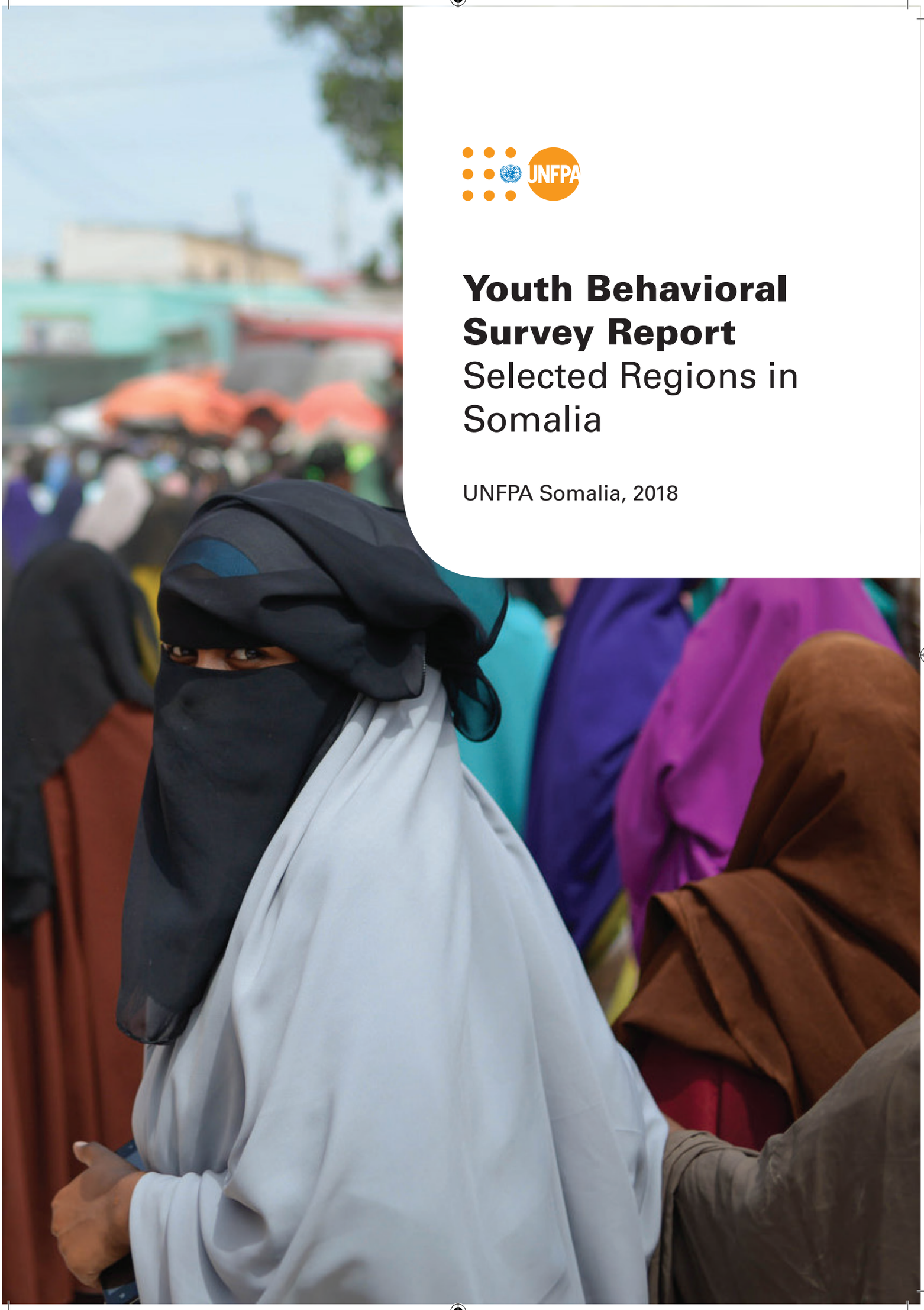

Youth Behavioral Survey Report

Selected Regions in Somalia

UNFPA Somalia, 2018

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UNFPA Somalia, 2018

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The report was compiled by Dr. Tabither Gitau, Director of Enrich Research Hut, and lecturer at Mount Kenya University's Department of Epidemiology and Biostatistics.

As lead consultant, Dr. Gitau headed a team of research assistants from Garowe, Mogadishu and Hargeisa and is responsible for the survey design, associated workshops and related data collection.

Presentation of the material in this report does not imply UNPA's endorsement of the views reflected or confirmation of the information contained.

UNFPA thanks its partners for their leadership, ethical approval, and support for the data collection process and validation workshop: Ministry of Health, Federal Government of Somalia; Ministry of Health, Somaliland; Puntland AIDS Commission; Somali AIDS Commission (South Central AIDS Commission –SCAC); Somaliland AIDS Commission; Somaliland Youth Organization (SONYO); Y-PEER Network; and, Talawadaq.

UNFPA salutes the young adults who participated in the HIV Youth Behavioural Survey.

UNFPA is committed to the principle of delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled.

UNFPA calls for the realization of reproductive rights for all and supports access to a wide range of sexual and reproductive health services -- including voluntary family planning, maternal health care and comprehensive sexuality education.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
FGDs	Focus Group Discussions
HIV	Human Immunodeficiency Virus
IDI	In-depth Interview
KIIs	Key Informant Interviews
NGO	Non-Governmental Organization
PLWHIV	People Living With HIV
PMTC	Prevention of Mother to Child
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STIs	Sexually-transmitted infections
SOLNAC	Somaliland AIDS Commission
SONYO	Somaliland National Youth Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
VCT	Voluntary Counselling and Testing
YBS	Youth Behavioural Survey
YFS	Youth Friendly Services
YFHS	Youth Friendly Health Service

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EXECUTIVE SUMMARY

The limited information available on the HIV pandemic in Somalia stems from the prevailing insecurity situation which hinders data collection efforts, making it hard to arrive at more accurate estimates of the HIV prevalence in the country. According to the UNAIDS study conducted in 2017, HIV & AIDS were reported at less than 1% for youth in Somalia. Five years earlier, in 2012, the HIV Youth Behavioural Survey indicated that knowledge about HIV prevention was very low with lots of misinformation and misconceptions.

In 2018, UNFPA Somalia decided to undertake an HIV Youth Behavioural Survey to assess and measure the knowledge, attitudes, behaviours and practices of young people at risk of HIV in and out of schools in Somalia. A mixed method cross-sectional study was carried out in areas identified as HIV ''hot-spot" areas with a total of 492 participants aged between 15-24 years sampled from five selected sites: Hargesia, Wajale, Dullow, Garowe, Bossaso and Mogadishu. The study found the following;

1. While most participants claimed to be knowledgeable about HIV & AIDS, this proved to be inaccurate, since most **lacked detailed knowledge about HIV & AIDS**. The majority had very basic knowledge about HIV. Few participants had an in-depth understanding about HIV & AIDS. It was also noted **a lot of misconceptions** and misinformation about HIV & AIDS transmission modes. This appeared to play a significant role is shaping youth perceptions, their sexual behaviour and the approach to treatment of PLWHIV in the community. Most respondents believed that **greater awareness about HIV** would be the best way to address existing misconceptions and stigma around HIV.
2. The evidence suggests that **Stigma and Discrimination associated with HIV** in the community, attributable to judgmental or ill-informed attitudes among various groups, including **family members, community and health care facilities** represent a major challenge when trying to respond to HIV. This was mainly driven by fear of contracting the virus due to misconceptions about the modes of HIV transmission and sources of infection among PLHIV (illicit sex).
3. Issues to do with **sex and sexuality are a taboo subject and perceived stigma and associated embarrassment contributes to a general reluctance to discuss and address HIV and SRH issues**. Because sex and sexuality are not openly discussed, this impedes and inhibits open discussions about HIV & AIDS.

4. **Reportedly, lack of financial support** from the Government and reduced funding from international organizations also has had a significant impact on HIV prevention and care activities
5. R**eported barriers in health facilities** included: communication, health workers' ignorance about HIV, mistaken and judgmental attitudes about PLWHIV, and lack of privacy and confidentiality.
6. Because of restrictive laws affecting FP commodities, **condoms sold at a high price** ($2 apiece) made it hard for youth to afford much less practice safe sex. Various organizations that tried distributing condoms for free were accused of promoting illicit sexual activity. Reasons cited for very low **condom usage ranged from** partner objection/dislike and/or not considered necessary to unavailability or embarrassment about purchasing them.
7. Also cited was the lack of **youth-friendly centres** where youth can access SRH services in an empathic and comfortable environment.
8. In as much as young people prefer to receive HIV information from health workers, **access to HIV services was limited, facilities were not youth- friendly and lacked** privacy, while health workers often displayed negative attitudes about youth and their sexuality. These were among the issues contributing to the stigma and discrimination associated with the disease, compounded by the **lack of confidentiality when healthcare workers provide services to young people**.
9. In Somalia, **cultural and social norms strongly forbid premarital sex**. Consequently, unmarried adolescents are likely to shy away from seeking SRH services when in need. Age of sexual debut among male respondents (17.7 years) was almost the same as that of female respondents (17.4 years).
10. **Risky sexual behaviours** such as **drug use** while having sexual intercourse or **transactional sex** while numerically low were nonetheless significant for a conservative community where HIV & AIDS and SRHR issues are frowned upon. Given these circumstances, the need to empower **and enhance young people's negotiation skills is a prerequisite if** youth are to take the lead in making responsible and safe decisions about their sexual health.

