

Progress report for Somali HIV and AIDS Response 2014



June 2015

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List of Acronyms

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

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

Executive Summary

Epidemiology

The number of people living with HIV (PLHIV) is increasing and estimated at 35,000 in 2014 (UNAIDS). The adult HIV prevalence rate in 2014 was 0.55%. However, integrated bio-behaviour surveys conducted in Hargeisa found HIV prevalence of approximately 5% among sex workers in 2008 and 2014. The annual number of new infections is not reducing, remaining at around 3,200 new infections indicating that prevention efforts are not bearing impact. Similarly, annual AIDS deaths have remained at approximately 2,300 per year.

Response

There is an increase in ART coverage from 569 in 2009 to 1,748 in 2013 and 1,916 in 2014. However, there is still low coverage (8%) of ART (8% in adults and 4% in children) using the national eligibility criteria in 2014 (CD4 count \leq 500) translating to 6% adults receiving ART as a percentage of the total HIV population. Integrated Bio-Behavioural Surveys of female sex workers conducted in 2008 and repeated in 2014 in Hargeisa revealed that nearly ten times (21.3%) more women had an HIV test in the last 12 months and received the results compared with in 2008 (2.4%). However, only 2.5% of mothers received ARVs for PMTCT in 2014. Due to low coverage of PMTCT, the mother to child transmission rate (modelled) is estimated at 47% in 2014.

Opportunities

A National Strategic Plan for HIV and AIDS for 2015 to 2019 has been developed costing approximately USD 57 million and was used to access USD 22 million from the GFATM. A Health Sector Strategic Plan (HSSP) 2013-2016 has been developed and is being implemented using an Essential Package of Health Services (EPHS) delivery funded by a multi donor Joint Health and Nutrition Programme (JHNP) that provides for integration HIV and AIDS into health services delivery

Challenges and gaps

Stigma and discrimination is prevalent and impedes access to and utilization of HIV and AIDS services, particularly those residing in rural areas and key affected populations. Sexual and Gender based violence is also reported to be high. The monitoring and evaluation of the response has challenges with regard to adequacy of skills with only 46% providing quality reports. The response has been dependent on the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for over 85% of its HIV and AIDS related expenditure. Insecurity is a great challenge to service delivery including for HIV and AIDS. There are high transaction costs of program implementation. Refugees have begun moving to and from neighboring countries with higher HIV prevalence mainly to South Central Somalia that has been plagued with war for over 20 years and is in the process of state formation.

Recommendation: Action is required now to reduce new HIV infections and prevent unsustainable control of HIV in the future.

1. Introduction

Throughout 2014, the Somali authorities in partnership with civil society and development partners continued to make strides in implementing HIV and AIDS programmes. Working independently on some activities and collaboratively on many others, the Somali authorities were actively engaged in a wide variety of programmes from assessments, policy making to training, public awareness, and resource mobilization. This progress report, prepared collectively by all stakeholders highlights the key accomplishments during calendar year 2014. It is, however, just a sample of the myriad activities taken by the several stakeholders engaged in HIV and AIDS programmes.

These selected highlights include many actions specifically detailed in quarterly reports that are reviewed in the coordination meeting. In several instances, they also reflect achievements that go beyond planned actions.

One of the notable highlights of 2014 involving all key stakeholders and many other partners was the development of the Somali National Strategic Plan for HIV and AIDS 2015-19 (NSP). The development process of the NSP brought together more than 100 participants representing government, civil society and development partners in different forum at the peripheral level and subsequently as a joint meeting. The process was indeed very collaborative and consultative.

1.1 Overview of the document

The Progress report is presented in seven parts that are preceded by this introduction (Part 1). Part 2 provides a situational assessment based on the most up- to-date epidemiological analysis of HIV and AIDS in the country. Part 3 provides an assessment of the Somali response to HIV and AIDS to date including achievements, challenges and key gaps in the response to HIV and AIDS to date.

2.0 Overview of the Somali HIV and AIDS epidemic

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

2.1 HIV prevalence and Incidence in Somalia

2.1.1 HIV prevalence

The Somali HIV and AIDS epidemic is characterized as geographically heterogeneous: low level in Puntland (PL) and South Central (SC), and generalised in Somaliland (SL) with higher prevalence rates reported in locations of significant trade-driven mobility across all zones.

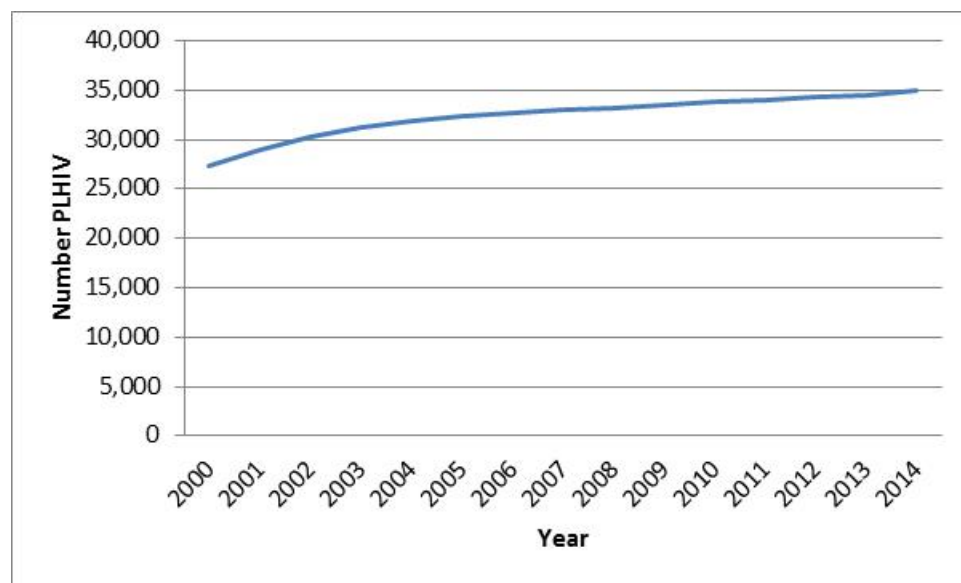
The recent round of HIV estimates approximates the number of people living with HIV in 2014 at approximately 35,000 and increasing with an HIV prevalence (15-49 years) of 0.55%. In 2014, the population of adult PLHIV in Somaliland is estimated at 9,531, while in South Central at 16,363 and Puntland at 3,832. (Table 1). The HIV Prevalence (15-49) in 2014 is estimated at 0.78% in Somaliland, 0.59% in Puntland and 0.38% in South Central.

