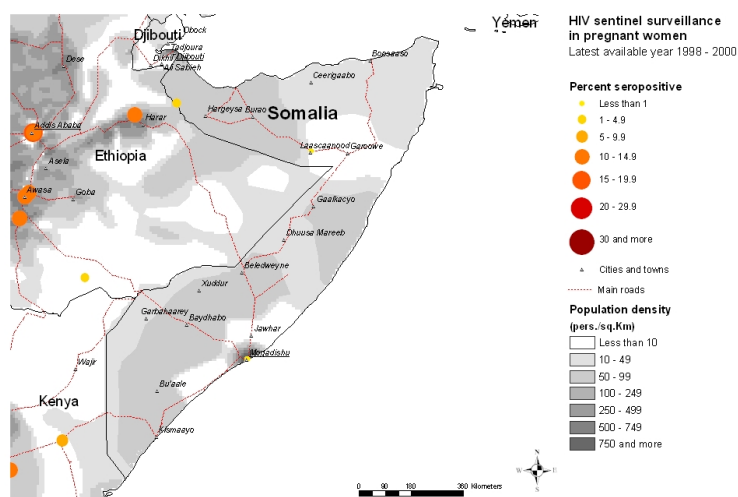


## SOMALIA

Estimated number of people needing antiretroviral therapy (0-49 years), 2005: 6 000  
 Antiretroviral therapy target declared by country: 6000 by the end of 2005

6 000



## 1. Demographic and socioeconomic data

	Date	Estimate	Source
Total population (millions)	2004	10.3	United Nations
Population in urban areas (%)	2005	35.9	United Nations
Life expectancy at birth (years)	2003	44	WHO
Gross domestic product per capita (US\$)		NA	
Government budget spent on health care (%)		NA	
Per capita expenditure on health (US\$)	2001	6	WHO
Human Development Index		NA	

°= Percentage of young people 15-24 years who correctly identify two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy looking person can transmit HIV.

\*\*=Percentage of young people 15-24 years reporting the use of a condom during sex with a non-regular partner in the last 12 months.

\* At the antiretroviral therapy site in Hargeysa.

## 2. HIV indicators

	Date	Estimate	Source
Adult prevalence of HIV/AIDS (15-49 years)		NA	
Estimated number of people living with HIV/AIDS (0-49 years)		NA	
Reported number of people receiving antiretroviral therapy (0-49 years), 2005	Dec 2005	35*	WHO/UNAIDS
Estimated number of people needing antiretroviral therapy (0-49 years), 2005	Dec 2005	6 000	WHO/UNAIDS
HIV testing and counselling sites: number of sites		NA	
HIV testing and counselling sites: number of people tested at all sites		NA	
Knowledge of HIV prevention methods (15-24 years)% - female°		NA	
Knowledge of HIV prevention methods (15-24 years)% - male°		NA	
Reported condom use at last higher risk sex (15-24 years)% - female**		NA	
Reported condom use at last higher risk sex (15-24 years)% - male**		NA	

## 3. Situation analysis

### Epidemic level and trend and gender data

Somalia has suffered from prolonged civil strife since the central government collapsed in 1991 and is ranked among the world's least-developed countries. It is in a period of considerable political, social and economic transition, compounded by the emergence of HIV/AIDS and risk factors that may lead to a rapid escalation of the epidemic. Prevalence surveys conducted in 1999 and 2004 by WHO provide the only reliable data currently available. The 1999 studies conducted only in the North West Zone (Somaliland) revealed 0.8% prevalence among blood donors and 0.9% among women attending antenatal clinics; in 2004, they revealed higher prevalence rates among the three groups studied, with variation between zones. The prevalence among women attending antenatal care clinics in the North West Zone was 1.4% and 0.6% in the Central South Zone (Somalia). In 2002, UNAIDS estimated an average prevalence of 1% among adults. The number of people 0-49 years old living with HIV/AIDS is estimated to be between 43 000 and 100 000. Although Somalia is still experiencing relatively low rates of HIV and little is really known about the epidemic, the country still has an opportunity to prevent the significant escalation of the epidemic that has occurred in neighbouring countries. As one of the only countries in sub-Saharan Africa not dealing with significant epidemic proportions of HIV/AIDS, it is widely recognized that the prevalence rates within Somalia could rapidly increase over the next few years, especially given the prevalence rates in neighbouring countries. These include Djibouti, Ethiopia and Kenya, all of which have highly fluid populations and porous boundaries.