1

BACKGROUND

Somalia continues to suffer the ripple effects of political, social and economic transition, as a result of the prolonged civil strife since 1991 following the collapse of the central government.

1. BACKGROUND

Somalia continues to suffer the ripple effects of political, social and economic transition, as a result of the prolonged civil strife since 1991 following the collapse of the central government. The emergence of HIV & AIDS and other risk factors compound the situation and may have contributed to the increase of the epidemic[1]. According to a study carried out by UNAIDS in 2017, HIV prevalence was estimated at **0.5% (0.3-0.7%) for adolescents** and adults aged 15-49 translating to 30,000 persons living with HIV (PLWHIV) [2]with an annual increase of 2,700-3,000 new HIV infections per annum[3]. The main modes of HIV transmission in Somalia are heterosexual transmission followed by perinatal transmission[4]

According to the Somalia IOM Youth Behavioural Survey conducted in 2012**, HIV prevalence remains low** and the country still has an opportunity to prevent further escalation of the epidemic that has occurred in such neighbouring countries as Kenya, Ethiopia and Djibouti. In addition, it is important to take note of the porous borders and the flow of in- and out-migration. Uncontrolled immigration can contribute to increased new infections given the comparatively high prevalence rates in neighboring countries. The youth behavioural survey covering different regions sampled a total of 395 participants. Of these only **5.4% and 4.3% of unmarried men and women respectively between ages15-24 years** had a good understanding of HIV & AIDS and could correctly identify the different ways of preventing sexual transmission and answer questions about major misconceptions about HIV & AIDS [5].

Studies have shown that utilization of HIV services have been greatly affected by **inadequate human resource and the absence of targeted interventions for young people**. Lack of access to information on HIV prevention such as condom use plus lack of youth-friendly services have been cited also as factors limiting utilization of HIV services.

A **lack of information and awareness about HIV & AIDS in the country** (about vulnerable groups too), and a lack of support for people living with HIV/AIDS, including pregnant women living with HIV & AIDS, are among the main challenges associated with HIV prevention and reduction in Somalia.

Equally important, as noted, is the **need to address the considerable stigma and discrimination experienced by people living with HIV & AIDS in Somalia**. Specifically, it is vital to address community norms and health practices, the low awareness levels of the modes of transmission of HIV infection and disease, the stigmatization and discriminatory attitudes against those living with HIV, and general misconceptions surrounding HIV &

1 https://www.who.int/hiv/HIVCP_SOM.pdf
2 http://www.unaids.org/sites/default/files/country/documents/SOM_narrative_report_2015.pdf
3 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Guidelines on Construction of Core Indicators: 2008 Reporting. UNAIDS March 2007.
4 Somali HIV Epidemic and response 2013
5 http://publications.iom.int/system/files/pdf/somalia_youth_survey_final.pdf

AIDS. Failure to address these issues leaves the Somali population vulnerable to increased rates of infection [6].

This report provides the **outcomes of the HIV Youth Behavioural Survey** that was conducted by the UNFPA in selected areas in Somalia (Hargesia, Wajale, Dullow, Garowe, Bossaso and Mogadishu). The HIV Youth Behavioural Survey aims to evaluate young peoples' preferred channels and sources of information in order to plan and tailor **effective communication and advocacy interventions** with maximum outreach and impact. The Survey also provides insights into the sources of HIV information and service utilization among youth, and the role of sexual behaviour, stigma and culture in HIV prevention.

Objectives

1. To **assess and measure the knowledge, attitudes, behaviours and practices** of young people at risk of HIV and those in schools.

2. To assess the **changing patterns** among young people and gender groups, of different regions

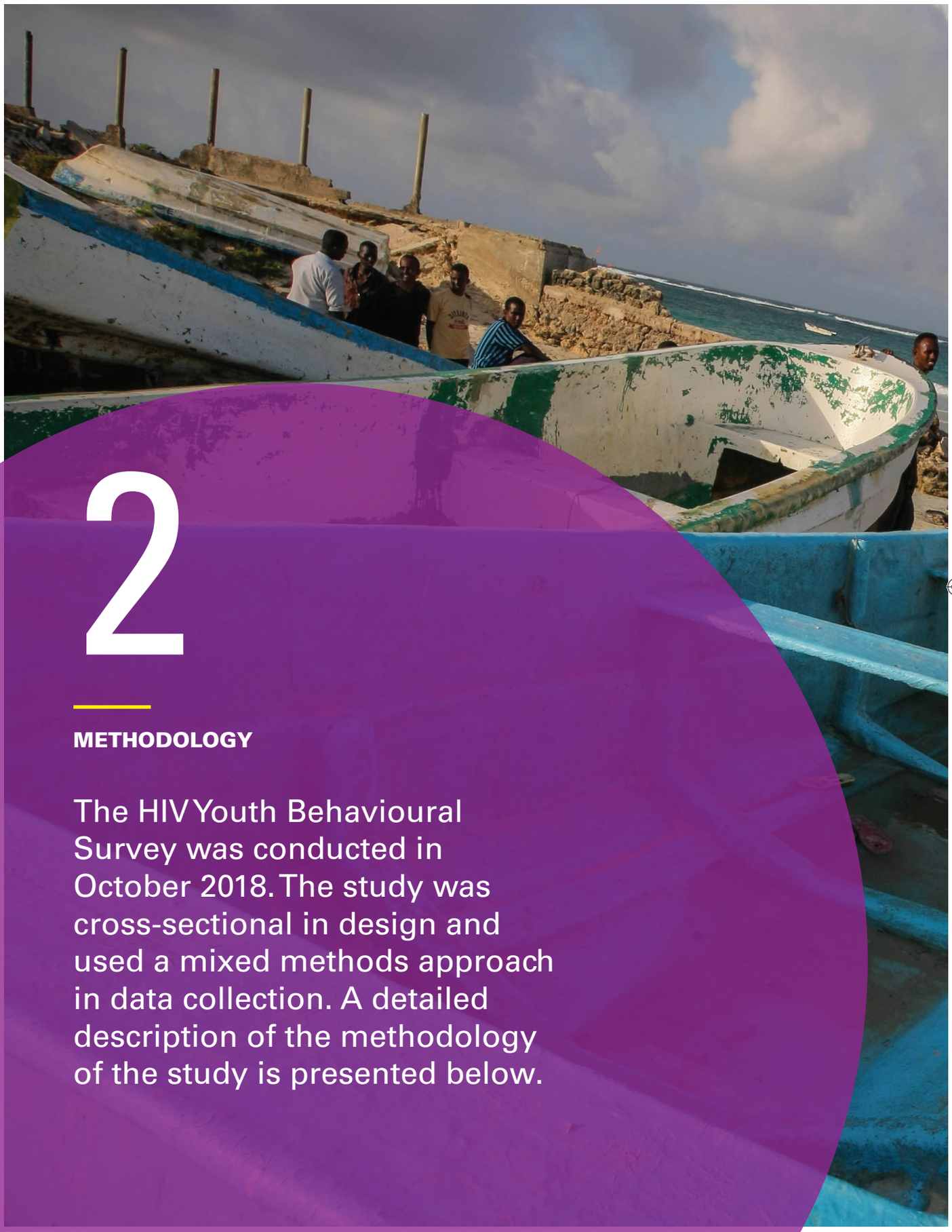
3. To establish **levels of sexual experience** in terms of age at first sex, forced sex and coercion

4. To determine the **characteristics of sexual activity** (partners, condom usage, alcohol and drug use, and transactional sex)

5. To determine the **educational level, HIV knowledge, communication and perceived risk,** testing and exposure to interventions.

6. To evaluate **young people's preferred channels and sources of information in order to** plan and tailor effective communication and advocacy interventions with maximum reach and impact.

6 https://www.africasvoices.org/wp-content/uploads/2015/03/UNICEF-Somalia-HIV_AIDS-brief-March-2017.pdf



2

METHODOLOGY

The HIV Youth Behavioural Survey was conducted in October 2018. The study was cross-sectional in design and used a mixed methods approach in data collection. A detailed description of the methodology of the study is presented below.

2. METHODOLOGY

The HIV Youth Behavioural Survey was conducted in October 2018. The study was cross-sectional in design and used a mixed methods approach in data collection. A detailed description of the methodology of the study is presented below.

Approach

A mixed method approach was adopted to assess **knowledge, attitudes, practices and behaviour related to HIV and SRH of young people**, and the factors that influence access to and utilization of SRH services. The quantitative approach involved using a **structured questionnaire to interview young adults** (females and males) between 15-24 years of age in **Hargeisa, Dullow, Mogadishu, Bosasso, Garowe and Wajale** since these were identified as "hot-spots" for HIV. Qualitative interviews were conducted to provide insights into the "how" and the "why". The qualitative interviews focused on young adults (15-24-year-olds), a young person living with HIV (15-24), religious and traditional leaders, health and social workers and Non-Governmental Organization (NGO)/ Community-Based Organization (CBO) youth organization staff and policy makers. During qualitative interviews, the study explored **participants' opinions and feelings about social and cultural norms and values associated with HIV and SRH** among young people; availability of platforms for self-expression on sensitive issues; availability of HIV prevention and care services; and, SRHR-related policies and laws, plus other issues.

Focus group discussions (FGDs) were held with groups of females/males in schools and out of school. These FGDs provided information about joint or diverging views, knowledge, attitudes and practices around HIV, community norms and values, myths, stigma and taboos around HIV, SRHR and issues influencing access and utilization of SRHR services.

