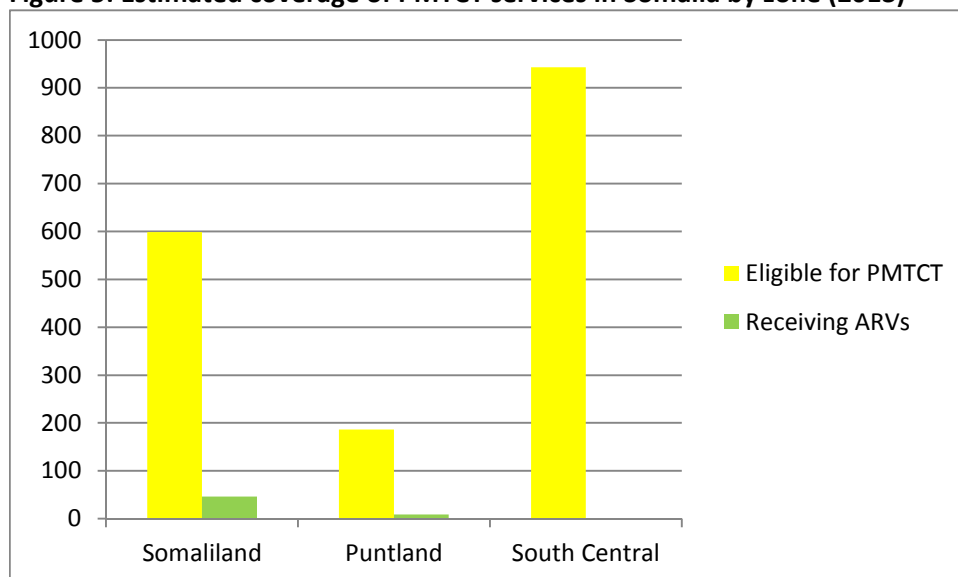
Virtually all HIV-infected children acquire the infection through MTCT, which can occur during pregnancy, labour and delivery, or through breastfeeding. In the absence of any intervention an

⁷ Only 9% of women aged 15-49 in Puntland and 8% in Somaliland expressed accepting attitudes towards PLHIV in the 2011 MICS survey.

estimated 15-30% 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.

Figure 5: Estimated coverage of PMTCT services in Somalia by zone (2013)



Source: Program reports/EPP Spectrum estimates (2013)

As figure 5 above indicates, with an estimated need of 1,728 for PMTCT on 1,728 at the end of 2013, only 56 (3.2%) had received it.

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;
- 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 3 zones offer PMTCT services, limiting availability of services to those eligible women that may require them.

3.1.3 Comprehensive condom programming

The strategic framework 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 3 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. 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, availability 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)

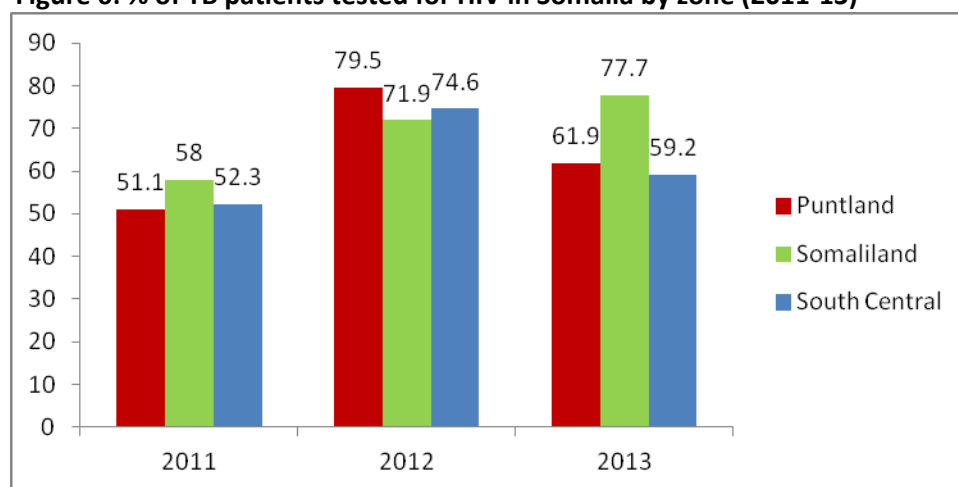
The strategic framework proposed the following actions in order to increase availability and access to HIV testing: development of standardized Operating Procedures (SOPs) for the delivery of HTC; integrating diagnostic HTC amongst TB and other patients; training of service providers in HTC and establishment 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. 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 zones⁸.