The most recent (2014) rounds of Ante Natal Care (ANC) sentinel surveillance found mean HIV prevalence rates of 0.67% in Somaliland and 0.49% and 0.22% in Puntland and South Central respectively.

Although it would appear that HIV prevalence rates among ANC attendees declined between the period 2004 and 2010/11 and subsequently in 2014, this reduction over time is not statistically significant.

To date, there has been no population based 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 behaviours to the impact level indicator of HIV prevalence or to triangulate the sentinel biological data.

Fig. 1 HIV population, 2000 to 2014



2.1.2 HIV prevalence amongst Key Affected Populations (KAPs)

Limited bio-behavioral surveillance of higher-risk (and often invisible) populations (called Key Affected Populations throughout this strategy document) has been conducted in recent years in Somalia. The last such survey conducted amongst Female Sex Workers (FSW) in 2014 in Hargeisa (Somaliland) reported prevalence rates of approximately 5%.

2.1.3 HIV incidence

It is estimated that in 2014, approximately 3,256 new infections occurred in adults and children. Of these, 2,338 were adults (aged 15 years plus) with an adult (15-49 years) incidence per 100 of 0.05% (0.07% in Puntland, 0.07% in Somaliland and 0.04% in South central) in 2014. South Central zone had 1,352 of adult new infections while Somaliland had 636 and Puntland 349. The number of new child infections due to mother to child transmission is estimated at 920 in 2014. It is estimated that there is no significant difference in incidence among the sexes. However, sero-behavioural surveys among men are required to obtain a more precise sex disaggregation of incidence.

2.1.4 AIDS mortality

The total annual AIDS deaths in 2014 are estimated at 2,370 giving an AIDS mortality per 100,000 of 22. The adult annual AIDS deaths in 2014 were approximately 1,912 (613 in Somaliland, 1,052 in South Central and 246 in Puntland).

Table 1: Zonal summary HIV estimates for 2014

	Somalia	Somaliland	South-Central	Puntland
Year = 2014				
Adults 15+				
HIV population				
Total	29,726	9,531	16,363	3,832
Male	14,589	4,677	8,030	1,881
Female	15,137	4,853	8,333	1,951
Prevalence (15-49) %	0.55	0.78	0.38	0.59
New HIV infections				
Total	2,338	636	1,352	349
Male	1,171	319	677	175
Female	1,167	318	675	174
Incidence (15-49) %	0.05	0.07	0.04	0.07
Annual AIDS deaths				
Total	1,912	613	1,052	246
Male	996	319	548	128
Female	916	294	504	118
Total number receiving ART				
Total	1,823	584	1,003	235
Male	740	237	407	95
Female	1,083	347	596	140
Total need for ART				
Total	22,422	7,189	12,343	2,891
Male	10,496	3,365	5,778	1,353
Female	11,926	3,824	6,565	1,538

Source: UNAIDS (2015) Spectrum model v5.3

3.0 HIV and AIDS Response

3.1 HIV Prevention

3.1.1 Building capacity on HIV prevention programmes for young people

International Y-PEER fellow was seconded to UNFPA Somalia to provide support for youth and HIV prevention. Four Y-PEER focal persons and UNFPA staff joined Y-PEER forum in Cairo on HIV.

UNFPA trained 11 youth focal persons who reached 363 youth in south central Somalia. In Puntland, Culturally sensitive awareness raising campaigns on reproductive health issues including STIs/HIV AIDS among university students were conducted by Y-PEER and 40 university students were reached. One Y-peer fellow sent to the regional symposium on SRHR and HIV in Africa held in Lusaka Zambia. Condom use was at the heart of this international event.

In Somaliland, UNFPA supported clubs of secondary school in programming adolescent sexual and reproductive health through Y-PEER approaches like HIV and STI prevention, drug abuse and conflict resolution.

UNFPA supported the construction and equipment of the new Youth Center Hargeisa. This center will be developed to be a center of excellence for youth sexual education and HIV prevention.

In Somaliland, community conversations were held for male youth. In Somaliland 127 youth at risk (M:78; F: 49) attended Basic HIV training. In South Central Somalia, 191 (F:81, M: 110) youth at risk received training on HIV.

In Puntland, 306 (F:131, M:175) Police officers and youth at risk groups attended HIV basic (BCC) training.

3.1.2 Ensure high quality education for a more effective HIV response

Through Y-PEER Clubs, four Secondary Schools and two Universities, UNFPA reached 60 beneficiaries directly and an estimated 10,766 indirectly on sexual education and HIV prevention

In Somaliland, a training manual on sexual education was prepared for the purpose of using it as a text for the training of school teachers on sex education. This newly designed curriculum will be institutionalized in training schools.

In Somaliland, 200 teachers from local schools were trained on sexuality education with the aim of equipping teachers with adequate knowledge on HIV and sexuality so that they would share with their students. Teachers were mainly social and science instructors. This competency transfer activity has been instrumental in reaching more young people, including adolescent girls in schools.

3.1.3 Strengthened capacity for combination prevention programmes

UNFPA procured and supplied 150,000 condoms for all the zones with South central zone receiving 97,000. All condoms were distributed through the Ministry of Health HIV and AIDS

units to the PMTCT, ART and VCT clinics. This initiative will serve as a breaking ground for the introduction of condom use among young people in all zones. Two staff attended HIV in reach training in Dubai.

100 people attended an HIV prevention workshop in Banadir region organized by UNFPA. 642 people were reached through promotional messages on HIV awareness raising with approximately 3,852 indirect beneficiaries. The impact of such training programmes has contributed in expanding awareness building on HIV prevention.

UNFPA trained 100 (50 youth groups and 50 health service providers) on adolescent reproductive health covering STDs including HIV, Family Planning and Principles of GBV. UNFPA reached directly 90 beneficiaries with peer education on HIV training in the Banadir region and another 540 benefitted indirectly. This is a fairly commendable example of linkages between HIV, GBV and Family planning.

In Puntland, awareness raising campaign on prevention and management of STIs including HIV as a part of re-integration program was provided to 50 people.