### Major vulnerable and affected groups

HIV transmission occurs predominantly through sexual contact, and a certain percentage is assumed to occur through blood transfusion and unsafe health care practices. The HIV/AIDS rates are significantly lower than in neighbouring countries (Djibouti, Ethiopia and Kenya), but population mobility between these countries increases the vulnerability of Somali populations. The local nomadic lifestyle (40% of the inhabitants are nomads) and the returnees from refugee camps in Djibouti and Ethiopia present an increased threat of an HIV/AIDS epidemic in the country. Seroprevalence surveillance among vulnerable groups such as truck drivers, tea sellers, dock workers, youth and sex workers was planned for 2005.

### Policy on HIV testing and treatment

The North West Zone (Somaliland) has developed a draft National Policy for HIV/AIDS and Sexually Transmitted Infection Prevention and Control assisted by International Cooperation for Development (an international nongovernmental organization) and WHO. The HIV/AIDS National Technical Committee prepared the draft under the auspices of the HIV/AIDS Inter-Ministerial Committee. This draft policy recommends voluntary testing and appropriate counselling, development of comprehensive guidelines on the delivery of voluntary counselling and testing services and the progressive provision of antiretroviral therapy, including applying it for preventing mother-to-child transmission. It recommends the development of a national plan for the progressive realization of universal access to treatment and the development and implementation of comprehensive guidelines on antiretroviral therapy service delivery.

Antiretroviral therapy: first-line drug regimen, cost per person per year

An integrated prevention, treatment, care and support strategic plan and a plan to build human capacity to support the national antiretroviral therapy program in Somalia have been developed with support from WHO. Similarly guidelines, modules and training manuals to roll out antiretroviral therapy in Somalia are in progress. Until recently, antiretroviral therapy was not provided formally in Somalia. In response to the "3 by 5" Initiative, authorities of the three zones, Central South, Puntland and Somaliland, requested WHO for assistance in implementing antiretroviral therapy programmes. The first antiretroviral therapy clinic was opened in Hargeysa in 2005 in collaboration with national health authorities in Somaliland (Ministry of Health and Labour) as well as the support of United Nations agencies (Office of the United Nations Commissioner for Human Rights, UNAIDS, UNICEF, WHO and the United Nations Office for the Coordination of Humanitarian Affairs) and nongovernmental organizations including World Vision International.

#### Assessment of overall health sector reponse and capacity

Health sector capacity is concentrated in urban areas and is generally very limited. In 2003, the Strategic Framework for HIV/AIDS Prevention and Control in Somalia Populations for 2003-2008 was endorsed by all existing health authorities in the three zones of Somalia and by the Health Sector Committee of the Somalia Aid Coordinating Body. Central South, Puntland and Somaliland each participated in developing individual action plans, which have been endorsed by the respective coordinating committees within Somalia. The Somali HIV/AIDS response has been developed based on a regional model, which allows each administrative area to have its implementation action plans and to flexibly promote interventions that are identified at a community level. The HIV/AIDS Working Group, part of the Somalia Aid Coordinating Body, working under the umbrella of the Health Sector Committee, operates as an Expanded Theme Group on HIV/AIDS in Somalia. The Health Sector Committee is currently responsible for ensuring that financing from the Global Fund to Fight AIDS, Tuberculosis and Malaria is allocated in a transparent and accountable manner to service the programmes in the three zones. Services for preventing mother-to-child transmission are currently scarce. Provision of antiretroviral therapy began in 2005 in a clinic in Hargeysa, demonstrating that even in emergency situations and in the absence of a strong national programme, coordinating efforts among a large number of partners, national and international can make access to antiretroviral therapy possible. The experience has shown that the availability of treatment is encouraging people living with HIV/AIDS to disclose their HIV status within their families, which is a good step in reducing stigma. The experience has also shown a very high percentage of adherence to treatment, reflecting successful counselling and raised awareness among the people receiving therapy. An integrated prevention, treatment, care and support strategic plan and a plan for building human capacity to support the national antiretroviral therapy programme in Somalia have been developed. HIV/AIDS will be a cross-cutting issue in any training course for health workers. AIDS commissions were established in Somaliland and in Puntland to further strengthen coordination and increase commitment.