Key Informant Interviews (KIIs) took place with People Living With HIV (PLWHIV) who also doubled up as youth HIV counsellors. These interviews allowed researchers to obtain **in-depth information about the knowledge, practices, attitudes, social norms, SRHR information and service utilization of those interviewed.** They provided an in-depth understanding of the realities and experiences that young people living with HIV go through in accessing care and SRH services. This information is key to developing effective interventions to address gaps and leverage opportunities.

All interviews were conducted in private, with no record kept of information that might identify respondents. Respondents were assured that recorded interviews would be kept confidential in a password protected computer accessible only to the research consultant and the Principal Investigator (PI).

Stakeholders' workshop

In June 2019, three stakeholders' workshops were held in Somaliland, Puntland and Federal Government Mogadishu. The stakeholders were: the AIDS Commissioner, Community-based organizations (CBOs), networks working with people living with HIV and peer educators. The workshop/s served as a platform where preliminary survey findings could be exchanged, discussed and even validated with the resultant input incorporated into the study findings. In addition to

validating the findings, stakeholders also discussed and planned strategic interventions and proposed activities (see annex 1).

Selection of study participants

Survey respondents were young people aged **15-to-24 years** randomly selected through a two-stage cluster sampling. Cluster selection was proportional to population size for the **five sites** as shown in table 1. The process aimed to include a 50/50 male/female breakdown, with 50% of the participants being school-enrolled, the other 50% being out of school. Schools in the cluster groups were randomly selected.

Selection of participants for the qualitative component of the study was done purposively. With the help of a team leader and local UNFPA staff, participants who were thought to be knowledgeable or to have experience of HIV and SRHR issues among young people were selected for in-depth interviews and focus group discussions.

Research areas

The study was conducted in Somalia in the following areas: Mogadishu, Dollow, Hargeisa, Wajale, Garowe and Bosaso. These areas were identified as HIV risk zones based on the IOM report on HIV Youth Behavioural Survey's HIV hot-spot mapping done in 2008 by the IOM 2012 survey. The sampling strategy aimed at getting a representative sample of HIV hot-spots for different parts of Somalia drawing on these areas. Figure 1 shows a pictorial representation of Somalia.

Sample size

To calculate the minimum sample size for the survey, baseline prevalence of HIV knowledge in Somalia as per the IOM 2012 HIV survey was used. The IOM survey found that **13.4%**

Figure 1 Pictorial presentation of Somalia

of the females and 8.7% of the males were knowledgeable about the various ways of preventing HIV. We considered the highest prevalence which was 13.4% at an alpha=0.05 and a design effect of 2.0. This gave us a total sample size of 444 respondents. Consequently, we aimed to interview 222 girls/women and 222 boys/men, aged 15 – 24 in the selected areas. We considered observations with missing information and refusals and therefore oversampled our study population 11%. After this adjustment, the total sample size for the study was 492 respondents.

This study used **proportionate sampling** to proportionately distribute the total sample (see Table 2. We obtained the 2018 population projections from the UNFPA population projection estimate study and used them in calculating the sample size for each of the regions. Table 2 shows the total population in each of the selected areas with an estimated

Table 1: Sample calculations by site.

Region	Total population	Proportion of youth (15-24 years)	Population of youth (15-24 years)
Garowe	473,940	23%	109,006
Bosaso	950,644	23%	218,648
Mogadishu	2,300,708	23%	529,162
Dullow	566,319	23%	130,253
Woqooyi Galbeed (Hargeisa and Wajale)	1,744,367	23%	401,204
Total			**1,388,273**

Table 2: Targeted Sampling for each area

Region	Sample of youth	In school	Out of school
Hargeisa and Wajale	401,204/1,388,273*444 =128	64	64
Mogadishu	529,162/1,388,273*444 =169	85	84
Dullow	130,253/1,388,273*444 =42	21	21
Garowe	109,006/1,388,273*444 =35	17	18
Bossaso	218,648/,388,273*444 =70	35	35
Total	**445**	**222**	**222**

23% being young people between ages 15-24, accounting for a total of 1,388,273.

Data collection tools

The questionnaires used were based on available literature and partly consisted of questions from existing tools used by IOM in its youth behavioural survey in 2012. The survey tool captured various aspects including: socio-demographic characteristics, migration and mobility, knowledge about HIV, stigmatization and discrimination, sexual behaviour, transactional sex, STI symptoms, HIV risks and perceptions, and exposure to HIV programmes and information.

For qualitative interviews (IDIs, KIIs and FGDs) we used topic guides to guide probing and ensure that all themes were discussed. Some of the topic guides used included: HIV knowledge; barriers in accessing health services; myths and misconceptions about HIV; culture and HIV; sources of HIV information; stigmatization among persons living with HIV (PLWHIV); and, available services.

Data collection process

Prior to data collection, research assistants from every site went through an intensive two-day training session that focused on introduction to the study, research ethics, data collection methods, review of the study tools, and active participation in role play for familiarization with the study tools. The study tools were pre-tested, and findings used to adjust the questionnaires and interview guides. During the survey, quantitative data was collected using tablets. As part of the fieldwork, the research team met on a daily basis to discuss any challenges arising during interviews, which might have had implications for the quality of the data collected. Strategies were put in place to address identified challenges. Data quality was monitored all the way through the data collection process using tablets which limited mistakes in data-entry. Completed questionnaires were sent automatically to a server, at which point data was extracted by the research consultant for review. Qualitative discussions and interviews were conducted in Somali to ensure maximum participation and ease of expression by the study participants. During the researchers' training, key terms were translated into Somali and translated back to confirm and ensure that the terms were understood in the same way by all research assistants.

With the verbal and written consent of study

participants, digital tape recorders were used in recording the qualitative interviews/ discussions. Each session of the focus group discussion required the presence of two research assistants; one to acting as a note taker, the other to moderate the discussion. These interviews were conducted in congenial environments free of noise and distractions.

Data management and analysis

Quantitative data were analyzed using STATA version 13. Descriptive statistics were employed to describe demographical and behavioural data across the different sites. Categorical data is presented in frequency and percentages whereas numerical data is presented in means with standard deviation or median with interquartile range for skewed data. We analyzed possible differences across the sites, male and female, age groups, in and out of school youth and marital status, where relevant. Bivariate and multi-variate analyses were conducted to test for associations between the dependent and independent variables. A p-value of less than 0.05 was considered significant (indicated with *).

Qualitative data were digitally recorded and transcribed. During data collection, daily review meetings were held to identify emerging themes, completeness of work and any inconsistencies. Content analysis of the data was carried out using a comprehensive thematic matrix that facilitated identification of common patterns and trends arising from the narratives. Emerging themes were added to this matrix and the matrix was used to code the transcripts. We used Dedoose software to support the analysis of the data. Narratives were written based on main themes.

Quality assurance

Research tools for this study were developed based on existing tools that were used during the 2012 HIV Youth Behavioural Survey that had been validated. The tools were adjusted to suit the local context and were pre-tested before data collection started.

To ensure validity and reliability of research findings, research assistants were trained in quantitative and qualitative sampling, data collection, data capturing and reporting skills. Research assistants were also trained on ethical issues to ensure that guidance on ethical conduct was clearly understood and implemented. Training included focus sessions and exercises regarding the meaning and process of informed consent, the importance of protecting the privacy of subjects, and confidentiality of the information obtained from them.

During the fieldwork, the research consultant worked with research assistants and other project staff on a daily basis to discuss any challenges arising during interviews. Attention was given to issues which might have implications for the quality of the data collected. Strategies were put in place to address identified challenges.

To enable data triangulation, multiple sources of information were reviewed (including literature review); mixed methods of data collection were used; a wide variety of study participants were selected; and, stakeholder workshops were held to acquire firsthand information through observations and opinions from multiple inquiries.

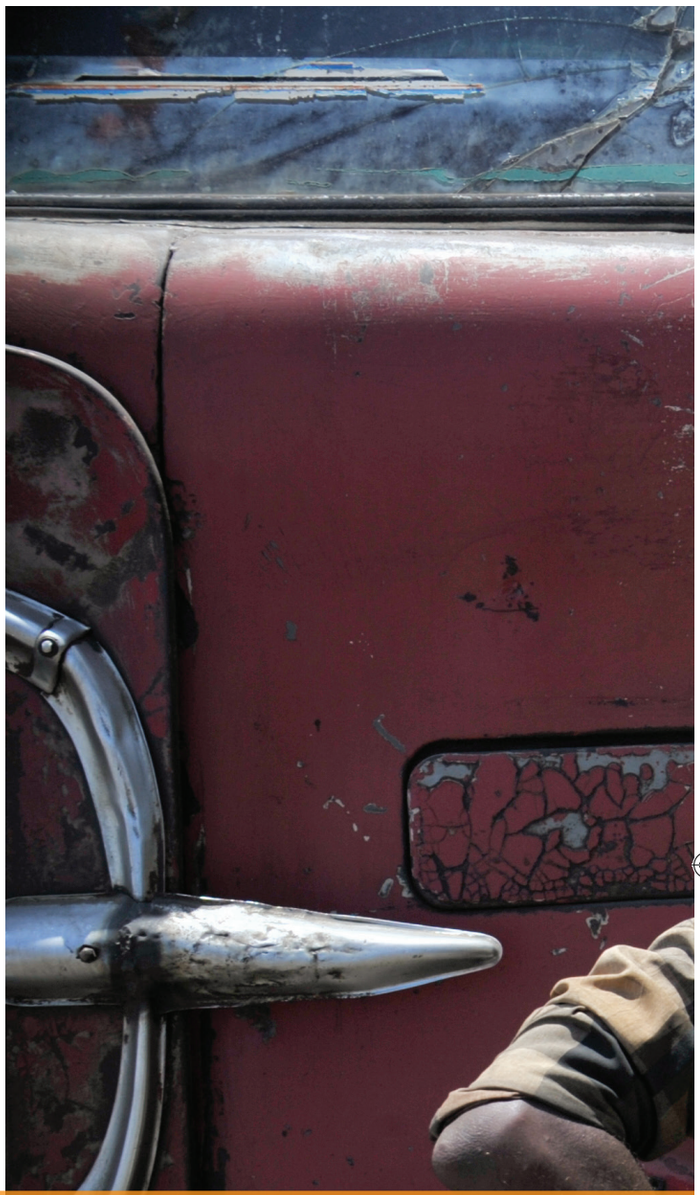
During data analysis, we conducted data cleaning for quantitative data to identify missing information, extreme cases and any form of inconsistency. For qualitative data, independent persons transcribed the recordings.