With support of UNFPA, a popular song on HIV&AIDS awareness was composed in Somaliland using the most prominent singers in the area. The song which is very short and comprehensive covers a range of topics from test and treatment to stigma reduction and prevention. The song was aired on national TVs and local radios and proved to be popular especially among the youth. The messages in the song are culturally sensitive but yet very catchy.

An assessment on SRH/HIV linkages using rapid assessment tool finalized on Somaliland, the findings will be disseminated in 2015.

The HIV Radio Project funded by UNDP is helping to reach large numbers of people with correct information on HIV. In 2014, approximately 1,664 HIV messages were aired by 7 radio stations in Somaliland, Puntland and Mogadishu. Indeed, the year 2014 marked the first time that it felt safe enough for these messages to be aired by 4 radio stations in Mogadishu which is a milestone in terms of creating a more supportive environment for all HIV work in Somalia.

World AIDS Day, 2014 was commemorated and was used for high level advocacy for HIV prevention, care and treatment with participation of political leaders in all zones including the Federal government.

In total 4,419 (M: 1,458, F: 2,961) people were reached through HIV & AIDS awareness and outreach programmes in 2014 in Somaliland. 270 HIV Radio messages were aired by Radio Hargeisa in 2014. HIV messages aired were the 15 HIV radio messages developed in collaboration with BBC Media Action in 2012. Each message was aired twice a day. The AIDS Commission has developed a strong partnerships with Radio Hargeisa who shall continue to air HIV messages in 2015.

In total 3,220 (M: 1,148, F: 2,072) persons were reached through HIV awareness raising in Bosaso and Garowe in Puntland. Approximately 2,674 of the participants reached were through Community Conversation on HIV (M: 833; F: 1,841). NGO partners reported that 55 people went for VCT as a result of attending Community Conversation on HIV sessions.

In South Central Somalia, a total of 2,346 (F: 1,383, M: 963) people were reached through HIV & AIDS awareness raising in Banadir and Gedo regions. This is the first year that this project is being implemented at the Federal Level. The majority of people reached this year attended Community Conversation on HIV sessions, similar to the above two regions. 1464 HIV radio messages (the 15 HIV messages produced in collaboration with BBC Media Action) were aired by 4 Radio stations in 2014. The 4 Radio stations that aired the HIV messages were those with the largest coverage, namely Radio Kulmiye, Radio VOD, Radio Banadir and Radio Risala.

3.1.4 Strategic information for HIV prevention

The latest two sources of Knowledge, Attitudes, Practices and Behavioural data are Youth Behavioural and the Multiple Indicator Cluster Surveys of 2011. With a recommended 3 to 5 year frequency, the KAPB studies need to be repeated.

3.1.4.1 Young People: Knowledge about HIV prevention

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' aged 15-24 reporting comprehensive knowledge of HIV.

UNESCO supported the development of HIV and AIDS banners for the World AIDS Day 2015. The banners had messages on the importance of the education sector in response to HIV and AIDS. The messages were in both English and Somali languages.

3.1.4.2 Sex before the age of 15

The YBS (2011) revealed that 10% of the youth have ever had sex. In Somaliland for instance, almost one in every five young people have had sexual intercourse. Sexual intercourse in half of the youth who ever had sex took place before age 15. The mean age at sexual debut is 15.9 years, the first encounter being with a peer.

3.1.4.3 Multiple sexual partners

In the Youth Behavioural survey of 2011, a slight proportion of youth (3%) had more than one sexual partner.

3.1.4.4 Condom use at last sex among people with multiple sexual partnerships

In the YBS 2011, approximately one third of the youth who reported multiple sexual relationships (35%) reported to using a condom with their partner during their most recent sexual encounter.

3.1.5 HIV testing

In YBS (2011), 9.6% and 7.2% boys and girls reported having been tested for HIV.

By December 2014, 73 health facilities provide HIV testing and counselling services of which 70 are public health facilities.

During 2014, 800 children received HIV testing and counselling in the past 12 months and know their results. Of these, 419 were females and 381 were males.

There were 79,722 adults who received HIV testing and counselling in the past 12 months and know their results. Of these, 68,503 were females and 11,219 were males. Out of the adult females, 52,795 pregnant women aged 15 and older received testing and counselling in the past 12 months and received their results.

Current HTC guidelines address adolescents and key populations. The guidelines recommend PITC to all people in TB and STI clinics, use of rapid tests for same day results

3.1.6 HIV prevalence in young people

Preliminary results of the recent (2014) HIV ANC sentinel surveillance show a slight reduction in HIV prevalence among pregnant women with a mean prevalence of 0.67% in Somaliland, 0.22% in South Central and 0.49% in Puntland.

3.1.7 Key populations

The last size estimation of female sex workers was performed in 2011 with the upper limits estimated at 400 for Berbera and 1000 for Bosasso. Size estimations for FSWs in Hargeisa, Mogadishu and Bosasso are planned in 2015. There have been no size estimations for MSM or PWID.

3.1.7.4 Female Sex workers

An Integrated Bio-Behavioural Surveillance (IBBS) survey of Female Sex Workers has been conducted in 2014 in Hargeisa, Somaliland using Respondent Driven Sampling (RDS). Out of 85 respondents surveyed, 5.9% of sex workers knew where you can go if you wish to receive an HIV test. Out of 60 sex workers surveyed, 5% reported having been given condoms in the past 12 months. Out of 92 sex workers who reported having commercial sex in the last 12 months, 33.7 percent of them reported the use of a condom with their most recent client. Out of 85 female sex workers included in the sample, 20 percent of sex workers (17) received an HIV test in the past 12 months and know their results. Out of 96 sex workers tested for HIV, five (5.2 percent) were living with HIV.

When the IBBS 2014 results are compared to those of 2008, they reveal that nearly ten times (21.3%) more women had an HIV test in the last 12 months and received the results compared with in 2008 (2.4%).

3.1.8 Sexually Transmitted Infections

During 2014, there were 8,179 women attending ANC services who were tested for syphilis at first ANC visit. The sentinel sites are all urban, and there are large parts of South central Somalia that are not accessible due to the security situation there.

Out of 8,179 antenatal care attendees who were tested for syphilis, 1,222 (1.5 percent) tested positive for syphilis.

Out of the 122 antenatal care attendees with a positive syphilis serology, 57 (46.7 percent) antenatal care attendees with a positive syphilis serology received at least one dose of benzathine penicillin 2.4 mU IM.

