SOMALI HIV NATIONAL STRATEGIC PLAN AND M&E FRAMEWORK 2021 to 2023

Somali HIV National Strategic Plan and M&E Framework

2021 to 2023

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BCC	Behaviour Change Communication
CEDAW	the Committee on the Elimination of Discrimination against Women
CIA	Central Intelligence Agency
CMR	Clinical Management of Rape
CPT	Co-trimoxazole
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
DFID	Department for International Development
DOTS	Directly Observed Treatment (short course)
EID	Early Infant Diagnosis
EPHS	Essential Package of Health Services (EPHS)
EPP	Estimation and Projection Package
FGS	Federal Government of Somalia
FHW	Female Health Workers
FMS	Federal Member States
FRS	Federal Republic of Somalia
FSW	Female Sex Worker
GBV	Gender Based Violence
GF	The Global Fund
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counselling
IBBS	Integrated Biological and Behavioural Survey
IDP	Internally displaced persons
IEC	Information, Education and Communication
INH	Isoniazid
IPT	Isoniazid Preventive Therapy
IPTCS	Integrated Prevention, Treatment, Care and Support
ISBCC	Integrated Social and Behaviour Change Communication
JUNTA	Joint United Nations Team on HIV and AIDS
KVP	Key Vulnerable Populations
LMIS	Logistic Management Information System
M&E	Monitoring and Evaluation
MARP	Most at Risk Population
MCH	Maternal and Child Health Centres
MDAs	Ministries, Departments and Agencies
MDR – TB	Multi-Drug Resistance Tuberculosis
MEAL	Monitoring, Evaluation and Learning
MICS	Multi-Indicator Cluster Survey
MIPA	Meaningful Involvement of People Living with HIV and AIDS
MoH	Ministry of Health
MoT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Commission
NCPI	National Composite Policy Index
NDP	National Development Plan
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living With HIV
PMTCT	Prevention of Mother to Child Transmission
PSCM	Procurement and Supply Chain Management
SARA	Service Availability and Readiness Assessment
SMS	Short Message Service
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint UN Program on HIV and AIDS
UNFPA	United Nations Population Fund
UNGASS	UN General Assembly Special Session
UNICEF	United Nations Children Fund
VAW/G	Violence Against Women and Girls
VCT	Voluntary Counselling and Testing
WB	World Bank
WHO	World Health Organisation

Foreword

This is the fourth HIV National Strategic Plan (NSP) that Somalia has developed to guide its response to HIV and AIDS. The HIV National Strategic Plan 2021-2023 is a clear demonstration of Somalia's commitment to HIV and AIDS.

The main purpose of the HIV and AIDS National Strategic Plan 2021-2023 (NSP) is to support a well-coordinated, evidence-based and contextualised national response to the HIV epidemic in Somalia.

The HIV National Strategic Plan 2021-2023 provides detailed information on key strategies and priority actions and describes key impact, outcome and coverage results, building on epidemiological data and existing structural, legal and other barriers to accelerate an end to AIDS.

The NSP 2021-2023 takes into account improved strategic information that has become available, lessons learned from a review of progress undertaken during the implementation of the NSP 2018-2020, as well as discussions from Country Dialogue meetings that took place in Somalia in early 2020.

We believe we can end the AIDS epidemic, by keeping the focus on the needs and rights of key populations, in order to prevent new HIV infections and ensure that those living with HIV and AIDS receive the treatment they need. Over the last few years, HIV prevention programmes with key vulnerable populations in Somalia have expanded. In addition, HIV Testing and Counselling programmes have increased, which has led to more people accessing HIV testing services. More people in Somalia are also getting the treatment they need than ever before.

Nevertheless, there is still a long way to go, and the success of this NSP will depend on the active participation and involvement of all sectors in Somalia – government, business, labour, civil society, development agencies, research institutions and communities – in order to end AIDS by 2030.

HIV and AIDS remain a major development challenge as well as a health, human rights and gender issue in Somalia. In this regard, we believe that the NSP 2021-2023 provides a comprehensive strategy to support the effective management and control of HIV and AIDS in Somalia.

The AIDS Commissions in collaboration with the Ministries of Health and other HIV stakeholders will continue to provide technical support to all stakeholders, in order to ensure the effective implementation of the proposed activities.

We encourage all our partners to use this NSP to support their work and encourage all partners to continue their work with renewed energy and determination.

Thank you in advance, **Executive Directors, AIDS Commissions 2020**

Mr. Ahmed Mohammed Jimale Executive Director AIDS Commission Mogadishu	**Mr Abdukadir Mohamed Ahmed** Executive Director Puntland AIDS Commission (PAC)

GUDDIGA LA-DAGAALANKA AYDHISKA EE KOONFURTA & BARTAMAHA SOOMAALIYA
حكومة الإقليمية لمكافحة الإيدز في جنوب و وسط الصومال
South & Central Somalia AIDS Commission

PUNTLAND AIDS COMMISSION
PAC
EXECUTIVE DIRECTOR

Acknowledgements

This HIV National Strategic Plan 2021-2023 was developed through a participatory process over a period of several months under the leadership of the National AIDS Commissions (NACs). This included multiple consultations with key Somali stakeholders including representatives from the NACs, Federal and State Health Ministries, other line/mandated ministries, Networks of People Living with HIV and Civil Society Organisations (CSOs) in Somalia, as well as consultations with United Nations and Donor Agencies.

We are grateful to everyone who gave their time and contributed to this process, as well as to all development partners who provided technical and financial support for the development of this NSP. In particular, we would like to thank the Somali AIDS Commissions who took the lead to coordinate and develop this NSP 2021-2023, ensuring that all key stakeholders had an opportunity to contribute.

We would also like to thank UNICEF Somalia and the Global Fund (GF) without whose support the development of this strategy would not have been possible.

Finally, we are grateful to all those who provided technical support to enrich and strengthen the NSP.

Executive Summary

Introduction

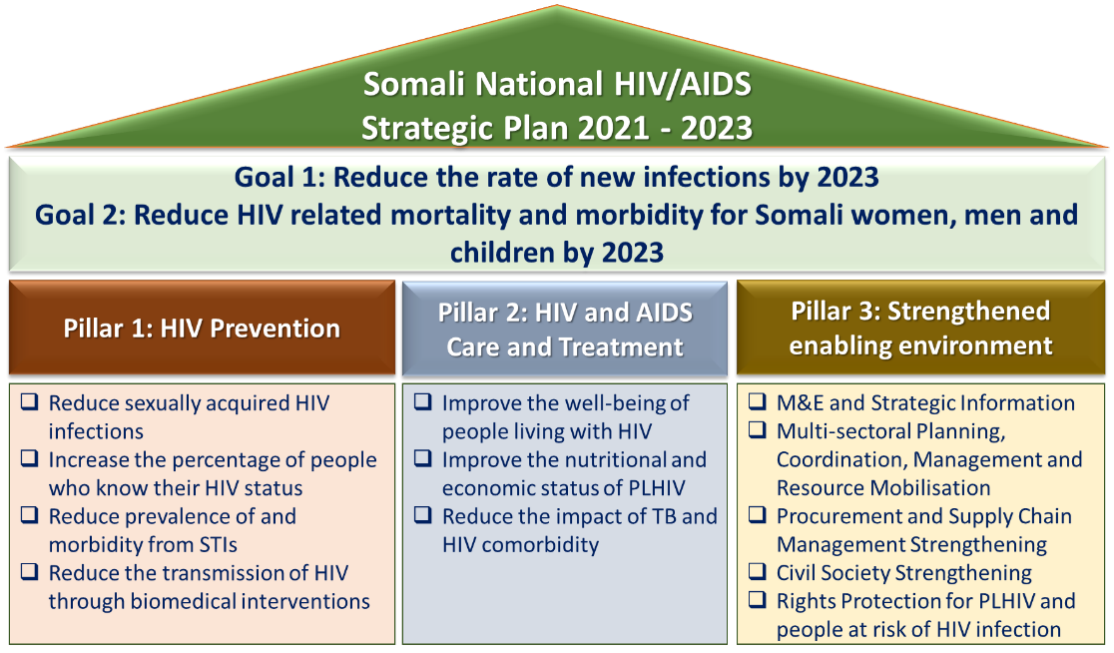
This Somalia strategy to respond to HIV and AIDS for the period of 2021-2023 has been developed to provide a framework for a coordinated, evidence-based and contextualised national response to the epidemic. This Somalia HIV NSP serves to:

i. Articulate a strategic framework for the implementation of the multi–sectoral HIV and AIDS response guided by one NSP and one Monitoring and Evaluation (M&E) framework;
ii. Identify and articulate priorities and results for the multi-sectoral HIV and AIDS response;
iii. Support a decentralized planning and implementation framework where communities identify strategic priorities, and design and implement appropriate evidence-based and results-focused interventions that contribute to results (targets);
iv. Provide a resource mobilisation tool for the HIV and AIDS response.

This NSP was developed through a highly consultative, participatory and evidence-driven process over a period of two months under the leadership of the National AIDS Commissions (NACs) with multiple stakeholder consultation activities. The NSP articulates a strategic direction that builds on understanding the epidemiology and the existing structural, legal and other barriers to accelerating an end to the epidemics in a complex operating environment.

Strategic Framework of the NSP

This NSP identifies two goals and three strategic objectives (pillars) for enhanced national response. The two goals and three pillars with their strategies as illustrated in the figure below.



The 2021 – 2023 NSP is framed around three objectives, considering the important inter-relationship and cross cutting nature of coordination, management, M&E, strategic information and rights protections. The NSP aims to: reduce HIV infections and HIV related mortality and morbidity among Somalis based on currently available baselines by:

(i) Reducing new infections by 30% by 2023
(ii) Reducing HIV related deaths by 30 percent by 2023

The aims of this NDP will be achieved through a total of nine key strategies and by ensuring:

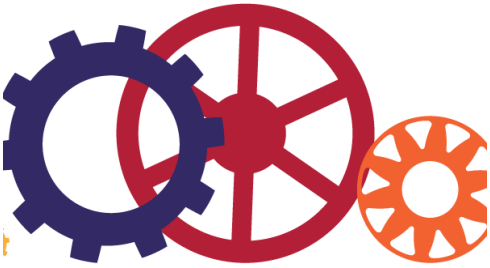
1. Prevention of new HIV infections especially among key populations such as women most vulnerable to HIV and their partners through a combination of HIV prevention interventions;
2. Increased access to and utilisation of quality integrated prevention, treatment, care and support; and
3. A strengthened enabling environment focused on coordinated leadership and management, rights protections for people living with, and at risk of, HIV, improved strategic information and response monitoring.

Implementation Arrangement

This NSP will be a guiding document with a multi-sectoral dimension coordinated by the AIDS Commissions that will be responsible for effective monitoring, evaluation and reporting. The NSP will strengthen coordination platforms and other mechanisms to ensure accountability for results, linkage of the response to the situation and environment, use of local evidence to improve programming, and a country-led integrated national response.

Resources need for the NSP

This NSP was costed using costings developed to support the Somali HIV NSP 2015-2019. Budgets for activities included in this NSP have however been increased to match increased testing and treatment targets included in this NSP. The total projected resources needed to implement this NSP at the Federal Level are: US$46,645,307. During the implementation period, the NACs, MoH and partners will undertake to mobilise resources from different partners for implementation of the activities.



Part 1: Country HIV and AIDS Political, Epidemiological and Performance Context for Federal States of Somalia

- Section 1. Introduction
- Section 2: Somalia Context and HIV and AIDS Epidemic Overview
- Section 3: Achievements and Challenges in the Somalia HIV Response

Section 1: Introduction

The HIV response in the Federal Republic of Somalia has continued to change over the years guided by different strategic plans, frameworks and action plans. This document describes Somalia's strategy to respond to HIV and AIDS for the period of 2021-2023. This revised strategy utilises lessons learned from implementation of the 2018-2020 Strategic Framework and two previous strategic frameworks: Strategic Framework for the Somali AIDS Response 2009–2013, and the Strategic Framework for the Somali AIDS Response 2015–2017. This update of the National Strategic Plan (NSP) was built on the new emerging changes in the country context, new global guidance and emerging best practices while maintaining the goals, objectives and broader strategies.

1.1 Purpose of the National Strategic Plan

The purpose of Somalia's HIV National Strategic Plan 2021 to 2023 is to:

i. Articulate a strategic framework for the implementation of the multi–sectoral HIV and AIDS; response guided by one NSP and one Monitoring and Evaluation (M&E) framework;
ii. Identify and articulate priorities and results for the multi-sectoral HIV and AIDS response;
iii. Enable decentralized planning and implementation framework where communities identify strategic priorities, and design and implement appropriate evidence-based and results-focused interventions that contribute to results (targets); and
iv. Provide a resource mobilisation tool for the HIV and AIDS response.

1.2 NSP Guiding Principles

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

i. Meaningful Involvement of women and men living with HIV and AIDS (MIPA) and key populations;
ii. Promotion and protection of human rights as per provisional Somalia Constitution adopted on 1st August 2012 by a National Constitutional Assembly;
iii. Alignment and harmonisation with the National Development Plan, Health Sector Strategic Plans (HSSP) and other national and development plans;
iv. Equity, including gender equity;
v. Measurable results;
vi. Grounding proposed actions in evidence and prioritizing what is most efficient and effective;
vii. Value for money; and
viii. Integration and sustainability.

1.3 NSP Development Process

This NSP was developed through a highly consultative, participatory and evidence-driven process over a period of two months under leadership of the National AIDS Commissions (NACs). There was a comprehensive review of progress made in the implementation of the 2018-2020 NSP. A comprehensive analysis of the Somali HIV response was conducted to provide firm epidemiological

and implementation context. This analysis was used to update strategic information and, as well, set the right context for the next implementation period.

Stakeholder consultations were conducted to include representation of the NACs, Federal and State health ministries, other line/mandated ministries, as well as partners involved in the response. This was through programme reviews, and validation meetings in late 2019 and early 2020 and through multiple stages starting with a five-day consultative meeting for participants from across Somalia. Draft versions of the document were reviewed by different stakeholders and comments incorporated following consensus. The NSP was costed using costings developed to support the Somali HIV NSP 2015 - 2019. Budgets for testing and treatment however have been increased as per the increased testing and treatment targets included in this NSP. The updated NSP 2021 - 2023 also aims to use lessons learned and new available strategic information to better target the response. This NSP provides a policy framework for the implementation of HIV programmes in order to achieve stated goals and objectives based on identified gaps and opportunities for meaningful impact on the HIV and AIDS response.

1.4 Layout of this NSP document

This NSP includes eleven sections as outlined below:

i. *Preliminary pages:* this takes care of the table of contents, acronyms, acknowledgement, foreword and the executive summary.

ii. *Introduction* (this section): provides the overview of the entire NSP.

iii. *Somalia Context and HIV and AIDS Epidemic Overview*: provides strategic information and country contextual issues relevant to the national AIDS response.

iv. *Achievements/Challenges section*: summarises lessons learned from previous implementation as well putting into context emerging issues from strategic information.

v. *NSP Strategic Framework* (Somalia's NSPS for the Response to HIV and AIDS 2021 - 2023): provides detailed description of the goals, objectives and specific interventions to be undertaken over the period of implementation.

vi. *Prioritisation of country actions*: describes priority actions to drive impact to the response.

vii. *Risk and Mitigation Strategies*: provides a risk management framework for the NSP.

viii. *Monitoring and Evaluation (M&E)*: provides guidance on M&E Coordination, Data Collection and Reporting, M&E plan overview, and the M&E framework linked to the detailed M&E plan.

ix. *Implementation Arrangements*: brings together the linkage between the strategic framework and the roles of key entities to be involved in implementation of the NSP.

x. *NSP Costing*: provides summary costing by objectives and interventions, gap analysis and resource mobilisation strategies/approaches for the NSP.

xi. *Annexes*: provide detailed information on the M&E plan and detailed budget.

Section 2: Somalia Context and HIV and AIDS epidemic Overview

2.1 The Somalia Context

i. Geography

The Federal Republic of Somalia (*Jamhuuriyadda Federaalka Soomaaliya*) is situated in the most eastern part of the African continent in what is commonly referred to as the "Horn of Africa", and has a surface area of 637,540 square kilometres (Figure 1), with terrain consisting mainly of plateaus, plains and highlands. Somalia is bordered by Djibouti and Ethiopia to the west and Kenya in the south. Across the Gulf of Aden is Yemen. Its coastline is more than 3,333 kilometres in length, the longest of any country in mainland Africa and the Middle East region.

Figure 1: Map of the Federal Republic of Somalia inclusive of all territories

ii. Demography and population

The United Nations estimated Somalia's population to be 15,442,906 mid 2019, with an annual growth rate of 2.9 percent (inclusive of Somaliland).[1] However, due to complexities in the country, population data varies. The 2014 PESS (Population Estimates Survey) places the population of Somaliland at 4,066,942.[2] There is a significant challenge in correctly estimating Somali population coverage.

The 2014 PESS states that 42 per cent of the population lives in urban areas while other surveys indicate that as of 2017 it was at 44.4 per cent.[3] A quarter of the country's population is nomadic living mainly in the rural areas. The Federal Government and Puntland as of September 2019 had a total of 995,650 registered Internally Displaced Persons (IDPs)[4] with the country estimated to have over 2.6 displaced by March 2020[5]. More people have become internally displaced in Somalia since November 2016 because of drought, conflict and flooding.[6] Most people have self-settled in sub-standard IDP sites and are repeatedly identified as the poorest and most vulnerable, often with limited local acceptance due to their social background. The distribution of the confirmed IDPs as well as urban and nomadic populations in the region are illustrated in figures 2 and 3.

[1] United Nations, Department of Economic and Social Affairs, Population Division (2019). World Population Prospects 2019, Online Edition. Rev. 1. Available from https://population.un.org/wpp/.
[2] 2014, UNFPA, Population Estimates Survey.
[3] Urbanization in Somalia 2017; Statista; Published by H. Plecher, Jun 24, 2019. Available from https://www.statista.com/statistics/455928/urbanization-in-somalia/.
[4] CCCM Somalia | Detailed Site Assessment CCCM; available from https://data2.unhcr.org/en/documents/download/71992
[5] IOM/UNHRC August 2019.
[6] UNHCR, 2019; available from https://data2.unhcr.org/en/situations/cccm_somalia.

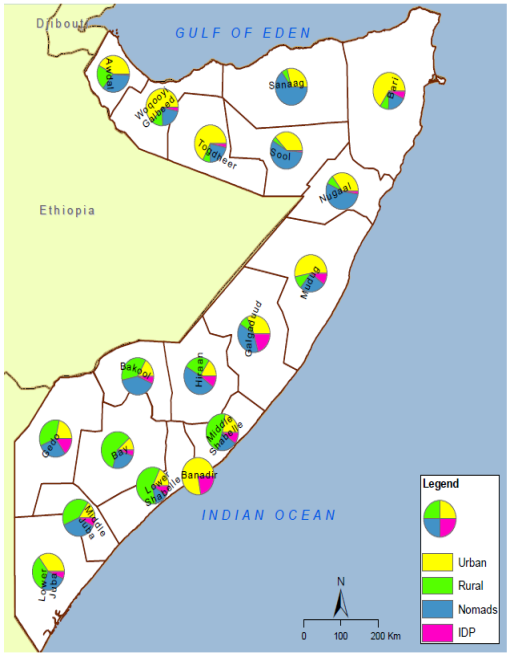


Figure 2: Urban, rural, nomadic and IDP population by region

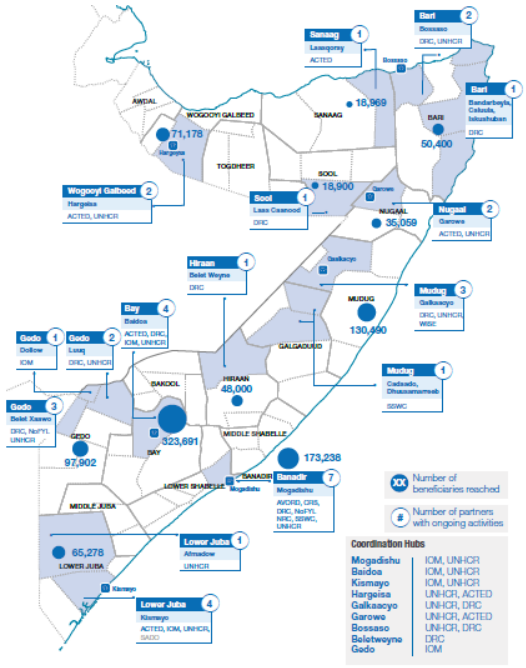


Figure 3: distribution of mapped IDPs by different regions and locations (Source: UNHCR, 2019)

The population pyramid (figure 4) and distribution over different age brackets remains close to a normal distribution curve but with 46 per cent of the population below the age of 15 years. This is a major contributor to dependency ratio and as well other challenges in improving social welfare among the whole population. It is estimated that on a daily basis there are 1,745 births, 451 deaths, negative 104 net migrations, and 1,190 net population change per day.