The UNFPA Somalia team and the consultant

worked together throughout the research process. Frequent meetings were held to ensure that any issues emerging were addressed as soon as possible.

Ethical considerations

Prior to seeking ethical approval from the different states, the research tools were shared with various stakeholders and their input and suggestions were adopted. Ethical approval for this research was obtained from the different states in Somalia where research was conducted. During data collection, both oral and written consent was obtained from the respondents. Privacy and confidentiality of their responses was also assured by coding each participant/respondent with a unique identification.



The survey tool captured various aspects including: socio-demographic characteristics, migration and mobility, knowledge about HIV, stigmatization and discrimination, sexual behaviour, transactional sex, STI symptoms, HIV risks and perceptions, and exposure to HIV programmes and information.

3

RESULTS

This section outlines the key findings from both the quantitative and qualitative components. The section begins by describing the demographic characteristics of the study population and later delves into specific aspects on HIV ad SRH among young people.

3. RESULTS

This section outlines the key findings from both the quantitative and qualitative components. The section begins by describing the demographic characteristics of the study population and later delves into specific aspects on HIV ad SRH among young people.

Site distribution

Table 3 is a summary of the distribution of study participants across the six regions by gender. Mogadishu had the highest number of participants (33%) this is because it has the highest population whereas, Garowe had the lowest. There were almost twice as many male participants in Wajale whereas in all the other sites the proportions of males and females were almost equal.

Table 3: Gender distribution by site

Area	Females	Males	Total
Bossaso	36(50.7%)	35(49.3%)	71(14.4%)
Dullow	18(41.9%)	25(58.1%)	43(8.7%)
Garowe	16(45.7%)	19(54.3%)	35(7.1%)
Hargesia	64(47.4%)	71(52.6%)	135(27.4%)
Mogadishu	78(47.9%)	85(52.2%)	163(33.1%)
Wajale	16(35.6%)	29(64.4%)	45(9.1%)
Total	**228(46.3%)**	**264(53.7%)**	**492(100.0%)**

Figure 2 shows distribution of participants aged 15-19 and 20-24 across gender. Among the females, majority (50.6%) were younger (15-19 years) whereas more (58.2%) males were older (20-24 years).

Figure 3 highlights the distribution of study participants by their school attendance by gender. More females (19.7%) than males (11.7%) participants had never attended school.

Table 4 summarizes the socio-demographic

Figure 2 Sample distribution of gender by age group

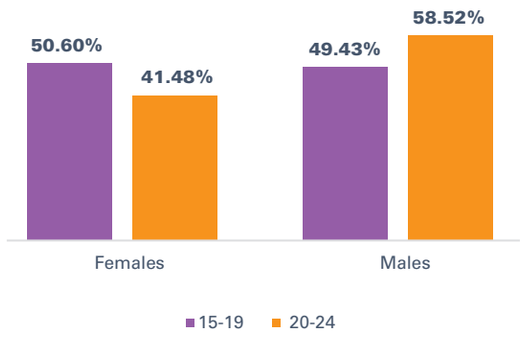
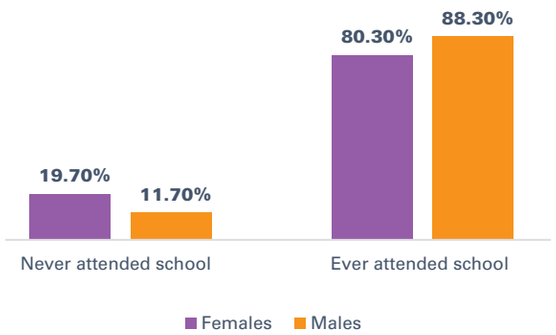


Figure 3 Sample distribution school attendance by gender



characteristics of the study participants by gender. Slightly over half of the sample 264 (54%) were male and 228 (46%) were female. Mean age of respondents was 19.7 (SD=2.6), with a significant mean age difference between the male and female respondents — males being slightly older ($p<0.007$).

More males (59.6%) than females (40.4%) indicated they had dropped out of school, the main reason cited being the financial challenge. Also cited were difficulties in comprehending school curricula, getting married, and boredom with school. The majority of sample respondents indicated secondary education to be their highest level of education. A total of 78 (16%) respondents reported having children, most y of them residing in Mogadishu 42(20%).

Table 4: Socio-demographic characteristics by gender.

Variable	Females	Males	Totals
Age			
15-19	133(50.6%)	130(49.4%)	263(53.5%)
20-24	95(41.5%)	134(58.5%)	229(46.5%)
Ever married*			
No	170(44.7%)	210(55.3%)	380(77.2%)
Yes	58(51.79%)	54(48.21%)	122(22.8%)
Current marital status*			
Single	178(44.9%)	221(55.5%)	398(80.9%)
Married	42(51.8%)	39(48.2%)	81(16.5%)
Separated/divorced	8(66.7%)	4(33.3%)	12(2.4%)
Number of children	2.3±1.6	2.7±2.2	2.5±1.9
Ever dropped out of school			
No	167(49%)	174(51%)	34169.3%)
Yes	61(40.4%)	90(59.6%)	151(30.7%)
Reasons for dropping out			
Bullying	2(22.2 %)	7(77.8%)	9(6%)
Difficulty understanding at school	7(26.9%)	19(73.1%)	26(17.2%)
Financial challenges	21(40.4%)	31(59.6 %)	52(34.4%)
Got bored with school	5(29.4%)	12(70.6%)	17(11.3%)
Got married	15(83.3%)	3(16.7%)	18(11.9%)
Got pregnant	3(100%)	0	3(2%)
Parents got sick/died	3(21.4%)	11(78.6%)	14(9.1%)
Other reason	5(41.7%)	7(58.3%)	12(8%)
Highest level of schooling			
Primary	58(40.6%)	85(59.4%)	143(29.1%)
Secondary	75(44.6%)	93(55.4%)	168(34.1%)
Tertiary	3(40.0%)	54(60%)	57(20.7%)
Madrassa	18(51.4%)	17(48.6%)	35(7.1%)
None	31(67.4%)	15(32.6%)	46(9%)

Nationality, mobility and migration

Table 5 provides a summary of the nationality and movement patterns of study participants. Almost all respondents were of Somali origin - 480 (97.6%). With regards to mobility, 61% of the participants indicated they had lived in Somalia from birth. A majority of respondents live with their families (85.6%).

Sample description of the qualitative data

Table 6 shows a summary of the number of interviews and focus group discussions conducted in the study areas. A total of 18 KIIs with NGO staff and policy makers was conducted. In addition, 10 FGDs were held with 15-24-year-old participants in and out of school.

Figure 5 Nationality, mobility and migration patterns

	Total
Nationality	
Somali	480(97.6%)
Other (Djibouti, Kenya)	12(2.4%)
Length of stay	
Less than 1 year	23(4.7%)
Between 1-3 years	58(11.8%)
Between 4-10 years	75(15.2%)
Between 11-15 years	34(6.9%)
Since birth	302(61.4%)
Reason for moving here	n=190
Resident	52(27.4%)
To find work	49(25.8%)
Returnee to Somalia	63.2%)
Refugee	7(3.7%)
IDP	24(12.6%)
To study	48(25.3%)
Other	4(2.1%)
Lives with	
Family	421(85.6%)
Peers/friends/co-workers/students)	8(1.6%)
No response	2(0.4%)
Alone	39(7.9%)
Employer	4(0.8%)
Other	18(3.7%)

Table 6: Number of KIIs and FGDs conducted

	Hargeisa and Wajale	Mogadishu	Garowe and Bosaso
Persons interviewed (KII)	1 Directorate of community health 1 SONYO staff 1 MOYS 1 YPEER 1 Talawadaaq-CSO 1 PLWHIV	1 UN Youth adviser 1 RH manager 1 YPEER 1 AIDS commissioner 2 CSOs	1 Religious leader 1 Health worker 1 UN staff 2 CSOs 1 UNICEF staff
Total KIIs	**6**	**6**	**6**
FGD Categories	1 FGD with girls in school 1 FGD with boys in school 1 FGD with boys out of school 1 FGD with girls out of school	1 FGD with girls in school 1 FGD with boys in school	1 FGD with girls in school 1 FGD with boys in school 1 FGD with IDPs boys 1 FGD with IDPs girls
Total FGDs	**4**	**2**	**4**

Knowledge about HIV and AIDS

Knowledge about HIV/AIDS among young people in the three study areas is summarized in Table 7. Out of 492, 459 (93%) indicated they had heard about HIV & AIDS. When stratified by gender, an almost equal proportion of females (92%) and males (93%) indicated having heard of HIV & AIDS. The quantitative findings were in line with the qualitative discussions held with both boys and girls, a majority of whom were conversant with HIV/AIDS-related issues. For example, during FGDs, young people showed great understanding of the modes through which HIV is transmitted including: sexual contact; child birth and breastfeeding by infected mothers; , and sharing of personal hygiene effects such as toothbrushes.