Out 9,184 individuals aged 15 and older, 184 reported with syphilis during the reporting period. Apart from HIV sentinel surveillance testing which includes syphilis testing, there is no other system for etiological reporting of other STI diagnosis.

3.1.9 Prevention of mother-to-child transmission

Only 2.5% (49) of mothers received ARVs for PMTCT in 2013. Due to low coverage of PMTCT,

the mother to child transmission rate (modelled) is estimated at 47% in 2014. Out of the 49 HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery, 39 were already on ART before the current pregnancy. There were 36,856 pregnant women were tested for HIV in the last 12 months and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status. Out of 426,194 pregnant women, 12.39% were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status.

3.1.9.1 Scale-up plan for eMTCT-keeping mothers alive

Access to services for preventing MTCT in Somalia started in late 2010 in Somaliland and South Central and early 2011 in Puntland. Thus the provision of PMTCT services are still at a nascent stage with only 35 health facilities providing the full package of PMTCT services. To address the challenges, the PMTCT guidelines have been reviewed and a scale up plan finalized. Adoption of Option B+ is expected to improve the efficacy of PMTCT. There was resistance to ambitious targets for PMTCT due to current very low coverage and because an estimate of 50% of the population is not easily accessible.

UNICEF led the development of a scale up plan for PMTCT which informed the development of the NSP 2015 to 2019 and the HIV concept note. With support from UNICEF, stakeholders in the zones met to review PMTCT guidelines and drafted a scale up plan. Scale up plan includes strategies for increasing demand for PMTCT. All 4 prongs are detailed in strategy.

3.1.9.2 Maternal and child health systems with PMTCT integration into SRH

As part of the NSP development, integration of HIV and MCH services has been envisaged through the Essential Package of Health Services (EPHS) framework. The NSP 2015-19 has included a strategic action to implement Provider Initiated Testing and Counselling (PITC) services with an emphasis on STI patients and Maternal and Child Health (MCH) attendees.

3.2 HIV Treatment and Care

3.2.1 HIV treatment: Antiretroviral therapy

WHO 2013 ART Guidelines on the use of ARVs for prevention and treatment of HIV have been adapted with a CD4 threshold of ≤ 500 for initiating ART in adults and adolescents. PMTCT guidelines have been completed and recommend Option B+. The age cut off to treat all children irrespective of symptoms is < 5 years.

There were 1,916 adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period. Of these, 1,135 were female and 781 were male. 1,823 were adults older than 15 years) and 93 were children. There is an increase in ART coverage from 569 in 2009 to 1,748 in 2013 and 1,916 in 2014. However, there is still low coverage of ART (7% in adults and 3.6% in children) using the national eligibility criteria in 2013 translating to 5% adults receiving ART as a percentage of the total HIV population.

Out of 557 persons newly initiating antiretroviral therapy during the last reporting year, 353 were females and 204 were males.

Out of 468 adults and children who initiated antiretroviral therapy who were expected to achieve 12 month outcomes within the reporting period including those who have died 353 (75.4%) adults and children with HIV known to be on treatment 12 months after initiating treatment among patients initiating antiretroviral therapy.

There are 11 health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up) all of which are public hospitals. There were no ART stock outs reported during the period under review.

Out of **248** HIV-positive people with first CD4 cell count in 2014, 138 (55.6%) HIV-positive people with first CD4 cell count <200 cells/ μ l in 2014.

3.2.2 Paediatric HIV treatment and child health care integrated

Previously, WHO had conducted adaptation of the IMAI training module, under which paediatric ART elements are integrated. Because of the low prevalence of HIV, it would not be cost effective to integrate anti-retroviral therapy (ART) general child health programs. During 2014, WHO formal training sessions, and supportive supervision included ART for children. Paediatric ART continued to be provided at 11 ART sites in the three zones, with 36 patients aged 0-14 being enrolled into HIV care, and 32 of these starting ART during 2014. By the end of the year a total of 93 children were on ART, this constituting 4.9% of the 1,916 patients on reported alive and on ART by end of December 2014. The consultancy mission to strengthen paediatric ART did not take place due to funding constraints, but paediatric ART is already integrated in the IMAI ART training modules. During 2014, 57 ART site staff received this IMAI training.

3.2.3 Global guidance for Treatment 2.0 implemented

The total number of patients on ART has increased threefold from 578 in 2009 to 1,916 by December 2014. ART targets were revised and WHO 2013 guidance for ART adopted.

ART coverage is generally low reflecting challenges of accessibility to ART. There is a need to increase the number of ART centres from the current number of 11. Adherence to treatment and counseling for HIV/AIDS patients has led to remarkable results, with 84% of patients surviving a year after initiation of ART. Stakeholders met to review ART guidelines. PSM was reviewed and recommendations for better forecasting made. Food support for vulnerable PLHIV ceased in Somaliland and is affecting uptake of ART. UNAIDS advocated with WFP to address it and an agreement with Somaliland is due. PSM is inefficient with stock outs of test kits. Low in-country capacities for programme management. Insecurity affecting reach of some populations. High sensitivities, stigma to PLHIV affecting uptake and use of ART services.

WHO remained a sub recipient of the Global Fund round 8 HIV and round 10 TB grant resources, for technical assistance to HIV/AIDS treatment and TB/HIV program strengthening. During Jan – Dec 2014, a total of 530 patients were enrolled into HIV care and treatment. Unfortunately, 63 of these patients died before initiation of ART. In total 557 patients were enrolled onto ART, bringing the cumulative total ever enrolled to 4,654. By the end of December 2014, 1,916 patients were alive and on ART. *Cohort analysis of survival, defaulting, deaths and loss to follow up on ART is not yet complete, and will follow in due course.*

WHO co-facilitated zonal level consultations on the adaptation of the WHO 2013 recommendations on ARV use for prevention and treatment of HIV. The first meeting was held in Hargeisa and was co-facilitated by the WHO EMRO Treatment Expert, followed by a separate meeting for Puntland in Garowe. These meetings' deliberations included, and were informed

by, analysis of the treatment cascade data for the three Somali zones. The key findings from the treatment cascade were that since 2004, 5,581 persons had tested HIV positive in the three zone. But these cases diagnosed were only equivalent to **21%** of the estimated total number persons living with HIV (5,581/26,350) during 2013. While 4,219 of these diagnosed HIV positive cases had been enrolled into HIV care by the end of 2013, this coverage left **24%** of those diagnosed never having enrolled into HIV care. Furthermore, by December 2013, only **57%** (2,424 of the 4,219) of those who had been enrolled into HIV care had ever been started on ART.