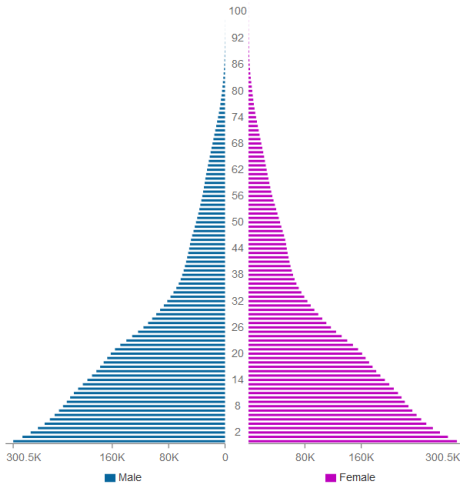


Figure 4: 2019 Somalia Population Pyramid

2.2 Political Context

Unlike many African populations, the majority of the Somalis are part of a single, homogeneous ethnic group with a common language and culture. Described as the most culturally homogenous country in Africa, the country has Somali and Arabic as the two major spoken languages. Despite being ranked second on the Fragile States Index each year since 2014[7], the country has continued the path of recovery from decades of civil strife building on the establishment of the Federal Government in

[7] "Fragile States Index 2018". The Fund for Peace. 10 April 2019. Retrieved June 9, 2019. Accessed on November 29, 2019 from https://fundforpeace.org/2019/04/10/fragile-states-index-2019/.

2012. That same year, a provisional Somali Constitution[8] was established based on the principles of power-sharing in a Federal State. The Provisional Constitution promotes human rights, the rule of law, justice, participatory consultation and separation of legislative, executive and judiciary powers. It also emphasizes the role of women's participation in national institutions including elected and appointed positions. The provisional constitution lays the foundation for the establishment of a Human Rights Commission which will be tasked with education on human rights and addressing situations where human rights breaches have occurred.

Somalia is a parliamentary democratic republic with the President as head of state and the executive. The other arms of government are the legislature (Federal Parliament of Somalia) and judiciary. The parliament elects the President, Speaker of Parliament and Deputy Speakers; and has the authority to pass and veto laws. The national judiciary structure is organized into three tiers: The Constitutional Court, Federal Government level courts and State level courts. The country operates decentralised governance with devolution of some level of autonomy to the lower levels. Somali law draws from a mixture of three different systems: civil law, Islamic law and customary law.[9] The Constitution of Somalia defines Islam as the state religion of the Federal Republic of Somalia, and Islamic sharia law as the basic source for national legislation. The allocation of powers and resources between the Federal Government and the Federal Republic of Somalia's constituent Federal Member States is negotiated and agreed by the Federal Government and the Federal Member States.[10]

The country is a member of many international organisations and coalitions particularly the United Nations (UN), African Union (AU), Arab League, Intergovernmental Authority on Development (IGAD), World Health Organisation, among others. Through these and other mechanisms the Federal Government has ratified multiple treaties and agreements related to health and social development. In particular, the country subscribes to the UN Sustainable Development Goals (SDGs), the 2013 AU Abuja Declaration accords priority to the area of health in the Post-2015 Development Agenda and the AU Agenda 2013[11], and the UNAIDS 90-90-90 global initiative to end AIDS.[12] To date, there has been political stewardship towards HIV and AIDS in the country with establishment of National AIDS Commissions (NACs) and other sectoral committees. Protracted fragility of the health systems remains a challenge for the implementation and management capacity of the HIV Programme and therefore capacity building remains key in this updated strategy. Owing to insecurity, the geopolitical context and the expanse of the country, transactional costs tend to be very high which is reflected in this strategy. Health systems have also been affected by long-standing insecurity.

[8] The United Nations Political Office for Somalia (UNPOS). The Provisional Constitution of the Federal Republic of Somalia. Available from https://unpos.unmissions.org/sites/default/files/Adopted_Constitition_ENG_Final percent20for percent20Printing_19SEPT12_0.pdf.
[9] "CIA, The World Factbook – Somalia". Available from https://www.cia.gov/library/Publications/the-world-factbook/geos/print_so.html.
[10] The Provisional Constitution of the Federal Republic of Somalia; article 54.
[11] African Union, 2013. Declaration of the Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria-Abuja Actions Tow ard the Elimination of HIV and AIDS, Tuberculosis and Malaria in Africa by 2030."
[12] UNAIDS; 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Available from https://www.unaids.org/en/resources/909090.

2.3 Somalia Development Indicators

i. Strategic Framework for Development

The Federal Government drafted the first National Development Plan (NDP) 2017 – 2019, and the recently endorsed NDP 2020-24 that stipulates the short to medium term strategic direction, development priorities and proposed implementation mechanisms including the use of development aid.[13] The theme of the NDP is to accelerate socio-economic transformation to achieve stated objectives for poverty alleviation, economic revival and societal transformation in a socially just and gender equitable manner. The NDP articulates the need for the health sector to address the burden of communicable and non-communicable diseases such as malaria, HIV, TB, hepatitis, and other diseases through coordinated and targeted behaviour change communication, improved case detection and treatment.[14]

ii. Key Development Indicators

Key development indicators for the country reflect wide variances in achievement, with missing information leaving an incomplete picture of the actual situation.

Table 1: Key Development Indicators[15]

Development Indicators	Latest data	References/notes
Human Development Index	Not ranked	United Nations Development Program (UNDP)
Gross domestic product (GDP)	USD 4,721,000,393	The World Bank, 2018
Estimated per capita GDP	US$ 314.56, 2018	The World Bank estimate
Life expectancy at birth (years)	56.7	UNDP
Employment in services (per cent of total employment)	21.17 per cent, 2019 ILO estimate	UNDP
Employment in services, male	21.48 per cent, 2019	World Bank; per cent of male employment, ILO estimate
Employment in services, female	19.99 per cent, 2019	World Bank; per cent of female employment, ILO estimate
Per cent of population using the Internet	2.0 per cent, 2017	World Bank
Mobile phone subscriptions (per 100 people)	46.5, 2019	UNDP
Annual population growth rate	2.83 per cent, 2018	World Bank
Urban population	44.97 per cent, 2018	World Bank
Urban population growth rate	4.13 per cent, 2018	World Bank
Rural population growth rate	1.78 per cent, 2018	World Bank
Age dependency ratio (per cent of working-age population)	97.82 per cent, 2018	World Bank

[13] Somalia National Development Plan (2017-2019) [SNDP] –Towards Recovery, Democracy and Prosperity; Ministry of Planning and International Cooperation.
[14] Somalia NDP 2017 – 2019 page 107.
[15] References used: UNDP Human Development Reports (HDR) available from http://hdr.undp.org/en/countries/profiles/SOM; World Bank data available from https://data.worldbank.org/country/somalia.

Table 1: Key Development Indicators[15]		
Development Indicators	**Latest data**	**References/notes**
Ease of doing business index	190, 2018	World bank data; (1=most business-friendly)
Ease of doing business score	20.04, 2018	World bank data; (0 = lowest, 100 = best performance)
Unemployment, total (per cent of total labour force)	13.96 per cent, 2019	World Bank based on modelled ILO estimate
Foreign direct investment, net inflows (per cent of GDP)	8.66 per cent, 2018	World Bank
Health expenditure (per cent of GDP)	67 per cent, 2018	World Bank

The 2018 UN Development Program (UNDP) Human Development Index report does not rank Somalia in any category. The country remains considered among the least developed countries (LDCs) and has low performances across most development indicators. Comparatively, the country has progressed from being among the bottom 10 LDCs over the last decade following the recovery from civil strife. There remains a high level of social dependency and inequality in the population. The country has the lowest GDP and GDP per capita in the horn of Africa and is considered among the lowest ranked countries in Africa. There has been a marked decline in inflation rates over the last five years due to increased stability and more production.

Nearly 75 per cent of females between 15-24 years are illiterate, one of the world's highest levels of gender disparity. Over 50 per cent of the population lives in poverty, with people in IDP camps experiencing the highest rates of poverty (up to 70 per cent). In addition to armed conflict, poverty in Somalia is exacerbated by ongoing natural disasters including periods of drought. This gender disparity, poverty level and other socio-development factors continue to contribute to the rise in number of HIV Key Populations (KPs).

2.4 Somalia Health Systems Overview

i. Health Sector Overview and Structure

The Somali health sector is organised into public and private service providers under the stewardship and regulation of the Federal Ministry of Health (MoH). Although healthcare is largely concentrated in the private sector, the country's public healthcare system is in the process of being rebuilt and is overseen by the Ministry of Health (MoH) across each zone. Somalia's health indicators are among the poorest in Africa (Table 2).

Table 2: Key Health indicators at a glance	
Health Indicators	**Latest data**
Under-five mortality rate (per 1,000 live births), 2018 data	121.53 (2018)[16]

[16] UN Inter-agency Group for Child Mortality Estimation. Available from https://childmortality.org/data/Somalia.

Table 2: Key Health indicators at a glance	
Health Indicators	**Latest data**
Neonatal mortality rate (per 1,000 live births)	37.53 (2019)[17]
Births attended by skilled personnel	9.4 per cent (2006)[18]
Maternal mortality ratio	829 (2017)[19]
Unmet need for family planning among women of childbearing age	29.3 (2018)[20]
Life expectancy at birth (years)	All: 56.7, Male: 55.1, Female: 58.4 (2019)[21]
Physician density per 1,000 population	0.229 (2014)[22]
Nursing and Midwifery personnel density per 10,000 population	0.611 (2014)[23]
Routine immunisation coverage	46 per cent (MCV1), 47 per cent (Polio3)[24]

Mortality and morbidity are mostly because of communicable diseases, reproductive health conditions and malnutrition. Women's health and well-being is furthered hindered because of the 98 per cent of women who experience Female Genital Mutilation (FGM). Somalia has the highest prevalence of mental illness in the world, according to the World Health Organization (WHO). Provision of health care is largely provided by private facilities although the public health system is steadily recovering from the collapse experienced during the long period of civil war.[25] Most health services are financed using out of pocket payments with significant variation on health purchasing abilities between the urban and rural population.

ii. Health Sector Strategic Planning

The FGS National Development Plan (NDP) 2020-24 incorporates health sector planning within the Social Development Pillar.

The Federal health sector plans are detailed in the first Health Sector Strategic Plan (HSSP) 2013 – 2016[26] and subsequent HSSP for 2017-2021 (HSSP II). The HSSP provides for a pragmatic approach to the provision of essential services across Somalia recognizing the current situation of near collapse of health services in some areas coupled with humanitarian and emergency needs.[27]

The HSSP-II identifies nine broad areas and 31 strategic objectives to address strategic issues identified from the implementation of the first national health sector strategic plan while expanding the goals identified by the NDP. The first broad area of Health Service Delivery identifies the

[17] Ibid.
[18] UNICEF, State of the World's Children, Childinfo, and Demographic and Health Surveys.
[19] WHO, UNICEF, UNFPA, World Bank Group, Trends in Maternal Mortality: 2000 to 2017. Geneva, World Health Organization, 2019.
[20] Family Planning 2020. Accessed on November 30, 2019 from https://www.familyplanning2020.org/somalia.
[21] World Bank. World Development Indicators, Accessed November 27, 2019 from https://data.worldbank.org/country/somalia.
[22] WHO, Global Health Observatory (GHO) data? Available from https://www.who.int/gho/health_workforce/physicians_density/en/.
[23] Ibid.
[24] July 2, 2019; WHO and UNICEF estimates of national immunization coverage. Available from https://www.who.int/immunization/monitoring_surveillance/data/som.pdf.
[25] WHO, 2016. Somalia Service Availability and Readiness Assessment (SARA).
[26] Somalia Health Sector Strategy (2013-2016).
[27] Somalia Health Sector Strategy (2013-2016), page 5.

increase in HIV prevalence as a key area of strategic action for the health sector. Under the strategic Objective 1 of the health services delivery broad area, priority strategy 1.9 aims to: Implement the National HIV/AIDS Prevention and Control Strategy with expanded access to HIV/AIDS prevention and treatment services including Anti-Retroviral Therapy (ART) services for adults and children, Sexually Transmitted Infection (STI) control, Prevention of Mother-To-Child Transmission of HIV (PMTCT) and provision of safe blood.[28]

The Essential Package of Health Services (EPHS) was designed in 2009 and is widely endorsed and is currently undergoing review. It comprises: four levels of service provision, ten health programmes, and six management components[29]. The four levels of services provision are: (i) The primary health unit (PHU), (ii) the health centre (HC), (iii) the referral health centre (RHC), and (iv) the hospital (H), all supported by community health service delivery. Six core programmes are found at all four levels and four additional programmes are found only at referral levels, with HIV, STIs and TB considered a core program of EPHS. The delivery of health services for HIV will be premised around this structure of the health system.

iii. Health Services and Facilities

Health services are delivered through the EPHS arrangements that consider the integrated health services delivery mode. In July 2019, there were approximately 106 hospitals/referral centres, 391 Maternal and Child Health Centres (MCH)/health centres and 620 health posts. As of 2014, 9,856 personnel worked in the health sector including 621 physicians, 2653 registered nurses, 636 registered midwives and 198 Female Health Workers. This falls far short of WHO recommended minimum levels of health worker to population ratio, which identified a need for 30,000 skilled health workers. Over 45 health worker training programs tend to operate in an unregulated and unmonitored environment. There has been a steady increase in number of private health facilities across all states and zones since 2016.

The 2016 Service Availability and Readiness Assessment (SARA) identified a serious shortfall in service availability with less than 1 health facility per 10,000 population, less than half the facility density target. In terms of health workers, the country has 4.28 core health workers per 10,000 population, less than 20 per cent of the overall target. The density of maternity beds is also very low with 10 maternity beds per 10,000 population or 25 per cent of the target. The overall general service availability index is 18 per cent of the target. Service utilisation rates were even lower, at 8 per cent and 5 per cent for inpatient and outpatient services respectively. Less than 10 per cent of facilities had a computer with internet access and only 28 per cent had a power source.[30]

Regarding infection prevention, 72 per cent of facilities reported having gloves and 68 per cent has appropriate storage of sharps waste. There was significant variation, with 50 per cent of hospitals having all nine measures and health posts only 2 per cent having all items. Laboratory testing availability for all 8 testing, including HIV, was only 19 per cent and only 4 per cent of sites had

[28] Second Phase Health Sector Strategic Plan 2017 – 2021 (HSSP-II), page 27.
[29] Nigel Pearson and Jeff Muschell, 2009. The Essential Package of Health Services; UNICEF Somalia.
[30] WHO, 2016; Somalia Service Availability and Readiness Assessment (SARA).

capacity for all 8 tests. For essential medicines, facilities had only 15 per cent of the essential medicines and only 1 per cent had all 20 medicines.[31]

Procurement and supply chain readiness scores showed 77 per cent of facilities had a monthly stock reporting system and 57 per cent had commodity storage rooms. Only 38 per cent of facilities reported receiving ordered goods within two weeks of ordering. Non-Government Organisations (NGOs)/Donors are the main source of commodities, particularly for non-governmental facilities.[32]

For maternal and child health there was a significant variation between the type of services, with ANC readiness at 66 per cent and comprehensive obstetric care at 24 per cent. For reproductive health and birth spacing, condoms were only available at 3 per cent of facilities. In total, 66 per cent of facilities offered ANC services, with only 15 per cent offering HIV testing. For emergency obstetrics, only 59 per cent of hospitals had blood transfusion capability, with 2 per cent for other health facilities. In addition to the public health sector, is a rapidly increasing un-regulated private sector including general practice, specialists and pharmacies. However, it is widely recognized that there are few qualified practitioners.

iv. Health Sector Financing

National funding to the health sector varies across Ministries of Health and at Federal Government level. The Somalia government health spending has been around 1 per cent of the total budget and far below the targets of the Abuja Declaration on Health. With significantly negative net income of USD (-)34m in 2018, coupled with high dependence on foreign support[33], the country health budget will require some time before being able to increase domestic financing for health. The financing level by the state governments towards health remains higher than those for the Federal Government as several obligations are absorbed at Federal level.

Somalia's Health Sector is heavily reliant on a range of bilateral aid and technical assistance. The Global Fund, Department for International Development (DFID) of the United Kingdom (UK), Islamic Development Bank and the World Bank remain key bilateral financing partners for major health investments. The Department for International Development (DFID) provided bridging funding of $6.2 million through to March 2017 and has also flagged probable ongoing support for EPHS initiatives. DFID has also committed to the provision of essential medicines through to 2021. The Health Consortium of Somalia, through the Somali Health and Nutrition Program, is supporting three regions (Gedo, Sahil and Karkaar) in EPHS health provision reaching approximately 678,276 people. This is for approximately £27 million over five years (April 2016 to March 2021). The Global Fund has committed financing for HIV for the period 2021-2023 and finances over 90 per cent of the national response to HIV, TB and malaria. Additional funding for the Somali HIV NSP 2021-23 implementation is being sought from the Global Fund.[34]

[31] Ibid.
[32] Ibid.
[33] World Bank data available from https://data.worldbank.org/country/somalia.
[34] The Global Fund, 2020 – 2022 Country eligibility list 2019. Accessed on December 2, 2019 from https://www.theglobalfund.org/media/8340/core_eligiblecountries2019_list_en.pdf?u=637066556670000000.

2.5 Somalia HIV Situational and Response Analysis

i. Overview of the HIV Response

Somalia has one of the lowest HIV infection rates in Africa and it is typical of a highly religious and culturally knitted society. The strong Muslim nature of Somali society and adherence of Somalis to Islamic morals are key factors in the low prevalence and transmission of HIV.[35] The first HIV-antibody positive sample in Somalia was found in 1987 among serum samples collected from 287 women engaged in transactional sex in Mogadishu and reported first by Burans at the 4th International Conference on AIDS, Stockholm, in 1988.[36] The country has adopted the UNAIDS ambitious 90-90-90 ambitious but achievable targets towards a new narrative on HIV[37]. These targets are: (i) By 2020, 90 per cent of all people living with HIV will know their HIV status; (ii) By 2020, 90 per cent of all people with diagnosed HIV infection will receive sustained antiretroviral therapy; and (iii) By 2020, 90 per cent of all people receiving antiretroviral therapy will have viral suppression. By June 2019, the country was not meeting all the three targets with the first and third 90 needing significant reduction if the national HIV burden is to be significantly lowered. There have been challenges with treatment adherence and capacity to monitor viral suppression in the country.

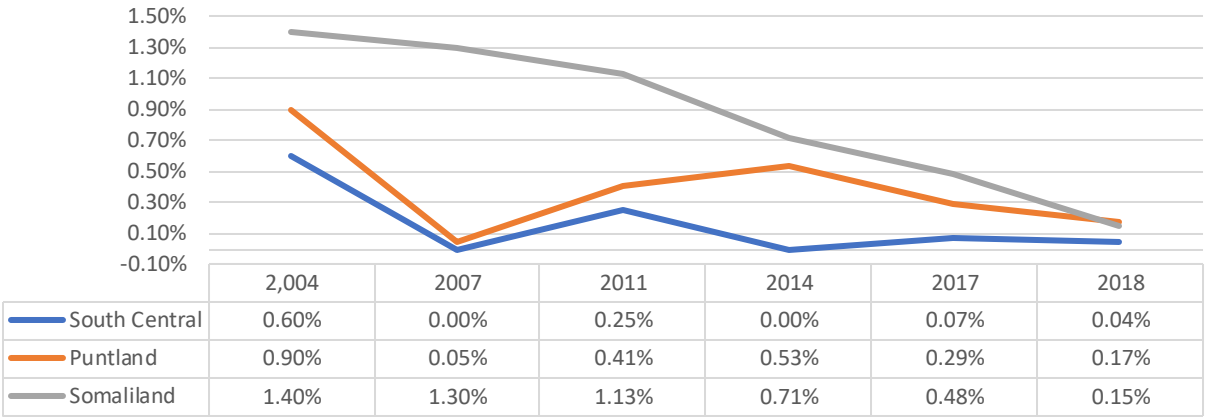
Table 3: Country Performance on the UNAIDS 90-90-90 targets

Health Indicators	Latest data	Notes and data sources
Percentage of all people living with HIV who know their HIV status	32 per cent	*Data source: Program data and reports, and Spectrum 2019*[38]
Percentage of all people diagnosed with HIV that receive sustained ART	79.4 per cent	Data source: 2018 Cohort Analysis[39]
Percentage of all people receiving ART that have viral suppression	73.7 per cent	Data source: Dec 2019 WHO Programme Data[40]

ii. HIV Prevalence

Somalia's HIV and AIDS epidemic is characterized as geographically heterogeneous with Puntland and South-Central States demonstrating a similar trend of prevalence based on antenatal care (ANC) sentinel surveillance over the years (figure 5).

