

2008

Strategic Framework for the Somali AIDS Response (2009-2013)

Intensifying Integrated Prevention, Treatment, Care and Support
for HIV towards Universal Access in Somali Populations



Scale up HIV prevention interventions with the aim of reaching universal access targets by 2010, and the Millennium Development Goals by 2015.

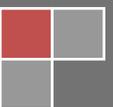
Improve availability and access to quality treatment, care, and support services for HIV

Halt and reverse the spread of HIV in Somaliland, Puntland and South Central Somalia by 2015,

Strengthen M&E systems and produce reliable data on AIDS for evidence-informed planning.

Improve coordination and management capacities for an effective HIV response

Steering Committee for Somali AIDS Response
Working Draft, July 2008



**Strategic Framework for the Somali AIDS Response
2009-2013**

Draft

July 2008

Working Draft

Somaliland AIDS Commission (SOLNAC)

Puntland AIDS Commission (PAC)

South Central AIDS Commission (SCAC)

Table of Contents

1	Introduction
1.1	Background
1.2	Rational for the Revised Strategic Framework
1.3	Adopting the “Three Ones” Principle in the Somali HIV response
1.4	Formulation of the Revised Strategic Framework
1.5	Context and Potential Security and Humanitarian Scenarios for the Implementation of the Somali HIV Response
2	The Somali HIV Epidemic and the Response to date: HIV in Somaliland, Puntland and South Central Somalia
2.1	The Status of the HIV Epidemic in Somaliland, Puntland, and South Central Somalia
2.2	Overview of the Somali HIV response (2003-2008)
2.2.1	Achievements in the Somali HIV response
2.2.2	Challenges in the Somali HIV response
3	Core Principles of the Somali HIV response
3.1	Enhancing the participation and ownership by Somali Society at all levels
3.2	Multisectoral approach
3.3	Gender Equality and Human Rights
3.4	Focus reducing risks to HIV Infection among young people, women and girls, and most at risk populations
3.5	Ensure the Involvement of people living with HIV
3.6	Strengthen Evidence-informed Planning at all levels
3.7	Participation of key constituencies stakeholders
3.8	Alignment with international and regional initiatives
4	The Strategic Vision, 2009-2013
4.1	The Goal, Objectives, key outcomes, and targets
4.1.1	Objective 1: To scale up HIV prevention interventions towards universal access targets by 2010, and the Millennium Development Goals by 2015.
4.1.2	Objective 2: To improve availability and access to quality treatment, care, and support services for HIV
4.1.3	Objective 3: To strengthen M&E systems and produce reliable data on AIDS for evidence-informed planning.
4.1.4	Objective 4: To improve coordination and management capacities for an effective HIV response
5	Creating an Enabling Environment for the Implementation of the Somali HIV response
5.1	Research
5.2	Institutional capacity building
5.3	Communications, Coordination and Networking

5.4 Financing, and Procurement and Supplies Management

6 Implementing the Somali HIV response

6.1 Coordination and Institutional arrangements for Implementation of the Somali HIV response

6.2 The Results Framework and Targets for the Somali HIV response (2009-2013)

7 Risk Analysis and Key Assumptions

8 Resource Mobilization

8.1 Key assumptions in Costing the Somali HIV response

8.2 Costing Estimates

Annex A: TOR for the Steering Committee for the Somali AIDS Response

Annex B: Risk Analysis and Mitigating Measures

Annex C: Results Framework for the Somali HIV response

Annex D: Coordination Mechanisms for One Framework for Action

Annex E: The Monitoring and Evaluation Model

Annex F: Participating Organizations and Institutions

1 Introduction

1.1 Background:

An estimated population of 8.1 million in 2008 live in the three Somali entities, Somaliland, Puntland, and South Central Somalia, with over 50 percent of the population under the age of 15 years. The ongoing conflict and instability has severely affected household economic security, further exacerbated disparities in gender relations increasing the vulnerability of women and children, and created an environment for human rights violations; these factors increase the populations' vulnerability to HIV. Under five and maternal mortality rates are among the worst in the world, at 225 and 11-16 per 1,000 live births respectively¹. Estimated per capita income was \$226 in 2002 (UNDP 2003). Less than 1 in 5 children are enrolled in primary school, and out of the few who complete primary school only 1 in 8 are girls. Somali women suffer Sexual Gender Based Violence (SGBV); social norms often exclude women from decision making, access and control of resources.

A growing number of people continue being displaced as a result of conflict in the central south, which continues to erode the livelihoods of families and communities, particularly increasing the vulnerabilities of women and girls. In Puntland, Somaliland, and South Central Somalia, violations of human rights have been reported, including discrimination and violence against women, minorities, and internally displaced persons, as well as exploitation of children. The practice of female genital mutilation (FGM) is almost universal, affecting 98% of women and girls.

Political instability and insecurity have hampered economic growth and human development; the overall situation is grave. Central and local governments have not recovered since their collapse following the fall of the government in 1991; these structures lack resources and social services are very poor. School enrolment and basic health services coverage are very low. The UN and development partners formulated the Recovery and Development Plan, in 2006, to work with government entities in the three zones, civil society, and community groups to promote stability, improve social services, and creating conditions for economic recovery. The recovery and development plan recognizes relative variations in capacities and resources of local governing authorities between the three zones; there is need to strengthen local government capacity at district level in all three zones.

There is a protracted humanitarian emergency situation that increases the vulnerability to HIV infection among affected populations. The majority of the Somali population have been affected by emergencies, including those: 1) that are directly affected by conflict or natural disasters, both displaced and non-displaced persons; 2) persons indirectly or previously affected, such as host populations, returnees, those in transition to recover, and humanitarian workers; and 3) armed or uniformed groups involved in the humanitarian emergency situations. Recognizing this vulnerability among emergency affected populations², the Declaration of Commitment adopted at the 2001 General Assembly Special Session on HIV/AIDS (UNGASS) called for the development and implementation of national strategies that incorporate HIV awareness, prevention, and care and treatment elements into programs or actions that respond to emergency situations. In such environments, the vulnerabilities of

¹ World Bank, Somalia: From Resilience Towards Recovery and Development

² Emergency affected populations includes:

women In addition, due to its potential threat to the maintenance of peace and security, the UN Security Council adopted resolutions addressing the role of gender based and sexual violence in the spread of HIV³. There is a need for a coordinated and evidence informed interventions that strategically reduce the risk to HIV infection among vulnerable groups, including most at risk populations in priority risk settings identified.

Following the reconciliation talks at the end of 2004, that sought to bring an end of the conflict and insecurity development partners have taken steps that will promote peace and stability, and create opportunities to boost development and economic growth in Somaliland, Puntland and South Central Somalia, as outlined in the Somali Reconstruction and Development Programme and the United Nations Transition Plan for Somalia, coordinating international assistance through the Coordination of International Support to Somalia (CISS). The RDP is built around three overall goals: 1) deepening peace, improving security and establishing good governance; 2) investing in people through improved social services; and 3) creating an enabling environment for private sector led growth to expand employment and reduce poverty. Aligned with the RDP, the UNTP seeks to support local governance, improve rule of law and security, increase access to and use of education and health services, and improve livelihoods to vulnerable and marginalized groups.

UNAIDS and WHO estimate 22,810 people live with HIV in Somaliland, Puntland, and South Central Somalia, among adults 15-49 years, of which 9,240 are male (40.5%) and 13,580 are female (59.5%). The total number of estimated new infections is 2180, of which 930 are male (42.7%) and 1250 are female (57.3%). By the end of 2007, an estimated 3% of those in need of ART were on treatment, 0.4% received interventions for prevention of mother to child transmission of HIV. Stigma surrounding HIV and discussions on high risk behaviors remains very high, prohibiting open dialogue at various levels and contributing to low up take in services. Foundations have been laid through pilot programs, and progress on track against the milestones set by partners. However, in order to be able to achieve the universal access targets, there is an urgent need to intensify advocacy for open dialogue on HIV, gender equality and human rights, and rapid scale up in access to information and services to contain the epidemic and improve quality of live for people living with HIV in Somaliland, Puntland and South Central Somalia.

1.2 Rational for the Revised Strategic Framework

“The Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations, 2003-2008”, ends in December 2008. The current strategic framework informed and guided the design of The Global Fund financed project, and sought to empower communities and individuals with knowledge and skills HIV prevention, and reduce stigma and discrimination against PLHIV; strengthening structures and systems for coordination and monitoring and evaluation of the HIV response in Somali populations; and to increase access to high quality treatment and care services.

This revised strategic framework, “Strategic Framework for the Somali HIV Response, 2009-2013, provides overall guidance for the AIDS response in Somaliland, Puntland, and South Central Somalia. Partners will prioritize the selected strategies to be reflected in the two year operational plans that will be developed within each zone, and will be costed for accordingly. The operational plans and their costing will reflect two scenarios, i.e. one optimistic with

³ UN Security Council Resolutions 1308 and 1325

ambitious targets, and a second option that will reflect more realistic based on available resources and humanitarian access to affected populations.

The Somali HIV response is set in a unique and dynamic political, security, social, and economic environment. This environment impacts different sub-groups of the population with varying levels of risks and vulnerability to HIV infection; insecurity, displacement, and breakup in societal units that provide protection to vulnerable members of the community increase their risk to HIV infection. Recent assessment of high risk behaviour among various groups in Somali populations has indicated the need to redirect the HIV response to better target the drivers and risk factors that are fuelling the HIV epidemic in the Somali context, with a particular focus on women and girls, mobile cross border populations and most-at-risk populations. The assessments have also demonstrated there are effective strategies to reach out to these groups, despite the challenges in the context.

Significant progress has been made in the implementation of the current framework (2003-2008), and foundations have been laid to enable significant progress towards the achievement of the universal access targets. However, success in efforts to intensify and scale up the response in the current situation depends on increased Somali ownership and broader participation and engagement of stakeholders. In line with the principles of greater involvement of people living with HIV (GIPA), there is need to increase the role of PLHIV in advocacy and prevention, promote greater participation of women in leadership role in the HIV response, and active and meaningful engagement of civil society organizations that are working with women and girls, and most-at-risk populations as well as to promote gender equality in order to reduce vulnerabilities of women and men to HIV infection. The revised framework seeks to address this as priority through measures that will strengthen the capacity at various levels to increase participation in assessment, planning and execution by these groups and institutions, and mobilizing adequate resources.