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 6 below indicates, although there remains clear scope for improvement particularly in South Central and Puntland.

Figure 6: % 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;
- 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;

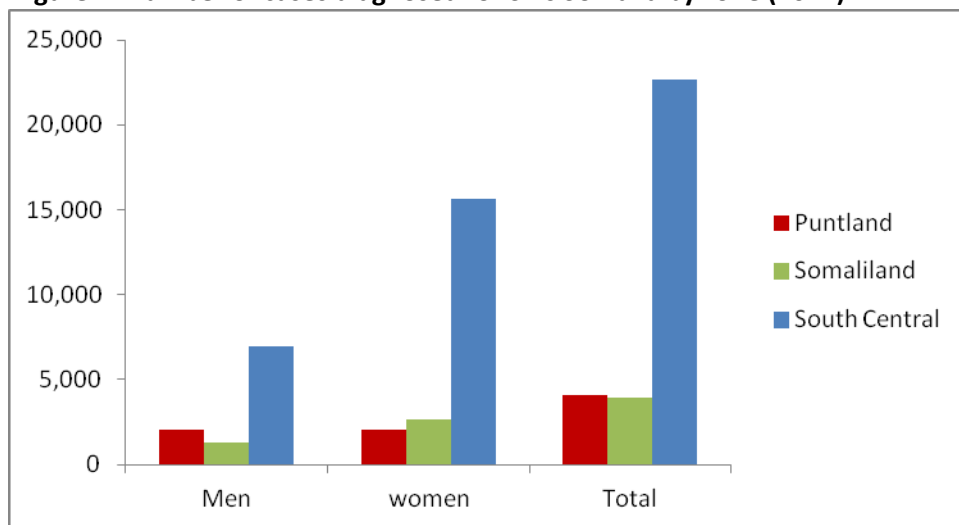
⁸ No gender disaggregated HTC data was available at the time of the development of this strategy

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.

Figure 7 below shows the number of cases diagnosed and treated for STIs in Somalia by zone at the end of 2012

Figure 7: Number of cases diagnosed for STIs Somalia by zone (2012)



As the figure above 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.

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

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

The strategic framework proposed 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. Furthermore, Staff in health facilities and the relevant authorities are inadequately trained in PEP and clinical management of rape (CMR).

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 weak.

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 strategic framework, the number of PLHIV has increased steadily from just 569 in 2009 to 1,580 at the end of September 2013 as the Table below indicates:

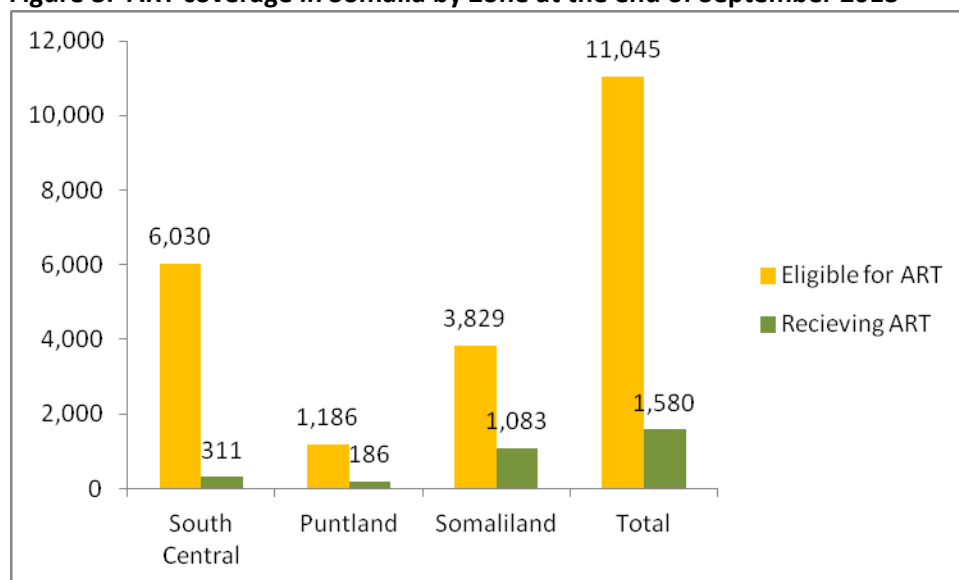
Table 1: Number of Somali's on ART from 2009-2013⁹

| Year | Number of People on ART |
|------|-------------------------|
| 2009 | 569 |
| 2010 | 878 |
| 2011 | 1,139 |
| 2012 | 1,450 |
| 2013 | 1,580 |