[35] Hasnain M. Cultural approach to HIV/AIDS harm reduction in Muslim countries. *Harm Reduct J*. 2005;2:23. Published 2005 Oct 27. doi:10.1186/1477-7517-2-23.
[36] Ahmed HJ et al. Syphilis and human immunodeficiency virus seroconversion during a six-month follow-up of female prostitutes in Mogadishu, Somalia. International Journal of STD and AIDS, 1991, 2:119–123.
[37] UNAIDS; 90-90-90: An ambitious treatment target to help end the AIDS epidemic. Available from https://www.unaids.org/en/resources/909090.
[38] *Key issue to note*: This covers for both federal states and Somaliland as it is currently not possible to disaggregate the denominator of the estimated number of persons living with HIV/AIDS.
[39] This is based on the retention on care from 2014-2018 ART cohort analysis. Highest was 81.9 percent in 2015 and lowest was 74.8 percent in 2017. Data includes Federal States as well.
[40] The tracking of viral suppression had just been rolled out with the ongoing rollout of Viral Load machines.



	2,004	2007	2011	2014	2017	2018
South Central	0.60%	0.00%	0.25%	0.00%	0.07%	0.04%
Puntland	0.90%	0.05%	0.41%	0.53%	0.29%	0.17%
Somaliland	1.40%	1.30%	1.13%	0.71%	0.48%	0.15%

Figure 5: Median HIV prevalence rates among ANC attendees in Somalia 2004 - 2018[41]

The prevalence level has demonstrated a consistent level of decline in Puntland through the years while at the Federal Level it has been slower. The 2018 ANC surveillance considered many more sites than the previous year and it also provides a more general picture of the whole population. The HIV prevalence among key vulnerable populations (KVP) is much higher than in the general population (Figure 6). The prevalence is significantly higher among vulnerable women and lowest with truckers.

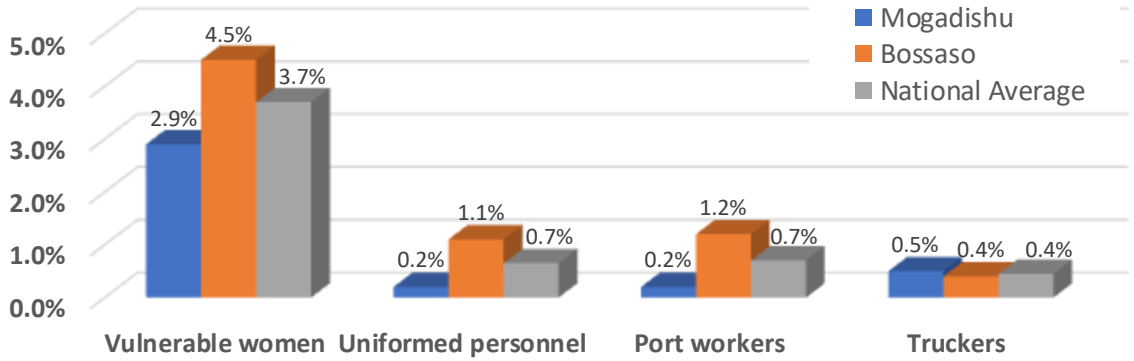


Figure 6: HIV prevalence among key populations (Based on 2017 IBBS)[42]

iii. HIV New Infections, Burden and Mortality

Projected rates of new HIV infections dropped significantly from year 2000 to 2010 with numbers plateauing from 2012 to date (figure 7). The early decline of new infections could be attributed to the strong cultural drive as well as heightened prevention interventions.

[41] Data obtained from ANC surveillance. No survey was conducted in South Central in 2007 and 2014
[42] Population based estimate, Integrated HIV and Sexually Transmitted Infections (STIs) Bio-Behavioural Survey (IBBS) Amongst Key Populations in Somalia (2017).

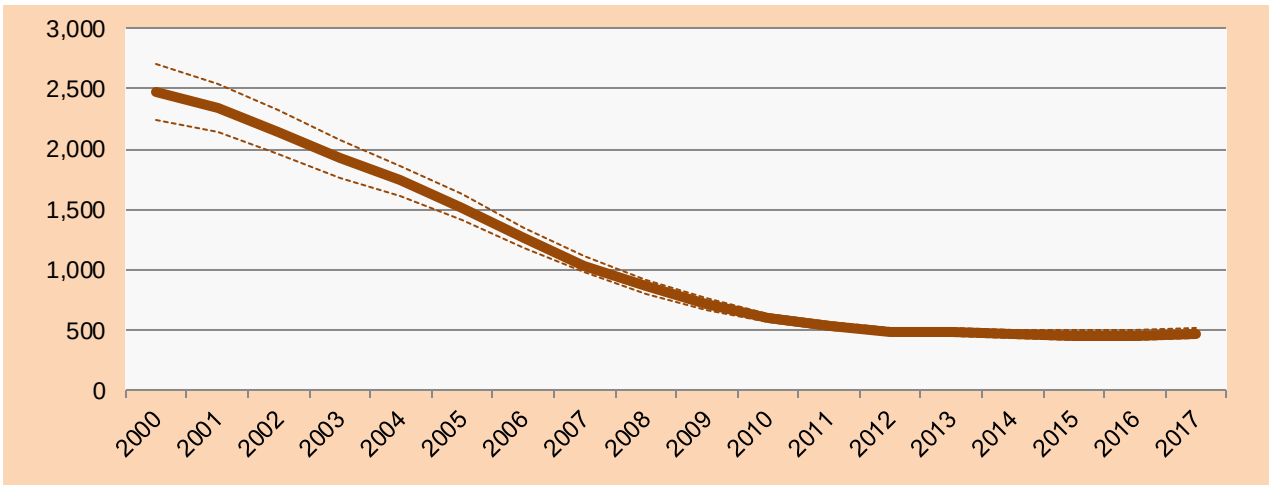


Figure 7: Trends of new HIV infections 2000 to 2017 (Spectrum modelling)[43]

The projected number of people living with HIV went up from 2002 and peaked in 2005 and has steadily been on a slow decline (figure 8). This trend aligns with the trend of HIV prevalence indicated in figure 5. On the other hand, a greater number of PLHIV are now living longer due to increased coverage of ART compared to early years. The biggest gap remains to identify missing HIV cases in the population as characterised by the significantly high gap in the proportion of people who know their HIV status.

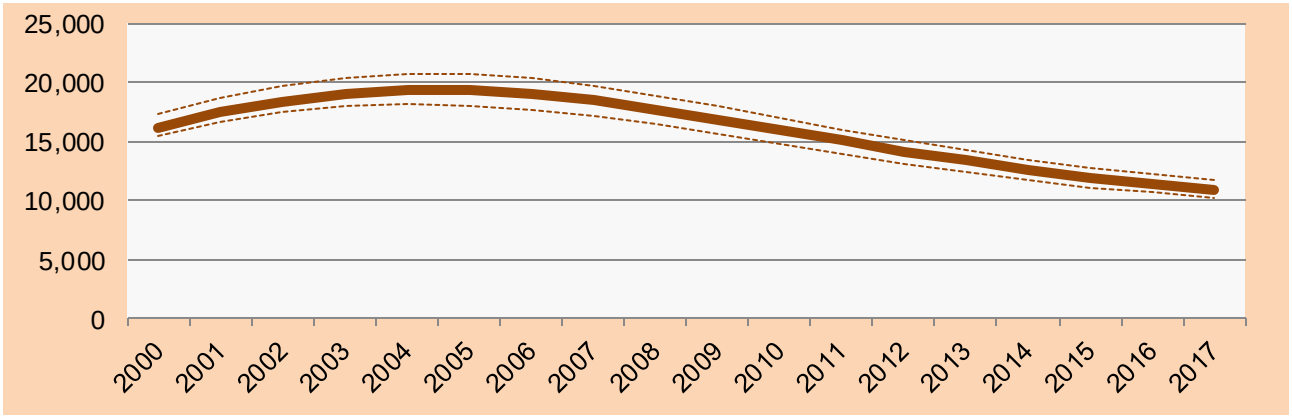


Figure 8: Number of People Living with HIV[44]

The number of AIDS related deaths has shown a constant decline since 2010 (figure 9), attributed to the improvement in HIV services, introduction of ART and strengthened HIV response. There remains a lot to be done in addressing the gap in unmet ART needs as less than half all estimated HIV cases are on ART, far from the global target of 90 per cent.

[43] Based on 2018 spectrum modelling for South central, Puntland and Somaliland. The data could not be disaggregated
[44] Ibid.

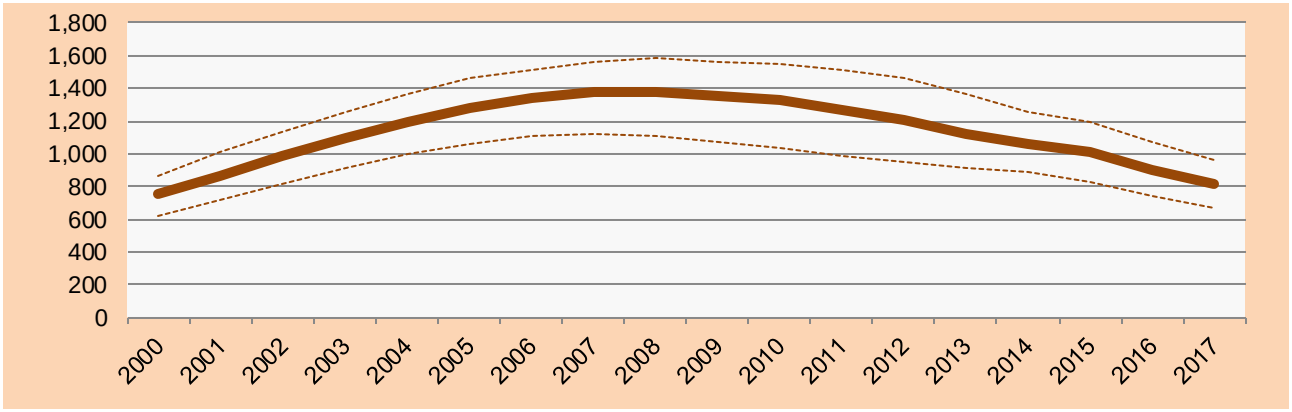


Figure 9: Number of AIDS-related Deaths[45]

iv. Coverage of HIV Prevention

Across the country, the HIV prevention program has continued to operate with different level of coverage. The HIV burden in the country is generally linked to key populations who face challenges with existing legal and cultural frameworks that make them keep away from seeking services.[46,47] The key HIV prevention measures among the major KVP are shown in table 4 below.

Table 4: Summary of HIV prevention situation among KVP (2017 IBBS)[48]

KVP group	Mean age (years)	HIV Prevalence	Syphilis Prevalence (Non-active)	Syphilis Prevalence (Active)	HIV composite knowledge	condom use during last transactional sex	Know their HIV status	HIV prevention programmes coverage
Vulnerable women	29.1	3.70 per cent	3.70 per cent	1.45 per cent	15.34 per cent	43.61 per cent	14.00 per cent	3.46 per cent
Uniformed personnel	32.6	0.65 per cent	18.25 per cent	1.15 per cent	12.20 per cent	51.35 per cent	6.20 per cent	3.15 per cent
Port workers	32.3	0.70 per cent	1.65 per cent	1.35 per cent	4.96 per cent	22.59 per cent	6.21 per cent	14.42 per cent
Truckers	31.8	0.45 per cent	0.70 per cent	0.10 per cent	14.94 per cent	31.61 per cent	12.55 per cent	8.51 per cent

[45] Based on current Somali Spectrum Modelling (2018 data).
[46] 2019 Somali HIV Legal Environmental Assessment (LEA); Draft version 29th November 2019.
[47] 2017 Risk Assessment of Key Populations Accessing HIV Services in Somalia.
[48] Population based estimate, IBBS Amongst Key Populations in Somalia (2017).

It is evident that HIV prevention coverage remains below 15 per cent across all groups with a significantly larger gap among vulnerable women who have the highest HIV prevalence in the population. Condom use is highest among the uniformed personnel who also have the lowest coverage of prevention. There is greater need to address the HIV prevention services in integration to the other sexually transmitted infections if high impact is to be attained.

v. Behavioural, Social and Religious Factors associated with HIV Transmission Risks in Somalia

The heterogeneous cultural situation in Somalia coupled with strong Muslim religious set up provides a unique blend of risk and preventive factors for HIV transmission. According to the Federal Ministry of Religious Affairs, more than 99 per cent of the population is Sunni Muslim. As such, there is a strict connection towards adoption and application of religious values across the population. About 93 per cent of Somalia's male population is also reportedly circumcised owing to requirements enshrined in religion[49], something considered protective in other population.[50] While this is protective from a cultural perspective, it also provides a barrier to access to HIV combination prevention services especially by KVP generally considered to be operating totally outside the law.[51] Many KVP consider it highly risky to openly seek HIV prevention services, including male and female condoms for fear of stigma, victimisation and social discrimination.[52]

Approximately 99% of Somalia's women and girls have undergone female circumcision/female genital mutilation[53], a pre-marital custom mainly endemic to Northeast Africa, and parts of the Near East.[54] Concerted efforts to combat this within society have been able to lead to a slow decline over the years. Generally, the practice potentially provides a high risk of HIV transmission during surgical procedures especially if carried out by unqualified personnel. It is however still practiced across the country and to some extent is driven by a deeply rooted cultural systems that doesn't promote open reporting by women.

Perceived as an "immoral disease," HIV-related stigma remains a major challenge. The 2017 HIV stigma study in Somalia[55] found the main common forms of stigma and discrimination against PLHIV to be: Non-invasive contact (56 per cent), Shame, Blame and Judgement (77.9 per cent), enacted stigma (42.5 per cent). Some 47.3 per cent of the had either lost customers to buy produce/goods or lost a job, and 34.8 per cent had been denied promotion or further training owing to their HIV status. These together with other factors lead to non-disclosure, loss to follow-up and unwillingness to go for appropriate services. Factors that perpetuate or mitigate stigma associated with HIV and AIDS include:[56] myths and misconceptions about HIV; inappropriate HIV prevention messages;

[49] "Male Circumcision and AIDS: The Macroeconomic Impact of a Health Crisis by Eric Werker, Amrita Ahuja, and Brian Wendell: NEUDC 2007 Papers: Northeast Universities Development Consortium Conference" (PDF). *Center for International Development at Harvard eUniversity.*
[50] The WHO, 2017. Models to inform fast tracking voluntary medical male circumcision in HIV combination prevention. Meeting report. Geneva, Switzerland.
[51] 2019 Somali HIV Legal Environmental Assessment (LEA); Draft version 29th November 2019.
[52] 2017 Risk Assessment of Key Populations Accessing HIV Services in Somalia.
[53] Somalia Health and Demographic Survey 2020, p213.
[54] Rose Oldfield Hayes (1975). "Female genital mutilation, fertility control, women's roles, and the patri-lineage in modern Sudan: a functional analysis". American Ethnologist. 2 (4): 617–633. doi:10.1525/ae.1975.2.4.02a00030.
[55] 2017 National Somali Survey HIV and AIDS Related Stigma and Discrimination Index.
[56] Ibid.

unpreparedness of the health human resource work force; inadequate distribution of care and support services provided through the HIV Treatment and Care Centre's; inadequate involvement of PLHIV in planning and decision making; and low PLHIV Network activities.

Stigma and discrimination against PLHIV are very high in Somalia, both in terms of self-stigma among PLHIV and in terms of stigma manifested by the general community against PLHIV. The main factors behind high levels of stigma include low levels of HIV knowledge and awareness in the community, leaving room for myths and misconceptions to thrive in the community. Knowledge and awareness gaps are further confounded by religious perspectives regarding HIV transmission and treatment. While efforts have been made at various levels, to address HIV knowledge gaps, results are yet to be realized.

2.6 Structural Barriers that impede Access to HIV Prevention, Treatment and Care Services

As the epidemiological analysis of the HIV epidemic in Somalia has shown that KVP, especially women most vulnerable to HIV infection, appear to be disproportionately affected by HIV and are susceptible to adverse impacts of human rights barriers. As is the case elsewhere in many parts of Africa and the Middle East, sex work is criminalized. Women engaging in transactional sex have been driven underground and avoid utilizing HIV prevention, treatment and care services for fear of losing their livelihood and being imprisoned. The criminalisation of sex work constitutes a serious constraint to an effective HIV response among this population.

The delivery system for health care services is highly fragmented with public health service provision primarily concentrated in urban and insecure areas, with an estimated 80 per cent of Somalis not having access to basic health care. It is also suggested that women would prefer female doctors of which there are few.[57] Indeed, the rate of access to health services by the urban population is 50 per cent versus 15 per cent for the rural population. Lack of accessibility to health services and infrastructure is therefore a significant impediment to an effective response to HIV prevention, treatment and care services in Somalia. Insecurity and instability as well as the high cost of program implementation in Somalia are other important barriers to access.

2.7 Legal Environment and HIV and AIDS in Somalia

In 2019, an HIV Legal Environmental Assessment (LEA) identified numerous on-going challenges relating to HIV, the law and human rights in Somalia. Firstly, vulnerable and key populations in Somalia, including PLHIV and Key Vulnerable Populations (that include women engaged in transactional sex and their clients), are at higher risk of HIV exposure and /or of vulnerability owing to high levels of stigma and discrimination that continue to prevent these groups from accessing health services.

[57] Padela AI, Rodriguez del Pozo P. Muslim patients and cross-gender interactions in medicine: An Islamic bioethical perspective. *J Med Ethics*. 2011;37(1):40-44.

Secondly, although protective provisions exist in Somali law and policy, HIV-related stigma continues to fuel the spread of HIV in Somalia and exacerbate the negative impact of HIV. In addition, access to justice and law enforcement for human rights violations remains seriously limited. Key Populations are neither fully aware of their rights, nor of how to enforce these rights, with enforcement mechanisms and essential support generally unavailable.

Thirdly, several punitive or coercive provisions in law are widely recognized as creating barriers to an effective HIV and AIDS response, e.g., the criminalization of sex work and homosexuality outlined in articles of Somalia's Penal Code (1962) (which applies to Puntland and Somaliland), as well as the intentional transmission of HIV included in the Puntland Rape Act (2015). Punitive laws and criminalization of these behaviours are seen globally to be counter-productive, as they deter those most vulnerable and at risk of HIV from seeking essential services. As a result, such laws effectively fuel stigma, discrimination and the spread of HIV, rather than prevent them.

Fourthly, the LEA found that while various laws and policies promote the health rights of all people, including the National HIV Policies, limited resources, low levels of knowledge and other constraints mean that principles included in these policies are often neither implemented nor supported.

Section 3: Achievements and Challenges in Somalia's HIV Response

Spectrum modelling in 2019 estimated the number of people living with HIV at 10,874 with an incidence of 0.03 per cent, and prevalence at 0.1 per cent.[58] Given challenges of modelling in low prevalence countries with limited strategic information, coupled with evidence generated in 2017 on key populations, the Spectrum modelling frame was shifted in 2018 from general population to concentrated epidemic, leading to decreased incidence and prevalence estimates from 2017 to 2018 modelling.

While the adult HIV prevalence rate in 2018 was 0.1 per cent, integrated bio-behavioural surveys conducted in 2016 found HIV prevalence of 2.9 per cent and 4.5 per cent among women engaged in transactional sex in Mogadishu and Bossaso respectively. The 2020 IBBS will expand to additional sites. These additional sites will provide a more accurate picture of the prevalence among most at risk populations, particularly vulnerable women.

3.1 Key Achievements

Across the key priority areas progress has been made towards the 2019 targets outlined in the 2018 – 2020 NSP.[59]

i. Prevention

Key prevention achievements include:

- The number of people who obtained an HIV test increased from a total of 149,315 in 2016 to 249,709 Year 2019. This increase was achieved due to sustained availability of test kits, improved linkages between peer education outreach and facilities, health worker capacity building, sustained PMTCT uptake, and referral efforts.
- HIV testing rates amongst TB patients in Somalia have increased from 80.7 per cent at the end of 2016, to 92 per cent at the end of 2019. As of June 2019, all 71 TB treatment sites (37 in Puntland) were undertaking HTC and by end September, testing rates among TB patients in the Federal States of Somalia increased to 92 per cent.
- Of the TB patients tested for HIV in 2019 in Somalia, 0.73 per cent were HIV positive. Of all HIV positive cases identified through HTC at TB sites, 65.63 per cent were placed on ART and 62.5 per cent received cotrimoxazole preventive therapy (CPT)[60].
- The number of pregnant women who know their HIV status has continued to increase through enhanced PMTCT coverage.
- From March 2018 through June 2019, the Peer Education Programme reached 2,538 new persons in the Federal States of Somalia considered to be key populations (including PLHIV) who received information and referral support.

ii. Treatment and Care

Key treatment and care achievements include:

[58] Based on current Somali Spectrum Modelling (2018 data).
[59] Unless otherwise stated, data sources are the United Nations Children's Fund (UNICEF) Global Fund progress reports.
[60] TB Program reporting, WVI, 2019.