Some sample responses follow:

R1: HIV is transmitted through sex, when an infected person makes sexual contact with an uninfected person, then the uninfected person becomes positive…it has been said if this item called Condom is used, the virus won't transmit.
R2: HIV is also transmitted through using used razors and injection materials. If an infected person's blood is transmitted to a healthy person then the virus will transmit to the uninfected person; if a needle injected to infected person is used again to inject uninfected person, the disease will transmit; also, if a razor used by a person living with the virus is re-used by healthy person, then that person will become infected with the virus.
R3: There is also mother to child transmission, if the mother is infected with the virus, her child can [be infected] by the virus when breastfeeding, …when the mother is giving birth – though skilled doctors can save the child from getting transmitted by the mother's virus.

FGD with young boys at Imamu-nawawi school

As to knowledge about someone infected with HIV or dying of HIV/AIDS-related complications, nine out of ten students reported being aware of HIV/AIDS and 38% reported knowing someone who had been infected with HIV or who had died of AIDS. A total of 37% indicated having heard about HIV/AIDS through the radio, while the smallest percentage (1.3%) learned about HIV/AIDS from posters. For most, the primary source of HIV information was in schools (Puntland

Table 7: Knowledge about HIV and AIDS by gender

	Female	Male	Total
Ever heard of HIV/AIDS (n=492)			
No	18(52.9%)	16(47.1 %)	34(6.9%)
Yes	210(45.9%)	248(54.1%)	458(93.1%)
Heard about HIV or AIDS through			
TV	72(58.5%)	51(41.5%)	123(26.8%)
Radio	81(47.7%)	89(52.3%)	170(37.0%)
Friends	52(46.6%)	62(54.4%)	114(24.8%)
Partner	6(75.0%)	2(25%)	8(1.7%)
Health workers	48(46.2%)	56(53.8%)	104(22.7%)
Religious leaders	13(32.5%)	27(67.5%)	40(8.7%)
Agencies/NGO	15(34.9%)	28(65.1%)	43(9.4%)
Posters	2(33.3%)	4(66.7%)	6(1.3%)
Print media	4(36.4%)	7(63.6%)	11(2.4%)
School	34(58.6%)	24(41.4%)	58(12.6%)
Know anyone infected with HIV or who died of AIDS(n=459)			
No	129(45.4%)	155(54.6%)	284(61.9%)
Yes	81(46.3%)	94(53.7%)	175(38.1%)

had the least 67%) followed by radio, friends, health workers and TV.

Modes of transmission

Questions on mode of HIV transmission were restricted to participants (459) indicating they had knowledge about HIV/AIDS. Just over half (54%) the respondents were aware that a pregnant woman infected with HIV/AIDS can transmit the virus to her unborn child. When stratified by site, more participants in Somaliland (compared to other sites) reported that an HIV/AIDS-infected pregnant woman can transmit the virus to her unborn child ($p<0.001$). Five respondents (33%) indicated that there was no way a pregnant mother could prevent the transmission of HIV to her unborn baby. Four respondents (27%) indicated that special care delivery during child birth would reduce the risk of HIV transmission. Slightly over half of the participants (51.2%) knew that correct use of condoms during sexual intercourse can reduce HIV transmission.

It is important to note that despite the respondents' greater awareness of modes of HIV transmission, the **level of misconception and misinformation among young adults was also quite high.** For example, almost half (48.8%) of the participants believed that it is possible to contract HIV by sharing cutlery with an infected person; 35% believed that a traditional healer can cure HIV; 47% believed that mosquitos can spread HIV; and, 38% believed that performing female genital mutilation/cutting reduces the risk of HIV infection.

The quantitative findings on mode of HIV transmission corroborated findings from qualitative inquiries. Some of the misconceptions and misinformation reported included: HIV/AIDS is a punishment from Allah; HIV only infects those that have illicit sex; when it comes to getting infected, men are weaker compared to women; HIV mainly infects non-Muslims and homosexuals; and, those that get infected as a result of illicit sex don't recover whereas those that get infected in other ways do recover. Some felt that with prayers the virus would disappear.

Sample responses from the FGD with boys from Imamu-nawawi school included the following:

When it comes its illness, men are weaker in terms of the illness, women seem to live with

the disease more. But it can be prevented in many ways the person can live with the virus is he gets treatment, if the person is god fearing person. There are people who are infected by the disease but gone to the mosques to ask God for forgiveness and they become negative.... But those who are infected by the disease through sex do not easily recover but those who get the virus through other ways normally get recovered.
- FGD with girls out of school

I believe the cure of this virus is discovered because I ask myself why this virus is a problem to only Muslim countries while the other countries practice thing like sex and there are many people living with the virus in those countries. It is not possible while they [non-Muslims] are irreligious and are the most people infected by the virus and still not dying or suffering like we are [Muslims], I personally believe they have their own cure and they cure their people and we are told that this virus is cureless.
- FGD with boys from Imamu-nawawi school

Table 8: Knowledge on modes of HIV transmission

	Females	Males	Total
A pregnant woman can reduce the risk of transmitting the virus to her unborn child by*;			
Taking medication	87(44.2%)	110(55.8%)	197(42.9%)
Not breastfeeding	34(47.2%)	38(52.9%)	72(15.7%)
Exclusively breastfeed	11(61.1%)	7(38.9%)	18(3.9%)
Other	5(33.3%)	10(66.7%)	15(3.3%)
Don't know/No response	73(46.5%)	84(53.5%)	157(34.2%)
Knows a person can reduce risk of HIV transmission by having sex with only one faithful, uninfected partner who has no other partner*	159(43.6%)	206(56.4%)	365(79.5%)
Knows a person can protect themselves from HIV infection by using a condom correctly every time they have sex*	100(42.5%)	135(57.5%)	235(51.2%)
Believes a person can get infected with HIV through a mosquito bite	91(42.1%)	125(57.8%)	216(47.1%)
Believes a person can get infected with HIV by sharing food with someone who is infected*	79(41.4%)	112(58.6%)	191(41.6%)
Knows it is possible for a healthy-looking person to have HIV, the virus that causes AIDS* (n=459)	133(47.8%)	146(52.3%)	279(60.8%)
Knows a person can protect themselves from HIV infection by abstaining from sex	125(44.8%)	154(55.2%)	279(60.8%)
Knows a mother can pass HIV on to her baby through breastfeeding*	133(46.2%)	155(53.8%)	288(62.8%)
Believes a person can get HIV by sharing cutlery, plates and cups with someone who is infected*	98(43.7%)	126(56.3%)	224(48.8%)
Knows a person can get HIV by getting injections with a needle that was already used by someone else*	174(48.3%)	186(51.7%)	360(78.4%)
Believes that circumcising girls can reduce the transmission of HIV*	79(45.1%)	96(54.9%)	175(38.1%)
Knows that male circumcision can reduce the transmission of HIV*	63(43.8%)	81(56.2%)	144(31.4%)
Believes a traditional healer can cure HIV*	72(44.%)	90(56%)	162(35.3%)
Believes a person can get the AIDS virus because of witchcraft or other supernatural means*	84(49.4%)	86(34.5%)	170(37.4%)
Believes re-using circumcision tools can transmit HIV	179(51.4%)	169(48.6%)	348(75.8%)

Stigma and discrimination

We measured stigma and discrimination related to HIV/AIDS by asking study participants what groups of people they thought are responsible for spreading HIV/AIDS. We also assessed their attitudes towards people living with HIV/AIDS and other issues around HIV/AIDS.

Groups responsible for spreading HIV/AIDS

Among groups deemed by study participants to be responsible for spreading HIV/AIDS, sex workers were ranked highest, followed by women (12%) and unmarried youth. In Banadir/Gedo sex workers (66%), women (12%) and unmarried youth (6%) were cited. In Puntland, sex workers (57%), unmarried youth (47%), khat sellers (39%), and drug users (37%) were mentioned. In Somaliland, sex workers (69%), unmarried youth (29%), truck drivers (24%) and Khat sellers (24%) were the main groups identified as responsible for spreading HIV.