In the Somali context, the HIV epidemic is fueled by structural and social factors, such as poverty, gender inequalities and human rights violations increase vulnerabilities to HIV infection; these factors significantly determine access to information and services, and people's access to information and services that reduce their vulnerability to HIV infection. The revised strategic framework seeks to improve knowledge of the epidemic and develop mechanisms for evidence-informed approaches within the context of the current political, legal, cultural and other factors that are the drivers and risk factors to HIV transmission in Somali populations.

The current framework also seeks to ensure alignment between the strategies in the Somali HIV response at various levels, including zonal, regional, and local government with the initiatives supported by international partners. These include The Somali Reconstruction and Development Program (RDP)⁴, United Nations Transition Plan for Somalia (UNTP). The current framework seeks to improve mainstreaming of the HIV response into the capacity building and institutional development initiatives, and promoting respect for human rights and gender equality, as outlined in the RDP and UNTP. The framework has adopted recommendations of the IASC clusters on HIV interventions in emergency settings.

Strengthening health system will have a direct impact on capacity for services delivery and monitoring the response, e.g. improving human resource capacity, strengthening monitoring and evaluation systems to ensure accurate tracking of progress in the HIV response, ensure

⁴ UN and World Bank, "Somali Reconstruction and Development Programme: Deepening Peace and Reducing Poverty" (Nairobi: UN and World Bank, 2007).

availability of quality drugs at service delivery points, etc. The framework seeks to improve systems capacity to support improvement in quality of HIV services, and scale up of the response towards the universal access targets.

1.3 Commitment to the “Three Ones” principle in the Somali HIV response

HIV response in Somali populations poses a unique challenge in terms of the adoption of the “Three-one” principle; following the fall of the government in 1991, three autonomous entities in Somaliland, Puntland and South Central Somalia, with their respective AIDS Commissions and Secretariats. However, there is also deep recognition that, due to high mobility of Somali populations within the Horn of Africa sub-region, there is a need for an effective and harmonized strategy to contain the spread of HIV across the three entities and beyond. Therefore, partners adopted a harmonized framework for action that will inform and guide the overall response across the three entities.

1.4 Formulation of the Revised Strategic Framework- The Process

The process for the formulation of the revised strategic framework reflects wide consultations between various stakeholders and sectors in the analysis of the current situation and identification of priorities for the coming five years. The process was led jointly by the AIDS commissions from Somaliland, Puntland, and South Central Somalia, with support from the Steering Committee members, coordinated through UNAIDS. This has widened the inclusiveness of the process, increased the level of consultations in review, analysis, and recommendations by Somali AIDS Commissions from the three zones, civil society networks, women’s groups, people living with HIV, youth networks. Service providers from various levels participated in the review through the IPTCS groups in the three zones.

The review of “The Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations, 2003-2008”, and development of a revised strategy has been built into various processes, including consultations for UNGASS Reporting, Monitoring and Evaluations Systems Strengthening, GFATM Round 8 Proposal Development, Annual Program Review for Round 4 HIV Grant implementation, and the assessment of Country Harmonization and Alignment the HIV response. Partners held consultative meetings through four Thematic Groups (prevention; treatment, care, and support; monitoring and evaluation; and coordination, harmonization and alignment; and Zonal IPTCS groups in Somaliland, Puntland, and South Central Somalia. A consultative meeting of stakeholders from Somaliland, Puntland and South Central Somalia was held in Djibouti with representatives from various sectors and constituencies, 5-7 May 2008. A draft results framework, defining goal and objectives, and outcome areas was formulated following the initial consultations. Additional input was gathered during the meetings in Djibouti.

1.5 Context and Potential Security and Humanitarian Scenarios for the Implementation of the Somali HIV Response

Developments in 2007 and 2008 have the potential to significantly shape the humanitarian emergency situation, and emergency response, and how HIV will be addressed in the evolving situation. These developments include evolving security situation that causes increased population displacement, increasing violence and further deterioration of the security level that constrains humanitarian access to vulnerable populations. The UNTP identifies administration

in South Central Somalia, national level dialogue, disarmament and demobilization, and progress in the humanitarian situation as some of the indicators that should be noted and outlines the following potential scenarios:-

- 1.5.1 **Best case scenario:** Good progress is made on reconciliation between the TFG and other political forces, international political and donor support, security improves significantly, creating an environment for strengthening national institutions and mobilizing the community to curb human rights violations. Such a scenario could potentially lead to scale-up of reconstruction and development work, and an integrated multisectoral comprehensive HIV response, a significantly increased Somali ownership and participation at various levels, broader Somali dialogue and action on the drivers of the epidemic, scale-up
- 1.5.2 **Most likely scenario:** Progress on reconciliation is slow, with continued deterioration of security situation, coupled with natural disasters, that causes further displacements and growing humanitarian needs. HIV response in Somaliland and Puntland will be integrated into the recovery and reconstruction efforts in Somaliland and Puntland, through a strategy that brings together both international and indigenous partners, with the scope of interventions and scale-up determined by local capacity in priority areas. Priority HIV interventions will be integrated into the humanitarian response in south-central Somalia.
- 1.5.3 **Worst case:** There is no effective progress in reconciliation, and insecurity significantly increases in south-central Somalia, and conflict escalates. Access to IDPs and other communities is difficult, and large numbers of people in south-central Somalia suffer deterioration in living conditions. In such developments, opportunity for reconstruction and development will be limited to areas with relative stability in Somaliland and parts of Puntland. Partners will explore opportunities for the integration of a minimum package of HIV interventions into the humanitarian response, and explore opportunities for scale up through

2 The Somali HIV Epidemic and the Status of the Response

2.1 *The Status of the HIV Epidemic in Somaliland, Puntland, and South Central Somalia*

Information on HIV epidemiology in Somali populations is very limited; available data indicates that the Somali HIV epidemic is relatively higher in the port cities across the three zones, with relatively lower rates in towns further from these port cities along the major transport corridors. Among the three zones, relatively higher prevalence was reported from Somaliland (1.7%), followed by Puntland (0.5%), and South Central Somalia (0.3%), during the ANC surveillance done in 2004. There is no sero-surveillance data to assess prevalence levels in the general population or any of the populations considered most-at-risk to HIV infection.

While data collection in South Central is ongoing, a similar pattern was documented in Somaliland and Puntland, in 2007. Preliminary data in Somaliland from a survey conducted among 1766 young women aged 15-25 attending ANC recorded a HIV prevalence of 1.7%. Prevalence among patients with STD syndromes was 6.3% and was higher among males (7.4%) compared to the females at (5.4%). HIV prevalence ranged from 0.0% in Boroma to 2.7% in Berbera, with a median of 1.3%. The ANC site in the port city of Berbera has shown a steady increase in the trend of HIV infection, with a prevalence of 0.0%, 2.3%, and 2.7% in the

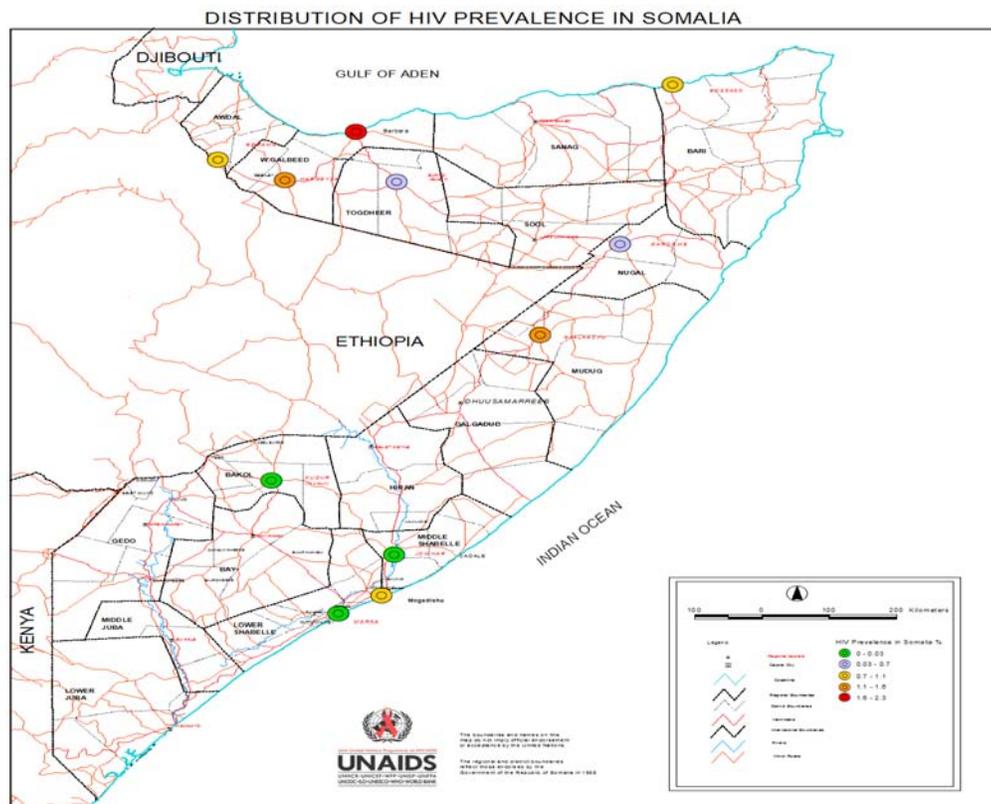
year 1999, 2004, and 2007 respectively. Other sites, in Puntland and South Central have demonstrated a similar trend, according to prevalence of HIV among pregnant women surveyed at this sites was relatively lower than Berbera.