- The number of PLHIV who are on ART increased from 2,671 in 2016 to 3,192 in June 2019 at the Federal Level, in Puntland and Somaliland combined.
- Option B+ for PMTCT was successfully rolled out in the country with every HIV positive pregnant woman being placed on to ART.
- Introduction of the 'Test and Treat' protocols to improve treatment commencement and adherence rates.
- Improved linkages and referral systems between health facilities and community outreach and PLHIV networks.
- Peer Educators and all other referring hospitals will now have confidence that they are referring clients to a known health facility including the confidence it will give clients themselves.
- Retention on ART after 12 months on initiation is at 75.5 per cent.[61]
- The number of viral load machines installed and in use increased from none in 2016 to 9 by June 2019. This has led to at least 1,291 out of 1,752 eligible clients on ART receiving at least one viral load test in Year 2019.
- The number of facilities providing ART in all Federal States of Somalia and Somaliland grew from 15 in 2016 to 16 in 2019 with seven of those at the Federal Level.
- The number of patients on ART has tripled since 2013 with a four-fold rise in number of children being put on ART across the same period (table 5). The increase is similar for both Puntland and South Central.

Table 5: Number of Females, Males and Children on treatment, 2013 & 2016[62]

Location	Total Number on ART 2013				Total Number on ART 2019			
	Female	Male	Total Adults	Children	Female	Male	Total Adults	Children
Puntland	120	80	200	5	195	275	470	26
Federal: South and Central States & Banadir Region	200	152	352	14	674	467	1,141	60
Total	**220**	**232**	**552**	**19**	**869**	**742**	**1,631**	**86**

iii. HIV and TB co-infection

Key HIV and TB co-infection include:

- HTC is now available in all TB centres and is routinely offered to the TB patients. By June 2019, there were 71 TB/HIV testing sites with 37 of those being in Puntland.
- Over 90 per cent of TB patients are routinely screened for HIV with 65.6 per cent of those found positive started on to ART.
- By June 2019, 78.9 per cent of all PLHIV are routinely screened for TB and 100 per cent of those found with TB linked for TB care and treatment.

[61] WHO 2018 Cohort Analysis.
[62] Ibid.

iv. Enabling Environment

Since 2016, a concerted effort has been made to invest in building improved **strategic information** to guide and monitor the response:

- 2016 Key Population Mapping;
- 2016/17 IBBS in Hargeisa, Bossaso and Mogadishu where previous IBBS in 2008 and 2014 were only conducted in Hargeisa;
- 2018 ANC Sentinel Surveillance Report;
- 2018 Annual Spectrum Analysis with 2017 results;
- 2017 Stigma Survey;
- 2016/7 Risk Assessment of Key Populations;
- 2017 PLHIV Strategy;
- 2017 Key Populations Strategy rolled out;
- HIV Policies and Guidelines updated (Draft);
- 2019 Somalia HIV/AIDS Legal Environment Assessment completed.

Stigma and discrimination are prevalent and impede access to and utilisation of prevention, treatment and care and support services for all Somalis, particularly those residing in rural areas and KVP. Efforts will be expanded under this new NSP to address stigma and discrimination for PLHIV and key populations in the community and at health facilities. Sexual and gender-based violence is also reported to be high and interventions linked to HIV vulnerability have been included in this updated NSP.

Monitoring and Evaluation: Key HIV indicators have been incorporated into Somalia's HMIS. Annual program review meetings have been held to review the response.

Program management and coordination continues through the National AIDS Commissions and Ministries of Health. The National AIDS Commissions ensure representation from different ministries on the AIDS Coordination Committees.

Civil Society continues to play an important role in the response including stigma reduction, PLHIV support, education and awareness-raising. **PLHIV Networks are operational in** Mogadishu and Garowe and provide a range of services from psych-social support, nutrition support, referral, information and counselling. Telephone hotlines provide free anonymous advice, information and support.

Resource Mobilisation: To support implementation of the NSP, funding from the Global Fund support remains secure through 2023. National funding has also been allocated, mainly supporting health facilities and personnel. HIV vulnerability is also being addressed through broader development initiatives including gender-based violence and female genital mutilation prevention.

3.2 Key Challenges

Ongoing challenges continue to hinder the achievement of Somalia's HIV goals and objectives and in general challenges resemble those faced by the broader health sector with the addition of specific issues faced in the HIV response.

i. Integrated Prevention, Treatment and Care Services

- Stigma, including self-stigma, facility-based stigma and community-based stigma, limits access to HIV-related services.
- Health service demand is very low in general and is further exacerbated in HIV program delivery by significant rates of stigma and discrimination.
- Poor service linkages and referral mechanisms limit the capacity for diagnosis and treatment.
- Even where services exist overall readiness and capacity to deliver services needs strengthening and monitoring, including improvements in forecasting commodities and reporting capacity.
- There has been a shift to 'Test and Treat' protocols but not all facilities have adopted this methodology and people are being lost following diagnosis.
- Syphilis testing using rapid diagnostic testing has decreased significantly from 2018 when the Global Fund stopped funding syphilis testing.
- HIV testing services have been established in private health facilities and pharmacies in parallel and outside the existing public health services without regulation or regular referral to ART services.
- Many health services are operational solely due to the support of international or national NGOs.
- Retention on ART remains a key challenge decreasing from 81.9 per cent in 2015 to 74.8 per cent in 2017 primarily due to lack of social support (food, transport) and stigma.

ii. Human Resources

- Trained personnel limitations further exacerbated by poor retention of staff.
- Even where staff are trained there has been little follow-up and supervision is limited.
- Training has been heavily dependent on external 'experts' and on short term face to face training rather than building national capacities to develop sustainable capacity building models.
- Qualitative measurement of capacity building outcomes is weak, including limited measurement of pre and post training knowledge and retention/implementation six and twelve months after training.
- High rates of trained health professionals are lost to the private sector or donor/multilateral/NGOs.

iii. Program Coordination and Management

- Although increasing, there is still limited capacity for coordination within HIV services and programs as well as with other health and broader development programs.
- Quality of reporting by implementers is inconsistent with limited data analysis for programme improvement at implementation level.

- Limited strategic information analysis and feedback to partners necessitates an evidence-based approach in planning and programme improvement.
- Limited institutional capacity at national, sub-national and regional levels for overall governance and coordination.
- Little effort has been made to integrate HIV programming with other health programmes (e.g. EPHS) and other sectors. A strategy to integrate HIV, TB and malaria into primary healthcare will be available beginning 2020.
- Historically, limited funding has been available to support the implementation of NSPs and levels of funding from the primary source of funding[63] have been significantly reducing over time.

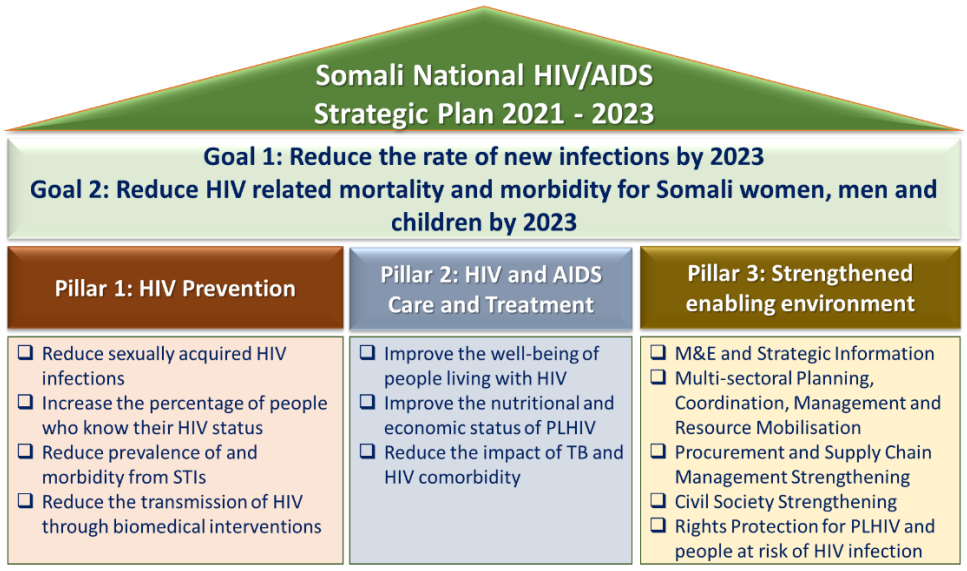
iv. Monitoring and Evaluation

- Few indicators are actively monitored outside those required for the Global Fund Reporting.
- No qualitative review and evaluation of interventions is undertaken on a routine basis.
- There is no systematic analysis and feedback of data to reporting partners.
- There is limited capacity outside the national levels for comprehensive M&E support and reporting.
- Limited strategic information has resulted in the development of insecure estimates.

[63] Global Fund.

Part 2: Somalia HIV and AIDS Strategic Framework, Prioritisation and Risk Analysis for 2021 - 2023

- Section 4. Somalia NSP for the Response to HIV and AIDS 2021 to 2023
- Section 5: Prioritisation
- Section 6: Risk and Mitigation Strategies



Section 4. Somalia HIV National Strategic Plan 2021 to 2023

NSP 2021 - 2023 Goals and Objectives

The goal of the NSP is to reduce HIV infections and HIV-related mortality and morbidity among Somalis. Reflecting a commitment to achieving an impact within the population, the NSP 2021 to 2023 is focused on achieving two primary impact goals:

1. Goals of the NSP

Goal 1: Reduce the rate of new infections by 2023;

Goal 2: Reduce HIV related mortality and morbidity for Somali women, men and children by 2023.

2. Interventions

The 2021 – 2023 NSP is framed around three objectives, considering the important inter-relationship and cross cutting nature of coordination, management, M&E, strategic information and rights protections:

1. **Prevention of new HIV infections** especially among key populations such as women most vulnerable to HIV and their partners through a combination of HIV prevention interventions[64];
2. Increased access **to and utilisation of quality integrated prevention, treatment, care and support;** and
3. A strengthened **enabling environment** focused on coordinated leadership and management, rights protections for people living with and at risk of HIV, improved strategic information and response monitoring.

1. Objective One – Prevention of New HIV Infections

This objective focusses on application of the principles of combination prevention[65] as the backbone to HIV prevention solutions at scale across the country. The combination prevention entails application of a combination of behavioural, biomedical and structural interventions (Figure 11). Objective 1 covers four intervention areas: reducing sexually acquired HIV infections; increasing the per centage of people who know their HIV status; reducing the prevalence of and morbidity from STIs; and reducing the transmission of HIV through blood, occupational and non-occupational exposure. Behavioural interventions will include a wide range that focus on improving knowledge, practices and attitudes for enhanced prevention. The biomedical prevention covered under this NSP is divided between this objective and the second objective (care and treatment) and includes condom programming, HTC, and antiretroviral-based preventions.

[64] Combination prevention interventions are a set of strategically selected interventions which include behavioural, biomedical and structural interventions. In this update NSP, structural interventions can primarily be found under objective 3 "strengthened enabled environment."

[65] UNAIDS, 2010. Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections A UNAIDS Discussion Paper.

Structural interventions refer to strategies meant to change social, political and economic factors that increase an individual's vulnerability to HIV. Structural interventions under this NSP are divided between this objective and objective 3 on improving the enabling environment.

Figure 10: Framework for Combination Prevention[66]

1.1 Reduce Sexually Acquired HIV Infections

To achieve this aim, the NSP articulates strategies of combination prevention focusing on evidence-based biomedical and social behavioural interventions, with a focus on targeting the most vulnerable to HIV transmission. Interventions will include strategies to reduce sexually acquired HIV infection; increase the proportion of people who know their status; STI prevention, diagnosis and treatment; reduced transmission through blood transfusions and occupation/non-occupational exposure; and the prevention of mother to child transmission.

1.1.1 Prevention with People Living with HIV (PLHIV)

i. **Behaviour change communication and psycho-social support for PLHIV** and their families to reduce the risk of further transmission. Education and support programs are provided through PLHIV networks and are available through telephone hotlines. Direct referral to existing support groups will be included as part of HTC services. The use of contraceptives among PLHIV to prevent unintended pregnancies will be promoted.

1.1.2 Integrated Social and Behaviour Change Communication (ISBCC) for Key Populations

i. **Behaviour Change Programs for Key Populations:** Key populations most at risk of HIV in the Somali context include vulnerable women engaging in risk behaviours[67] (*khat* and tea sellers, single headed households and internally displaced women), and their clients (uniformed personnel, truck drivers and their assistants, and port workers).

ii. **Peer Education Programme:** Building on results of key population mapping and key population risk assessments (2017), a peer education programme was implemented in the highest prevalence areas, including trade routes, border crossing points and ports and major urban centres – as well as in areas with HIV Treatment and Care Centres. Peer educators are linked with existing community and health services as a means of support and touch point for referrals and linkages for ongoing HIV, STI, GBV and other related services. Peer educators assist in providing information and resources to prevent HIV transmission. Interventions will be strengthened based on outcomes of the 2020 Peer Education Programme evaluation. Peer

[66] Illustration credit to Populations Services International.
[67] Engaged in transactional sex.

counselling will be expanded through additional training and support and provision of HIV self-tests.

iii. **HIV and STI Community Hotlines:** Existing hotlines will be reviewed and strengthened. Strategies to incorporate PLHIV leaders and key populations as hotline staff will be explored. New and refresher telephone information and counselling training and capacity-building will be implemented. Promotion of the hotlines will be expanded and increased in number through peer education, health services community conversations, and youth programs. A community directory of services will be developed to support improved referral and access to prevention strategies and support services.

iv. **Targeted Media Campaigns:** Through use of radio and other media, key population groups will be targeted with identified prevention messaging at border crossing points, ports and identified 'hot spot' locations. General media campaigns will also be held, including key events such as World AIDS Day, International Women's Day, Children's Day, and 16 Days of Activism against GBV. Civil society organisations will be encouraged to lead local media and community campaigns to support prevention education and stigma reduction.

1.1.3 Condom Distribution and Utilisation

i. **Condom Promotion and Distribution:** Through existing health facilities, PLHIV networks, and peer education programs with key populations, condoms will be made available for HIV and STI prevention. Distribution remains a significant challenge and will be supported through advocacy and awareness raising. Work will also be undertaken with the private sector to map condom availability. Strengthening of the United Nations Population Fund (UNFPA) 10 step approach to comprehensive programming and support to private sector condom promotion will be strengthened.

1.1.4 ISBCC for General Public, including Youth

i. **School Based Reproductive Health Programs**: In collaboration with the Ministries of Education and Health, existing curriculum will be reviewed and updated to include age-appropriate and relevant RH information. Schools will be supported to implement education and awareness raising activities, including with previously trained religious leaders, PLHIV leaders and existing National AIDS Commission (NAC) and medical personnel.

ii. **Youth Peer Education Program:** Utilising existing youth peer education programs including YPEER, and existing HIV prevention education materials, youth peer educators will work to reach young people particularly those not involved in formal education. Peer education strategies will include information, awareness-raising, stigma reduction and referral services including to HTC and gender-based violence GBV services where appropriate.

iii. **Community based HIV/STI education and Awareness Raising**: continuation of community conversations particularly in high risk areas such as border crossing points, ports, trade routes, IDP camps and existing higher prevalence areas.

iv. **Media Programs:** Utilizing existing radio programs and the Africa Voices initiatives, and other media including social media, to improve understanding and knowledge about HIV prevention, reducing stigma and discrimination, generating service demand and knowledge about available services.

1.2 Increase the per centage of people who know their HIV status

To achieve this aim, NSP articulates strategies of combination prevention to focus on the evidence based biomedical and social behavioural interventions, with a focus on targeting the most vulnerable to HIV transmission. Interventions will include strategies to reduce sexually acquired HIV infection; increase the number of people who know their status; STI prevention, diagnosis and treatment; reduced transmission through blood transfusions and occupation/non-occupational exposure; and the prevention of mother to child transmission.

1.2.1 HIV Counselling and Testing

i. **HTC Expansion:** Expand the number of facilities that provide HTC, integrate HTC into existing facilities at community levels, strengthen index case tracing and referral mechanisms between lower level health facilities and existing ART services. Community based health workers and health facilities (including TB centres) will be key to increasing knowledge and demand for HTC services.

ii. **Integrate HTC training in medical and health schools**: The Ministry of Education will be engaged through the multi-sectoral framework of the NACs to gradually introduce and enhance contents related to HIV and AIDS into the curricula of all medical and health institutions. existing materials will be updated and aligned to known standards. Key persons from each training institution will be trained to support others.

iii. **HTC Capacity Building:** Strengthen HTC capacity and refresher training for all facilities offering HTC. This will involve having at least two persons from each facility trained; and all facilities conducting at least two major HIV and AIDS-related internal sensitisation of health workers.

iv. **Stabilise Mobile HTC for key population:** The Mobile HTC services were established during the last strategic plan and incorporated under broader women's and men's health initiatives to reach key populations and reduce stigma and discrimination. Mobile and outreach HTC will continue to be focused in areas with the highest numbers of key populations. In this NSP, the mobile HTC will be stabilised, and supervision strengthened to enhance quality and effective referrals.

v. **Expand the availability of provider-initiated testing and counselling (PITC) in STI, MCH**[68] **and TB Services:** Work with existing STI, MCH and TB services to integrate HTC using PITC

[68] Including as part of Somalia's Essential Package of Health Services (EPHS).

guidelines and where HTC does not exist strengthen referral linkages with external HTC services.

vi. **HTC Quality Assurance Measures:** Conduct quarterly supportive supervision for facilities providing HTC services & perform annual proficiency test for health care providers offering HTC.

vii. **HTC Supplies Procurement and Distribution:** Linking in with broader health sector quantification and forecasting, strengthen the capacity for HIV test kit forecasting to mitigate stock out.

1.3 Reduce the Prevalence of and Morbidity from STIs

To achieve this aim, the NSP articulates strategies of combination prevention that will focus on evidence based biomedical and social behavioural interventions, and on targeting the most vulnerable to HIV transmission. Interventions will include strategies to reduce sexually acquired HIV infection; increase the number of people who know their status, STI prevention, diagnosis and treatment; reduced transmission through blood transfusions and occupation/non-occupational exposure; and the prevention of mother to child transmission.

i. **Capacity building of laboratory staff and other relevant health and community workers on syphilis diagnosis:** Provide new and refresher training, particularly to lab, health and community workers to support improved syphilis diagnosis through rapid testing and dual syphilis/HIV rapid testing and linkages to HTC and care.

ii. **Syndromic STI Case Management:** Provide new and refresher training, particularly to community health workers to support improved syndromic case management and referral. Develop updated tools and resources for STI diagnosis and case management.

iii. **Promote HTC Services for positive STI cases:** Through integration of HTC including PITC into the health services providing STI diagnosis and management and strengthening referral mechanisms to HTC services where integration is not feasible.

iv. **Quality Assurance for STI Diagnosis and Management:** MOH & WHO will perform re-testing and confirmation for 20 per cent of Syphilis Positive cases annually

v. **STI diagnosis and treatment commodities:** Provide Syphilis rapid test kits, STI laboratory commodities and STI drugs. Work with facilities and the broader Procurement and Supply Chain Management (PSCM) strengthening initiatives to improve stock management, forecasting and quantification to reduce stock-outs.

1.4 Reduce the Transmission of HIV through Biomedical Interventions

Continued HIV testing and treatment scale-up must be accompanied by a much stronger primary prevention response comprising biomedical, behavioural and structural dimensions, closely

integrated with treatment. This NSP recognises the role of biomedical interventions for prevention and pays close attention to 2, 3 and 5 described in the UNAIDS HIV Prevention 2020 Road Map[69] that will remain valid for the case of Somalia. These pillars are: Combination prevention programmes for all key populations; Strengthened national condom and related behavioural change programmes; and Offering pre-exposure prophylaxis (PrEP). The NSP considers other components of combination prevention in different places but key biomedical interventions prioritised are blood safety and pre- and post-exposure prophylaxis.

i. **Blood Safety:** Implement the Somalia blood transfusion guideline. Provide training and capacity building for facilities using transfused blood products. Procure and supply required reagents to support screening. Provide quality assurance and supportive supervision.

ii. **Occupational and Non-Occupational Exposure:** Train health workers in universal precautions and ensure all health schools incorporate universal precautions awareness in their curriculum. Procure and provide post-exposure prophylaxis (PEP) for those exposed occupationally and non-occupationally. Ensure the integration of HIV prevention information into female genital mutilation and other traditional practices prevention programs.

iii. **Pre-Exposure Prophylaxis (PrEP):** Pilot and scale up PrEP interventions with relevant populations including sero-discordant couples and women most vulnerable to HIV infection. Implement readiness assessment for PrEP through HIV Treatment and Care Centrs; development of implementation framework to pilot; adapt PrEP guidelines.

2. Objective Two: Reduce HIV related Mortality and Morbidity

This objective focuses on the increasing access to HIV care and treatment services under two major intervention areas of (i) Improve the well-being of people living with HIV, and (ii) Reduce the impact of TB and HIV comorbidity. These are described below into detail.