Attitudes around HIV

As shown in table 9, the level of **misinformation and misconception about HIV was quite high** among study participants. Nine out of ten participants believed that HIV is a punishment from God. When stratified by site, 69-80% of participants reported that if a member of their family became ill with HIV, they would want to keep it a secret. When asked to indicate their level of willingness to share a meal with a person who has HIV/AIDS, less than 50% of participants in Banadir/Gedo and Somaliland -- slightly higher for Puntland (57%) -- were willing to share a meal with a person infected with HIV. A majority (75.8%) of participants reported that if a member of their family became ill with HIV, they would want to keep it a secret. , **Less**

Table 9: Attitudes around HIV and persons living with HIV

	Females	Males	Total
Groups responsible for spreading HIV/AIDS			
Sex workers	130(65.7%)	54(56.8%)	115(69.3%)
Men	12(6.1%)	16(16.8%)	36(21.7%)
Women	24(12.1%)	25(26.3%)	14(8.4%)
Unmarried youth	12(6.1%)	45(47.4%)	48(28.9%)
Military	5(2.5%)	23(24.2%)	3(1.8%)
Truck drivers	1(0.5%)	25(26.3%)	39(23.5%)
Khat sellers	2(1.0%)	37(38.9%)	36(21.7%)
Drug users	4(2.0%)	35(36.8%)	32(19.3%)
Attitudes (459)			
HIV is a punishment from God	191(45.9%)	225(54.9%)	419(90.6%)
Would be willing to share a meal with a person who has HIV/AIDS	106(48.4%)	113(51.6%)	219(47.7%)
If a male or female relative became ill with HIV, the virus that causes AIDS, I would be willing to care for them in my household	140(46.7%)	150(53.3%)	300(65.4%)
If a member of my family became ill with HIV, the virus that causes AIDS, I would want to keep it a secret	165(47.4%)	183(52.6%)	348(75.8%)
If a student has HIV but is not sick he or she should be allowed to continue attending school	85(49.7%)	86(50.3%)	171(37.2%)
If I knew a shopkeeper or food vendor had HIV/AIDS I would continue to buy food from them	141(46.1%)	165(53.9%)	306(66.7%)
If a teacher has HIV but is not sick he or she should be allowed to continue teaching in school	72(39.3%)	111(60.7%)	183(39.9%)
If a work colleague told me that he/she had HIV I would support them	144(46.1%)	168(53.8%)	312(68%)
If a mother has HIV she should breastfeed	168(46.4%)	194(53.6%)	362(78.9%)

than 50% of participants (47%) said they were willing to share a meal with a person infected with HIV. Over 50% of the participants agreed that if a student has HIV but is not sick he or she should be allowed to continue attending school. However, less than 45% agreed that a mother who has HIV should breastfeed. Interestingly, 78.9% agreed that if a colleague has HIV, they would support them and 40% agreed that they would continue to buy food from a food vendor who has HIV/AIDS.

There is evidence of discrimination and stigma in the community perpetrated by various groups of people. However, few in the community were supportive and/or had a positive attitude towards HIV & AIDS. From the qualitative findings we observed negative attitudes towards people living with HIV & AIDS. Stigmatization and discrimination can be categorized into three levels: by family members, by community and by health care providers. This was mainly driven by fear of contracting the virus due to misconceptions of modes of transmission and source of infection among PLHIV (illicit sex).

Here are some examples:

They expel the person with HIV from the house. I witnessed a girl infected by HIV in HARGAYSA, Somaliland, and saw her parents burn the house ... finally other people helped her and gave her a room... The community discriminates against people living with HIV due to the wrong perception or misconceptions they have about the disease.
- FGD with boys out of school Hargeisa

R1: HIV is assumed to be an evil disease -- when people even hear the name of the disease, they are in shock. Those people living with the virus are discriminated from the community ...that is bad ...[since] it encourages the disease to spread ... those infected with the virus are victimized and they feel hated.

R2: The person is stigmatized by isolating him from the community; he is blamed for being positive, the community gossips and looks at him badly and advise other members of the community to stay away from that person. He can be expelled from home, ...denied a room to rent -- that disheartens the person.
- FGD with Young boys at Imamu-Nawawi school

Noteworthy, in as much as discrimination and stigma exists, there are people in the community who are supportive and have a positive attitude towards people living with HIV & AIDS. Some young participants held less discriminatory views about people living with HIV & AIDS. Focus group discussions with boys out of school and girls in school found that they would treat those living with HIV just as they would treat anyone else in the community. Others indicated they would offer words of encouragement and moral support.

I would treat that person as I treat normal society ... I would befriend the HIV- affected person and encourage him to continue his life and ignore the disappointers' reactions.
I would treat a person affected by the HIV Virus in a good way and encourage him and give him moral support not to lose hope in life and to practice a religion so that Allah would help and heal the disease from him.
I would first give that HIV-affected person psychological counselling whether he is my family member or my neighbour's and I would make friendly contact with him. Giving psychological support to this person would be my greatest care.
-FGD with boys out of school Hargesia

According to the executive director of Talawadaag, **stigma is mainly the result**

of lack of knowledge. Talawadaag has had to build accommodation to shelter those pushed out of the community for being HIV positive. Reportedly, the director has been subjected to backlash from the community because of the organization's support for community members living with HIV. As part of its community education and sensitization initiatives, the Talawadaag organization stages theatres pieces and shows to educate the public on how HIV is transmitted and to discourage discrimination against people living with HIV/AIDS.

If you meet with someone who has HIV AIDS, don't stigmatize them. -- It is about stigma reduction and HIV prevention -- the main components we work on. -- We go to a village or a neighbourhood or an IDP camp and we take a theatre group and do a play in a public place. We're doing this in the schools, in theatre, on social media and in workshops, so the method we use to spread the message is different. Sometimes we use the mass media -- a TV talk show, or a sports event, advertisements or TV or radio announcements. We are doing it in a different way and it is all about stigma reduction. and HIV Prevention. Those with HIV are treated differently -- some are stigmatized. For example, we rented a house where PLWHIV were staying near the University of Hargeisa, so that some of the youth could sleep there because of the discrimination they faced from their families. Mostly, when youth become infected, both family and community stigmatize them saying they are very bad people. Other adults living with HIV face this challenge too. Some community members sometimes called us HIV transmitters because we take care of those infected with HIV. However, we have to struggle. We have to break the silence. Then we conduct community consultations and explain what we really do, why we exist, and they accept.
Executive director of Talawadaag

In addition to stigma and discrimination, study participants reported observing that those **living with HIV were being isolated or lived in self-imposed isolation from friends, families and community members** because of the kind of treatment they received such as being chased out of their homes or rented houses. Self-isolation resulting from discrimination hinders timely access to treatment and an opportunity to get support.

The person living with HIV is isolated from the people; people gossip about that person -- you will be finger-pointed as the one who is infected with the disease -- do not get close to him -- avoid that person as much as you can. There are people who believe that they can get infected through breathing…many think this disease is caused by the wrath of God. Those people living with the virus are finger-pointed, which is very sad. Another thing is that when a person gets infected by the virus, they stigmatize themselves by not going to the health centres, or seeking more information; they victimize themselves more than any other.
Young boys at Imamu-Nawawi school

R: I think they get the treatment, but it is not the best treatment that they need. Maybe some who are already infected with HIV AIDS are unwilling to go to the hospital, due to their fears about confidentiality. Even in the normal community, they are afraid to test whether they hav HIV or not. Everyone says, if I go to that place (hospital), everyone will think that I already have HIV and that is a stereotyping. That is very difficult. They discriminate. They are isolated, because this community has no knowledge on how HIV/AIDS is transmitted from one person to another. They don't know. They believe if this person has HIV AIDS, it is the end of life

and that he/she can infect other members of the family. But their community finds it very difficult to accept someone who has been infected with HIV AIDS. There is a group that accepts those few people who already are infected by HIV/ AIDS. They welcome anyone in their network and to register with the Puntland AIDS Commission. Someone infected with HIV/AIDS go to live in a different place to avoid discrimination and isolation from family and the community. The family believes that a person is infected with HIV/ AIDS because i of illicit sex. And they say, ''you are not a good person" because of this. . They do not believe that there are many ways that HIV AIDS can affect a person. They don't know. Due to the limited knowledge of the community, they cannot accept that person.
Puntland None-State Actors Association

Available services for people living with HIV

From the qualitative interviews it was reported that government facilities offer ARV for PLWHIV for free with no other additional services. Some organizations like Talawadaag offer additional services like economic empowerment, nutritional support and shelter. However, due to funding constraints, these services are limited and unable to reach all those affected by or infected with HIV/ AIDS.

There is free treatment, free ARV services, free testing and we have integrated Prevention HIV Treatment Services available at five hospitals. So, when a person becomes infected with HIV, the treatment is available but that is associated with stigma and discrimination. If a person tries to go the place, people say "ooh that person is HIV positive".
We also offer food on a quarterly basis. Unfortunately, we are supporting only 100 persons when initially there were 509. We also offered economic empowerment, a project based on proposals we submitted to the donors, particularly through Agencies. Just four years ago, UNDP helped 100 persons, equipping them with small-scale businesses. Most are still running but currently we don't have grants.
Executive director for Talawadaag

It is very hard to go to the health centre and get some medical assistance or at least medical counseling, even to get ideas how one can get infected or ways of preventing the spread of HIV. People prefer not to go to the health centres. The only service they get is the medicine. When they want to go for treatment in the health centre, they cover themselves because they don't want people to see their faces, and maybe they go early in the morning, when there are not many people around. Some also struggle finding a suitable time to try to get their medicine. Some even fail to pick up their medicine because they are afraid they will face stigma and discrimination.
Ministry of Health Somaliland

A peer educator claimed being unfamiliar with any site in Mogadishu that offered support services for those living with HIV.

I haven't seen any kind of services being offered to people living with HIV… If I see someone living with HIV AIDS, I don't know where I can advise him to go so he can get services.
Youth Peer Educator-Youth Activist Mogadishu

GAPS AND STRATEGIES FOR HIV PREVENTION

Some of the factors identified in the prevention and reduction of HIV in the selected study sites in Somalia include socio-cultural, economical, structural and individual factors.

Socio-cultural factors

Somalia being predominantly Muslim is culturally sensitive about dealing with issues about sex and sexuality to the point where the topic can be taboo. As a result, perceived stigma and embarrassment contribute to a reluctance to discuss and address HIV and SRH issues. All our participants reported that when it came to matters of sex and sexuality, these were topics that could not be discussed openly. In addition, it was pointed out that since it is not socially acceptable for young unmarried persons to engage in sex before marriage. unmarried persons are routinely denied or restricted from accessing some SRH services.