Data source: Program reports

Based on the context in which this programme has been implemented, significant progress has been achieved. However, coverage is only 14% based on the new WHO eligibility requirements for the provision of ART (CD4 count eligibility of less than 500). Figure 8 below shows ART coverage rates by zone at the end of September 2013

Figure 8: ART coverage in Somalia by Zone at the end of September 2013



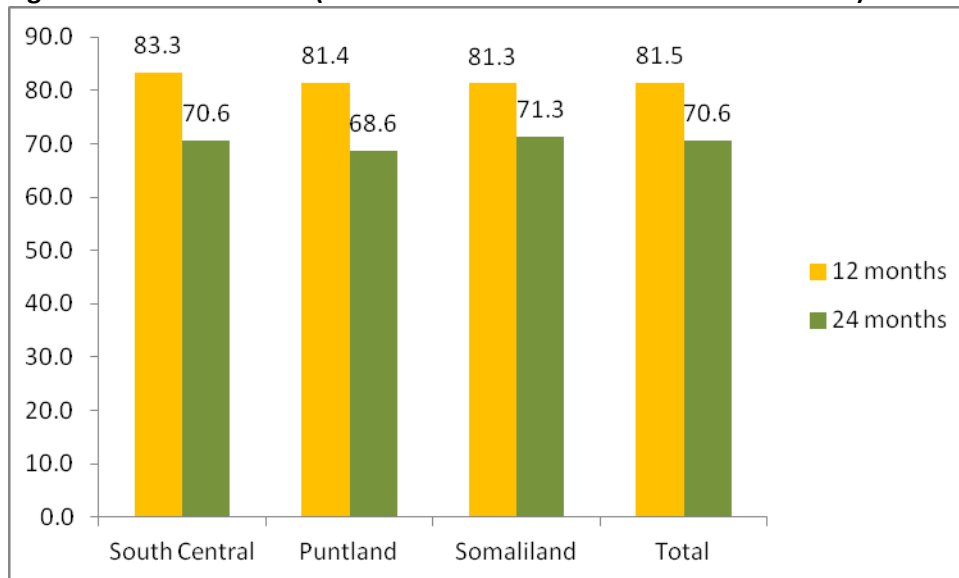
Source: program reports/EPP Spectrum estimates 2013

As the figure indicates, coverage is generally very low across the whole country, with coverage highest in Somaliland (28%) followed by Puntland (16%) and South Central with the lowest coverage at 5%. Disaggregating the data by gender, reveals there is no statistical differences between the number of men and women on treatment. 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 across the 3 zones to at least 3 times that number by 2016.

At the outcome level, the ART programme has achieved commendable retention rates (comparable to those achieved amongst its neighbors) linked to adherence and survival as the figure 9 below illustrates:

⁹ As at 30th September 2013

Figure 9: Retention rates (still alive on treatment at 12 and 24 months) in Somalia by zone



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 programme.

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 is often no opportunity for appropriate monitoring of patients to ensure that Pre-ART clients are followed up or for clients on ART, there is limited quality follow up to ensure medication adherence ;
- 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 in the public health sector;

- Coverage of virologic testing (EID) for HIV exposed infant’s remains unacceptably low at 13% resulting in many HIV positive infants unidentified in the postnatal period, thereby missing out on critical interventions;
- The ART data is not collected in a manner that lends itself to cohort analyses;
- Coverage of cotrimoxazole prophylaxis remains alarmingly low;
- Preventing unintended pregnancies among HIV positive women (and other women as women) by increasing the voluntary use of contraception has been undervalued and may be culturally opposed;

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 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.

Key gaps and challenges relating to Pre-ART Care

- Lack of a Pre-ART package – patients are not followed 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, high default rate and non-compliance to treatment.

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 this has not been systematically addressed or prioritized over the life of the strategic framework. As a consequence, numerous gaps and challenges have been noted.

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

- The lack of laboratory scientists in-country negatively affected the laboratory services;
- 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 current laboratory infrastructure in place is inadequate to respond to the diagnostic needs of 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 lab 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 a lack 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 TB¹⁰. Cotrimoxazole preventive therapy (CPT) has been proven to reduce morbidity and mortality among PLHIV and TB.

Out of 66 TB centres, 30 (36%) of them are providing HIV testing and counseling. During 2012, 87% of TB patients were counseled and tested for HIV of whom 5% tested positive and either received treatment or was referred. 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. Only 79% of HIV-TB patients were reported to have received cotrimoxazole in 2012. 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.

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, but being initiated in one zone.