By December 2013 **1,700** patients were reported alive and on ART, while another 647 patients were reported active in pre-ART care. By this date, those who had ever been enrolled into care but had not started ART should have been 1,795 (Number ever enrolled in care *minus* number ever enrolled on ART: 4,219 - 2,424 = **1,795**). And subtracting the number actually reported as active on Pre-ART by Dec 2013 (647) from this figure of 1,795 that should have been in pre-ART showed that **1,148** patients had died or been otherwise lost to follow up in pre-ART care (1,795 - 647 = 1,148). These 1,148 represented **a loss of 43% of all patients who had ever enrolled into HIV care**. Needless to say, this loss of patients before starting ART was the highest area of attrition in the HIV/AIDS treatment cascade.

Retention on ART was decent, ranging from around 80% at 12 months to 60% at 60 months. Therefore, given the reasonable retention after starting ART, it was clear that it was critical to get patients onto ART earlier, to more effectively make a dent on overall attrition along the whole treatment cascade, and improve overall HIV/AIDS patient outcomes. But the difficulties in ensuring sustained CD4 machine functionality even at the sites where the machines are on the premises had proved insurmountable in the context of all three Somali zones. The CD4 threshold had become a **barrier** to accessing ART, instead of the doorway that could be 'opened wider' by increasing the ART eligibility CD4 threshold. Merely raising this threshold from 350 to 500 would still translate into patients continuing to wait in pre-ART until they got a stage 3 or 4 event, since the CD4 service continued to be unavailable almost all the time.

Accordingly, while the participants concurred to adapt all the other WHO 2013 recommendations for use of ARVs for adults, pregnant women, adolescents and children, in the case of when to start ART, the consensus was to go further by adopting a **Test and Treat approach**, as had already been done in some other countries.

The actual roll out of this **Test and Treat approach** would await the completion of key preparatory steps such as first ensuring the availability of additional required ARVs and other supplies.

3.2.3.1 Drug regimens optimized (Treatment 2.0 Pillar 1)

The ART regimens in use take advantage of availability of fixed dose combination, and the WHO 2013 ART guidelines recommendation preferred regimens, such as use Tenoforvir based regimens, have been adapted. Regimens with D4T have been fully phased out.

3.2.3.2 POC and simplified platforms for diagnosis and treatment monitoring (Treatment 2.0 Pillar 1)

Although CD4 machines have been available at 10 ART of the 11 ART sites the intractable challenges of keeping the service uninterrupted informed a decision to program for use of alternative PoC technologies, which was included in the proposal to the Global Fund under the

new funding model application. This proposal was approved towards the end of 2014. Operationalisation of this programming is to follow in 2015 and beyond.

3.2.3.3 National drug and procurement systems strengthened (Treatment 2.0 Pillar 3)

A WHO consultant was contracted to review the procurement and supplies management system (PSM) situation and to support the PSM aspects such as quantification of ARVs and other supplies for the NSP operational plan and the New Funding Model application.

3.2.3.4 Service delivery decentralized and better integrated for access and sustainability (Treatment 2.0 Pillar 4)

As part of the new funding model application discussions towards during 2014, new locations for opening additional ART sites were identified, and resources for executing this expansion were secured with the approval of this application. Roll out is expected to proceed from July 2015.

3.2.3.5 Demand for treatment increased through community mobilization (Treatment 2.0 Pillar 5)

The HIV Community Conversation project continues to reach a significant number of women and men in Somalia. In 2014, this project reached approximately 8,422 people, 5,652 of whom were women. This project appears to resonate strongly with Somalis based on the large number of people that regularly participate in these meetings. The Community Conversation on HIV project is also helping to bridge the gap between health services (VCT, ART etc) and communities by encouraging more people to access these services, which is essential in order to increase the uptake of VCT, ART and PMTCT in order to reduce new infections.

In Somaliland, the majority of people reached in 2014 (3,713) participated in Community Conversations on HIV (F: 2,601, M: 1,112). 78 Community Conversations on HIV took place in Hargeisa (10), Berbera (54) and Borama (14). These are gatherings that usually take place outside. Community Conversations on HIV are rolled out in hot spots where there is greater risk of HIV. Religious & Community Leaders as well as PLHIV act as Resource Persons. As a result of this project, several Districts in Somaliland have allocated funds to support HIV work. The HIV Project is working together with UNDP's Gender Project on this initiative. .

In Puntland, 2,674 (M: 833, F: 1841) people were reached through Community Conversation on HIV in the last 12 months. The majority of participants were women but the number of men is increasing compared to last year. Community Conversations are helping to reduce stigma and discrimination linked to HIV in Puntland as well as encourage more people to access HIV services such as VCT, ART and PMTCT.

In South Central Somalia, 2,035 people (F:1,210, M: 825) were reached through the CCE Project on HIV over the last 12 months. 39 Community Conversations on HIV took place in Gedo and Banadir regions in the last 12 months. Both men and women participated in Community Conversations on HIV in Mogadishu and Gedo Regions. However, there were more women than men participating in the sessions. Noting women's increased vulnerability to HIV this is a positive trend.

As in previous years, the World AIDS Day 2014 commemorations were used as an opportunity for public advocacy for HIV AIDS treatment. A total of 9,000 brochures in the Somali language were printed following adaptation of Generic templates prepared by WHO EMRO HIV department. As part of this adaptation, the messaging was revised to better fit the Somali context to help in countering stigma and discrimination and promote compassion and care for

people infected with HIV/AIDS, and inform the public of the locations of HIV treatment facilities in the three Somali zones. TB/HIV messaging was also added.

World AIDS Day 2014 commemorations were used as an opportunity for public advocacy for HIV AIDS treatment. Brochures provided by WHO in the Somali language were distributed among different groups of the communities who reside in Afmadow district in Dhobley with a population of approximately 30,000 people who took part in marking the event. Awareness raising, sensitization and dissemination of messages was done among the host community, IDPs and returnees (from Dadaab refugee camp in Kenya) in Dhobley and in the four villages of the town. Among the participants were also the local authorities; the Dhobley District Commissioner (DC), the humanitarian coordinator, Dhobley Officer Commander Police (OCS) and the local religious leaders. During the awareness raising IOM visited the Dhobley general hospital and many health workers shared great speeches of HIV/AIDS with the patients attending the hospital.