#### Critical issues and major challenges

The lack of a recognized, centralized and unified government in Somalia poses challenges for a coordinated HIV/AIDS response. Lack of human resource capacity is also a major challenge. Other major challenges include: absence of targeted interventions, especially among young people; lack of access to information on HIV prevention, including condom use; lack of availability of and access to antiretroviral therapy; absence of information on the HIV/AIDS situation in the country (including on vulnerable groups), and lack of support for people living with HIV/AIDS, including pregnant women living with HIV/AIDS. Much work is required to reduce the considerable stigma and discrimination experienced by people with AIDS in Somalia. There is also a lack of infrastructure and systems to ensure adequate monitoring and evaluation and to effect the procurement and supply management of commodities for a large-scale HIV/AIDS programme. Security concerns and the ongoing reliance on the peace process to build a more secure environment in Somalia will dramatically affect the capacity and ability to scale up and establish services.

## 4. Resource requirements and funds committed for scaling up treatment and prevention in 2004-2005

WHO estimates that between US\$ 12.7 million and US\$ 14.7 million was required to support scaling up antiretroviral therapy in Somalia during 2004-2005. The main sources of funding for the national HIV/AIDS programme include the United Kingdom Department for International Development, UNAIDS, UNICEF, the World Bank, WHO and the Global Fund. However, as one of the poorest countries in the world, Somalia has few resources to contribute to any collective HIV response. Somalia submitted a Global Fund Round 4 proposal for total funding of US\$ 25 million over five years for HIV/AIDS, focusing on preventing mother-to-child transmission, expanding voluntary counselling and testing and providing HIV treatment and social support to orphaned children and people living with AIDS. Of this amount, an estimated US\$ 10 million will be allocated during the first two years. The proposal, coordinated by the Health Sector Committee, covers implementation of the HIV/AIDS programme in the three regions of the country over five years, with a focus on reducing the incidence of HIV/AIDS in Somalia and mitigating the impact on the infected and affected individuals, families and communities. The HIV/AIDS Working Group has already identified and begun to implement a range of strategies for mobilizing resources, including donor round-table meetings and contact with schemes for donating drugs and medical supplies. The Global Fund Round 4 grant agreement was signed in May 2005, and as of December 2005, US\$ 4.1 million has been disbursed.

## 5. Treatment and prevention coverage

- Health authorities in the three zones declared a national treatment target of 6000 for 2005. Somalia's Global Fund Round 4 proposal includes funding to support free access to antiretroviral drugs and monitoring for 1000 people by 2009.
- The first site providing antiretroviral therapy in Somalia was established as a pilot project in 2005 in Hargeysa at a time when the numbers of refugees residing near the border between Somalia and Ethiopian and of Somalis with advanced HIV infection were increasing. The site is expected to provide sustainable services to up to 100 people living with HIV/AIDS. People are referred to the antiretroviral therapy service hospital outpatient clinics, hospital voluntary counselling and testing service as well as tuberculosis hospitals and private clinics. This project will be an entry point for the integrated prevention, treatment, care and support programme for Somalia. A total of 82 people were registered and followed up by December 2005, and 35 of these were receiving antiretroviral therapy. This successful pilot project in Hargeysa has encouraged partners to proceed towards developing a country-level antiretroviral therapy programme. Seven antiretroviral therapy sites are planned to be established by June 2006.