ANC data also demonstrates diversity within each Zone, between the Zones, and between various age groups; there are variation among men and women attending STI clinics. Preliminary data in from a survey in Puntland conducted among 1884 clients attending ANC showed variation in prevalence Galkaayo (0.3%), Garowe (0.6%) and Bossaso (1.6%) with a mean prevalence of 0.5% in the whole of Puntland. A mean prevalence of 0.9% was recorded among young women aged 15-24, being higher (1.3%) among women aged 15-19. Among STI clinic clients with STI syndromes surveyed in the same year, HIV prevalence was 2.2%. Overall, HIV prevalence was higher amongst females (2.7%) than in males (1.5%). Syphilis prevalence among ANC attendees in Puntland was 1.9%.

Gender inequalities both fuel and are exacerbated by the epidemic, affecting primarily women and girls but involving men and boys as well. Majority of women surveyed through a social mapping done in 2007 reporting lack of means of support to themselves and their families, a situation they reported forces these women and girls to engage in high-risk coping strategies, which dramatically increased their vulnerability to HIV infection. Women living with HIV may lose their homes and livelihoods, engaging in more risky behaviour to provide for basic needs for themselves and their children.

Discrimination against girls in education (the gross enrolment ratio according to PSS 2007 in Somalia is 24.3% for girls and 36.3% for boys) prevents them from gaining greater independence, being better equipped to make decisions about their reproductive health, economic empowerment, associated with increased factors that would lower HIV risk.

Map 1: Sentinel Surveillance Data from Antenatal clinics in Somaliland, Puntland, and South Central Somalia



Gender based violence as well is a relevant component in the spread of the epidemic, in its different forms. Intimate partner violence affects the capacity of women and girls to refuse sex or to negotiate safer sex; sexual violence, widespread in Somalia, is most likely to result in trauma and internal tearing which significantly enhances the risk of contracting HIV or other STIs, furthermore survivors of sexual violence are stigmatized, increasing their economic and social vulnerability. Early marriage puts young girls in a situation of economic and social dependence from much older men, who may have already been exposed to HIV, furthermore their reproductive tracts are not mature and hence more prone to HIV infection.

On the other side, gender norms on masculine behavior and sexuality promote men and boys as assertive, dominant, knowledgeable about sex, and not afraid of taking risks, which makes more difficult for them to openly discuss sexual matters, practice safer sex and promote gender equitable relationships, all factors that increases the vulnerability of men and boys as well to HIV infection.

The Somali HIV epidemic is heterosexually driven and great cause for concern especially amongst young people. Data from ANC surveillance, STI clinics, and mapping amongst most-at-risk populations all indicate towards potentially concentrated epidemic among most-at-risk populations, a low-level HIV epidemic in Puntland and South Central Somalia, with a potentially generalized epidemic in Somaliland. There is need for additional behavioral and biological surveillance data through population based surveys in the general population, most-at-risk populations, mobile cross border populations, and populations of humanitarian concern. Strategies for delivery of integrated prevention, treatment, care and support services in HIV in Somaliland, Puntland and South Central Somalia will take these recommendations for the above scenarios into consideration, with regular revisions to priorities and program strategies on the basis of better knowledge of the Somali HIV epidemic. .

2.2 Overview of the Achievements in the Implementation of Somali HIV response (2003-2008)

The Somali HIV response partners formulated a multisectoral framework (2003-2008), which informed and guided the design of projects, such as the Round 4 GFATM application, and the M&E Plan. Through the GFATM grant and other programs, the following key achievements have been made to date, despite the complexity of the environment due to the civil conflict and humanitarian emergency situation:

- Multisectoral AIDS Commissions were established in the three zones, representing line ministries, civil society networks, including the PLHIV groups. Secretariats have been established to coordinate the works of the AIDS Commissions, with technical and operational support provided by the international partners.
- Guidelines have been developed to support the delivery of facility based services, including ART, STI management, safe blood transfusions, improve safety of injections at facilities, counseling and testing for HIV, management of TB HIV co-infections,

- Technical and financial support has been provided to civil society organizations, including training and supervision of personnel, increasing human resource capacity to deliver HIV interventions, including condom distribution, STI care, ART, VCT, TB-HIV co-management, home-based care for chronically ill, and support to PLHIV networks;
- Networks of civil society organizations established in Somaliland, Puntland, and South Central, mobilizing women's groups and PLHIV, and services initiated to improve awareness and protection of human rights;
- Strategy developed to increase awareness and improve skills for HIV prevention among young people, with interventions that will increase their access to information on HIV and reproductive health, improve their skills in decision making to reduce their risk, and increase access to youth friendly services.
- Systems capacity strengthened to improve quality assurance in laboratory diagnosis to support services, monitor ART, procurement and management of drug supplies at various levels. Human resource capacity improved, to provide counseling and testing, ART, management of opportunistic infections, STI care, improve safety of blood transfusions and overall practice of universal precautions at facilities, and centers of excellence established to deliver a package of IPTCS services across the three zones;
- Services have improve the quality of life for PLHIV, and progress is on track towards the achievement of the universal access targets set for the Somali HIV response;
- Initial progress has been made in accessing marginalized most-at-risk groups in research and in breaking down the cultural and psychological barriers to improve dialogue on sensitive subjects, such as transactional sex;
- A monitoring and evaluation framework was developed to guide M&E systems strengthening activities, including the roll out of Country Response Information which has improved tracking of performance, and increase dissemination of information on the HIV epidemic and the response;
- Progress on track towards the achievement of the universal access targets agreed by all stakeholders;
- Progress made in improving understanding among partners on linkages between the HIV response and prevention and response to sexual and gender based violence (SGBV); partnership between the zonal AIDS Commission and the respective Ministries of Women/Family Affairs to tackle the gender dimension of the epidemic has been explored and are progressing towards joint planning on gender and HIV.

2.3 Overview of the Challenges in the Implementation of Somali HIV response (2003-2008)

Though a foundation has been laid towards a comprehensive HIV response, several challenges remain in the way of efforts to scale-up the response, and improve its effectiveness to target the drivers and risk factors contributing to the HIV epidemic in Somali populations.

Socioeconomic Environment:

- High levels of poverty, further exacerbated by the conflict that is causing displacement and fragmentation of family units, and increasing vulnerability of communities, and women and girls in particular
- High prevalence of violence against women and weak capacity and/or lack of commitment to address gender based violence

- Very high levels of stigma surrounding HIV and risk practices, combined with deep rooted cultural taboos that inhibit dialogue and communications on sexual and reproductive health issues;
- Limited access to social services, particularly among women and girls; nearly 80 percent of children are out of school;
- Weak legal framework for the protection of human rights, especially rights of people living with HIV.

Prevention

- Current prevention, treatment, care, and support interventions target the general population across all regions, while evidence to date indicates that the epidemic is likely to be concentrated in specific risk settings among most-at-risk populations, mobile cross border populations,
- Current prevention efforts do not effectively engage various constituencies, such as parliamentarians, religious leaders, young people, women, PLHIV, most-at-risk populations and other mobile cross border groups, including participation in the response, access to information and services.
- Life skills based education incorporating HIV prevention is not fully developed and not provided in schools;

Coordination of the response:

- Limited or very weak Somali participation and involvement: Support to coordination mechanisms have been focused at higher level, with limited or no investment to strengthen or create structures for effective mobilization of all Somalis regional, district, and community levels;
- Limited understanding on the respective roles and responsibilities of structures at various levels, such as at national versus district level,
- Coordination structures at zonal levels require significant capacity development support to be able to provide effective coordination and leadership,
- Coordination structures for HIV at district levels do not exist are very weak, and current social mobilization strategies have not been effective in enhancing broader participation of Somalis in the HIV response;

Treatment, Care, and Support

- Health services coverage is low, with weak human resource, procurement and supplies management, and monitoring and evaluation systems capacity. WHO assessments indicated poor compliance among care providers to treatment guidelines
- Utilization of health services in general very low, with even lower use of services for PMTCT, ART or TB and HIV collaborative services, condoms programming, STI care, counseling and testing services very low in general; there is need to rapidly increase access to and use, strategically targeting select risk settings and most-at-risk populations;
- Programs for the protection of orphans and street children are very weak; strategies have not been developed to improve access to nutritional supplements among PLHIV and affected families,

Monitoring and Evaluation

- The monitoring and evaluation framework needs to be translated into an operational plan, and implementation manual developed to support full roll out of the Country Response Information System
- Limited information on the epidemic and gaps in studying key factors like gender roles which affect vulnerability. Limited disaggregation of data and limited use of gender specific indicators among the agreed indicators used in monitoring the epidemic and the response.
- Routine information systems weak and data quality poor.

3 Core Principles of the Somali HIV response

The Somali HIV response is based on a set of core principles, shared by the key stakeholders, and determines the priorities and strategy, interventions, and the approach to implementation. These key principles are reflected, where possible, in the results framework for the strategy. These core principles are: multisectoral approach; targeting vulnerable and most-at-risk population groups; focus on gender equality and youth; greater involvement of people living with HIV; evidence-informed programming; ensuring participation of all stakeholders; and alignment with international and regional initiatives.

3.1 *Enhancing participation and ownership by Somali Society at all levels*

The current framework seeks to increase the participation of all relevant partners and stakeholders to participate in the prioritization and planning, implementation, and monitoring and evaluation of the Somali HIV response. Particular effort will be made to ensure greater participation and leadership role of Somali institutions in the HIV response at all levels, including participation of people living with HIV and of most-at-risk populations. Concrete steps will be taken to ensure local level (including Regional, Municipal or District councils as appropriate, and community) inputs and participation in the HIV response through local government authority and Somali civil society networks.

3.2 *Multisectoral approach*

The Somali HIV response recognizes that the threat of HIV affects all aspects of life in Somali populations; therefore the overall response cannot be led by one sector. In line with the “Three-Ones” principle, it will be guided by the Steering Committee for the Somali AIDS Response (SCSAR) and the AIDS Commissions in Somaliland, Puntland and South Central Somalia, with a commitment to the implementation of one harmonized framework for action across all Somali populations, one M&E framework. Interventions through various sectors will be devolved, based on the comparative advantages of each sector in reaching population at risk or affected communities, families and individuals effectively.

The multisectoral approach requires the following:-

- Effective advocacy at senior policy levels in government, development partners, international and indigenous civil society and the private sector to increase awareness of the threat HIV poses to early recovery and development of Somali populations, and if left unaddressed, could further exacerbate vulnerabilities of women and girls, orphans, and internally displaced populations.