3.2.4 HIV Care

Out of 530 adults and children newly enrolled in HIV care during the reporting period, 321 were females and 209 were males while 36 were children (< 15 years) and 494 were adults 15 years and older.

3.2.4.1 Isoniazid preventive therapy (IPT)

Out of 530 adults and children newly enrolled (i.e. started) in HIV care during the reporting period, 226 (42.6 percent) adults and children newly enrolled (i.e. started) in HIV care (pre-ART and ART) who also start (i.e. given at least one dose) isoniazid preventive therapy treatment during the reporting period.

WHO supported the roll out and reporting of Isoniazid preventive therapy (IPT). Although guidelines for IPT had been adapted, endorsed by the three zonal Ministers of Health, printed and distributed since 2012, influential clinicians had continued to express misgivings about IPT. This had been strongest in Somaliland, the zone with two thirds of the patients in HIV care and treatment. These clinicians had prevailed upon the others not to start IPT, and this had put off the roll out of this program. To address this constraint, WHO undertook advocacy with partners and engaged in dialogue with these clinicians. As a result of these efforts, during the second quarter of the year, IPT was finally started, and by the end of the year 226 patients in HIV care had been started on IPT. While the coverage is clearly sub-optimal, the pace is picking up, and the plan is to build on this momentum in 2015 with the procurement of additional Isoniazid supplies so the service can be launched at all ART sites.

With regard to TB screening for PLWHs enrolled in HIV care, WHO-facilitated IMAI trainings include training of staffs on screening and reporting of TB symptom screening PLWH and HIV care and treatment. Furthermore, the upgrading and training on ART patient monitoring tools included improvement to the capture and monthly reporting of TB screening and IPT. During the year, a total of 18,231 patient-clinician encounters were reported to have involved TB screening of PLWHs. As a monthly breakdown, these figures averaged 1,519 encounters, representing 74.3% of the average number of patients reported to be active in HIV care (both ART and pre-ART). For the month of December 2014, the figures were 1,776 screened, out of a total of 2,146 reported to be alive and on ART and Pre-ART care, coverage of about 83%.

3.2.4.2 TB status assessed

Out of 2,247 adults and children in HIV care in the reporting period, 1,714 (76.3%) adults and children in HIV care, had their TB status assessed and recorded during their last visit. With the Support of the round 10 TB grant under World Vision international, WHO quantified, procured and distributed supplies for HIV testing at TB sites. Additional counselors were trained to provide HIV counseling at TB sites, and those sites located in accessible areas were provided with supportive supervision. During 2014, 7,630 out of 13,041 of all the TB patients in the three zones of Somalia received HIV testing and counseling, yielding coverage of 58.5%. This represented a positive trend, having risen from 43.1% (5,296/12,290) in 2012 and 50.4% (5,064 / 10,042) in 2013. The number of facilities who provided this service went up from 38 in 2013 to 42 as of the end of 2014. In terms of the yield of HIV positive cases, 3.3% of the TB patients tested during 2014 were HIV positive.

3.2.4.3 HIV/TB collaborative activities

WHO continued to provide support for TB/HIV collaborative activities under funding from the round 10 TB Global Fund support, for which World Vision international in the Principal Recipient (PR). WHO staff co-facilitated quarterly and in some cases, monthly, TB/HIV coordination meetings and conducted joint TB/HIV supervision activities at TB and HIV facilities. As a result of the support to improvement and adaptation of ART patient monitoring and training tools the reporting of TB screening for patients in HIV care and treatment improved, and by mid Jan 2015, this data was already in hand at the national level. WHO also conducted analysis of HIV testing data among TB patients sharing the findings and trends over the last four years with partners at quarterly TB review meetings. Furthermore,, sentinel surveillance of HIV prevalence among TB patients was also started, as part of the 2014 round of the sentinel survey. However, because funds for this component were secured later than those for pregnant women and STI patients, this TB patient data will be available later than that for the other two groups.

3.3 Close the resource gap

One of the main achievements over the last year was the finalization of the National HIV strategy 2015-2019 and submission of Somalia's Concept note to the Global Fund. UNDP, UNICEF, WHO, UNAIDS, IOM, UNFPA, FAO, UNESCO provided technical support and the necessary arrangements for the regional consultations of validating these above documents, as well as arranging a meeting in Kampala to have all documents endorsed by all partners. This resulted in the Global Fund allocating a grant of \$22 million to support all HIV work in Somalia for the next three years (2015-2017).

UNICEF is the Principal Recipient of the Somalia HIV grant from the Global Fund. The grant registered and A1 rating during 2014. UNICEF support the preparation of a no cost extension for 6 months to bridge between Round and the new grant that starts in mid-2015. UNICEF also provided financial and technical support to the HIV concept note development and as Principal Recipient, will be leading the grant making process.

UNDP managed the logistics of the HIV concept note dialogue and supported the AIDS Commissions in convening all stakeholders.

UNAIDS coordinated the Joint UN Team support to the HIV concept note development including mobilizing resources for the process.

3.4 HIV in national gender plans and women's human rights frameworks

UNAIDS, UNFPA, UNDP funded and provided technical assessment for a gender assessment of the HIV response and supported use of recommendations for drafting NSP and HIV concept note. HIV interventions were drafted into the UNDP Gender Equality and Women Empowerment (GEWE) project plan 2015 to 2017. The assessment recommended the following areas as drivers of change:

- Empowerment of young girls as drivers for change in the areas of HIV prevention, care and support
- Increasing the collection and analysis of sex and age disaggregated data
- Targeted interventions for key affected populations MSM, FSW and truck drivers
- Addressing the issues of intergenerational sex including within marriage – i.e. considering the statistics around early marriage.
- Use promising approaches in the *Shar'ia* law to protect victims and survivors of sexual and gender-based violence, i.e. the harsh punishments for perpetrators of gender based violence.
- Increase access to educational opportunities for both boys and girls
- Strengthen the legal and policy framework to address gender related barriers that impact on women, girls and other vulnerable groups from accessing comprehensive HIV prevention information and services
- Strengthen community based participatory approaches that take into account the local contexts
- The monitoring and evaluation system should be designed to provide gender disaggregated data required to monitor the HIV and AIDS response.