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:

- The non availability of TB drugs due to frequent stock outs.
- Isoniazid preventive therapy roll out has not proceeded as planned due to INH procurement constraints;

¹⁰ Lawn SD, Churchyard G. Epidemiology of HIV-associated tuberculosis. *Curr Opin HIV AIDS*. 2009 Jul; 4(4):325-33.

- Low uptake of ART service due to limited ART coverage among health workers in TB/HIV co-management as well as limited ART initiation capacity the challenge of which has been described in earlier section;
- 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 lack of resources has limited the roll-out of these 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 and initiation of ART;
- 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; and
- 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

3.2.6 Nutrition programming 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 programmes have reported high mortality in the first 90 days of ART treatment correlated strongly with low body mass index (BMI<16)¹¹.

The World Food Programme (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

¹¹ Greenaway K, 2009, No 2: Food by Prescription: A Landscape Paper, GAIN working paper series.

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 programme for TB and HIV patients in Somalia is therefore paramount.

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 ZACs 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 is 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 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 to enable them to fulfil their role in coordinating M&E of the national response;
- There is insufficient technical capacity for HIV M & E at all levels;
- Evidence based decision making is weak;
- Routine HIV programme monitoring is weak;
- Surveillance is weak, non-comprehensive and sporadic especially for bio-behavioural surveillance of key affected populations ;
- National database is non-existent and zonal ones where available are weak (does 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;
- All rounds of ANC surveillance data for the country have targeted only Puntland and Somaliland, leaving out South Central except in 2004 and 2011. With this, national reference can only be made to 2004 data in which the three zones were part. This has implications for analysis of the national response and the input data used for the country estimations;
- The analysis of prevalence trends is limited by sample sizes of pregnant women targeted at ante-natal care (ANC). The numbers of positive cases in surveillance results are quite few and therefore changes in prevalence by sites may be a result of very small variations. Thus, the analysis of trends cannot be expressed in absolute terms of increase or decline due to this limitation;
- 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. 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 key sub-populations, the integrated biological and behavioural surveillance (IBSS 2008) provided comprehensive on testing for HIV and STIs and behaviours of FSWs. However, the study only covered Hargeisa in Somaliland, and which makes it difficult to generalize findings for the whole country. In addition the data set is over 5 years old and thus outdated; and
- No size estimations of key populations such as sex workers, uniformed personnel has been undertaken

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

Participation and involvement of PLHIV CBO level as one PLHIV group has been established in each zone. Somalia is committed to fulfilling its international obligations as party to the UNGASS Declaration of Commitment on HIV and AIDS (UNGASS 2001), 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*: There has been no significant, formal, overall policy development for HIV. where some rudimentary or zonal draft policies exist, they needs to be reviewed and updated in light of new evidence and the evolving epidemic; and then laws enacted to protect the rights of PLHIV and enable effective programming for HIV and AIDS.

A gender policy for Somalia has been developed. Although empirical data is limited, it is acknowledged that gender based violence and inequalities are important in Somalia and are further fueled by the

conflict. The goal of the gender policy is to promote gender equality and sustainable human development. Among other objectives, the policy seeks to improve equal access to HIV/AIDS information for prevention, treatment and care for women and men living with HIV/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 by males prior to marriage. 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 reporting through judicial procedures, in addition to a disconnection and inefficiency of traditional and formal judiciary procedures for perpetrators of SGBV, reducing willingness to report SGBV incidents.

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

- Stigma (social, institutional and personal) remains the biggest barriers 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 PLHV 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

3.4 Strengthening management and coordination of the national response

Somalia's multisectoral response to HIV and AIDS is managed and coordinated by the National AIDS Commissions (NAC) 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.

Somalia's health sector (biomedical) response is coordinated by the MOH/DOH HIV and AIDS and TB unit. 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 three 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, meeting and sharing of information among the 3 NACs.

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:

- There is inadequate capacity and experience in operational planning;
- There are no consistent joint annual planning and review process for the national response to HIV and AIDS;
- There does not appear to be a consistent mechanism for producing zonal-level estimates of disease burden, targets and levels of achievement;
- 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
- Coordinating the mobilisation and strategic allocation of financing to different areas of the national HIV and AIDS response has been difficult. Many parallel financing systems exist and in most cases NACs don't feel empowered to engage donors to re-direct resources; and
- 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 lower levels.
- Reliance almost exclusively on one external funder to fund the response to HIV and AIDS.

3.5 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 \$43,365,731¹² 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.

¹² As at 22 October 2013 (Round 4 and Round 8 HIV grants)