- Somalis take an active and leading role in policy development, strategic planning, resource mobilization; coordination and the monitoring and evaluation of program implementation.
- Engagement of stakeholders across sectors at the local level to create the necessary space to enable marginalized most-at-risk populations to negotiate safe sex, access condoms, and benefit from prevention, treatment, care, and support.
- Within Somaliland, Puntland, and South Central Somalia, engagement of political, civil society and private sector leaders in the Somali HIV response
- Effective inclusion of civil society, communities, populations most-at-risk of HIV infection, PLHIV, and others affected by the epidemic, in a program strategy that builds upon the comparative advantages of each constituency or sector
- Strengthening and enhancing the role of AIDS Commissions in Somaliland, Puntland and South Central Somalia
- Investment to strengthen the capacity and enable all constituencies and sectors, at all levels, ensuring their full participation and contribution to the overall response
- Accountability and communications among all partners and stakeholders
- Mobilize all sectors, in particular judiciary, health, education, and other social services to promote and protect human rights overall, and in particular the rights of women and girls, people living with HIV, marginalized groups by creating awareness and ensuring they are enshrined in legislation, and enforced at all levels.

The Somali HIV response enhances the multisectoral approach through strategies that strengthen the AIDS Commissions' capacity to coordinate across sectors; strengthening partnerships at various levels; and mainstreaming the HIV response in all sectors.

3.3 Gender equality and Human Rights

The partners will promote and ensure that all HIV programs have as their basis the promotion, protection and respect of human right, including gender equality. Programs will focus on multiple vulnerabilities and risks faced by women and girls to HIV infection, including lack of access to correct information and opportunities to develop skills to reduce or avert associated HIV risk. The program will work with Somali civil society to advocate for and ensure the participation of marginalized groups in planning and decision making, and increasing their access to integrated prevention, treatment, care, and support services for HIV. Service provision to Somali women and girls, including unmarried girls and women will be improved, including increased access to treatment much greater care and support, prevention of mother to child transmission through services.

Partners will promote and increase greater participation of women and women's organizations in leadership in the Somali HIV response, at various levels, engaging men as key actors towards gender equality and prevention of gender based and sexual violence against women and girls. Program strategies will be developed and implemented to address vulnerability of men and boys due to gender roles and norms around gender relations and on masculinities. Research

priorities within the M&E Framework for the Somali HIV response will reflect gender considerations, and better understanding of the intricate relationship between gender and youth with regards to the risk of HIV infection in the Somali context (including operational research on SGBV, disaggregation of program data to monitor gender-specific indicators).

3.4 Focus reducing risks to HIV Infection among young people, women and girls, and most at risk populations

Recent data from sentinel surveillance and social mapping of “hot spots” indicate the need to target interventions more effectively on vulnerable populations and populations most-at-risk of HIV infection. The partners will ensure that HIV prevention efforts are intensified and scaled-up to increase access to services and These groups include commercial sex workers and their clients, orphans and vulnerable children, women and girls, internally displaced people, mobile populations and populations of humanitarian concern, uniformed personnel, and survivors of sexual and gender based violence

3.4.1 HIV prevention among women and girls

Gender norms and stereotypes increase vulnerability of both women and men to engaging in risk behavior, and they need to be addressed in order to prevent HIV infection. In the Somali case however, vulnerability of women and girls due to gender discrimination and inequalities is widespread, therefore it needs to be addressed separately as a specific concern. To prevent HIV infection among women and girls, a number of measures need to be taken, among others:

- Reduce economic vulnerability that would force women and girls towards high-risk coping strategies
- Improving girls access to education and skills training, particularly in IDP camps and surrounding host communities
- Reduce sexual and gender based violence, working especially with men and boys
- Improve legal protection of women’s rights
- Address negative effects of cultural norms and traditional practices
- Increasing access to HIV and reproductive health information and services that are friendly to women and girls, including unmarried mothers, widows, or women separated from family units for various reasons, HIV and reproductive health information and services
- Carefully targeting prevention messages to promote protection of women and girls, using culturally appropriate approaches and media
- Strengthening capacity of community based organizations and NGOs working with women and girls,
- Strengthen women’s leadership in the HIV response

While they represent a population at significant risk, women and young people also provide a window of opportunity for shaping the course of the epidemic.

3.4.2 HIV prevention among vulnerable adolescents

A UNICEF report 53% of the Somali population is under the age of 18 and many are not in schools and suffer from the consequences of conflict. Young Somali women and men need correct information about HIV, skills to avert and reduce risk behaviour and access to comprehensive HIV services. This has to be complemented by efforts which ensure a protective and enabling environment. It is understood that vulnerable adolescents are adolescents based on determining what behaviours around which ages and which contexts and

settings constitute risk in areas where there is a high HIV background prevalence. Somali communities and parents have to provide greater support and protection to adolescents to prevent new infections and to care and support those affected or infected

Educate adolescents on gender norms and stereotypes that influence their behaviour and promote among them equitable relationships will also contribute to the reduction of HIV infections.

3.4.3 Most-at-risk populations

Social vulnerabilities, biological and behavioral factors place some population groups at significantly higher risk of acquiring and or transmitting HIV; these include transactional sex workers and their clients, injecting drug users, men who have sex with men, and prisoners. Depending on local situations, people with sexually transmitted infections, mobile and migrant workers, ethnic or cultural minority groups may also be exposed to HIV infection at a significantly higher level than the general population.

Recent qualitative research (IOM 2008) explored risk behaviors among transactional sex workers and their clients, and PLHIV. While quantitative data is still limited, further exploration needs to be carried out into bridging populations and the general population. Further HIV Behavioral Surveillance Surveys (BSS+) and operational research are vital to understanding better the drivers of the epidemic and this is planned to begin soon.

The IOM survey covered sites across Puntland, Somaliland and South Central. Populations sampled included transactional sex workers, transactional sex clients and PLHIV. Sub-populations among the transactional sex workers and their clients include asylum seekers, refugees, internally displaced persons, uniformed services, militia, seafarers and truck drivers. The response rate of 93% is remarkable, given the cultural and religious challenges conducting sexual behaviour research in the Somali context. The major findings included:

- Entry into “survival sex” work was most common, particularly among women who headed their household; earning per sex act was low.
- Sex workers and their clients reported highly inconsistent or no use of condoms
- High levels of mobility among transactional sex workers both before and after starting transactional sex
- Sex workers’ clients reported inconsistent condom use with multiple, concurrent sexual partners in multiple locations among mobile populations e.g. uniformed services, truck drivers

A key implication highlighted by these findings is the need to shift the Somali HIV & AIDS response from the general population to targeting Most-At-Risk Populations, many of whom are mobile. Recommended approaches to achieving a targeted response include strengthening links with transactional sex work groups to develop effective interventions.⁵

Program strategies will be developed to increase access to information, targeted prevention, and services by these population groups, including access to condoms and STI treatment. Relationships will be fostered at the local level to create enabling spaces for reaching marginalized groups and advocacy undertaken for the rights to access to services for ethnic minority groups. Behavioral and biological surveillance activities will include these groups as a

⁵ HIV Hot Spot Mapping – by International Organisation for Immigration

priority to monitor the status of the HIV epidemic, level of knowledge and skills in risk reduction measures and practices, and care seeking behavior and its determinants in these groups.

3.4.5 Populations of humanitarian concern

Mobility is one of the characteristics of Somali populations, i.e. the general population across borders. This has been further exacerbated by displacement of populations due to conflict; UNHCR estimates over nine hundred thousand Somalis are in IDP settlement areas as a result of the conflict. Somali populations have suffered a complex and protracted emergency situation that has increased vulnerabilities of women and girls, deepening poverty and limited coping mechanisms for families many of whom are headed by women due to break up of family units. Loss of protection from family units exposes women to sexual and gender based violence. In these settings, women are forced to engage in high-risk coping strategies, such as increased transactional sex. Essential services are disrupted, causing disruptions to access to ART, PMTCT, management of opportunistic infections, or other life-saving HIV prevention interventions.

Programs will be developed to ensure delivery of HIV prevention, treatment, care and support services to populations of humanitarian concern, and improve emergency preparedness and strengthen the capacity of civil society organizations that provide services in IDP settlement areas by mobilizing technical and financial resources. Support will also be provided to civil society organizations to promote respect for human rights and advocate for the protection of women and girls in IDP settlement areas. IDP settlement areas will be included in the routine behavioral and biological surveillance system.

3.4.5 HIV prevention among mobile cross border populations

With the longest coastline in East Africa, expanded regional trade, important international ports, and economic inequalities (and opportunities), the Somali HIV epidemic is characterized by high levels of trans-border population movement. HIV prevalence is highest in areas of trade-driven mobility, with the highest prevalence among pregnant women attending prenatal services reported from the port city of Berbera. In addition, Somalia has large numbers of cross-border traders, humanitarian workers, and non-Somali uniformed services, most importantly the trucking routes between Somaliland and Ethiopia.

Programming needs to encompass the trans-border dimension of population movement, with harmonized packages of tailored prevention, treatment, and care services. This requires a degree of regional coordination with programs targeting important spaces in the region where sex workers and their mobile clients congregate. Along major transport corridors, peer education programs are required among sex workers, together with access of sex workers and clients to condoms, appropriate STI treatment, and access to VCCT and ART through integrated clinics. Similar targeted programming is required for other groups, each of which has specific service access needs.