2.1 Improve the Well-Being of People Living with HIV

Universal access to and utilisation of optimally efficient, effective and integrated treatment care and support services for PLHIV remains a major component of Somalia's response to HIV and AIDS. This is expected to contribute to the reduction of HIV-associated mortality and morbidity. By June 2019, less than one third of the PLHIV knew their status[70], making identification and linkage of the missing persons once diagnosed to immediate enrolment on to ART a high priority. The country has now adopted the HIV Test and Treat Policy as a central pillar of the care and treatment and has continuously expanded coverage of PMTCT services, of which Early Infant Diagnosis (EID) is a key linked component. There is increased linkage and integration of HTC, PMTCT, ART and the TB/HIV collaborative services. The NSP also seeks to significantly expand the coverage of paediatric and

[69] UNAIDS, 2016. HIV Prevention 2020Road Map: Accelerating HIV prevention to reduce new infections by 75%. Accessed on November 30, 2019 from https://www.unaids.org/sites/default/files/media_asset/hiv-prevention-2020-road-map_en.pdf.
[70] Data from Global Fund Progress Update reports and Spectrum 2018.

adult ART services, reduce the burden of TB-associated HIV and reduce severe malnutrition among PLHIV in order to improve case fatality.

The implementation of this updated NSP will build on efforts to target KVP, TB patients and other vulnerable groups for early diagnosis and linkage to life-long ART. These activities will need to be supported by strengthened laboratory and diagnostics services for ART, TB, and PMTCT as well as pharmaceutical and health product management in order to achieve the outcomes proposed. The strategy to improve well-being of PLHIV will consist of Integrated ART and PMTCT service delivery, improving nutritional and economic status, and better services integration.

2.1.1 Integrated ART and PMTCT service delivery, including laboratory and diagnostic services

i. **Scaling up the availability of high quality paediatric and adult ART and PMTCT services:** Rollout and implementation of the 'Test and Treat' with increased integration of PMTCT protocols, including EID, supporting further training and capacity building. There will be a focus on integration capacity building for ART and PMTCT into existing health schools and associations. Strengthen HTC linkages to ART and PMTCT. The provision of ART and PMTCT will cover all regions, including outreach and mobile service delivery models where appropriate. Regular supportive supervision of ART and PMTCT services will be enhanced throughout the federal states.

ii. **Strengthening ART services and linkage with HTC:** The NSP will focus on increasing uptake of preventive services for newly diagnosed HIV patients, linkage to ART, and uptake of CPT for HIV – TB co-infected patients and IPT for PLHIV who do not have active TB. There will be a focus on stepping up retention on ART through improved quality of patient follow-up, community linkages and social support systems including nutrition. Partnerships and referral between PLHIV networks and support groups will be strengthened through the involvement of the networks; this is expected to improve treatment adherence and increase the use of 'Test and Treat' protocols wherever possible.

iii. **Strengthening laboratory and diagnostic services for ART and PMTCT delivery:** Establish and scale up availability of EID. Strengthen the capacity for CD4 and viral load testing to improve patient monitoring. The existing viral load testing capacity in the country will be optimised with focus on effective samples referral and results notification and will be available in every HIV Treatment and Care Centre. This in turn will strengthen the availability of data on viral suppression in line with global recommendations. Required laboratory supplies, equipment and diagnostic reagents for ART treatment monitoring and PMTCT services will l be procured and equitably located and distributed. The existing HIV laboratory system quality assurance for equipment, diagnostics and human resources will be enhanced and made regular.

iv. **Procure and distribute HIV and PMTCT related pharmaceuticals and health products:** Procurement and supply of ART and PMTCT pharmaceuticals and health products will be undertaken to meet targets and capacity described within this NSP. There will be regular

quantifications and support for health facilities to maintain the desired stock levels and prevent both stock out and expiries. The NSP describes further systems strengthening efforts for delivery of these products under 3.3 (Procurement and Supply Chain Management Strengthening).

v. **Expand Community Mobilisation for Service Demand:** Work with community health workers, peer educators, and communities to improve service utilisation and demand. Strengthen referrals networks and service linkages.

vi. **Psychosocial support for PLHIV and their families**: Through strengthened PLHIV networks, Civil Society Organisations and supported health facilities delivering HIV services, PLHIV will have access to a range of psycho-social support including treatment adherence, counselling, support groups, with linkages to referral for TB services, livelihoods, and food and nutrition programs.

2.1.2 Improve the Nutritional and Economic Status of PLHIV

i. **Nutritional care for PLHIV:** Strengthen nutritional support to PLHIV following the Food Security and Nutrition Vulnerability Assessment for HIV and TB programmes in Somalia (2020). Continue therapeutic nutritional support to malnourished PLHIV, including paediatric, in accordance with WFP protocols. Improve food security for vulnerable PLHIV. There will be increased linkage with other service providers for nutrition in the country including, but not limited to, World Food Program (WFP), UNICEF and other existing in-country partners.

ii. **Socio-Economic Support and strengthening and Social Protection:** Scale up access to income generating activities and livelihood options for PLHIV and their families, and social protection programmes following outcomes of the social protection mapping and guidance for PLHIV (2020 – WFP and UNICEF). Income support will continue to be made available to PLHIV and their families via the SCOPE programme. Specific linkages to the national social protection cash transfer programme will be made. Partners will also be encouraged to identify broader development programs aimed at income generation and livelihoods to advocate the prioritisation of PLHIV as participants.

2.2 Reduce the Impact of TB and HIV Comorbidity

The goal of **collaborative TB/HIV activities** is to decrease the burden of **TB** and **HIV** in people at risk of or affected by both diseases. This is achieved through three broad approaches: (i) establishment and strengthening mechanisms of collaboration and joint management between HIV programs and TB-control programs for delivering integrated TB and HIV services; (ii) reducing the burden of TB in people living with HIV, their families and communities by ensuring the delivery of the *Three I's for HIV/TB* and the early initiation of ART; and (iii) reducing the burden of HIV in patients with presumptive and diagnosed TB, their families and communities by providing HIV prevention, diagnosis and treatment. This NSP will continue to strengthen the TB/HIV collaborative activities to reduce the impact of co-morbidity.

2.2.1 TB/HIV Collaborative Efforts

i. **Scale up HIV diagnostics and treatment for TB patients:** As TB centres expand, ensure HTC services are provided through PITC, and improve referral of patients to HTC services where HTC is unable to be integrated. Improve access to ART for HIV+ TB patients, including treatment adherence and monitoring. Increase the availability of co-trimoxazole for HIV+ TB patients.

ii. **Scale up access to TB screening and treatment for PLHIV:** Improve the rates of TB screening and treatment for PLHIV and access to IPT for PLHIV who do not have active TB.

iii. **Improved TB/HIV Coordination and Collaboration:** Maintain regular national and sub-national coordination meetings between TB and HIV implementing partners. Improve access to information regarding co-morbidity through PLHIV networks and support groups. Appoint TB focal points within PLHIV networks and MoH HIV units.

3. Objective Three. Strengthened Enabling Environment

The enabling environment consists of all the actions and support mechanisms beyond HTC and HIV care and treatment. These include the M&E systems and practices; management functions (coordination, planning, policy, etc), PSCM, legal barriers and civil society capacity strengthening.

3.1 Monitoring and Evaluation (M&E) and Strategic Information

The M&E system and framework for the HIV response will provide for the tracking of results, data use and strategic information to demonstrate performances against set results. Monitoring & Evaluation is essential to establish performance incentives for program implementers; detect and address problems so that programs can be re-designed and improvements become standard operating procedures; provide early evidence of program effectiveness. M&E will also support communicating to those infected and affected by HIV and AIDS in a transparent and objective way, ensuring that efforts are made to improve prevention, care, treatment and mitigation programs. It is essential that M&E must be relevant, objective, transparent, and most importantly deliver outputs as (i) a source of information on performance for the public and for donors and (ii) a management tool for implementation agencies. M&E interventions all aim to strengthen the country's capacity to deliver M&E functions as detailed in the M&E plan (Section 7 and Annex B).

3.1.1 National HIV and AIDS M&E Staffing, Capacity Building and Supervision

The country will enhance the number of M&E staff at the NAC and MOH, at national and regional levels, ensuring adequacy in terms of skills and numbers. Capacity building programmes will be supported to ensure these staff have the necessary skills to carry out their jobs.

Building the capacity of M&E Staff will be supported by the NAC and MOH establishing Joint Supervision Teams with ToR to support quarterly monitoring of all HIV related activities.

3.1.2 Annual and Quarterly M & E Reviews and Reporting

The NAC in collaboration with the MoH shall host quarterly M&E meetings for partners, where all stakeholders will be asked to present their quarterly achievements and challenges. HIV Stakeholders will discuss and address challenges, in order to improve on these issues in future. To support and strengthen HIV coordination efforts all partners will be asked to submit quarterly reports to the NACs, who will compile these into one report to keep all partners to monitor achievements towards the targets in the M&E plan.

The NACs and MOH will also support Annual Program Reviews to monitor annual progress against targets and indicators agreed. This will include conducting an Annual Review meeting to evaluate progress against the annual targets, in order to develop a comprehensive HIV Annual Report. Following each Annual Review, progress reports will be shared with stakeholders to support institutionalised data management, dissemination and use.

3.1.3 Strengthen and Integrate M&E Databases and Systems

The process of integrating the HIV data and indicators into the national aggregator (District Health Information System version two – DHIS2) shall be completed and the country reporting systematically migrated into a common platform. Similarly, all parallel data flow systems shall be integrated and harmonised for effective collection, storage and transmission of data for enhanced national response M&E. This will include reviewing HIV core indicators in the HMIS.

3.1.4 Enhance use of Strategic Information to Drive Impact

To support monitoring the HIV response and to assess progress against the NSP indicators and targets, the MOH and NAC will conduct different assessments and reviews to drive the impact. The MoH website will be updated with all new strategic documents and studies, as these are completed, and the NACs will regularly disseminate HIV information through Social Media and other community outreach activities.

Below is a list of priority studies to be completed during the course of this NSP:

i. Key Population IBBS;
ii. ANC Surveillance;
iii. Spectrum Analysis;
iv. HIV Stigma Survey;
v. National Composite Policy Index (NCPI);
vi. Key Population Mapping;
vii. Cohort analysis: To track and monitor PLHIV and well-being 12, 24 and 26 months after commencing treatment;
viii. Conduct a Comprehensive Program Review prior to the next NSP. This will incorporate a M&E capacity and needs assessment, epidemiological and impact analysis and will include the review of strategic information collection, program management and strategies.

3.2 Multi-Sectoral Planning, Coordination, Management and Resource Mobilisation

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

i. **National AIDS Commission Operations:** The NACs will be fully staffed and capacitated to conduct their mandate of ensuring effective coordination of the multi-sectoral response. Capacity-building shall be conducted for staff, partners and line ministries. Through the lifespan of this NSP, the NACs will be provided with necessary support tools, resources and capabilities to conduct their main mandates.

ii. **Mainstreaming of HIV within National and Sectoral Development Plans:** NAC directors will engage and advocate mainstreaming of HIV within broader development strategies through participation in coordination mechanisms and liaison with sector focal points and international development partners. The strategy will also identify where existing development programs are able to prioritise people living with or affected by HIV, key populations and other priority groups.

iii. **Multi-Sectoral Focal Points:** Establish and support the focal points in different Ministries and their participation in coordination and mainstreaming activities. Multi-sectoral focal points will be key to the mainstreaming of HIV programming across sectors.

iv. **Quarterly Coordination Meetings:** Each quarter NACs will undertake a coordination meeting involving all multi-sectorial focal points, PLHIV network representatives, national and international NGO partners, and bi/multilateral partners to review progress to date and address challenges and monitor the response. Coordination meetings will also support participation of key stakeholders in program review and planning processes.

v. **Six-Monthly Program Reporting:** Following every second coordination meeting, each NAC will release a program update outlining activity to date, achievements against the program indicators and targets, and outlining the next six-monthly work plan.

3.3 Procurement and Supply Chain Management Strengthening

i. **PSCM Systems Capacity Building:** as part of broader health system strengthening, an HIV-specific PSCM participatory, formative needs analysis will be undertaken in 2020 to support and improve procurement and supply chain management issues related to HIV. Based on the

findings of the assessment, relevant capacity-building efforts will be implemented to address identified needs.

ii. **Supportive Supervision:** National and sub-national supply and warehousing facilities will be supported through quarterly supervision and monitoring. National and sub-national warehousing and storage facilities will be visited on a quarterly basis.

iii. **Short Message Service (SMS) based on minimum stock reporting under the LMIS:** To improve existing reporting and stock management and reduce stock-outs at facility level, principal sites will advise stock levels via SMS to the national Supply Officers on a monthly basis.

iv. **Review Meetings for Forecasting and Quantification:** To improve forecasting and quantification of HIV supplies (ART, test kit, INH and co-trimoxazole) to health facilities.

v. **Strengthen Central and Regional Warehouses:** Proper care and storage of prescription drugs and medication at warehouses at different levels including cooling system and temperature monitoring to improve the condition and the quality of the HIV supplies.

vi. **Integrated Data Collection and Reporting Tools**: Ensure registers and other data collection tools are printed, distributed and aligned to LMIS requirements, also data verification protocols are available and used.

3.4 Civil Society Strengthening

i. **PLHIV Network Support and Strengthening:** PLHIV networks and support groups are fundamental to the overall well-being of PLHIV through advocacy, stigma reduction, psycho-social support, etc. Institutional and operational strengthening of networks is required to improve sustainability and operational capacity. Technical assistance will be provided to review and assess existing networks and support groups, identify locations for new groups and outline a plan to strengthen the networks. Networks will be supported by exchange visits and a national network forum to support capacity transfer and sharing of lessons learned. Networks and support groups will be key players in the delivery of PLHIV support, prevention and BCC information, treatment adherence, advocacy, and stigma reduction efforts (community and health facility based).

ii. **Civil Society Capacity Building:** Civil society organisations (CSOs) play a significant role in awareness raising, stigma reduction and mobilising communities to support improved HIV knowledge and access to services for both the general population and key populations. Capacity-building programs to support civil society organisations' roles in the response will be rolled out, including strengthening relationships and linkages between CSOs and health services, including the role of driving service demand and referral.

3.5 Rights Protection for PLHIV and People at Risk of HIV Infection

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

Gender. There is growing recognition that women's and girls' risk of, and vulnerability to, HIV infection is shaped by deep-rooted and pervasive gender inequalities including violence against them. A gender assessment of the Somali HIV and AIDS response indicates that a substantial proportion of Somali women have experienced violence in some form or another at some point in their life. In addition, social norms tend to be biased against Somali women. Studies from Rwanda, Tanzania, and South Africa show up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not. The NSP 2021 to 2023 therefore prioritises reduction of gender violence and gender inequality.

3.5.1 Legal and Policy Frameworks and Protection

i. **Policy and Legal Protections**: NAC to lead a review to update national and sub-national HIV policies and rights legislation. Relevant stakeholders will be engaged to work on key legislation and develop and roll out supporting advocacy material. NAC will lead a multi-sectoral effort to ensure legislation is enacted, including bills that provide a legal framework for the implementation of HIV policies inclusive of gender rights.

ii. **'Know Your Rights' and Leadership Workshops with PLHIV and their families:** Through the PLHIV networks, workshops will be undertaken with PLHIV and their families to educate them on their rights, including available legal services.

iii. **Advocacy and Sensitisation with Parliamentarians, Legal Personnel, and Community Leaders:** Annual forums with national and regional leaders will advocate for the protections of PLHIV, vulnerable persons and their families. Development of key advocacy materials.

iv. **Provision of Legal Aid Services**: Delivery of legal services to ensure the rights of PLHIV and their families are protected and assured.

3.5.2. PLHIV Social Inclusion

1. **PLHIV Advocacy and Participation:** Strengthen linkages between PLHIV networks, government, private sector and other civil society organisations. Support the participation of PLHIV in key decision-making forums.

2. **Health Worker Stigma Reduction Program:** Using key advocates including trained religious leaders, clinicians, government leaders and PLHIV, undertake stigma reduction programs with existing health facilities, health schools and health associations. Implement forums and sensitisation sessions at existing health facilities to advocate the rights of PLHIV and their families. Establish stigma-free health facilities with health facilities committing to being stigma-free environments. Build capacity of health workers on patients' rights and stigma reduction through expanded roll out of Health Worker Ethics and Stigma Reduction Modules through medical institutions and facilities.

3. **Community Based Stigma Reduction Campaigns**: Using community leaders, religious leaders and media, and CSOs to implement community-based stigma campaigns and awareness-raising. Expand and build local capacity for community conversations on HIV. Media training will be undertaken annually to sensitise and advocate with media, for factual and sensitive media coverage.

3.5.3 Gender Based Violence

i. **Access to PEP Kits:** Ensure the availability of PEP kits to support women who have been potentially exposed to HIV or STIs.

ii. **Referral and Psycho-Social Support:** Women who have been victims of gender-based violence will be offered psycho-social support and referral to appropriate health services.

Section 5: Prioritisation

5.1 First Level Prioritisation

Following the drafting of the NSP, implementing partners developed criteria for use in prioritizing interventions so that limited funding would be utilized on interventions with the most impact on achieving the NSP goals and would reach Key Vulnerable Populations (KVP). To assist in prioritizing interventions the following criteria were established and agreed:

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

Using the above criteria, interventions within each of the five priority areas were grouped. The following interventions were identified as important in achieving the principal aims of reducing HIV transmission and reducing HIV-related morbidity and mortality.

i. Reducing transmission of HIV

(i) Scale up HIV testing and counselling services;
(ii) Strengthen ART retention;
(iii) Ensure adequate supply of STI diagnostics and drugs including HIV test kits;
(iv) Implement Combination HIV Prevention interventions for vulnerable women and their clients;
(v) Implement ISBCC interventions for uniformed personnel, fisherman, truck drivers, and *khat* and drug users;
(vi) Improve and scale-up targeted condom use focused on KVP;
(vii) Ensure adequate screening of blood and blood products; implement blood safety SOP and guidelines in all blood transfusion units;
(viii) Infection Control and Post-Exposure Prophylaxis (PEP).

ii. Improving Monitoring and Evaluation

(i) Strengthen human resource capacity for M&E;
(ii) Strengthen data management, dissemination and use;
(iii) Strengthen routine program monitoring;
(iv) Strengthen supportive supervision;
(v) Strengthen HIV surveillance;
(vi) Undertake regularly planned program assessment, reviews and operational research;

(vii) Strengthen M&E coordination.

iii. Strengthening the Enabling Environment:

(i) Sensitisation of religious, political and community leaders and judicial officers to address HIV-related stigma and discrimination;
(ii) Strengthen networks of PLHIV associations and build national coordinating body;
(iii) Review and adopt legal frameworks and policies;
(iv) Improve PSM capacity to deliver adequate quantities and high-quality lifesaving supplies and drugs;
(v) Strengthen networks of religious leaders to address HIV-related stigma and discrimination;
(vi) Community, including schools', stigma reduction.

iv. Improving Management and Coordination

(i) Secure funding to implement the national response;
(ii) Advocacy for fund/resource mobilization;
(iii) Strengthen NAC capacity to plan, coordinate, manage and evaluate the national HIV response;
(iv) Implement regular multi-sectoral coordination/technical review at national and regional level.

5.2 Second Level Prioritisation

While interventions outlined above are deemed priorities for the overall achievement of the NSP aims, additional prioritisation was required to ensure those interventions/activities most ***critical*** to achieving impact and addressing needs of KVP were considered. Additional prioritisation centred on whether interventions were:

- Lifesaving or directly impacted on reducing mortality/morbidity, for example ART, OI, IPT drugs, etc.;
- Supporting the strengthening and scale up of existing high impact and life-saving services and programs, for example ART, TB/HIV collaboration, prevention;
- Focused on reaching the most at risk and vulnerable population groups, for example PLHIV, women engaged in transactional sex and their clients;
- Advocacy initiatives, including stigma and discrimination reduction initiatives, with government, religious leaders and health workers;
- Sustaining high performing and key prevention, treatment and care programs and services;
- Addressing critical constraints, barriers and gaps and built on lessons learned to date, for example improving strategic information to guide the response;
- Supporting broader aims for maternal and child health, for example PMTCT, and integration of services within ANC/MCH facilities; and
- Strengthening national ownership and capacity to manage and coordinate the HIV response.

Section 6: Risk and Mitigation Strategies

In developing the strategic framework 2021 to 2023, several risks that may affect its implementation have been identified. Potential risks and proposed mitigation strategies are described in the Table below. The following risk-rating codes are used: **H** (High Risk), S (Substantial Risk), M (Medium Risk), L (Low risk) and N (Negligible risk).