As an active member of the GBV working group and protection Cluster, IOM has been implementing GBV projects including GBV assessments among migrants, Internally Displaced Persons (IDPs) and other cross border populations in Somalia (Mogadishu), Puntland (Galkayo, Bossaso, Garowe) and Somaliland (Burao) while integrating and creating linkages of HIV/AIDS and GBV. Through awareness raising and campaigns on the elimination of harmful practices that can impact on HIV/AIDS such as Female Genital Mutilation (FGM) and forced marriages. Referral of services for GBV survivors is also strengthened by ensuring the provision of PEP-Kits for rape victims in the aim of prevention of HIV/AIDS.

Community Conversations on HIV attract significant numbers of women and girls which has increased the number of women that receive HIV information. Community Conversationa empower women and provide a platform for them to raise their issues and explore local solutions. Noting that women are more vulnerable to HIV infection, the HIV and Gender Projects at UNDP have also worked together over the last two years, to ensure that all Community Conversations address critical gender issues such a FGM, polygamy, wife inheritance and early/forced marriage, which make women particularly vulnerable to HIV. To help strengthen

this work the HIV & Gender Project recently supported joint refresher training for all partners rolling out Community Conversations in Somalia. The HIV Project also supports women living with HIV, with counseling support, 'Knowing Your Rights' training, legal aid and IGA support, noting the specific impact HIV has on women.

3.5 Transformative leadership and commitment for sustainable AIDS response

In Somaliland, 71 (M: 48; F: 23) people participated in basic HIV and Leadership Training. This was held for influential leaders in each of the Districts where the community conversation project is being rolled out. Berbera and Sheikh District Councils attended training on HIV & AIDS. Borama and Hargeisa community leaders participated in HIV and Leadership training. These trainings encouraged District Councillors and community leaders to participate in Community Conversation sessions and play a stronger leadership role.

In Puntland, 240 (M: 140, F: 100) Community leaders participated in HIV and Leadership training in Bosaso. The trained persons act as resource persons in Community Conversations on HIV sessions and their presence plays an important role in encouraging community members to attend and in shaping the community attitudes towards HIV & AIDS.

In South Central Somalia, 80 persons (F: 60, M: 20) from local governments of Hodan and Hamarweyne districts attended basic HIV training. The objective of these trainings was to equip the participants with basic information on HIV and strengthen their capacity to be able to support the smooth implementation of community conversations in Banadir and Gedo regions. 40 (F:32, M:8) community leaders attended basic HIV & AIDS training in June 2014. Participants included influential leaders such as Religious Leaders, Elders, District Councilors and teachers who now show their support for HIV work by attending Community Conversation on HIV in their district.

3.6 Access to HIV-related legal services and legal literacy increased

HIV was integrated into Police training and UNDP's legal aid project. As a result, approximately 498 police were trained on basic HIV & AIDS.

In Somaliland, 368 People (M:102, F:266) Living with HIV (PLHIV) participated in legal aid counseling (68) and training that focused on 'Knowing your rights' training (300) in the last 12 months. The objective of legal aid training was to increase the knowledge of PLHIV on the concepts of human rights in the field of HIV and better understand human rights violations relating to HIV & AIDS. The training also encouraged PLHIV to use UNDP Legal Aid Services when they need them.

3.7 Movements for HIV-related law reform

Following concerns expressed regarding criminalization of sexual transmission of HIV and STIs, UNAIDS and UNDP were invited to participate in a one-day meeting to review the draft of the Sexual Offences Bill. As a result of the intervention of UNAIDS and UNDP, the article on STI transmission was completely removed, however that for HIV was not deleted but limited prosecution to cases of intentional transmission and allowing for defences in cases of disclosure and safer sex. It was cautioned that if the article on HIV transmission is not deleted then the law must be well articulated to avoid miscarriage of justice and to avoid negative impact on HIV prevention. UNAIDS and UNDP asked the drafting team to include the People Living with HIV and the government and civil society organs working on HIV in their consultations which was agreed. The process is being funded by UNFPA and UNDP and the Ministry of Women and Human Rights Development (MoWHRD) is taking the lead on drafting Somalia's first ever

Sexual Offences Bill. Legal Action Worldwide (LAW) is providing technical advice to the Ministry.

3.8 Mainstreaming

UNDP continued to mainstream HIV into other UNDP projects in 2014. For example, HIV was integrated into training provided for Youth at Risk, Police training, prisoners and work being carried out by the Gender Project (Community Conversations on Gender issues); UNDP's legal aid project and UNDP's PREP project. As result approximately 498 police (one of the groups identified as at high risk of HIV infection in Somalia) and youth at risk groups were trained on basic HIV & AIDS. Another significant achievement and one of the highlights of the year was working with the Joint Programme for Local Governance (JPLG) to integrate HIV into District Development Plans of five districts including Berbera, Borama, Burao, Sheikh and Gabiley district. This resulted in the Mayors of these districts making a commitment to include HIV in their local district plans. Berbera, Sheikh and Gabiley decided to allocate funds to support PLHIV as well as support HIV awareness activities in 2015. UNDP will continue to work more closely with JPLG in Puntland and at the Federal Level to encourage other districts to do the same, noting the cuts for prevention work from the Global Fund grant in 2015.

3.9 Food by Prescription

Acknowledging the critical role played by the family in the treatment success, WFP also provided a household food ration to malnourished HIV and TB patients undertaking treatment. The household food assistance is part of WFP Food-by-Prescription, as a measure to mitigate the impact of HIV/AIDS for the clients and also the possibility of food being shared.

In total, in 2012 WFP delivered food and nutrition support to 40,176 HIV/TB clients and their families. In 2013, 17,218 ART and 61, 082 TB patients households were assisted, yielding a total of 118, 476 client households assisted. In 2014, 42,894 clients and families were supported.

Overall because of the Safety Net measure taken, by providing household food assistance to HIV and TB clients, the individual ART and TB-DOTS clients have witnessed better treatment and health outcome as a result of the nutrition support provided. WFP will continue to support and expand its supports to ART and TB-DOTS clients and families in Somaliland and other areas not previously reached.

WFP is also in the process for finalizing with the different MoH for the three regions the Nutrition Assessment, Education, Counseling and Support (NAECS), guideline which will be a useful tool to guide the Food-by-Prescription approach for TB/HIV clients. The guideline will also provide clarity on how to better combine modalities such as Cash and Voucher for TB/HIV client's households etc.