3.5 Greater involvement of PLHIV in the Somali HIV response

The Somali HIV response fully adopts the principles of Greater Involvement of People Living with HIV, focusing on

- Increasing the participation of PLHIV in high level planning, coordination of the HIV response
- Providing support to enhance the role of PLHIV groups to ensure their full participation in prevention, treatment, care and support interventions
- Strengthening existing and creating new networks of PLHIV to increase the representation of PLHIV at all levels

3.6 Evidence-informed planning

The Somali HIV response will continue to build up on the body of evidence to improve knowledge of the HIV epidemic and effective targeting of the drivers and risk factors for HIV infections in Somali populations. This will be achieved through the following:-

- Developing a prioritized, and results focused research agenda, which reflects the needs of all stakeholders
- Strengthening the mechanisms for monitoring and evaluation, and increased use of data at all levels, dissemination of information to all stakeholders
- Ensuring that planning and mobilization of resources are informed by operational and scientific information

3.7 Participation of key constituencies/stakeholders

The Somali HIV response pursues a coordination strategy that will increase the effective engagement and participation of all stakeholders in the design, implementation and monitoring the progress and effectiveness of the interventions. It will ensure the participation of PLHIV, women and young people, most-at-risk population groups, and create a mechanism at various levels for their effective and constructive contribution to the Somali HIV response, through the following:-

- Strengthen and provide support to most-at-risk and vulnerable groups to enable them to participate in the Somali HIV response,
- Provide opportunities for the participation of most-at-risk and vulnerable groups and their engagement at various levels of the Somali HIV response
- Encouraging and supporting the establishment of networks at various levels to ensure the representation of various constituencies

3.8 Alignment with international and regional initiatives

The Somali HIV response recognizes the role of mobile cross border populations in shaping the future of the epidemic. It is important that elements of the response are consistent and coordination with international initiatives, and particularly with regional and sub-regional initiatives that will enable effective targeting and monitoring and evaluation of the response.

The Somali HIV response seeks to achieve the Millennium Development Goal by 2015, and is consistent with the “Three-Ones” principle and approach, through adoption of one harmonized framework for action, one monitoring and evaluation framework, and coordinated implementation at various levels. At the regional level, the Somali HIV response is part of the IRAPP and HOAP initiatives.

4 The Strategic Vision, 2009-2013

This section sets out the goal, priority areas, targets and key strategies for the Somali HIV response, incorporating its core principles.

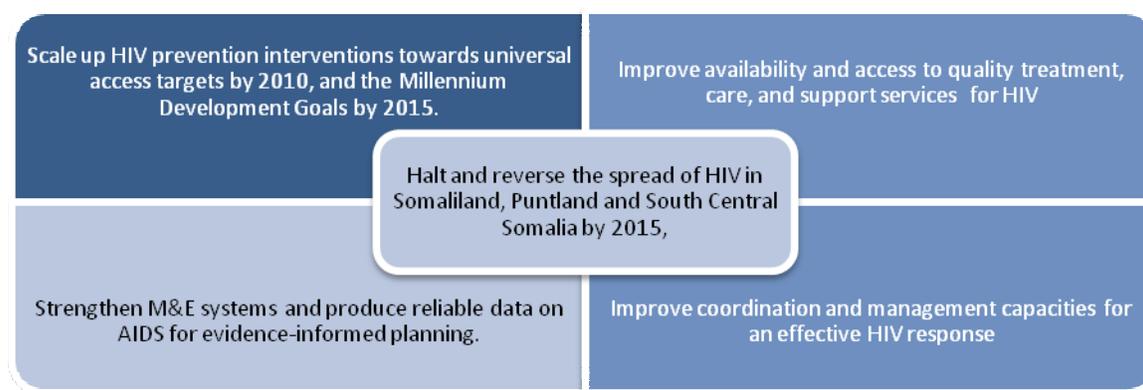
4.1 The Goal of the Somali HIV response

The Somali HIV response seeks to halt and reverse the spread of HIV in Somaliland, Puntland and South Central Somalia by 2015, and make progress towards the agreed Universal Access targets in integrated prevention, treatment, care and support by all Somalis by 2010.

4.2 Strategic Objectives, 2009-2013

The above goal will be achieved through the delivery of quality and integrated prevention, treatment, care and support interventions and services under four main objectives that cumulatively contribute to the overall goal. The response engages and mobilizes all sectors in the early recovery and development, and humanitarian operations, including uniformed services.

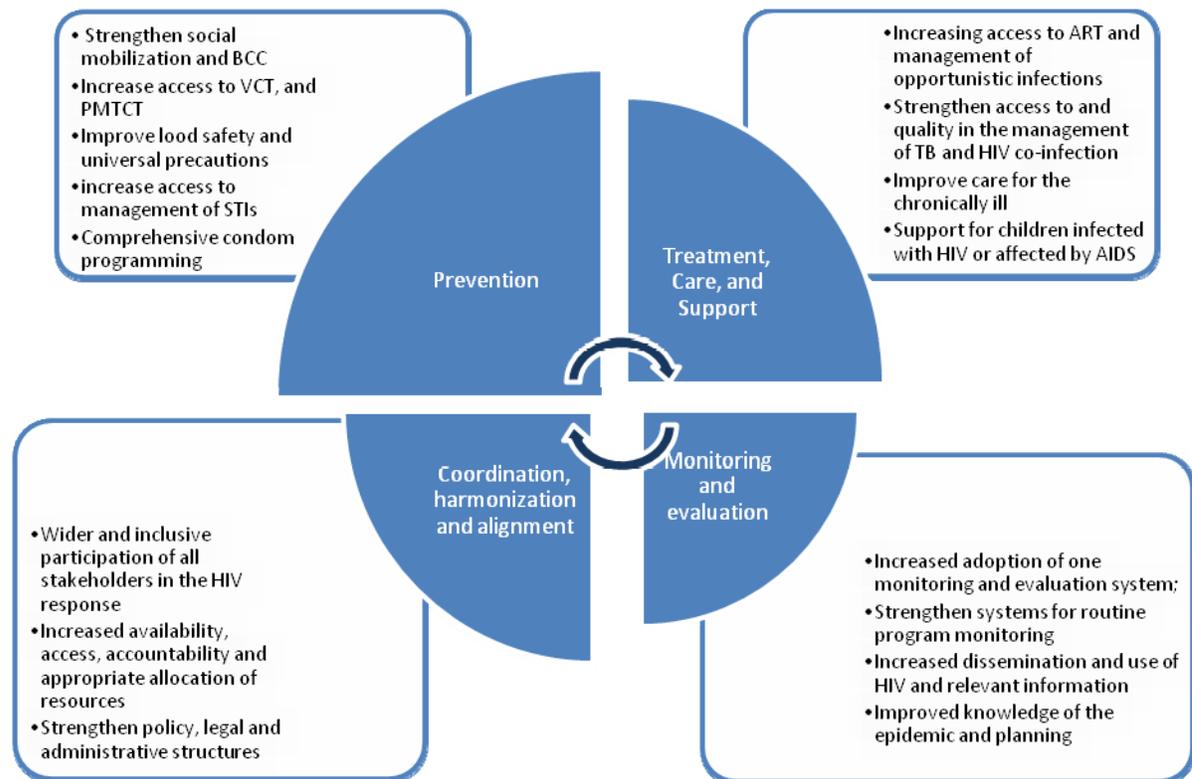
Figure : The Goal and Key Priorities in the Somali AIDS Response, 2009-2013



4.3 Expected Outcomes and Key Strategies, 2009-2013

The following outcome areas and key strategies have been identified to support the achievement of the four strategic objectives defined for the Somali HIV response. These outcomes and key strategies will inform and guide the design of projects and operational plans for all partners engaged in the response. Partners will conduct periodic reviews at different intervals appropriate for various levels, and monitor progress in the implementation and performance in the key strategies, and make recommendations to refine or substantial revision that will ensure that overall progress will be on track towards the achievement of the universal access targets by 2010, and the overall goal by 2015. The outcomes are outlined under the following four areas, which correspond to the strategic objectives under Section 4.2.

Figure : Key Outcomes and Priority Intervention areas for the Somali AIDS response, 2009-2013



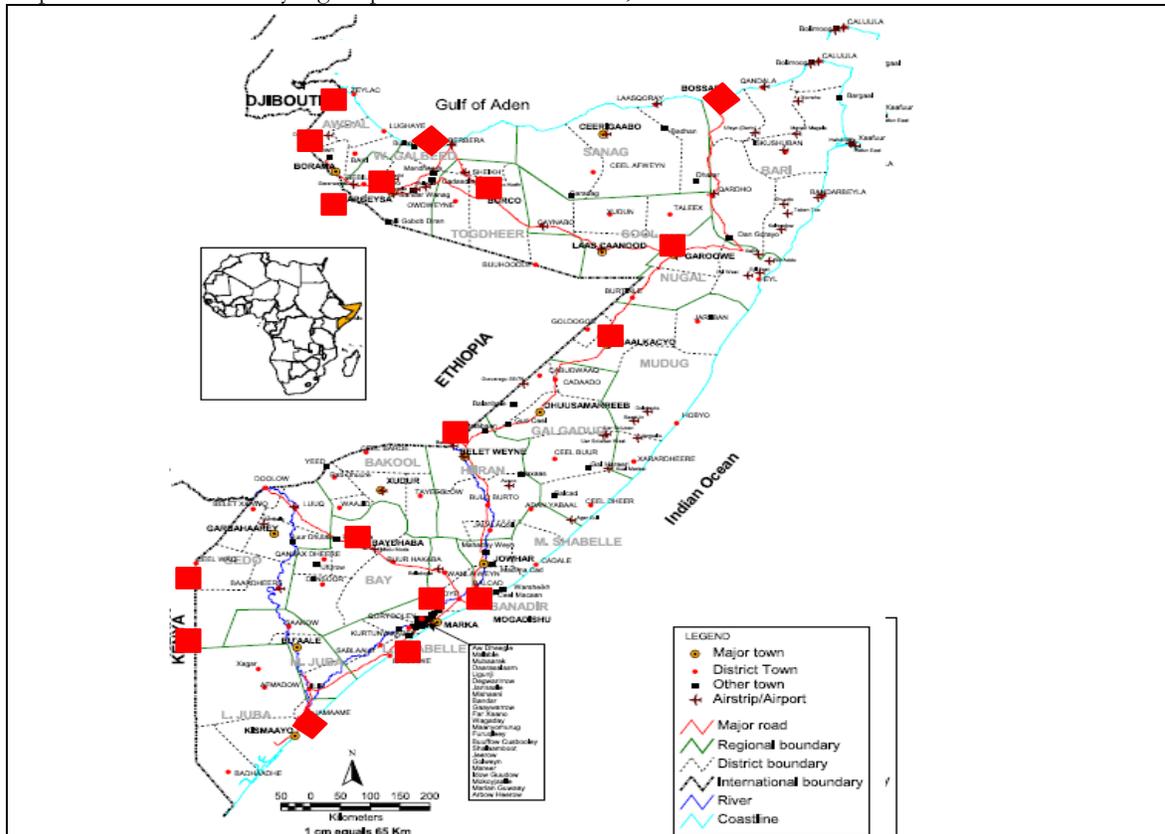
4.3.1 Preventing new HIV infections in Somali populations

The current framework seeks to reduce the number of new infections through measures that reduce vulnerabilities through advocacy to promote dialogue in Somali society that improve cultural, institutional and structural conditions supporting people’s abilities to access and use information on HIV and related services. HIV prevention interventions will be mainstreamed into programs in various sectors that address poverty, promote gender equality and protect and promote human rights, particularly addressing on the needs of women, girls, and young people. Partners will also develop and implement strategies that will reduce risk behavior and promote the adoption of protective behavior by individuals and communities, and continue to improve understanding among partners of the key risk behaviors and risk groups in each priority geographical zone, recognition of the behavioral characteristics of key population groups, delivery of services and interventions through effective and appropriate mechanisms engaging facilities, community systems, workplaces, involving all sectors.