Table 6: Somalia HIV Program Risks and Mitigations

	Risk	Risk Rating	Proposed mitigations	Residual risk
1.	Sustainability may be jeopardized by continued reliance on one major funding source without significant domestic contribution	**H**	Diversify funding sources beyond the Global Fund and increase domestic contributions by government. Improve mainstreaming of programs into broader development strategies and responses.	**M**
2.	Transaction costs of program implementation may affect efficiency and effectiveness of service delivery.	**H**	Increase domestic capacity for program management and implementation. Build local cadres of trainers and mentors.	**M**
3.	Political and economic instability may limit the measurable effectiveness of proposed interventions in short and medium term.	**H**	Lessons learned during the past instability in Somalia and elsewhere have been well documented and will be used to guide HIV interventions in emergency and avoid disruptions in services.	**S**
4.	Policy, regulatory and legislative constraints may impede the achievement of key results especially in relation to interventions for women engaged in transactional sex (sex work is illegal, and taboo and condoms religiously and culturally shunned in Somalia) and their clients.	**H**	The strategy proposes legislative, policy and regulatory reforms in key areas as well as advocacy activities with key stakeholders and policy makers.	**M**
5.	Rapid scale-up of ART and PMTCT is central to this plan. Weak systems, capacity, infrastructure, high security risk and Human Resources availability may impede the achievement of key results.	**M**	Technical assistance will also be provided to health ministries to ensure that implementation is not impeded and where possible outreaches will be conducted to increase access to ART and PMTCT.	**L**

	Risk	Risk Rating	Proposed mitigations	Residual risk
6.	HIV related stigma and discrimination will impede utilisation of HIV services proposed in this plan.	**H**	The strategy proposes robust strategies and interventions to challenge and address HIV related stigma and discrimination at all levels Advocacy and rights protection focus on ensuring the safety of PLHIV.	**M**
7.	TB related stigma and discrimination will impede utilisation of HIV services proposed in this plan.	**L**	The strategy proposes robust strategies and interventions to challenge and address HIV related stigma and discrimination at all levels Advocacy and rights protection focus on ensuring the safety of PLHIV.	**M**
8.	Limited health sector experience in enabling service delivery to KVP such as women engaged in transactional sex.	**M**	Sharing of experiences and or approaches from other national programs and technical capacity from partners on programming as well as implementing interventions to address HIV-related stigma amongst health providers. Training of female health workers/CHWs, peer educators and mobile VCT to IDP camps.	**L**
9.	Weak health system with challenges of access to some location make measurement of the effectiveness of proposed health sector interventions difficult.	**M**	Resources have been committed to support health system strengthening initiatives.	**M**
10.	Implementing partners (governments, private sector and communities) have limited capacity to implement interventions proposed.	**H**	Capacity building of all implementing partners will be scaled up.	**M**
11.	If the AIDS commissions fail in their key role, coordinating holding partners accountable for the implementation of Strategic Framework 2018 – 2020, especially as it relates to reporting implementation will suffer.	**H**	Strengthening AIDS Commissions on their M&E functions and closely linking that with policy and coordination to ensure evidence is leading the implementation of interventions in the HIV national response.	**M**

	Risk	Risk Rating	Proposed mitigations	Residual risk
12.	Weak capacity to develop and implement operational plans for the strategy that will guide results-oriented actions may limit ability to achieve proposed results.	**H**	Technical support will be sourced to build national capacity in action planning and implementation.	**L**
13.	Somalia is experiencing serious levels of drought and famine which may impact on the capacity of program partner's capacity to manage and coordinate the HIV response through to 2020.	**M**	Continue to monitor the response, and work through partners ensuring ongoing communication and dialogue. Support improved mainstreaming of interventions.	**L**
14.	High turn-over of staff in management and health service deliver roles.	**H**	Expand the scope of capacity building efforts beyond externally run face to face training including integrating into the health schools and working with health associations. Advocate for longer terms for management positions. Build cadres of national TOT and improve staff retention.	**M**
15.	PLHIV and key populations are unfairly targeted and discriminated against.	**H**	Improved community and health worker anti-stigma campaigns. Development of rights protections. Implementation of advocacy with community and religious leaders. Use ambassadors to give support to PLHIV. Conduct special studies and surveys on discrimination.	**M**
16.	Lack of strategic information and poor assumption of knowledge for spectrum analysis seriously overinflates the denominators for key targets resulting in an inability to achieve targets.	**H**	Improve strategic information, improve consultation and assumption building during spectrum analysis. Monitor targets and information.	**M**
17.	Poor quality service delivery and commodities are provided through the private sector.	**H**	Advocate for improved regulation of the private sector. Include private sector representatives in advocacy and capacity building efforts. Strengthen quality control; private sector engagement.	**M**

Part 3: Somalia HIV and AIDS NSP M&E Plan, Implementation Arrangements and Resourcing

- Section 7. The Monitoring and Evaluation Plan 2021 to 2023
- Section 8: Implementation Arrangement
- Section 9: Cost of Implementing the Strategic Plan for 2021 to 2023

Section 7. Monitoring and Evaluation (M&E) Plan 2021 to 2023

This section describes the M&E plan that aims at conducting the required M&E functions to drive impact. The development of this National HIV and AIDS Monitoring and Evaluation Plan was done through participatory and consultative process embedded within the NSP development process.

7.1 M & E Plan Purpose, Objectives and Guiding Principles

i. Purpose/Overall Aim

The overall aim of the M&E system is to provide high quality strategic information to track, guide and assess the implementation of the NSP 2021 – 2023. This plan therefore seeks to facilitate the tracking of the progress towards the NSP 2021 – 2023 results to inform evidence-based decision-making at the national, regional and local levels.

ii. Specific Objectives:

The specific objectives of the M&E plan are to:

(i) Define the indicators, data collection and reporting requirements for tracking the NSP progress;
(ii) Improve routine HIV data collection, management and quality;
(iii) Strengthen leadership and Coordination of HIV Monitoring, Evaluation, Accountability and Learning (MEAL), and enhance HIV Information & Knowledge Management;
(iv) Strengthen systems to undertake HIV and related Surveillance, Surveys and Research;
(v) Enhance Strategic, Human resource and Logistical capacity for M&E of the National Response;
(vi) Enhance Strategic, Human resource and Logistical capacity for M&E of the National Response.

iii. Guiding Principles for the M&E Plan

Anchored on the “three ones” principle which emphasizes the need for having one Country M&E System for effective coordination, the implementation of the M&E plan will be guided by the following principles:

(i) **Alignment of M&E Systems**: All MDAs, MMDAs, National level Programs, Projects and all implementing partners will align their HIV M&E systems with the M&E Plan to track NSP results in a harmonized and coordinated manner. This M&E Plan will therefore provide guidance to enable all implementing partners and organizations to harmonize their data and M&E processes and work collaboratively to facilitate an efficient and coordinated process of tracking, monitoring and evaluating NSP results.

(ii) **Harmonization of Indicators and Data Collection:** All NSP indicators and data collection tools, and methods will be harmonized and standardized to allow all IPs to use the standardized tools for data collection and reporting.

(iii) **Data Demand and Use:** Data collected at all levels will be made available to both national and decentralized levels for use in decision making and programming of HIV interventions.

(iv) **Transparency, Accountability and Feedback:** Various innovative Information dissemination mechanisms will be utilised to promote transparency and enhance accountability at national and decentralized levels.

iv. Considerations for the M&E Plan

The plan is based on the following key M&E considerations:

M&E is learning: M&E is meant to initiate a learning process in the course of HIV service delivery and implementation of other HIV support activities. Through collecting and analysing the experiences from implementation of programme activities, M&E will contribute to a learning and growing processes.

M&E is for accountability: proving to others that our work is effective. This accountability must be both towards those who provide resources for HIV programmes; and the people and communities served. It should include successes (what has worked well); and the failures and lessons learnt from them. This plan is based on the principle of social accountability; which is about holding all stakeholders accountable for
service delivery from two dimensions (Figure 12). This entails: (i) The right and opportunity for citizens to hold the state accountable for information and enforcement; through influencing policymakers, and policymakers influencing providers; and (ii) The exercise of client power by citizens through direct interaction with service providers; the 'short route' accountability based on client-provider relationship.

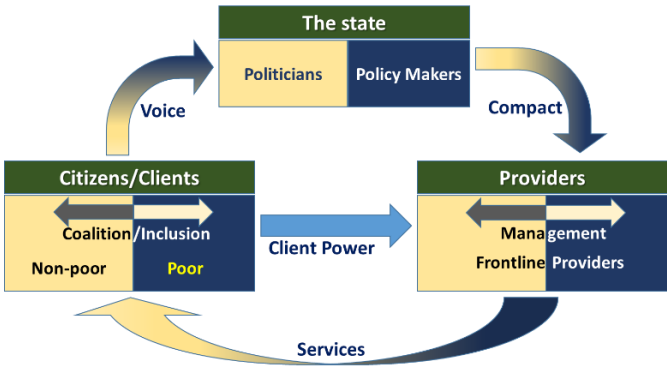


Figure 11: Framework of Accountability Relationships

M&E generates know-how and knowledge: Data collected in implementing HIV programmes can result in new knowledge and better understanding about service delivery. This knowledge can be used for advocacy and to share good practices while demonstrating results.

M&E is dialogue: M&E should be understood as a dialogue between all stakeholders in the process of service delivery and programme activities. This should always take into consideration the mechanisms and tools already in use to collect, process, use and share information building on existing foundations.

Participation is central: people at risk of HIV infection, and PLHIV are the primary beneficiaries of HIV programmes and services. For many HIV response interventions there is a strong emphasis on engaging local stakeholders and government institutions and civil society actors, in order to help build local ownership of and assist the long-term sustainability of services.

7.2 M&E Coordination

i. Coordination Arrangements

The coordination of the national M&E activities for the HIV response in the federal states of Somalia shall be led by the NACs M&E departments/units. Within each NAC, the M&E shall ensure the effective coordination with other sectors building on core mechanisms in place with the MoH and health sector implementers. In this coordination role, all actors are brought together to support a common reporting, monitoring, learning and evaluation approach. All stakeholders and implementing partners hold regular partnership forums and review meetings to provide updates, review progress, and address challenges and issues. In conjunction with the expansion to regional M&E personnel, AIDS Commission and MoH Health M&E personnel will provide mentoring and support and qualitative supervision.

ii. Roles and Responsibilities of Key M&E Stakeholders

The specific roles and responsibilities for key stakeholders in the management of the M&E plan are described below.

7.2.1 NAC & MoH Directors and M&E Personnel

They will have the following roles:

i) Supervise the implementation of this national M&E plan.
ii) Arrange for the dissemination of all information products as defined in this document.
iii) Ensure proper coordination of monitoring activities at all levels.
iv) Provide timely and quality data on relevant performance indicators to the stakeholders.
v) Strengthen capacity for collection, validation, analysis, dissemination and utilization of program data at all levels, including supporting training of health works and managers.
vi) Maintain an implementation tracker of annual reviews and evaluations recommendations, agreed upon follow-up actions, and status of these action.
vii) Utilize M&E findings to inform program, policy, and resource allocation decisions.

7.2.2 HIV Steering Committee:

The HIV Steering Committee will:

i) Articulate the policy direction for the sector, taking broader government objectives.
ii) Provide governance and partnership oversight to the sector, e.g. promote the 3 One's Principle and promote the M&E system within the public, private and civil society sectors, where possible.
iii) Review sector progress against the policy imperatives set out in the NSP and use M&E information to influence decisions on planning and implementation.
iv) Monitor adherence to the policy direction of the sector.
v) Mobilize enough resources (financial and human) to implement the M&E system.

7.2.3 Technical Working Group on M&E

The M&E TWG will:

i) Track and coordinate the implementation of the M&E plan and promoting joint
ii) monitoring and evaluation of the NSP.
iii) Participate in the annual program reviews meetings, providing technical input on reports.
iv) Discussions and recommendations during the quarterly meetings, accompanied with regular interactions with partners to track progress of achievement NSP targets.
v) Conduct joint field monitoring in conjunction with MOHs and AIDS Commissions to determine progress and identify bottlenecks to the realization of NSP targets.
vi) Identify and document lessons learned
vii) Identify capacity development needs, particularly in M&E.

7.2.4 Implementing Partners

The implementing partners will:

i) Complete and submit high quality program activity reports and data requirements from MOH/AIDS Commissions in a timely manner.
ii) Participate in planning activities, discussions, decision-making processes at program sector and all levels that review and comment on program performance and M&E.
iii) Utilize M&E findings to inform program, policy, and resource allocation decisions.
iv) Adopt lessons learnt in program reporting and responding to emerging strategic information

7.2.5 Funding Partners

The funding partners and financing mechanism will:

i) Provide an external perspective on the NSP and M&E framework performance and results.
ii) Support the refinement of indicators, tools and processes.
iii) Integrate their own monitoring frameworks and needs into government systems.
iv) Provide feedback to domestic and international constituencies on health sector performance.

v) Provide financial and technical support to strengthen M&E performance.
vi) Utilize M&E findings to inform program, policy, and resource allocation decisions.
vii) Ensure that the contracts that they sign with implementers include reference to the M&E system and that reporting to this system is clearly outlined/required.

7.3 Monitoring and Evaluation Framework

The NSP M&E Framework is fully outlined in **Annex B,** with a focus on impact, outcome and coverage level indicators. Sub strategies and operational plans are expected to document and quantify lower level outcome and output indicators and targets. This framework provides the details of the specific activities and their intended targets. A detailed three-year operational plan for the NSP to accompany the M&E framework will be developed to support this NSP and M & E Framework.

i. Core Impact, Outcome, Output and coverage indicators

To support integrated monitoring and reporting, key output indicators should be incorporated in operational plans and sub strategies to the NSP. Where appropriate the following indicators should be used across all relevant interventions with disaggregation by gender, age and location as a minimum.

Table 7: Core Impact, Outcome and Coverage indicators for the NSP M&E

Key Area and Indicators	Indicator type
A. Impact Indicators	
1. Number of new HIV infections per 1000 uninfected population.	Impact
2. Number of AIDS-related deaths per 100,000 population.	Impact
B. Outcome Indicators	
1. Per centage of people living with HIV who know their HIV status at the end of the reporting period	Outcome
2. Number of PLHIV reported on ART at the end of the last reporting period plus number of PLHIV newly initiated on ART during the current reporting period, that were not on treatment at the end of the current reporting period (including those who died, stopped treatment, and been lost-to-follow-up (LTFU).	Outcome
3. Per centage of people living with HIV and on ART who are virologically suppressed	Outcome
4. Per centage of people living with HIV who report experiences of HIV-related discrimination in health-care settings	Outcome
C. Coverage Indicators	
1. **Key Populations:** Per centage of other vulnerable populations reached with HIV prevention programs - defined package of services	Coverage
2. **HIV Testing Services**: Per centage of HIV-positive results among the total HIV tests performed during the reporting period	Coverage

Table 7: Core Impact, Outcome and Coverage indicators for the NSP M&E

Key Area and Indicators	Indicator type
3. **HIV Testing Services:** Per centage of other vulnerable populations that have received an HIV test during the reporting period and know their results	Coverage
4. **Treatment, Care and Support (TCS):** Per centage of people on ART among all people living with HIV at the end of the reporting period	Coverage
5. **TB/HIV:** Per centage of people living with HIV newly initiated on ART who were screened for TB	Coverage
6. **TB/HIV:** Per centage of PLHIV on ART who initiated TB preventive therapy among those eligible during the reporting period	Coverage
7. **PSM**: Per centage of health facilities with tracer medicines for the three diseases available on the day of the visit or day of reporting	Coverage
8. **M & E:** Completeness of facility reporting: Per centage of expected facility monthly reports (for the reporting period) that are actually received	Coverage

7.4 Data Collection and Reporting

Data for the M&E for the HIV response will come from both health and non-health sectors across the different states. It is critical that data collection and reporting is two-way with timely input from service delivery sites to regional, state and national levels, and feedback/analysis back to service delivery areas to support improved programming and capacity building. In this M&E plan, data collection has considered the key areas of routine reporting, aggregation and analysis, and reporting arrangements.

1. Routine Reporting

Identified output, coverages and outcome indicator data will be captured primarily through routine reporting systems. Implementing partners will be required to delivery regular standardized reporting on all relevant indicators, primarily facility-based reporting data sets and community-based reporting data sets. Standardised reporting tools, including facility and community health patient records and registers, training registers, outreach logs etc. Private sector partner records will be coloured differently to aid disaggregation. Through the DHIS2 and the national level and specific programmatic reporting mechanisms, health sector-related reporting is centralized through regional to national level M&E units.

7.4.1 Health Sector Reporting and Timeframes

In accordance with Somalia Health Strategic Plan, all health facilities in the country providing any of the Health services, regardless of the mother or founding agency and the sector they belong to (government departments, faith based, non-governmental, workplace based or private for profit) will be required to submit routine reports (few cases with capacity given data entry

right in the DHIS2) to the District Health Offices (DHMIS officer) and MoH every month and aggregated reports quarterly. The HIV Unit of the MoH is responsible for monitoring health facility based and other community health HIV services including HTC, ART, ANC, PMTCT, STI, OI management, care, blood products safety, PEP, PREP, and collecting HIV data and indicators as part of HMIS strengthening. The District MoH Department will be expected to enter this data, undertake a limited analysis and send the reports to the MoH Regional level which would then upload to the National level. The Health service providers or facilities at zonal level such as regional and national hospitals will directly remit the data/ reports to R/DHMIS. National HMIS will also aggregate and analyse the data from the reports, enter the reports into the data base (DHIS2) and share with SCAC and PAC who will be given viewer access to pull and analyse data.

1.4.2 Other Sectors Reporting and Timeframes

NAC will develop and harmonize reporting tools and reporting formats with existing sector specific reporting tools and formats to enhance the capture data on all non-health sectors HIV services (i.e. all HIV services that are not provided by the MoH. The data collected includes HIV prevention, care and impact mitigation interventions. This is a routine data source that requires strengthening and will not be limited to the ministries funded through NAC but will cover all Government Ministries, Departments and Agencies (MDAs) and private sector institutions implementing HIV and AIDS activities. Each AIDS Commission will publish overall quarterly reports by compiling and analysing data/reports received from Regional M&E Officers and other sources. Each AIDS Commission will also produce annual reports by compiling each quarterly report which will be used for annual program reviews. Copies will be provided to all stakeholders and reporting units.

2. Analysis and Reporting

Each AIDS Commission and MoH M&E Unit will collaborate to collate data and provide relevant health sector coordination, AIDS Coordination Committees and Global Fund Steering Committee members with detailed quarterly reports. Feedback will also be provided back to regional M&E units and implementing partners on issues, challenges and lessons learned. Annual Program Reviews will be undertaken with stakeholders, including people living with HIV, Government and Non- government implementing partners. A formal review in 2022 will occur to review progress, identify bottlenecks and issues and review and adapt operational plans to address issues and emerging strategic information. In 2023, an end of program review will be undertaken to examine achievements and challenges and support the development of a new NSP and M&E Plan.

7.5 Research, Evaluations and Learning

i. Priority Research Studies and Surveys

To support the effective monitoring of the NSP, the following research studies and surveys will be required to complete monitoring of all identified indicators at the impact and outcome levels.

Due to resource limitations the identified studies and surveys have been further prioritised to ensure key indicators can be monitored and reported, the most critical studies are highlighted in bold.

i) Integrated Bio---Behavioural Surveys (IBBS) of Key Populations
ii) Key Population Mapping
iii) Stigma Index
iv) ART Cohort Analysis
v) Spectrum Analysis
vi) HIV Risk Assessments for Key Populations
vii) Modes of Transmission Study
viii) Youth Behavioural Surveys
ix) NSP Comprehensive Evaluation

ii. Knowledge Management

The knowledge management for this NSP seeks to enhance timely access to the latest, up-to-the-minute, evidence-based information for quality program implementation. This includes internal access by the staff and personnel at the NACs, MoH and MDAs and by external persons and agencies working with and contributing to the national HIV response. In this strategic plan, there will be creation of an enhanced repository of data and interactive platforms for different levels of access to the strategic information to improve the quality of programming.

iii. Reporting

Research institutions, associations, universities, NGOs, UN agencies, sector ministries, agencies, etc. are expected to send a copy of any HIV related study reports to SCAC and PAC, who in turn will make all collected research results available for reference to all partners.

7.6 Quality Assurance and Quality Improvement

i. Field Support Supervision

Field support supervision reports by organizations responsible for the HIV and AIDS response coordination including NAC, MDAs, other agencies; District Assemblies, Development Partners and major National Projects such as Global Fund constitute another key source of data. These agencies/ organizations and projects will produce reports based on the field monitoring and support supervision undertaken. The field monitoring and support supervision reports will complement the data from the regular reporting generated from the M&E databases and other regular reports from the IPs or Grantees and sub grantees in their respective sectors, constituencies and projects.

ii. Supportive Supervision and Data Auditing

Data Quality refers to the “fitness for use” of the collected data and focuses on ensuring that the process of data collection, collation and analysis ensures that data reported is fit to be used

and can withstand an internal and external data quality audit If data management is flawed there is a risk that the data will be of poor value. As programme planners/implementers it is prudent to make plans to ensure that data collected will be of good quality. Data quality reflects the value / accuracy of data and is a measure of how well an information system represents the real world. There will be at least one data quality review and/or audit each year to inform the decisions on improvement.