WFP provision of food assistance to ART clients and TB-DOTS clients witnessed a sharp decline in the total number of clients assisted as a result of the suspension of the programme in Somaliland in 2013- 2014, due to pipeline breaks, donor restrictions and commodity preferences, amongst other challenges.

Additionally TB/HIV clients continue to suffer high levels of stigma and discrimination by virtue of their status. This predicament in many ways serious compromises WFP's effort to effectively reach the targeted group with much needed food and nutritional support.

WFP will explore new resource mobilization strategies; working with key partners to solicit additional resources to address current pipeline breaks and the issue of donor restricted funding.

WFP will explore and introduce Cash and Voucher as an added modality for TB/HIV household as a measure to reduce the stigma and discrimination challenges being faced by clients and their household. It is hoped that the programme will witness a better buy-in and acceptance by the beneficiaries and stakeholders, particularly the government counterparts

3.10 HIV plans alignment and integration into health and development plans

The National Strategic Plan for HIV and AIDS 2015 to 2019 has been aligned to the Health Sector Strategic Plans. Integration of HIV and AIDS into other health services delivery is a key feature of the NSP aligning it to the HSSPs. The Essential Package of Health Services (EPHS), Somalia's newly adopted framework for primary health care services will be used for the delivery of health sector HIV and AIDS services at ART, PMTCT and HTC accredited facilities. In this regard, the EPHS delivery mechanism for health services will be applied by including HIV and AIDS in the package. Capacity building efforts will be integrated by application of integrated health training curricula that include HIV and AIDS and targeted health infrastructure development around hot spots.

Scale up of HIV and AIDS services will be guided by regular analyses of geographical distribution of HIV prevalence, risk factors and available service infrastructure

3.11 Strategic information generation and management

With the support from the South Central AIDS Commission (SCAC) and line ministries, the Joint United Nations Team on HIV/AIDS (JUNTA) conducted a first ever HIV/AIDS Rapid Assessment among Key and Vulnerable Populations in Mogadishu, Somalia. The rapid assessment focused on enhancing the understanding of key populations such as female sex workers (FSWs), truck drivers, port workers, seafarers and uniformed services as primary key populations. The data from this study was used in the development of the Somali NSP and successful the Global Fund HIV proposal application (concept note) for 2015 to 2017.

With the support of the Somaliland AIDS Commission (SOLNAC) and line Ministries; a second Integrated Biological and Behavioural Surveillance (IBBS) among Female Sex Workers (FSWs) in Hargeisa, Somaliland was conducted. The data from this study was used in the development of the Somali NSP and successful the Global Fund HIV proposal application (concept note) for 2015 to 2017. Reports for the IBBS survey in Hargeisa and the rapid assessment of key populations in Mogadishu have been reviewed and are available. The reports were presented at the IGAD HIV/AIDS regional meeting in Addis Ababa in December 2014.

Use of the upgraded ART patient monitoring and reporting tools continued, with the eventual consensus for the ART facilities to use the unified ART facility monthly reporting formats for all purposes, to all partners. This has led to relatively earlier availability of totals of patients on ART, by gender and age at the national level, as compared to previous years. However, these reports do not distinguish whether or not particular patients are from the Key Populations, and so we are not able to report how many of the key populations are on ART.

UNESCO has supported a Needs Assessment on Skills for Life in Somalia and the report will be finalized in the first quarter of 2015.

UNDP, UNFPA and UNAIDS supported a gender assessment of the HIV and AIDS response and the recommendations informed the NSP 2015 to 2019.

Under the round 8 Global Fund grant, WHO carried out another round sentinel surveillance of HIV prevalence. Demographic data and samples were collected for pregnant women and STI patients. Approval for resources to include TB patients in this survey came late in 2014, and sample collection had started by the end of the year in two of the three ones, with the other to follow suit in early 2015. For the first time since 2004, owing to improved security situation in South Central Somalia, this sentinel survey was conducted concurrently in all three zones, improving the comparability of the data across the zones. As of the point of compiling of this report, the results of the survey are pending the completion of rigorous quality control testing at the Kenya Medical Research Institute.

While WHO conducted an adaptation of the ART patient monitoring training manual, in line with updated tools in use at the facilities, and use of these tools did improve timeliness and completeness of the reporting, just like the generic, global WHO tools, these tools do not distinguish whether or not particular patients are from the Key Populations. As a result, it is still not apparent from the facility reports, how many of the key populations are on accessing ART.

4.0 Conclusion and recommendations

During 2014, there were some significant achievements such as the development of a costed HIV and AIDS NSP, Zonal HIV and AIDS Operational plans and a Costed M&E plan that involved an inclusive, consultative and participatory process. ART guidelines were reviewed a repeat HIV ANC sentinel surveillance was conducted. PMTCT policy guidelines were reviewed. An HIV grant application to the Global Fund was allocated US\$ 22 million and the Round 8 HIV grant was rated A1.

A gender assessment of the Somali AIDS response was carried out and there was a repeat of an Integrated Bio-Behavioural Surveillance survey of Female Sex Workers in Hargeisa, Somaliland.

Despite the accomplishments, coverage of HIV and AIDS services is still very low. Funding of the response is almost solely by one donor and the new grant is mainly focused and HIV treatment and care services.

Stigma and discrimination remain a great challenge to access to HIV prevention and treatment services. This affects PLHIV, key populations and the general population with regard to condom use.

There are low in-country capacities of public and civil society to carry out technical roles such as M&E.

Insecurity in parts of the country affects reach of people in need of services. Food by prescription is not readily available to all PLHIV in need.

The procurement supply chain management of HIV commodities requires improved forecasting

4.1 Recommendations

In view of the challenges, the following recommendations are made:

- There is need for increased demand creation activities for ART and PMTCT using innovative means including mobile phone technology.
- Dissemination of NSP should be carried out to guide implementers.
- M&E Capacity should be built for operationalization of the M&E plan.
- More strategic information generation by surveys targeting affected populations should be carried out. This should include behavioural and bio-surveys as well as studies of social barriers such as stigma and discrimination.
- Resource mobilisation for the NSP beyond the Global Fund is required.
- Efforts to mainstream HIV and AIDS into other programmes and projects will ensure sustainability and efficiencies in implementation.
- Multisectoral coordination by the AIDS Commission to convene stakeholders and advocate for the AIDS response should be further strengthened.