## 6. Implementation partners involved in scaling up treatment and prevention

#### Leadership and management

The various sectoral committees of the Somalia Aid Coordinating Body will provide leadership for and manage treatment scale-up, in particular the integrated prevention, treatment, care and support task force. The Somalia Aid Coordinating Body is responsible for developing policies, strategies and guidelines for implementing the antiretroviral therapy programme. Through the strategic planning process and development of respective action plans, coordinating committees have been established in Somaliland, Puntland and Central South. The newly established AIDS commissions are expected to take the responsibility of all HIV/AIDS related work to further strengthen ownership of the programme. The WHO County Office for Somalia collaborates with UNICEF and UNAIDS in providing support to the Somalia Aid Coordinating Body for strengthening coordination mechanisms. The HIV/AIDS and Female Genital Mutilation Working Group is one of the working groups of the Somalia Aid Coordinating Body under the umbrella of the Health Sector Committee. The Working Group was established in 1999 and operates as a de facto United Nations Expanded Theme Group on HIV/AIDS in Somalia. Management and coordination structures are developed in support of each of the regional responses separately but with the highest-level body convening at national level. If a central government is established, the structures developed now will constitute regional coordination structures under the guidance of a national body. If the political fragmentation continues, each zone would be able to confront the pandemic, building up synergy with the other zones. WHO, UNAIDS and UNICEF are supporting the strengthening of the health infrastructure to implement the strategic framework action plans for HIV/AIDS and the integrated prevention, treatment, care and support plan.

#### Service delivery

The Somalia Aid Coordinating Body will provide supervision and technical support to public and private providers of services. WHO and UNICEF provide normative technical support. UNICEF is currently supporting four pilot centres for voluntary counselling and testing. The site at Hargeysa Hospital is a collaborative activity involving cooperation of national health authorities in Somaliland (Ministry of Health and Labor), as well as other national and international partners in Somalia including WHO, Office of the United Nations Commissioner for Human Rights, UNAIDS, UNICEF, World Vision International, International Cooperation for Development and the United Nations Office for the Coordination of Humanitarian Affairs. WHO is also supporting the training of health workers and the development of normative guidelines.

#### Community mobilization

Under the coordination of the Somalia Aid Coordinating Body, a comprehensive communication strategy is being developed. Many community-based organizations and local nongovernmental organizations will participate in mobilizing communities for providing antiretroviral therapy and supporting treatment. Many international nongovernmental organizations will also provide support in mobilizing communities and building capacity.

#### Strategic information

WHO, UNICEF and UNAIDS will provide technical support in HIV surveillance, monitoring drug resistance and operational research. A World Bank LICUS (Low-Income Countries Under Stress) project is funding a seroprevalence survey on sexually transmitted infections and activities for strengthening surveillance.

## 7. Staffing input for scaling up HIV treatment and prevention

WHO's response so far

- Conducting a mission to the WHO Country Office for Somalia in Nairobi in March 2004 to present the "3 by 5" Initiative to partners within and outside the United Nations system (including the World Bank and bilateral donors such as the European Union and the United Kingdom Department for International Development) and to advocate for including antiretroviral therapy in planning HIV/AIDS services in Somalia
- Supporting the development of the draft National Policy for HIV/AIDS and Sexually Transmitted Infection Prevention and Control
- Supporting the development of the Round 4 proposal for the Global Fund, including the objective of ensuring that people living with HIV/AIDS in Somalia and their families have access to high-quality, affordable care and support services
- Supporting the establishment of the first antiretroviral therapy site, including developing antiretroviral therapy guidelines, training health workers and supervising the implementation of service delivery
- Integrating HIV in the curricula of three nursing schools in Somalia, and establishing training units in three nursing schools
- Supporting blood safety interventions in 27 hospitals since 1995 and infection control
- Conducting seroprevalence surveillance among attendees of antenatal care and people with sexually transmitted infections and tuberculosis
- Conducting surveillance among vulnerable groups in Somalia
- Providing blood transfusion kits and training on blood safety to laboratories
- Supporting the development of an essential drug list, including drugs to combat opportunistic infections
- Establishing an HIV/AIDS country team to support the HIV/AIDS response in Somalia

#### Key areas for WHO support in the future

- Conducting strategic health sector planning for HIV/AIDS, including human resources, and supporting health infrastructure development
- Supporting the expansion of antiretroviral therapy service delivery, including developing a national operational plan for scaling up treatment and prevention and supporting the training of health workers within the framework of the WHO Integrated Management of Adult and Adolescent Illness (IMAI) approach
- Supporting coordination among efforts of various partners involved in the HIV/AIDS response
- Conducting surveillance among vulnerable groups and supporting monitoring and evaluation

#### Staffing input for scaling up HIV treatment and prevention

- Current WHO Country Office staff includes one Medical Officer to support activity related to HIV/AIDS and sexually transmitted infections. An International Human Capacity Building Officer was recruited for six months to support the implementation of the plan for building human capacity.