Data Quality Assessment is the process of verifying the completeness and accuracy of a selection of HIV output/program monitoring forms through, a) field visits to the organisations that submitted the forms; b) checking the quality of raw data kept by the reporting organisation by examining the daily records used to complete the output monitoring form for a specific reporting period; c) comparing the output monitoring form data against the raw data; and d) checking for internal consistency.

Data Quality Assessment involves both verifying that appropriate data management systems are in place and the quality of reported data, for key indicators. This implies that data-quality processes need to assess the design of the data management and reporting systems; check system implementation for design compliance at selected service delivery and intermediary reporting sites; trace and verify historical reporting on a limited number of indicators at a few sites; and communicate the audit findings and suggested improvements in a formal audit report. The quality of data and information generated by the M&E system is central to its effectiveness. NAC, in collaboration with other National partners will spearhead the Data Quality Assessment (DQA) using the current National DQA Protocol. The DQA will basically focus on verifying the quality of reported data and assessing the underlying data management and reporting systems for standard program-level output indicators. The Routine Data Quality Assessment facilitates programs and projects to strengthen their data management and reporting systems.

Section 8. Implementation Arrangements

8.1 Roles and Responsibilities in the NSP Implementation

Effective implementation of this NSP will depend on the technical, material and financial support from Somalia's Government and development partners. It will also rely on commitment from stakeholders at various levels. The NSP seeks to simplify implementation arrangements where possible and to further strengthen integration of HIV and AIDS into the health and development. It recognises the decentralized implementation of services and therefore specific operational plans will be developed to guide implementation.

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

For accountability purposes the AIDS Commissions will provide leadership and coordinate the implementation of the strategy. However, implementation of various components of the strategy will be housed to mandated line government ministries and coordinating organisations.

Scale up of HIV and AIDS services will be guided by regular analyses of geographical distribution of HIV prevalence, risk factors and available service infrastructure. PEP services will be available in all ART and PMTCT sites and expanded with the increase in ART and PMTCT sites.

Key Populations most at risk of HIV will be reached through "Combination HIV Prevention". A multi-sectoral approach involving government, civil society and other key stakeholders at all levels will be applied through a program which integrates behavioural, biomedical, and structural interventions to address both the immediate risks and underlying causes of vulnerability to HIV infection.

As key populations most at risk of HIV in Somalia are highly mobile and some are dispersed in remote areas, with distinct socio-economic characteristics and various health seeking behaviours that are often different from static populations, tailored approaches will be used to ensure effective and efficient intervention; for instance, existing mobile outreach teams with trained medical staff and counsellors that have access to hot spots, transportation corridors, and border areas through informal but knitted social networks that IOM has built over the years.

To support implementation through to 2020, a costed 2018 – 2020 Operational Plan for the NSP will be developed. This will be a cross-cutting document and will work to reduce duplication and improve coordination. The NSP operational plan will be supported by operational plans to document specific level components. The following table outlines the respective roles and responsibilities of key entities involved in supporting Somalia's response to HIV and AIDS.

Table 8: Implementing Partner Roles

Entity	Role
Organisations of People Living with HIV	○ Voice and accountability activities ○ Meaningful representation of PLHIV in all relevant coordination, planning and monitoring structures ○ Peer Education ○ Stigma Reduction ○ Participation in all design, planning, implementation and monitoring of the HIV and AIDS response
National AIDS Commissions	○ Coordination of the multi-sectoral response to HIV and AIDS ○ Guide the development and review of multi-sectoral strategic frameworks and operational plans for HIV and AIDS ○ Facilitate HIV and AIDS multi-sectoral policy and bill development, adoption, dissemination and periodic review; ○ Identify obstacles to AIDS control policy and Program implementation; ○ Ensure implementation and attainment of Program activities and targets; ○ Lead resource mobilisation allocation and tracking of effective utilisation; ○ Collect and collate aggregated data from regions, ministries and other partners; ○ Disseminate information on HIV and AIDS and its consequences; and ○ Monitor and evaluate the overall response to HIV and AIDS
Ministries of Health	○ Guide the development and review of Health Sector Strategic Plans and health components of the NSP ○ Ensure the integration of HIV and STI prevention, treatment and care services at all levels of the health sector ○ Develop and review policy guidelines for the health sector HIV response ○ Ensure implementation and attainment of health sector HIV program

	activities and targets respectively; ○ Collect and collate HIV aggregated data from health sector ○ Technical coordination and review of HIV program in the ministry ○ Conducting operational research ○ Develop and implement health regulatory frameworks
Line Mandated Ministries	○ HIV service delivery and program implementation within their mandates ○ Review of Ministry plans and policies impacting on the AIDS response ○ Monitor and evaluate the Ministry HIV and HIV Programs ○ Mainstream HIV and AIDS in their core business ○ Workplace policies and programs with the Ministry ○ Assign a focal person to support the HIV response implementation

8.2 Integration of HIV and AIDS into Other Sectors

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

i. Existing Integration

Table 9 below provides the summary of existing integrations in Somalia as well as detailing the level of functionality and responsibility centres.

Table 9: Summary of existing integrations

Integration type/description	Key partners involved	Functionality	Responsibility
HIV into Reproductive Health: this entails mainstreaming the HIV focussed activities into RH with focus on reduction of stigma and improving HTC and ART uptake	UNFPA, Save the children	Relatively fine. UNFPA has continued to provide a lot of support towards HIV prevention as well as access to services for vulnerable women and young women and men	MoH/IP

Table 9: Summary of existing integrations

Integration type/description	Key partners involved	Functionality	Responsibility
TB/HIV: This focuses on strengthening the treatment and prevention linkages of the two diseases	WV, WHO, MSF, Mercy USA	Currently functioning very well with all TB treatment centres being HTC sites and all HIV centres having TB screening as part of ART. There is need to improve on one-stop centre model to realise impact	MoH, WV
EPHS/PMTCT, PHC: This focusses on ensuring the link between the EPHS and PHC is enhanced for an integrated service delivery arrangement	Mercy USA, SCI, WVI, SRCS	ART and HTC are currently all implemented in EPHS sites with additional supplies coming through the mainstream. Services are provided by same human resources for PHC	MoH
HIV/HSS: This is aimed at ensuring the importance of HIV investments and interventions strengthening the health systems functions; and the investments in the health system do not leave out HIV core interventions and services	MoH, UNICEF, WHO	Currently HIV services are mainly vertical, and the main integration is that the HIV grant from Global Fund is also housing the HISS components. Most HIV interventions aim at improving the HIV implementation space. There is need to consider strengthening the disease related HSS aspects in the overarching national health strategy.	MoH/IP
Youth/HIV: Strengthening inclusion of HIV into youth programs at all level	YPEER, UNFPA	This is currently well integrated and the Ministry of Youth (MoY) has made good progress in ensuring strengthened HIV engagement albeit content challenges.	MoY
Religion: Enhancing the role of religious leaders in awareness, prevention and access to HIV services	PAC, MOJRACR	The religious leaders are involved in the HIV program but their level of knowledge and understanding the key issues requires further strengthening	MoRA
GBV: Prevention of GBV as a tool to reducing HIV stigma and transmission	UNFPA, MoW, UNICEF	There are on-going interventions aimed at this direction, but efforts still needed to enhance additional key interventions	MoW
PE, Private sector hospitals: Aimed at strengthening role of private sector in the provision of HIV services	UNICEF, MoH	Significant gap exists in the quality assurance of HTC in private sector and not many private sector facilities are providing services. Policy shift required	MoH
Nutrition, livelihood, living support	WFP		MoH
Blood bank	CDC, WHO	All blood are now screened for HIV. There is need to improve protocol	MoH

ii. Future integration Opportunities

There are several future integration opportunities as described below.

Table 10: Summary of Opportunities for Integration

Integration type	Anticipated benefit(s)	Key partners/entities to be involved	Responsibility
Legislature and parliament	Improved laws and legal frameworks	NACS, line ministries, parliament	NACS
Health promotion	Enhanced position of HIV in health promotion programs and hence better prevention	C4D, UNICEF, NACs	NACs
RL, mass media and awareness	Improved knowledge and better communications and awareness	NACs, MoRA	NACs
Sports and culture	Using sports to disseminate messages and improve uptake of HTC	NACs, MoSC	MoSC
Community health service	Extending HIV services to the community level	MoH, WHO	MoH
Human rights and legal services	Improving the legal environment for better access to HIV services	MoJ, NACs, UNDP	MoJ
School health and education (all levels)	Early education and awareness among young population	MoE, MoH, NACs	MoE
Gender	Addressing gender lesne in HIV	MoW, MoH, NACs	MoW
Social protection and workplace	Social protection for people affected by HIV and reducing vulnerability	MoL, MoWD&FA, NACs	MoL

Section 9. Cost of Implementing the HIV National Strategic Plan 2021 to 2023

9.1 Summary of the NSP Cost

i. Costing Methodology

This NSP was costed using costings developed to support the Somali HIV NSP 2015-2019. Budgets for activities included in this NSP 2021-2023 have however been increased as per interventions included in the NSP. Below is a summary of the overall budget required to implement this NSP.

ii. Summary of costs

Implementing Somalia's NSP's will require approximately $46,645,307 to support the HIV response at the Federal Level and in Puntland. A separate budget of $25,116,704 will be required to support the HIV response in Somaliland.

Table 11: Summary of Total Cost for implementation of the NSP at the Federal Level

Projected Somali NSP Cost

	NSP Focus Area	2021	2022	2023	2021-23 Total
1	STI Prevention and Management	$1,438,774	$1,458,884	$1,463,911	$4,361,569
2	Prevention	$1,177,179	$1,193,632	$1,197,745	$3,568,557
3	Differentiated HIV Testing Services	$894,614	$1,201,340	$1,508,065	$3,604,020
4	Occupational and Non-occupational exposure Management	$1,397,831	$1,478,475	$1,663,285	$4,539,591
5	PMTCT	$408,220	$431,772	$539,715	$1,379,707
6	Treatment, care and support	$4,754,879	$6,167,473	$7,580,066	$18,502,419
7	TB/HIV	$140,400	$146,250	$182,812	$469,462
8	RSSH: Health management information systems and M&E	$858,532	$1,170,725	$2,050,656	$4,079,913
9	Program Management	$927,526	$973,902	$1,022,597	$2,924,025
10	Reducing Human Rights-related barriers to HIV/TB services	$877,970	$935,229	$1,402,844	$3,216,043
	TOTALS	**12,875,927**	**15,157,683**	**18,611,697**	**46,645,307**

9.2 NSP Financial Gap Analysis

The Somali HIV response is heavily reliant on external sources of funding and there is minimal government funding available.

9.3 Resource Mobilisation

During the implementation period, the NACs, MoHs and partners shall undertake to mobilise resources from different partners for the implementation of the activities. In event resources are not adequate, the country will undertake to prioritise based on level of impact on the disease epidemiology and quality of life for PLHIV. Activities have been planned to target increasing domestic resources alongside existing development funding for the disease.

Annexes

ANNEX A: Glossary of Key Terms

- *Key Population*: Groups at a higher risk of HIV infection comprising Women Most at Risk for HIV (women engaged in transactional sex) and Other Vulnerable Populations (truckers, fishermen, port workers, seafarers, military and police personnel, tea and *khat* clients).
- *Transport Workers*: Long distance and intra-city truck drivers and their assistants
- *Port workers*: Individuals working as manual laborers at the sea/ocean ports
- *Fishermen*: Persons who work on boats/ships at sea and earn income through fishing.
- *Uniformed service personnel*: Individuals who belong to any uniformed services including military and police
- *Seafarer*s: Individuals who sail or work on the ships
- *Tea clients*: Men who consume tea at tea selling shops
- *Khat clients*: Men who consume *khat* at *khat chewing locales, or marfish.*
- *Women engaged in transactional sex:* Women who have engaged in sexual activity with men in exchange for money, favour or goods in the last 12 months
- *Women most at risk for HIV*: These are women who by virtue of their disadvantaged position in the community engage in risky behaviours that can lead to HIV transmission.

Annex B: Monitoring and Evaluation Framework

Annex B1: Impact Level Results Matrix

The impact level indicators are related to the two goals below:

- Goal 1: Reduce the rate of new infections by 2023
- Goal 2: Reduce HIV related mortality and morbidity for Somali women, men and children by 2023

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
1.	Per centage of people living with HIV	Impact	N: Number of people living with HIV D: Total population	0.1% (Spectrum 2019)	0.07%	Spectrum	Age (U15, 15+); Gender	Annually	Government UNAIDS, Partners
2.	Number of AIDS-related deaths per 100,000 population	Impact	Taken as actual number based on population-based modelling	5.12 (2019 Spectrum over PESS modelling)	3.58	Spectrum modelling	Age and Gender	Annually	Government UNAIDS, Partners
3.	HIV incidence	Impact	N: Number of people living with HIV D: Total population Calculated as a per centage	0.03 (2019, Spectrum)	0.21	Spectrum	Age (U15, 15+); Gender	Annually	Government, UNAIDS, Partners

Annex B2: Outcome Level Results Matrix

The outcome level indicators are related to the three NSP objectives and are aligned to each of the objectives.

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
	Objective One: Prevention of new HIV infections								
	ISBCC								
4.	The per centage of **women most vulnerable to HIV** who know their status	Outcome	N: number of vulnerable women tested and received results D: Total estimated number of vulnerable women	FL: 11.6% (2017, IBBS)	60%	IBBS, HIV reports	Age, Location	Quarterly & annually	National program, NACs, Partners
5.	Per centage of **women most vulnerable to HIV** who are infected with HIV	Outcome	N: number of women most vulnerable to HIV who are infected with HIV D: total number of women engaged in transactional sex that are reached/tested	2.9% (2017 IBBS Somalia)	below 2.4%	HIV testing data; IBBS	Age, location	Bi-annually	National program, NACs, Partners
6.	The per centage of **young men aged 15-24** with more than one sexual partner, who report **condom use** during their last sexual encounter	Outcome	N: number of young men aged 15-24 with more than one sexual partner, who report condom use during their last sexual encounter D: All eligible young men	26.5% (2018, Youth Behavioural Survey)	50%	Youth Behavioural Survey	Location, Gender	Annually	National program, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
			aged 15-24 years who responded						
7.	The per centage of **young women 15-24** with more than one sexual partner, who report **condom use** during their last sexual encounter	Outcome	N: number of young women aged 15-24 with more than one sexual partner, who report condom use during their last sexual encounter D: All eligible young women aged 15-24 years who responded	3% (2018, Youth Behavioural Survey)	50%	Youth Behavioural Survey	Location, Gender	Annually	National program, NACs, Partners
8.	The per centage of **young women and men** aged 15–24 who know where to get an HIV Test?	Outcome	N: number of young **women and men a**ged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission D: All sampled respondents aged 15 – 24 who responded	F: 43.4% M: 56.6% (Youth Behavioural Survey 2018)	75%	Youth Behavioural Survey	Location, Gender	Annually	National program, NACs, Partners
	HIV/TB								
9.	Proportion of all TB	Output	N: number of TB patients	FL: 93.8%	95%	2019 TB	Age,	Quarterly	National