The framework reflects efforts by partners to adopt evidence-informed approaches to address risk behaviors and risk settings in Somaliland, Puntland, and South Central Somalia. On the basis of available information from sentinel surveillance data, findings from mapping of most-at-risk populations, and data on mobile populations, major transport corridors from the port cities, and partners have identified the following priority populations and geographic areas as priority for the period 2009-2013. These will be revised periodically through annual reviews on the basis of evidence from behavioral and biological surveillance data on both the general population and most-at-risk populations.

In Somaliland, Berbera, Hargeisa, Burao, Borama, Togwachaale, and Lowyado were identified by partners as priority geographic areas; in Puntland, the port city of Bossaso, followed by Garowe and Galkayo; and in South Central, Mogadishu, Kismayo, Baidaba, Merka, Jowhar, Beletweyne, Doble, and Ceel Waq were prioritized. The basis for selection of these urban centres included relatively higher HIV prevalence reports from ANC surveillance, relatively high concentration most-at-risk populations, uniformed services personnel (including peacekeeping forces, police, and militia groups) high traffic including seaport and overland transport corridor, commercial activity and movement of general population, IDPs and refugees along the transport corridor and cross-border transit points with Ethiopia, Kenya, Djibouti, and Yemen.

Map 2: Areas with relatively higher prevalence in Somaliland, Puntland and South Central Somalia.



Key strategies for prevention of new HIV infections include the following:-

4.3.1.1 Social mobilization and Targeted Behavior Change Communications

The development of a revised a BCC strategy will be supported to deliver evidence-informed and effectively communication interventions addressing high risk behaviors’, create a supportive environment for behavior change, and reduce stigma and discrimination surrounding HIV and related issues. Participatory behavioral research, involving key populations, community leaders, service providers, and program managers will be conducted to promote collection and use of data at the district and community level. BCC interventions will consist of a strategic mix of interpersonal communication, mass media, community mobilization and advocacy and will be well coordinated to ensure consistency and synergies in messages or information disseminated through various channels.

The BCC programmes will reflect the need to target high risk behaviors, including among most-at-risk populations. Target locations for BCC interventions will be selected based on available research and surveillance information around risk behaviours, such as unprotected sex in the context of sex work or transactional sex, sex between men and injecting drug use, especially among sub populations such as prisoners, street children, uniformed personnel, militia, and mobile populations such as truckers, seafarers, port workers, internally displaced people, refugees and returnees. Through BCC, partners will promote delay in age of sexual debut among young people, practice of safer sex, and to create greater demand for counseling and testing, STI care, ART, use of condoms, PMTCT, management of TB-HIV co-infection, blood safety and the practice of universal precautions.

4.3.1.2 Increasing availability and access to Counseling and Testing

Counseling and testing is a key behavior change strategy in the fight against HIV. At the individual level, it reinforces motivation to maintain sero-negative status among those who test negative, while those that are infected would benefit from further counseling on how to protect their partners from infection, early referral to treatment and care, or planning on support for families and communities where appropriate.

The Somali HIV response will focus on establishment of standardized guidelines for delivery of counseling and testing services, including development of strategies to integrate diagnostic testing and counseling for HIV among TB and other patients. Strategies will be developed to increase access to VCT among hard to reach and most-at-risk populations. Service providers will be trained to enable scale up of services, with emphasis on counseling skills friendly to young women and men, mobile and cross border populations, and populations of humanitarian concern; provision support to improvement of infrastructure for counseling and testing services; provision of quality test kits and other supplies.

The partners seek to ensure equitable distribution of VCT services through establishment of at least 3 service delivery points in each of the 19 regions. Additional service delivery points will be established in prioritized geographical areas, port cities and major transport routes, areas with high concentration of IDPs and refugees, uniformed services personnel.

Specific effort will be made to mobilize technical and financial resources to develop a sustainable model that builds on the comparative advantages of international and indigenous CSOs for delivery of counseling and testing services, in a manner that will ensure uninterrupted delivery of services during different phases of security and stability in any part of Somali populations. Special focus will be placed to enhance the participation of women, PLHIV, and community members from among most-at-risk populations in the scale-up strategy.

Capacity assessment will be conducted to identify gaps and develop a plan to strengthen Somali CSO capacity for delivery of VCT. A small-grants program will be established to increase access by CBOs of resources, and build their capacity through a standardized training on counseling and testing services, and support their organizational development.

4.3.1.3 Comprehensive Condom Programming

The use of condoms is a key strategy for prevention of HIV; it also reduces the risk to other STIs that significantly increase risk of transmission of HIV. Effective and culturally appropriate strategies will be developed to increase acceptability and use of condoms in Somali populations. Operational research will be conducted 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 in Somali populations, especially among young men and women, mobile and cross border and most-at-risk populations, and uniformed services personnel. Condoms will be distributed through social marketing schemes, health facilities, work place programs, and community systems, including peer educators targeting specific groups.

4.3.1.4 Increased access to Management of STIs

Preventing STI transmission, early diagnosis, and treatment is a key strategy for HIV prevention. Comprehensive STI care, including diagnosis, treatment with according to established protocol for syndromic management, appropriate counseling of patients will be expanded through training of service providers in public and private sector facilities. Drugs, condoms and other commodities will be distributed to ensure increased availability at all facilities. Specific efforts will be made to increase access in port-cities, major transport corridors, and other areas with documented evidence of relatively higher HIV prevalence, and promote client-friendliness of services to mobile cross border and most-at-risk population groups.

4.3.1.5 Expanding Access to Prevention of Mother to Child Transmission of HIV

HIV transmission from parent-to-child accounts for the majority of all infections in children. Available strategies can reduce mother to child transmission from 30% to less than 1%. While the programme should address pregnant women, it is important that both parents understand their roles and responsibilities in HIV prevention. Services for Prevention of mother-to-child transmission of HIV have been initiated at a selected number of reproductive health services, in 2007. This has to be coupled with .increased community mobilization around prevention of mother-to-child transmission, with support for women who deliver at home, and development of strategies to reduce the risk of HIV transmission via breastfeeding and reduction of stigma related to exclusive breastfeeding.

4.3.1.6 Improve Blood safety, Practice of Universal Precaution, and Post-Exposure Prophylaxis

Strategies will be put in place to ensure all blood transfusions in Somaliland, Puntland, and South Central Somalia are effectively screened for HIV and other STIs, in a manner consistent with international standards. Blood transfusion centers will be strengthened with increased access to written standard operating procedures, supplies of test kits and other commodities, and training and supervisory support for personnel involved in blood transfusion services. All facilities providing the service will be included in an external quality assurance scheme to monitor and maintain high quality standards.

PEP services will be established to ensure availability at all ART sites. Youth and reproductive health workers, and members of uniformed services personnel will be trained on appropriate management of survivors of sexual violence and referral to health facilities offering PEP within an appropriate period of time.

4.3.2 Improving availability and access to Treatment, Care, and Support for PLHIV

Through the implementation of the strategic plan, partners seek to improve the quality of life among people living with HIV, including the lives of affected families and communities. This will be achieved through provision of treatment, care and support services, and advocacy to promote and protect the human rights of PLHIV and affected people, including the rights of orphans to access social services and support. The following key strategies will be employed towards this objective:

4.3.2.1 Increasing access to ART and management of opportunistic infections

Partners in the Somali HIV response have committed to the achievement of the universal access targets by 2010. Progress has been on track; through this revised strategy, partners are seeking to scale up access to ART, and improve targeting of the services towards areas most affected by the epidemic, i.e. port cities and high population movement corridors and cross border areas. Availability of ART, including early detection and management of opportunistic infections, will be increased by increasing the number of facilities providing a package of integrated prevention, treatment, care, and support (IPTCS) services, including ART; strengthening institutional capacity of hospitals and MCH centers, including private facilities, to provide ART.

4.3.2.2 Strengthen linkages between HIV and TB care, and

Linkages will be strengthened between HIV and TB services to ensure that all PLHIV and TB patients are screened for TB and HIV, respectively, and those that test positive have access to treatment and care services. Facilities providing TB management services will be assisted to ensure availability of provider initiated counseling and testing for HIV among TB patients; at VCT and ART sites, screening for HIV and early referral to treatment and care. Efforts will be made to ensure that patients have one-stop facilities that provide services in the management of TB and HIV co-infection.

4.3.2.3 Improve Care for the Chronically Ill

Community and home based care services for PLHIV and affected families will be strengthened, and linkages with facilities improved. PLHIV will be provided counseling and nutritional supplements. Partners will strengthen the linkage between facility and community based services to ensure a continuum of care, and efficient two way referral between facilities and community systems. Technical and financial resources will be mobilized to strengthen Somali civil society groups involved in care for PLHIV and affected communities.