What they need is more education and less bias... if young people go to health facilities the staff need to know their status, whether they are married or not, in order to be able to provide appropriate services within this particular culture. Otherwise, e they do not receive certain services automatically.
Reproductive and maternal health programme specialist at UNFPA Garowe

Some of the KIIs that we interviewed reported a disconnect between the Ministry of Religion and the Government. The Ministry of Health and the Ministry of Religion are keen on maintaining a conservative Muslim attitude towards sexuality (e.g. abstinence until legally married, fidelity to one's spouse, opposing the use of family planning commodities such as condoms by unmarried youth on grounds that it promotes promiscuity, etc.). So, when the Government wants to introduce FP commodities into the market, it faces a backlash from the Ministry of Religion resulting in restrictions on SRH services provision, sex education programmes and FP commodities supply.

This issue must be solved by the Ministry of Religion and the Ministry of Health. So, the Ministry of Health should justify the reasons for condom use to the Ministry of Religion. The Ministry of Religion claims condoms promote illicit sex particularly among young people, and that therefore the Ministry of Health must justify why condoms should be brought to Somaliland.
Somaliland national youth organization

In addition, the Government has played a key role in ensuring that all public hospitals offer free ARVs to persons living with HIV/AIDS. However, there has been some delay in implementing such SRH policies as holding perpetrators of sexual violence accountable and subject to legal proceedings.

One day I read in the news that ''we have sat with the President and now we are going to revise and remove whatever is against the religion or against the culture" Before there was not any law... '' il you raped this lady, you need to marry herb because you damaged her.... whatever the two families talk about, it is about the concern of the victim... they discuss the issue and then take [the decision about] compensation...yet the compensation has never been given to the victim...."
Chairperson of Somaliland Y-Peer organization

Economic and structural factors

Lack of financial support from the

Government and reduced funding from international organizations has reportedly had a huge impact on HIV prevention and care activities. All the KIIs interviewed reported significant reduction of funding from the Global Fund.

The Government should allocate some amount in the budget to such health issues in order to help provide prevention, care, treatment, and promote awareness outreach in the regions, ... The Government should undertake fundraising for the People Living with HIV AIDS to empower the lives of those families. If the Government stands to make these issues real, more people who were hiding would come forward.
FGD with girls out of school

The Global Fund supports HIV programmes in Somaliland and Somalia as well, but it covers very limited areas... No prevention activities targeted the general population. There are no prevention activities targeting youth or the rural communities, which are also at risk of HIV. Since they don't, it means that just very limited activities are supported by the Global Fund Project.
Executive director of Talawadaag

The HIV programme in the whole of Somalia was [receiving] funding from the Global Fund...[including funds for] the coming year 2019, ... mid-year they are cutting the funds... to support the AIDs commission for the whole country... This is another big problem, because the only funder for this programme was the Global Fund.
Executive director of AIDS Commission Mogadishu

Perceived barriers related to health facilities

Reported barriers in health facilities included: communications; health worker ignorance about HIV; attitudes towards PLWHIV; and, lack of privacy and confidentiality. An FGD with young boys and girls flagged that they are scared of using the health facilities out of fear that they will be treated with HIV-contaminated equipment, or unfairly discriminated against when being treated d by healthcare workers. Some reported that since most healthcare providers were males, female patients found it difficult to discuss their condition with male providers.

The nurse may not be well trained or skilled. ...The people fear being injected with used needles and [risk] getting infected from them. That is why many people don't dare to go the health centres.
FGD with girls out of school

The biggest barrier is that most of the doctors are men and girls are shy [about going] to see the male doctor. Cost is another challenge. Generally, there are few female doctors. Most well-known doctors are men. Women cannot be fully confident and openly talk to the male doctor -- that is a challenge.
FGD with girls aged 15-20 years Gacanlibaax

Some participants also drew attention to associated stigma in health facilities by healthcare givers when handling HIV-infected persons.

Staff providing the services at the IPTC centres do not stigmatize people but those around them stigmatize. Also, a lot of stigma occurs at health facilities so we have to raise this with the health workers and educate them.
Executive director of Talawadaag

I think Human Resources is very limited…they need some special training or skills to care for those people who are affected, including confidentiality and providing some form of entertainment, as well as giving some advice or counseling.
Puntland non-state actors association

Because of the restrictive laws applied to FP commodities, condoms being sold at a high price ($2 apiece) make safe sex practices hard to afford. Various organizations that tried distributing condoms for free were accused of promoting/encouraging/facilitating illicit sexual activity.

Somehow, it's a cultural thing… Last time, there was an issue about how and where we could distribute condoms … because people were unwilling to take these condoms n the daylight. And then you find in the chemists where people are buying a condom for like $2 just one condom…And then, If you announce that you are distributing them free of charge in a particular place, you may be accused of promoting adultery or illicit sex.
Youth peer -youth activist Mogadishu

Condoms have to be available. The number one missing thing is a prevention information education programme. We can try to do it at university level -- that would be important. Then there is the need for access to sexual reproductive health services: one, making sure the services are available; ensuring that youth aged 15+ have access iand that the range of products including condoms are available. When it comes to young adults, there is an information gap, they are simply not getting any information. The funding allocated to risk populations uses the peer education programme approach to try and promote awareness. Once you get them in for testing, you can talk about more in a clinical setting. Information is key. If you can get them into a testing environment, then the negative tests might have some residual impact in behavioural terms, since you can also talk about condoms within that kind of setting.
HIV and RSSH programme manager of UNICEF

It was reported that there are few if any youth-friendly centres where young people can access SRH services in a comfortable environment.

There are no proper health access and clinical posts for our youth dealing with HIV or other diseases. The youth population has no point of contact for information about the diseases, about treatments, or about how or where to undergo medical examination. The only one mentioned is the Commission of AIDS association operating in Somaliland.
FGD with boys out of school Hargesia

Awareness

Most respondents cited the great need for creating awareness on HIV -- i.e. modes of transmission, stigmatization and prevention strategies for youth, healthcare workers and parents alike. To address the existing misconception and stigma around HIV, a majority of respondents believed that awareness creation would offer a more effective solution.

R: Going to schools, Madrasa Quran and so on, because the local NGO is a a good influence able to make youth aware whether they are in school or outside school. Those in the school can communicate through the school. but a lot of youth without education in the community also need to be aware. This

holds true for both groups – whether they are inside or outside the education system. In addition, there is the sexual issue or problem. Our community is Muslim, a community in which sexual workers cannot appear directly. This is a problem since they hide themselves, out of fear and the associated stigma and discrimination. They keep a low profile when they work in the community. It's a problem. They need awareness about how to prevent the spread of HIV from other communities, about how to keep the community safe. They need a lot of awareness themselves.
Executive Director of AIDS Commission

Empowering people on preventative mechanisms is the most important thing. What I am proposing is that we have to emphasize youth living with HIV. We have to take them so they will be able to reach others. If we break through the silence, the problems that surround youth, then we will be able to reach others as well... because now when we are conducting community conversations, we invite the other resource person and persons living with HIV AIDS and then they share with the community about the reality on the ground. Perhaps your children or young people are HIV-positive but you are not aware. The vital thing is that they go and get tested in order to be aware of their status
Executive Director for Tawalaadag

The misconception is still there. First, we need to increase awareness. Some of the people, you know, especially the elderly, have not really grasped the concept fully. They need to be educated. The biggest gap is in the rural areas, that's where they need to be educated also.
UNFPA Gender and Youth Specialist

Respondent: For us to reduce HIV, it is very important that we have the tools we need to fight.... commodities... increasing young people's awareness... I don't know how easy it is but [we need] to change people's perceptions about HIV and AIDS. What people believe, their beliefs, is something that correlates with the narrative of HIV. If we can change that mindset regarding HIV to something real, that any person can understand and talk about, that would be something. All this requires is increasing people's knowledge. Maybe frequent trainings or even spreading messages through the media. Whatever channel we can use so that we can reach out further. People can know that there is HIV AIDS, that it is real and we must use every resource to save lives.
Youth peer -youth activist Mogadishu

Collaboration

Respondents were of the view that much more could be done if NGOs, the Government and all the other stakeholders in HIV/SRHR for young people worked together. This would ensure a synergy in programme implementation, reduce wastage of resources and establish an inbuilt self-learning mechanism among programme implementers.

You know the problem that NGOs have is limited resources and insofar as that limitation exists, maybe they cannot do so many things.... However, if NGOs are empowered financially and technically, then they can do so many things that youth need, especially when it comes to reproductive health services... Everything depends on resources – both human s and financial resources...We can come together [through] collaboration between NGOs and youth, with traditional elders, parents, Government, religious leaders. We can come up with a holistic programme approach that even

prevents repetition and duplication of same activities.
Executive director for Tawalaadag

Community engagement

There was need for meaningful community engagement. Given the fact that HIV/AIDS and SRHR issues especially among young people go against established community norms, it is important that there are discussions leading to consensus with community members before rolling out programmes.

R: I would say involving community health workers and going house-to-house in order to educate people about HIV/AIDS. And it is very important at unit level, that there are community meetings where these issues can be discussed. Otherwise, it is very difficult to change attitudes and existing norms or even to at least challenge people. If you believe certain things and people show you another way, it is natural at first to reject or resist especially if what they are saying goes very much against your existing beliefs. What we need is more intensive discussion of the issues. There should be c continuous and repeated awareness raising involving grassroot organizations, women's groups, youth groups and the like. One idea that I would suggest is now that young people especially in urban areas have increased access to the internet, it would be helpful to create a website where this information can be posted in the Somali language. Of course, it should be age and culturally appropriate.
Reproductive and maternal health programme specialist UNFPA

Role of stakeholders

Role of health workers

Among the most reported roles for health workers were talking to adolescents on HIV and SRH matters and educating the community on health issues.