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
	patients that are aware of their HIV status		that are aware of their HIV status D: Total number of TB patients	(11,922/12,709)		registers	Gender, location		program, NACs, Partners
10.	Per centage of TB centres that offer HTC	Output	N: number of TB Centres that offer HTC D: total number of HFs offering TB services	FL: 100% (71/71) 20/24	100%	2019 TB Program Records	Location	Annually	MoH, NACs, Partners
	Diagnostic Testing								
11.	Proportion of pregnant women who test HIV positive.	Output	N: number of pregnant women tested for HIV and received results D: All pregnant women attending ANC	FL: 0.04% (28/78,741)	% of pregnant women who know their results	HTC and ANC registers	Age, Location	Quarterly	National program, NACs, Partners
12.	The per centage of **infants born to HIV positive women** who received a virological test within eight weeks of birth	Output	N: number of infants born to HIV positive women who received a virological test within eight weeks of birth D: Total number of infants born to HIV positive women	N/A	60%	ANC and PMTCT registers	Location	Quarterly	National program, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
13.	Total number of **health facilities t**hat offer HIV testing and counselling services (HTC Sites, PMTCT)	Output	Total count of health facilities that offer HIV testing and counselling services including private facililties	84	170	HTC database	Location	Quarterly	National program, NACs, Partners
14.	Number of **health facilities providing HIV diagnostic services to pregnant women** (not including PMTCT sites above)	Output	N: number of MCH facilities that offer HTC services D: number of all MCH facilities	N/A	80%	HTC database	Location	Annually	MoH, NACs, Partners
15.	Proportion of **STI cases treated by the syndromic case management** approach	Output	N: number of STI cases treated by the syndromic case management approach D: Total number of STI cases treated	N/A	50%	Health facility STI register?	Gender, Age	Quarterly	MoH, NACs, Partners
16.	Per centage of **donated blood units** screened for HIV in a quality assured manner	Output	N: number of donated blood units screened for HIV is a quality assured manner D: Total number of blood units collected	N/A	100%	Blood bank blood screening register	National	Quarterly	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
17.	The number of health facilities (ART sites) with HIV **Post-Exposure Prophylaxis** (PEP) available	Output	Discrete count of the eligible number of HFs offering PEP	17 (HIV Treatment and Care Centres)	23	HIV database	National	Annually	MoH, NACs, Partners
18.	Proportion of all persons eligible for **PEP** that receive it within 48 hours	Output	N: total number of eligible persons that received PEP within 48 hours D: Total number persons eligible for PEP	N/A	100%	PEP register; GBV database	Location; Gender	Quarterly	MoH, NACs, Partners
	Objective Two: Reduce HIV related Mortality and Morbidity								
19.	Per centage of **people living with HIV who know their HIV status** at the end of the reporting period	Outcome	N = Number of people living with HIV who know their HIV status (case reporting or modelling) D = Number of people living with HIV (modelling)	31.9% (3,471/ 10,874) 2019	46.22% (5,027/10,874)	Spectrum	Gender, Age	Annually	MoH, NACs, Partners
20.	**Per centage of HIV-positive results** among the total HIV tests performed during the reporting period	Coverage Indicator	N = Number of HIV positive results D = Number of total HIV tests performed during reporting period	FL: 614/195919 =0.3%	0.47%	2019 Program Reports	Gender and Age	Quarterly	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
21.	**Per centage of other vulnerable populations that have received an HIV test** during the reporting period and know their results	Coverage Indicator	N = Per centage of other vulnerable populations that received an HIV test in reporting period and know their result D = 'Other vulnerable people reached with prevention package'	86.6% (4,626/5343) (2019 Programme Reports and Key Population Mapping)	89%	Number of other vulnerable populations reached who were referred for testing not including people who know their results.	Vulnerable women/vulnerable men	Quarterly	MoH, NACs, Partners
	Treatment and Care								
22.	**Number of PLHIV reported on ART** at the end of the last reporting period plus number of PLHIV newly initiated on ART during the current reporting period, that were not on treatment at the end of the current reporting period (including those who died, stopped treatment, and been lost-to-follow-up	Outcome Indicator	**N** = Number of PLHIV reported on ART at the end of the last reporting period plus number of PLHIV newly initiated on ART during the current reporting period, that were not on treatment at the end of the current reporting period (including those who died, stopped treatment, and been lost-to-follow-up (LTFU). **D** = Number of people	(3371+all who started treatment in 2019) minus those still on treatment/3371 +all who started treatment	15%	Cohort Analysis	Gender, Age	Annually	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
	(LTFU).		reported on ART at the end of the last reporting period plus new on ART during the current reporting period.						
23.	**Per centage of people on ART** among all people living with HIV at the end of the reporting period	Outcome Indicator	N: Number of people on ART at the end of the reporting period D: Estimated number of people living with HIV	31.9% (3,471/10, 874 (Total on ART as of 31 Dec 2019)	60%	Program Reports and Spectrum	Gender, Age	Quarterly	MoH, NACs, Partners
24.	Per centage of **identified PLHIV** during reporting period who **commenced treatment**	Outcome	N: number of identified HIV positive persons started on ART D: Total number of identified HIV positive persons	N: variable D: variable	93% (1,308/1,406)	ART and HTC registers	Gender, Age	Quarterly	MoH, NACs, Partners
25.	Per centage of **ART clients known to be alive on treatment 12 months** after ART initiation	Outcome	N: number of clients started on ART during the review period that are alive D: Total number of clients started on ART over the review period	75.5% (2019, cohort analysis)	90%	Cohort analysis	Gender, Age	Annually	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
26.	Number of **health facilities that provide ART** services	Outcome	Count of total number of HFs providing ART services	17 (2019, ART sites)	36	Program reports	Location	Annually	MoH, NACs, Partners
27.	Number of PLHIV in HIV care who received therapeutic or **supplementary food**	Output	Count of cumulative number of people served for the whole year	N/A	2,100	Register for supplements	National	Quarterly	MoH, NACs, Partners
28.	The Number of HIV positive adults linked to **social protection services**	Outcome	Count of the actual number of persons linked to social protection services by type	N/A	2,100	Linkages register, peer education log	National	Quarterly	MoH, NACs, Partners
	Diagnostic Testing								
29.	Proportion of patients on ART that receive at least one **viral load test per year**	Coverage	N: number of ART patients receiving at least one viral load test per year D: total number of patients receiving ART	50.4% (1,752/3472)	90%	ART/viral load database	Gender, Age	Annually	MoH, NACs, Partners
30.	Per centage of people living with HIV and on ART who are **virologically suppressed**	Outcome	N = Number of people living with HIV on ART for 12 or more months, with at least one routine VL test result who have virological suppression	73.7% (Program Reports) N: 1,291	80% (D: 5,026) by 2023.	Viral Load Test Reports	Gender, Age	Six monthly Viral Load Test Reports	MOH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
			(<1000 copies/mL) D = Number of people living with HIV on ART for 12 or more months who had a viral load test during the reporting period	D: 1,752					
31.	Number of HFs that provide **virological testing services for infant** diagnosis for HIV exposed infants, on site or DBS	Outcome	Count of HFs that is able provide virological testing services for infant diagnosis for HIV exposed infants	8 (2019 Equipment Stocktake)	23	HTC/PMTCT and viral load database	Location	Quarterly	MoH, NACs, Partners
	HIV/TB								
32.	Per centage of **people living with HIV** newly initiated on ART who were screened for TB	Coverage Indicator	**N =** Number of people living with HIV newly initiated on ART who were screened for TB **D =** No of people newly diagnosed	N/A	85%	ART and HIV TB screening registers	Gender, age, location	Quarterly	MoH, NACs, Partners
33.	Per centage of **PLHIV** on ART who **initiated TB preventive therapy** among those	Coverage Indicator	N = per centage of PLHIV who initiated on TB Preventive therapy D = Per centage of PLHIV	15.3% N: Q1-Q2 43 N: Q3-Q4: 91	80% by 2023	ART and HIV TB screening registers	Gender, age, location	Quarterly	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
	eligible during the reporting period		eligible for TB Preventive Therapy	D: Q1-Q2281 D: Q3-Q4:145 2019					
34.	Per centage of **TB patients who have a HIV test** result recorded in the TB register	Output	N: number of TB patients who receive HIV test and results recorded in the register D: total number of TB patients	94.3% (11,992/12,709) (2019 TB Patient Records)	95% Same for	TB register	Gender, Age	Quarterly	MoH, NACs, Partners
35.	Proportion of all HIV positive clients that **receive Co-trimoxazole Preventive Therapy (CPT)** throughout the implementation period	Output	N: number of HIV positive clients receive CPT D: Total number of HIV positive clients	FL: 66.6% (56/84) (TB 2019 data	90%	ART and HIV TB screening registers	Gender, age, location	Quarterly	MoH, NACs, Partners
	Procurement and Supply Chain Management								
36	Per centage of **health facilities** with tracer medicines (ART first line) available on the day of the visit or day of reporting	Coverage Indicator	N: Number of HFs with tracer **medicines** for the three diseases available on day of visit D: total number of HFs visited	100% (17/17) 2019	100% (23/23)	MOH and PUDR Reports	National	Quarterly	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
37.	Per centage of ART sites that have diagnostics for PMTCT	Output	N: Number of ART sites that have diagnostics for PMTCT D: Number of ART sites	16	22	MOH and PUDR Reports	National	Annually	MoH, NACs, Partners
	Objective Three: Strengthened Enabling Environment								
	HMIS and M & E								
38.	Per centage of annual expenditure on HIV and AIDS that is from **domestic sources** for the year in review	Outcome	N: total amount of HIV expenditure that is from domestic funding sources D: total amount of HIV expenditure for year in review	N/A	9%	National Health Accounts; national budget	National	Annually	MoH, NACs, Partners
39.	Per centage of expected **facility reports that are actually received**	Coverage Indicator	N: per centage facilities that submit timely, accurate and complete monthly reports D: total number of facilities	100% (17/17) (2019 Program Report)	100% (23/23)	Quarterly Service Data Report (as per agreed timeframe with PR)	National	Annually	MoH, NACs, Partners
40.	Per centage of **HF with no stock-outs of all HIV** tracer commodities	Outcome	N: Number of HFs with no stock-outs of First Line ART on the last day of the reporting period	N: 17 D: 19	100% (23/23)	LMIS/Stock cards, supervision reports	National	Quarterly	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
			D: total number of HFs providing ART						
41.	Per centage of health facilities providing diagnostic services with tracer items available	Outcome	N: Number of HFs providing HTC services with test kits available on the last day of the reporting period D: Total number of HFs providing HTC services (inc TB, HTC and PMTCT)	N: 17 D: 17	N: 23 D: 23	Quarterly Service Data Report (as per agreed timeframe with PR)	National	Annually	MoH, NACs, Partners
42.	**Annual forecast and quantification reports** published for HIV diagnostics, ARV medicines and OIs medicines	Output	Count of completed and published quantification reports for each product category (HIV medicines, HIV diagnostics, OI medicines, Viral load)	1	1	MoH reports; Global Fund PU/DR	National	Annually	MoH, NACs, Partners
43.	One **National MESST** conducted and results disseminated	Output	Number of MESST conducted and report submitted	0	1	Report	National	Annually	MoH, NACs, Partners
44.	One **Annual joint HIV Sector Review** conducted by NACs and MoH	Output	Number of joint reviews that is of national in nature that involves many stakeholders	1	1	Meeting report	National	Annually	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
45.	Per centage of the **activities in the annual M&E plans** that are implemented	Outcome	N: count of all M&E activities that were at least implemented during the year D: count of all M&E activities	N/A	100%	M&E annual report	National	Annually	MoH, NACs, Partners
46.	Proportion of NAC lead **multi-sectoral coordination meetings** held	Output	N: Number of NAC Multi-Sectoral Coordination meetings that take place D: Number of NAC Multi-Sectoral Coordination meetings planned for the year	100%	100%	Meeting report	National	Annually	MoH, NACs, Partners
47.	Per centage of Health Facilities providing ART with at least one operational PLHIV Support Group operating.	Output	N: Number of regions with at least 1 PLHIV support group in place D: Total number of regions	0	100%	NACs database and reports	National	Annually	MoH, NACs, Partners
48.	Per centage of **registered CSOs** providing HIV-related services that have received capacity building support	Output	N: number of registered CSOs providing HIV-related services that have received any capacity building support D: Total number of registered CSOs	N/A	70%	NACs database; partners mapping report	National	Annually	MoH, NACs, Partners

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
			providing HIV-related services						
	Legal Protection								
49.	Number of priority line ministries with documented HIV activities in the NAC annual action plans	Outcome	Number of priority ministries having the minimum of an action plan. The priority ministries are gender, works, information, education, religion, women, justice	2	6	NACs Annual Reports	National	Annually	Presidency, MOH, Partners
50.	One **National Commitments and Policy Instrument (NCPI) completed** and results disseminated	Output	NCPI completed to ensure an appropriate Legal Framework is in place to support the Somali HIV Response	0	1	NACs policies database	National	Annually	MoH, NACs, Partners
51.	Per centage of PLHIV that receive the '**Knowing Your Rights'** orientation	Output	N: number of identified PLHIV are provided with the "Know Your Rights" Training/orientation through the peer networks D: Total number of identified PLHIV	N/A	90%	Peer Educator database & Reports	National	Quarterly	MoH, NACs, Partners
52.	Per centage of **people**	Outcome	N = Number of people	37.6%	30%.	Stigma	Gender and	Biennial	National

	INDICATOR	Indicator type	DEFINITION How is it calculated? N=Numerator, D=Denominator	BASELINE What is the current value?	2023 TARGET	DATA SOURCE How will it be measured?	DISAGGREGATION	FREQUENCY How often will it be measured?	REPORTING Where will it be reported?
	living with HIV who report experiences of HIV-related **discrimination in health-care settings**.		living with HIV that report having experienced poor-quality health services at least once as a result of their HIV status in the last 12 months D = Number of people living with HIV interviewed for Stigma Index Study	(2017 Stigma Index)		Index	Sex	Stigma Index Reports	program, NACs, Partners
53.	Proportion of regions with HIV **stigma reduction initiatives**	Output	N: number of regions with at least one HIV stigma reduction initiative D: Total number of regions	N/A	100%	Program Reports	Location, Sex, Gender	Quarterly	MoH, NACs, Partners

Annex C: HIV National Strategic Plan 2021-2023 Operational Plan

Objective/Interventions			2021				2022				2023				Responsible Party
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Objective One – Prevention of New HIV infections															
1.1 Reduce Sexually Acquired HIV Infections															
1.1.1	**Prevention with Positives**														
	i	Provide Behaviour Change Communication and psycho-social support groups for PLHIV	x	x	x	x	x	x	x	x	x	x	x	x	PE, Networks/CSOs
1.1.2	**Integrated Social and Behaviour Change Communication (ISBCC) for Key Populations**														
	i	Behaviour Change Programs for Key Populations:	x	x	x	x	x	x	x	x	x	x	x	x	Networks/CSOs
	ii	HIV and STI Community Hotlines	x	x	x	x	x	x	x	x	x	x	x	x	Networks/ CSOs
	iii	Targeted Media Campaigns	x	x	x	x	x	x	x	x	x	x	x	x	NACs/PE/Networks
1.1.3	**Condom Distribution and Utilisation**														
	i	Condom Promotion and Distribution	x	x	x	x	x	x	x	x	x	x	x	x	MOH

1.1.4 ISBCC for General Public, including Youth															
i	Youth Peer Education Program	x	x	x	x	x	x	x	x	x	x	x	x	MOYS/CSO	
ii	Community Based HIV/STI Education and Awareness Raising - Community Conversations	x	x	x	x	x	x	x	x	x	x	x	x	NAC/CSO/RL	
iii	Media Programs	x	x	x	x	x	x	x	x	x	x	x	x	NACS/MOI	
1.2 Increase the per centage of people who know their HIV status															
1.2.1 HIV Counselling and Testing															
i	Increase Number of Facilities offering HTC service		x	x	x	x	x	x	x	x	x	x	v	MOH/UNICEF	
ii	Integrate HTC training in medical and health schools		x											MOH/WHO	
iii	HTC Capacity Building	x	x	x	x	x	x	x	x	x	x	x	x	MOH/WHO	
iv	Establish Mobile HTC for key population			X										MOH/UNICEF	
v	Expand the availability of provider-initiated testing and counselling (PITC) in STI, MCH and TB Services		X	X	X	X	X	X	X	X	X	X	X	MOH/UNICEF	

	vi	Conduct quarterly supportive supervision for facilities providing HTC services	x	x	x	x	x	x	x	x	x	x	x	x	x	MOH/WHO/UNICEF/NAC
	vii	Perform Annual proficiency test for health care providers offering HTC				x				x				x		MOH/WHO
	viii	HTC Supplies Procurement and Distribution	x	x	x	x	x	x	x	x	x	x	x	x	x	UNICEF/MOH
1.3. Reduce the Prevalence of and Morbidity from STIs																
	i	Train Laboratory staff on STI Diagnosis (Syphilis screening)		X				X			X					MOH/WHO
	ii	Provide new and refresher Training on Syndromic STI Case Management		X				X			X					MOH/WHO
	iii	Review and update Somali STI Syndromic Management Guideline				X										WHO/MOH
	iv	Promote HTC Services for positive STI Cases	x	X	x	x	x	x	x	x	x	x	x	x	x	MOH/UNICEF
	v	Perform re-testing and confirmation for 20% of Syphilis Positive cases				X				X				X		WHO/MOH
	vi	Provide STI diagnosis and treatment commodities		x	x	x	x	x	x	x	x	x	x	x	x	UNICEF/MOH

1.4. Reduce the Transmission of HIV through Blood, Occupational and Non-Occupational Exposure														
	i	Train Health Care Providers on Somali Blood Safety Guideline				X				X				X	MOH/WHO
	ii	Implement Somali Blood safety SOP and guideline in all blood tranfusion units				x	x	x	x	x	x	x	x	x	MOH/WHO
	iii	Provide Blood safety supplies	x	x	x	x	x	x	x	x	x	x	x	X	UNICEF/MOH
	iv	Train health care providers on universal precaution measures			X					X			X		MOH/WHO
	v	Provide Post Exposure Prophylaxis (PEP) for Occupational and Non--Occupational	X	x	x	x	x	x	x	x	x	x	x	x	UNICEF/MOH

Objective Two: Reduce HIV related Mortality and Morbidity														
2.1. Improve the Well-Being of People Living with HIV														
2.1.1 Integrated ART and PMTCT service delivery, including laboratory and diagnostic services														
i	Scale up the availability of high quality paediatric and adult ART and PMTCT Services	X	X	X	X	X	X	X	X	X	X	X	X	Govt and IPs
ii	Strengthening Pre-ART Services	X	X	X	X	X	X	X	X	X	X	X	X	Govt and IPs
iii	Strengthening laboratory & diagnostic services for ART & PMTCT Delivery	X	X	X	X	X	X	X	X	X	X	X	X	Govt and IPs
iv	Strengthening procurement and supply chain management capacity for HIV and PMTCT related pharmaceuticals and health products	X	X	X	X	X	X	X	X	X	X	X	X	Govt and IPs
v	Expand Community mobilization for Service Demand	X	X	X	X	X	X	X	X	X	X	X	X	Gov and IPs
vi	Psycho-social support for PLHIV and their families		X	X	X	X	X	X	X	X	X	X	X	Gov and IPs

2.1.2 Improve the Nutritional and Economic Status of PLHIV																
	i	Nutritional Care for PLHIV	X	X	X	X	X	X	X	X	X	X	X	X	X	Govt,WFP,IPs
	ii	Socio-Economic support and strengthening	X	X	X	X	X	X	X	X	X	X	X	X	X	Govt,WFP,IPs
2.2 Reduce the impact of TB and HIV comorbidity																
2.2.1 TB/HIV Collaborative Efforts																
	i	Scale up HIV diagnostics and treatment for TB Patients	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH and IPs
	ii	Scale up access to TB screening and treatment for PLHIV	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH and IPs
	iii	Improved TB/HIV Coordination and Collaboration	X	X	X	X	X	X	X	X	X	X	X	X	X	MOH and IPs
	iv	Expand Community mobilization for Service Demand	X	X	X	X	X	X	X	X	X	X	X	X	X	Gov and IPs
	v	Psycho-social support for PLHIV and their families		X	X	X	X	X	X	X	X	X	X	X	X	Gov and IPs

Objective Three: Enabling Environment															
3.1. M&E and Strategic Information															
3.1.1	**National HIV and AIDS M & E Staffing, Capacity Building and Supervision**														
	i	Enhance the number of M&E staff at the national and regional level	x	x	x										MoH & NACs
	ii	Capcity Building programs for M&E staff	x				x		x		x			x	MoH & NACs
	iii	Establish Joint Supervision with a TOR's (quarterly) including the extension of monitoring all HIV related activities	x	x	x	x	x	x	x	x	x	x	x	x	All key Stakeholders
	iv	Conduct monthly program monitoring	x	x	x	x	x	x	x	x	x	x	x	x	All key Stakeholders
3.1.2	**Annual and Quarterly M&E Reviews and Reporting**														
	i	Establishing Quarterly M&E Meetings for partners	x	x	x	x	x	x	x	x	x	x	x		MoH & NACs
	ii	All stakeholders present their quarterly acheivements, challenges and way forward	x	x	x	x	x	x	x	x	x	x	x		MoH & NACs
	iii	Ensure timely reports from all partners	x	x	x	x	x	x	x	x	x	x	x		MoH & NACs

	iv	All reports compiled to be shared	x	x	x	x	x	x	x	x	x	x	x		MoH & NACs
	v	Conduct Annual Review meeting to evaluate progresss against the annual targets				x				x				x	MoH & NACs
	vi	Compile and disseminate comprehensive Annual Reports				x				x				x	MoH & NACs
3.1.3	**Strengthen and Integrate M&E Databases and Systems**														
	i	Integrate HIV and AIDS data and indicators into the national aggregator (District Health Information System version two – DHIS2)	x	x	x	x	x	x	x	x	x	x	x	x	NACs & MoH
	ii	Review and harmonise HIV core indicators in the HMIS	x	x	x	x	x	x	x	x	x	x	x	x	NACs & MoH
	Iii	Strengthen the capacity of the M&E and HIV implementers to manage data and conduct key M&E activities for this NSP	x	x	x	x	x	x	x	x	x	x	x	x	NACs & MoH
	iv	Provide Technical support for data visualisation, quality assurance, simple to complex analyses, manipulation, among others.	x	x	x	x	x	x	x	x	x	x	x	x	NACs & MoH
3.1.4	**Enhance use of Strategic Information to Drive Impact**														

i	Key Population IBBS			x								x		MoH & NACs
ii	ANC Surveillance	x	x	x	x	x	x	x	x	x	x	x	x	MoH
iii	Spectrum Analysis			x				x				x		WHO & MoH
iv	HIV Stigma Survey				x				x				x	MoH & NACs
v	National Composite Policy Index (NCPI)													NACs
vi	Key Population Mapping													WHO, NACs & MoH
vii	Cohort analysis: To track and monitor PLHIV and well-being 12, 24 and 26 months after commencing treatment	x		x		x		x		x		x		WHO & MoH
xiii	Conduct a Comprehensive Program Review prior to the next NSP.										x	x		NACs & MoH
ix	MoH website to be updated and all strategic documents to be posted	x	x	x	x	x	x	x	x	x	x	x	x	NACs & MoH
x	NACs to regularly disseminate HIV information through Social Media and other approaches	x	x	x	x	x	x	x	x	x	x	x	x	NACs

3.2 Multi-sectoral Planning, Coordination, Management & Resource Mobilisation															
	i	National AIDS Commission Operations	x	x	x	x	x	X	X	X	X	X	X	X	NAC
	ii	Mainstreaming of HIV within National and Sectoral Development Plans	X	X	X	X	X	X	X	X	X	X	X	X	NAC
	iii	Multi--sectoral Focal Points	x	X	X	X	X	X	X	X	X	X	X	X	NAC
	iv	Quarterly Coordination Meetings	x	x	x	x	x	x	x	x	x	x	x	x	NAC
	v	Six Monthly Program Reporting		x		x		x		x		x		x	NAC
	vi	NSP 2024 – 2029 Development	x							x	x				NAC
	vii	Resource mobilisation for NSP implementation	x	x											NAC/PR
3.3 Procurement and Supply Chain Management Strengthening															
	i	PSCM Systems Capacity Building	X		X		X		X		X		X		MOH/UNICEF
	ii	Supportive Supervision		X		X		X		X		X		X	MOH/UNICEF
	iii	Short Message Service (SMS) based on minimum stock reporting under the LMIS	X	X	X	X	X	X	X	X	X	X	X	X	MOH/UNICEF

	iv	Strengthen central and regional warehouses			X				X				X		MOH/UNICEF
	v	Semesterly review meetings for forcasting and quantification	X		X		X		X		X		X		MOH/UNICEF/NAC
	vi	Integration of data collection reporting tools		X				X				X			MOH/UNICEF
3.4 Civil Society Strengthening															
	i	PLHIV Network Support and Strengthening	x	x	x	x	x	x	x	x	x	x	x	x	NAC/PR
	ii	Civil Society Capacity Building	X	X											NAC/MOH/PR
3.5 Rights Protection for PLHIV and people at risk of HIV infection															
3.5.1 Legal and Policy Frameworks and Protection															
	i	Policy and Legal Protections	X	X											NAC
	ii	Know Your Rights' & Leadership Workshops with PLHIV & their families	X	X											SR/NAC
	iii	Advocacy & Sensitisation with Parliamentarians, Legal Personnel, and Community Leaders	X	X	X	X	X	X	X	X	X	X	X	X	NAC/Line minsteries
	iv	Provision of Legal Aid Services	x	x	x	x	x	x	x	x	x	x	x	x	NAC

3.5.2	**PLHIV Social Inclusion**														
	i	PLHIV Advocacy and Participation	x	x	x	x	x	x	x	x	x	x	x	x	SR/NAC/PLHIV Network
	ii	Health Worker Stigma Reduction Program	x	x	x	x	x	x	x	x	x	x	x	x	NAC/Line minsteries
	iii	Community Based Stigma Reduction Campaigns	X	X	X	X	X	X	X	X	X	X	X	X	NAC/CSO
3.5.3	**Gender Based Violence**														
	i	Access to PEP Kits	X	X	X	X	X	X	X	X	X	X	X	X	NAC/MOH/CSO
	ii	Referral and psycho-social Support	X	X	X	X	X	X	X	X	X	X	X	X	NAC/MOH/CSO