Partners will develop a comprehensive strategy to reducing stigma and discriminations against PLHIV and their families, and to promote dialogue with the aim of creating a supportive environment for PLHIV in communities, and facilities providing health and education services. Particular effort will be made to increase the involvement of community, religious, and political leaders in the campaign against stigma and discrimination.

4.3.2.4 Support for children affected and infected by AIDS

Partners will strengthen existing and expand interventions that provide support to children infected and affected by AIDS, including orphans, to increase quality of life, ensure access to social and health services and access to educational opportunities. Efforts will include keeping children in families and communities, to build community capacity to care for children affected

and infected and supporting government and authorities to protect the most vulnerable children through improved policy and legislation and by channeling resources to families and communities at risk. Efforts will include prolonging and supporting the lives of parents and providing economic, psycho social and other support. Awareness will be raised at all levels to create a supportive environment for children and families affected by AIDS.

4.3.2.5 Strengthen health care system at facilities and community levels providing comprehensive and quality services for PLHIV

Support will be provided to strengthen elements of health systems that are essential for the delivery of integrated prevention, treatment, care and support services at health facilities level. The capacity of districts and health facilities will be strengthened to establish and support community systems with effective linkages and synergy between preventative, treatment, care, and support services. These include human resources at various levels, and improved systems for efficient management of procurement and distribution of drugs and supplies for HIV interventions, monitoring ART and other prevention interventions.

4.3.3 Strengthening Coordination, harmonization and alignment of the Somali HIV response

Partners will develop strategies and take concrete steps to strengthen institutional, technical, and financial management capacities of all stakeholders, with a focus on ensuring sustainable leadership and ownership of the response by Somalis. The strategies will be consistent with the commitment expressed to the "Three Ones" principles*. The HIV response will be mainstreamed into emergency, humanitarian, and early recovery and development initiatives in Somaliland, Puntland and South Central Somalia. This will be achieved through the following four key outcomes related to strengthening coordination, leadership capacity, harmonization and alignment and institutional systems that support the above functions.

4.3.3.1 Wider and more inclusive participation of all stakeholders in the HIV response, and ensuring participation of people living with HIV, women, most-at-risk population groups, religious leaders, and civil society*.

Somali communities will be mobilized at all levels, to promote wider involvement and ownership of the Somali HIV response and ensure gender and human rights are addressed at all levels. To encourage community participation in the response and increased adoption of protective practices, the AIDS Commissions will work with their respective governments in the three zones to formulate a policy on HIV. The policy, among other issues, will address the establishment of Zonal IPTCS Group and District IPTCS Committees mandated with the coordination of social mobilization and behavior change communications interventions at the district and lower levels, and coordinate the delivery and monitoring of treatment, care, and support services involving all stakeholders. The Zonal IPTCS Group will be based at the AIDS Commissions' Secretariats, while the District IPTCS Committees will be based in the District Medical Office, and report to their respective AIDS Commissions. Membership in the Zonal and District IPTCS and Community level structures will ensure the participation of women and girls, young people, PLHIV, representatives of populations affected by humanitarian emergencies, most-at-risk populations. Support will be provided to civil society organizations engaged in HIV and related services, or working with vulnerable groups, to strengthen their capacity and promote their participation.

4.3.3.2 Harmonized M&E framework adopted to facilitate evidence-informed HIV response

A harmonized M&E Framework will be adopted for the Somali HIV response. AIDS Commissions and District IPTCS, together with partners will explore various approaches strengthen monitoring and evaluation systems at Zonal, regional, district, service delivery point, and community level. Partners will provide support to the establishment of community system, including a joint-health facility and community forum to improve tracking of activities, increase information sharing, and ensure sustainable commitment involvement of the community with a focus on results.

4.3.3.3 Increased availability, access, accountability and appropriate allocation of resources for the HIV response at all levels

Technical and financial resources will be mobilized to build the capacity of the District IPTCS Committees, to ensure that they have necessary knowledge and skills to effectively discharge their responsibilities. Partners through their program technical team will train Somali civil society and NGO staff on community mobilization for the HIV response, focusing on social change to address gaps in current community mobilization approaches and skill. A community mobilization approach that will promote community ownership and sustained community action will be adopted; partners will develop approaches that will be used to guide the community mobilization process at multiple levels (district, villages, and households). Communities will be actively engaged in assessment, analysis, planning, and implementation of strategies, monitoring, and evaluation.

4.3.3.4 Strengthen policy, legal and administrative structures/ mechanisms/ procedures for the coordination and management of the HIV response, with alignment and harmonization with emergency humanitarian and development instruments.

In view of the current political context, the following coordination structures have been established in consultation with all stakeholders, as the mechanism to ensure adoption of a harmonized strategy consistent with the “Three-Ones” principle. A Steering Committee is established to improve coordination and harmonization of the HIV response in Somali populations, with membership of the AIDS Commissions from Somaliland, Puntland, and South Central Somalia.

The Steering Committee works through and is supported by the Health Sector Committee, and will be an inclusive multisectoral mechanism that promotes wider participation that brings together stakeholders at Community, District, Regional and Zonal levels. The Steering Committee works with and supports the three AIDS Commissions in leadership and strategic planning, monitoring progress in the response, and evaluating impact of the HIV response. It will ensure wider and inclusive participation and promote Somali ownership of the HIV response at all levels. (See Fig: Section 6.1). Key to this revised coordination mechanisms are consultative processes led by AIDS Commissions within each zone. The revised coordination mechanisms consist of the Steering Committee, Zonal IPTCS Groups, Regional/District IPTCS Committees, and community systems or structures that support partnership at the grass roots level between service providers and communities.

The Steering Committee is composed of AIDS Commissions from the three entities, international and Somali civil society organizations, PLHIV networks, development partners, and UN agencies. Partners will make specific effort to increase the participation of civil society organizations representing and working with PLHIV, women and girls and most-at-risk populations in decision making processes at all levels. The Steering Committee will oversee periodic reviews of the status of the HIV epidemic and the response, and strategic planning and coordination. The Committee will be supported by Thematic Working Groups. At the

zonal level, IPTCS Groups led by AIDS Commissions will coordinate the implementation of a zonal operational plan that is based on the overall Strategic Framework, and monitor progress using the harmonized M&E Framework.

4.3.4 Strengthening evidence-informed strategic planning, management, and monitoring and evaluation of a multisectoral HIV response

Evidence and information, generated through improved monitoring and evaluation system is critical for the success of the Somali HIV response. In line with the “Three Ones” principle, the response relies on establishment of a common monitoring and evaluation framework to track progress and performance in various areas towards the achievement of the stated universal access targets in Somali populations, and to evaluate the impact of the Somali response.

All partners involved in the implementation of the various elements of the Somali HIV response, shall report progress within the framework set out in the harmonized monitoring and evaluation system. The M&E framework also supports a consultative process for periodic program review by providing partners at district, regional and zonal levels with information on progress made in implementing the response.

4.3.4.1 Develop and promote adoption of one multi-sectoral Monitoring and Evaluation system for the Somali HIV response.

The M&E Framework will clearly define the indicators for specific HIV intervention areas, sources of data, frequency of data collection, responsible body for data collection, and the method of measurement. Overall, data for monitoring indicators will be collected through special surveys, like Behavioral Surveillance Surveys, Sentinel Surveillance Surveys, Blood Bank Data, Health facility surveys, routine data collected through projects and service delivery points.

4.3.4.2 Strengthen systems for routine tracking of the HIV response, at zonal, regional, district, service delivery points, and communities.

Routine program data from program and project implementing partners, on selected indicators. In order to facilitate data flow, support will be provided to AIDS Commissions to implement the Country Response Information Systems (CRIS) in the three zones. CRIS will be used to enhance the data collection and reporting requirements at regional and international levels, e.g. UNGASS.

4.3.4.3 Establish and implement a functional research framework on HIV, and ensure better understanding of the drivers and risk factors of the HIV epidemic in Somali populations.

Further data needs to be collected to better understand where current transmissions are occurring, and relative distribution in specific sub-populations in urban centers along major transport corridors originating from the port cities. There are no quantitative bio-behavioral data on specific populations, including most-at-risk populations, to evaluate the status of the epidemic and risk behaviors in these groups.

In view of the mobile life style of the general population across borders, displacement and disintegration of family units, increased vulnerability of women and girls due to gender inequalities exacerbated by the ongoing conflict, major trucking operations associated with

trade and humanitarian emergency services, uniformed services and other armed groups, IDPs, refugees, there is need to systematically monitor the HIV prevalence through a combination of population based surveys and targeted 2nd generation surveillance surveys that capture behavioural and epidemiological trends across the general population and most-at-risk populations in priority geographical settings.

4.3.4.4 Increased use and dissemination of HIV and other relevant data at all levels

Support will be provided to strengthen skills for data collection, analysis and decision making at all levels. Information sharing will be promoted at district and Zonal levels, the Country Response Information System will be used to support wider dissemination on the progress in the overall response. Emphasis will be placed on better knowledge of the risk factors contributing to the epidemic, and targeting resources and coordinated efforts towards to address these factors at various levels.

5 Creating an Enabling Environment for the Implementation of the Somali HIV response

The Somali HIV response will mobilize support services that will be required for its effective delivery through broad partnership that engages all stakeholders at various levels. Key partners involved in the response require significant support to be effective in their respective roles, and be efficient. The following are key support services that will be provided towards the implementation of the Somali HIV response.

5.1 Research

Despite recent progress made to improve understanding of the epidemic, a number of areas require further in-depth investigation to provide evidence that informs strategic decisions and interventions. A research strategy is to be developed to identify and prioritize research projects and ensures that information generated will improve understanding of the epidemic and results in strengthening effectiveness of interventions and their delivery mechanism. Partners will strengthen evidence-informed advocacy and promote dialogue at all levels.

5.2 Institutional Capacity building

The Somali HIV response will mobilize resources, both technical and financial, to implement institutional capacity building focusing on human resources development, systems development, generating and increasing access to information, and participation in networks and partnerships.

Priority will be given to strengthening the capacity of Somali civil society organizations and CBOs, to increase their role in the delivery of services. In view of the civil conflict, it is important to strengthen the partnership between international organizations and CBOs, providing opportunity for mentoring support that builds the capacity of Somali CBOs and non-governmental organizations to intensify and scale up community based services. This also has potential to ensure services are maintained and less interruption during different phases of conflict.

Capacity of Somali CSO will be strengthened through training and focus on community mobilization theories and best practices; planning, leadership, use of data for decision-making, experience-based advocacy, and monitoring and evaluating community capacity. An organizational assessment of current mobilization practices will be undertaken amongst partners, and strategy developed to address gaps and intensify and scale up the prevention efforts.

5.3 *Communication, Coordination and Networking*

Partnerships at various levels, PLHIV networks, and coordination and communications channels will be strengthened. It will broaden participation in periodic program review processes at various levels, particularly focusing on zonal and district level coordination and program reviews. Specific effort will be made to increase the participation of PLHIV, most-at-risk populations, women and girls and young people. Strategies will be developed to improve communications among partners at all levels.

5.4 *Financing, Procurement and Supplies Management*

Partners will identify priorities for resource mobilization and allocation on the basis of improved knowledge of the epidemic and its direction, and will periodically review these priorities in line with the epidemiological evidence to enable better targeting. Somali institutions, development partners, civil society, the private sector and communities will participate in resource mobilization.

Partners will develop strategies to strengthen absorption capacity, and to make the money work effectively towards the achievement of the universal access targets and the fulfillment of the Declarations of Commitment. To this end, partners will regularly review and analyze the challenges and opportunities, and ensure that practical solutions are developed and implemented to increase absorption capacity and accountability.

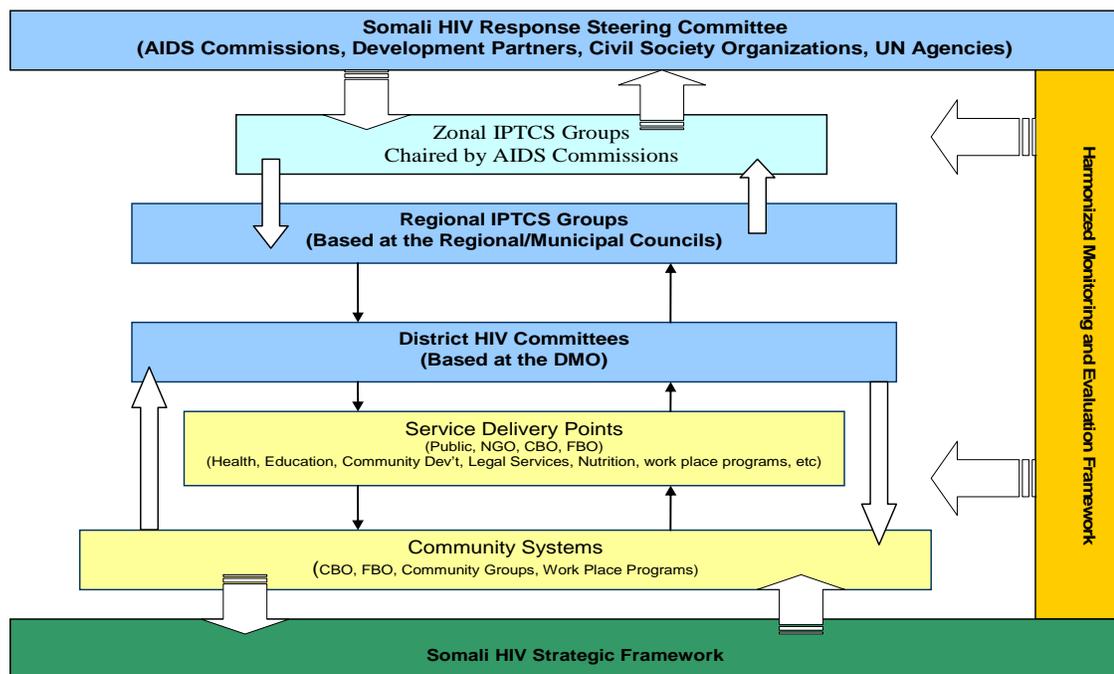
The framework recognizes the lack of a public sector procurement and distribution systems for drugs, medical equipment, and supplies and commodities that will be required to increase access to integrated prevention, treatment, care and support services; such a system is essential to the scale up of these services. Partners will support the development of a harmonized system for procurement and distribution of essential drugs that will ensure efficient use of resources.

6 Implementing the Somali HIV response

6.1 Coordination arrangements for Implementation of the Somali HIV response

The Somali HIV response is a multisectoral strategy; no single sector or agency has the overall responsibility for its implementation. In order to achieve the stated results set out in the framework, it is essential to have effective coordination mechanisms, led by the Steering Committee and AIDS Commissions in the three zones.

Figure : Coordination Structures for the Somali HIV response, 2009-2013



The Steering Committee provides an effective HIV stakeholder coordination mechanism, and will be responsible for high level technical coordination of the Somali HIV response, including coordination of annual review of the progress towards the overall goal and objectives. The Steering Committee will be supported by and receives report from Thematic Groups, coordinated by the Lead Agencies, on a quarterly basis.

AIDS Commissions will lead and coordinate all stakeholders in the three zones respectively, and ensure the participation of PLHIV, women's groups, and most-at-risk population groups. AIDS Commissions will led the Zonal IPTCS Group, as a multi-stakeholder forum for partnership in the implementation of an operational plan for each zone, regular review of progress, and identification of priorities for their respective zones.

Regional IPTCS Committees, or where appropriate Municipal and District IPTCS Committees, will coordinate implementation of HIV interventions that will be mainstreamed into health, education, and other sector activities. These Committees will be based within the Regional, Municipal or District Medical Office, with a focal point appointed to function as a secretariat;

these structures will be chaired by head of the government authority, and function as a forum for advocacy and bringing together local government, religious leaders, FBO, CSOs working on social mobilization and behavior change communications, service providers in health, education, livelihoods and other sectors.

Periodic joint reviews will be conducted on a quarterly and annual basis, to track performance towards agreed upon targets. Lead agencies and their key partners will provide updates on deliverables to which they have committed.

6.2 The Results Framework and Targets for the Somali HIV response (2009-2013)

The Results Framework for the Somali HIV response, which is set out in Annex XX, identifies the key milestones to be achieved in order to reach the universal access target by the year 2010, and to halt and reverse the HIV epidemic by the year 2015. These milestones serve as benchmarks for the overall response.

The results framework forms the primary instrument for planning, coordinating, and monitoring progress in the implementation of the Somali HIV response. The framework will be reviewed and updated annually through a consultative process involving all stakeholders, and forms the basis for progress reporting at the annual program review, using information collected through the Country Response Information System. Key components of the results framework are:

6.2.1 Results

The results constitute the key deliverables for the Somali HIV response for the period 2009-2013, which coordinating and implementing partners are expected to achieve through their combined efforts. The results are set for each year of Outcome Area of the response. These results include targets for Somali populations in Somaliland, Puntland, and South Central Somalia; these results will be further translated into zonal, regional and district level targets to enable AIDS Commissions and their partners in each zone to monitor progress towards specific deliverables for their respective areas.

6.2.2 Timeframes

The results, timeframes, and target dates do not represent a work plan; they are used to inform and guide implementing partners in prioritizing and scheduling their work, and assist in reviewing progress in the implementation of the Somali HIV response. Programs and implementing partners will reflect the timeframes in their own work plans, where appropriate.

6.2.3 Strategies

The results framework identifies appropriate strategies for delivering specific results, in order to facilitate coordination and avoid duplication of efforts.

6.2.4 Lead Organizations

The Steering Committee for the Somali HIV response has the overall responsibility to track progress. To facilitate the efforts of various partners and stakeholders contributing towards each strategic objective, lead agencies will be designated with overall responsibility for the delivery of the strategic objectives. The lead agencies chair the Thematic Groups.

6.2.5 Key partners

The key partners are agencies involved in supporting or implementing activities in specific target areas, and lead agencies will continue to engage additional partners in the course of the implementation of the Somali HIV response.

7 Risk Analysis and Key Assumptions

Partners have conducted a risk assessment and analysis of key assumptions for the successful achievement of the goals and objectives set in this framework for the HIV response. The analysis looked into potential degradation of the security situation, political conflict and associated instability, lack of support from government counterparts for the “Three-Ones” principle, and perceptions at various levels on support and level of engagement of Somali civil society and institutions, operational risks, as well as risks that could impact specific outcome areas in the HIV response.

The progress made in the delivery of social services over the last four years demonstrate that Somalis and international partners have developed strategies to mitigate against the above risks, and be able to maintain services. See Attached Risk analysis and mitigation measures for details.

8 Mobilizing Resources

Three key strategies have been adopted to mobilize resources for the Somali HIV response, for the period 2009-2013. These are:

- a. **The Global Fund for fighting AIDS, Tuberculosis, and Malaria:** To date, resources from The Global Fund Round IV grant to Somalia accounts for nearly 60 percent of the finances for HIV interventions in Somaliland, Puntland, and South and Central Somalia. The Steering Committee for the Somali AIDS response will work closely with the Acting Country Coordinating Mechanism to write proposals and submit applications to The Global Fund. The Steering Committee will conduct annual programme review, looking in programmatic and resource gaps, and make recommendations for revisions in service delivery strategy.
- b. **Mainstreaming HIV into the Emergency Humanitarian Response:** The Steering Committee will work closely with UNOCHA and IASC Clusters to support mainstreaming HIV into the humanitarian operations in Somaliland, Puntland, and South Central Somalia. The Steering Committee will designate HIV focal points to work with each of the IASC clusters to provide input, and ensure opportunities for integrated delivery of HIV interventions through education, health, water and sanitation or other services are fully utilized, and resources allocated.
- c. **Improved tracking of additional resources available through development partners, UNAIDS co-sponsors and other partners, and improve efficiency in the use towards key priorities.**

8.1 Costing Estimates

Based on the overall framework for the Somali AIDS response, partners will develop detailed Operational Plans for implementation at the zonal level. These operational plans will be differentiated according to the status of the epidemic, priority population groups, and estimated size of priority populations.