R: My advice to the Government of Somaliland would be to establish HIV medical testing centres and points of contact at the hospitals and institutions in order to research statistical data and assess just how many people are affected by HIV each year or at this moment. Lesson modules and courses educating youth about HIV issues should be included in the curriculum also.
FGD with boys out of school in Hargesia

R: Most of the health workers are not well trained when it comes to creating a youth-friendly environment that can provide treatment and counseling for young people
Garowe resident primary teacher and religious leader

Role of Religious Leaders

According to a participant who serves as a religious leader in Garowe, religious leaders emphasize moral uprightness e.g. abstinence. Among young people the issue of "morality" versus "rights" crops up repeatedly in discussions about access to SRH services and HIV/AIDS care. While religious leaders, politicians and traditional leaders tend to view SRH and HIV/AIDS as issues associated with "immoral' behaviour, the truth of the matter is that young people and the population at large suffer in silence. Having access to health care and SRH services is a human right. The Government working with all stakeholders should protect these rights.

Role of Political and Traditional Leaders

Key informants highlighted that the

government has an as yet unimplemented policy against sexual violence that involves minors. However, it seemed that the existence of this law is not enough and that political and traditional leaders could and should be doing more to prevent sexual violence.

Role of Peer Educators

There are peer educators in the community who play a fundamental role by reaching out to their young peers and educating them about health issues while encouraging them to seek healthcare. However, the challenge many face is having to contend with a working environment that does not allow them to operate freely since they fear being labelled "immoral".

Media like TV are their news sources. What would be great would be if the peer educator were invited to deliver awareness sessions on radio or TV. People are afraid and think that they will be harmed even killed for doing something like that.
Person living with HIV

Peer educators work in a way where they talk to the young people one-to-one. One peer educator may have 100 conversations, each time-sharing information and insights.

What I know from the interaction if I go and sit and talk to them is that we may get more information in more detail than we might otherwise have never known. We need peer educators doing what they call "interpersonal communication activities", because this is where we miss out the most, and this is where you get the most insightful and s and profound information.
Chairperson of Somaliland Y-peer organization

Sexual debut and activity

As shown in Table 10, a total of 126 respondents (25.6%) had engaged in sexual intercourse. When stratified by gender, more males than females had engaged in sex. When stratified by marital status, , 47 (13%) who had never been married indicated they had engaged in sexual activity. Stratified by gender, the age of sexual debut among male respondents (17.7 years) was almost the same as that of female respondents (17.4 years).

Surprisingly, only 17.7% reported to have used a condom during last sex. When stratified by site, none of the respondents in Puntland used a condom during last sex compared to the26.8% and 17.7% in Banadir/Gedo and Somaliland respectively, who reported using a condom during their last sexual intercourse.

Table 10: Sexual debut and sexual activities among young people

	Females	Males	Total
Ever had sex (n=492)	44(34.9%)	82(65.1%)	126(25.6%)
Mean age of first sex (n=126)	17.4± 2.5)	17.7± 2.5	17.6± 2.5
Mean age of partner at first sex (n=102)	25.0± 5.4	18.1± 3.3	20.7± 5.4
Condom used at first sex	3(18.7%)	13(81.2%)	16(12.6%)
Had sex in the last 12 months	29(38.2%)	47(61.8%)	76(59.8%)
Mean number of sexual partners in the 12 months (n=56)	1.4± 0.7	2.2± 1.9	1.8± 1.5
Condom used at last sex			
No	28(44.4%)	35(55.6%)	63 (79.8%)
No response	1(50%)	1(50%)	2(2.5%)
Yes	1(7.1%)	13(92.9%)	14(17.7%)

	Banadir/Gedo	Puntland	Somaliland
Ever given or received money, gifts or other favours in exchange for sex	126 14(20.3%)	4(14.3%)	5(16.7%)
Mean number of transactional encounters per month	8.37± 7.6	1	2± 1
Mean number of transactional partners per month	4.45± 3.0	1	1.25± 0.5
Did you or your most recent partner with whom you exchanged sex for money, gifts, favours use a condom the last time you had sexual intercourse.	n =23 11(73.3%)	1(25%)	2(40%)

Some of the reasons given for not using a condom during the last sexual intercourse (63 participants) included: partner objection, 5 (8%); dislike, 21(33%);; not considered necessary; 13(21%); non-availability, 13 (21%); too embarrassed to buy, 3 (5%).

Transactional sex

Out of the 127 participants that reported having had sexual intercourse, **23 (18.1%) indicated they received money, gifts or other favours in exchange for sex.** When stratified by gender, males had the highest mean number of transactional encounters per month (7.1**±** 7.6) and partners per month (4.45**±**3.04).

Insights from qualitative interviews showed that there is need for more meaningful engagement of young people through peer education to empower them with information and equip them with skills to negotiate their way out of transactional sexual encounters.

There are 11,000 people estimated to be HIV positive with the new modeling. We know that it's much, much higher in women who are engaged in transactional sex. Iin terms of young people, we need to find those who are at risk and programme for them in the way we programme for adults. So, for peer education programmes, we need to engage those adolescents and young people that you are able to find through the study and the hotspots and/or geographical areas and also in terms of types of population.

HIV and RSSH programme manager UNICEF

Two out of every 10 participants reported that their friends had more than one sexual partner and 54% believed it to be okay for men to have more than one sexual partner.

Table 11: Transactional sex by site

	Females	Males	Total
Ever given or received money, gifts or other favors in exchange for sex	127 3(13%)	20(87%)	23(18.1%)
Mean number of transactional encounters per month	3.3± 0.6	7.1± 7.8	6.1± 6.9
Mean number of transactional partners per month	2.0± 2.1	2.0± 3.2	2.0± 2.5
Did you or your most recent partner with whom you exchanged sex for money, gifts, favours use a condom the last time you had sexual intercourse.	n =24 1(7.1%)	13(92.9%)	14(58.3%)

Table 12: Risky sexual behaviour by site

	Females	Males	Total
I believe that my most recent sexual partner has had other sexual partners in the past month (n=127)			
N/A	5(20.8%)	19(79.2%)	24(18.9%)
Agree	10(34.5%)	19(65.5%)	29(22.8%)
Unsure	4(25%)	12(75%)	16(12.6%)
Disagree	25(56.8%)	33(39.8%)	58(45.7%)
I sometimes give/receive money or gifts in exchange for sex (n=127)			
N/A	5(29.4%)	12(70.6%)	17(13.4%)
Agree	4(15.4%)	22(84.6%)	26(20.5%)
Unsure	4(36.4%)	7(63.6%)	11(8.7%)
Disagree	31(42.5%)	42(57.5%)	73(57.5%)
Many of my friends currently have more than one sexual partner			
N/A	0	8(100%)	8(6.3%)
Agree	15(24.2%)	47(75.8%)	62(48.8%)
Unsure	4(36.4%)	7(63.6%)	11(8.7%)
Disagree	15(54.4%)	21(45.6%)	46(36.2%)

Access to condoms and barriers

Pharmacies, shops and health centres were the places most mentioned by young people when asked where they could obtain condoms. Yet 56% of the participants didn't know how long it would take to obtain a condom should they need to while 4.7% of respondents estimated it would take them more than an hour.

Despite some health workers, peer educators and NGO workers providing information to young people about the importance of condom use in HIV prevention, they seem not to be easily accessible and are deemed unacceptable in the Somali community since condom use is seen as a way of promoting promiscuity. Other challenges cited in relation to accessing condoms include their high cost plus the often-critical attitude of health workers towards young unmarried persons purchasing them. An additional factor was the very limited number of facilities that offer the requisite services and the lack of privacy on offer.

There are two barriers -- access to the commodities and access to information. If access to commodities is a challenge, how do you make them easily available and where can you buy these commodities?
If you go to the pharmacy, how do you ask, even if it's for the "birth spacing" pills. Here, that is a positive name. When you call it family planning in Somali they say ''child spacing tablet" because when a woman comes to the pharmacy and asks like this the pharmacy and the people automatically believe that she is married
Chairperson of Somaliland Y-PEER organization

If you are seen carrying a condom, the first thing that comes to people's minds is that ''you are doing adultery", a taboo in Somalia. The same applies to premarital sex. So, if you are married, you are married, if you are not married, you cannot engage in illicit sex. Anyone, a girl, a boy, a teenager, seen carrying a condom, will have a bad name in the community and will not be welcomed. . Even though people engage in illicit sex, it is not something you can talk about. Women cannot go and seek condoms even though they themselves are involved in illicit sex. There was a time we had a medical store in Galka'yo and South-Central when it was not peaceful --, Al-Shabaab were controlling these areas. Galka'yo was the humanitarian hub, where we stored reproductive health commodities once they were transported from the port city of Berbera. So, all the condoms that were meant for Somaliland were here and Somaliland refused to use the condoms. They demonstrated (Al-Shabaab) and the Ministry of Health refused.
UNFPA gender and youth specialist

Table 13: Accessibility to condom by gender

	Females	Males	Total
Time to obtain condom			
<10 minutes	3(18.7%)	13(81.2%)	16(12.6%)
<30 minutes	0	10(100%)	10(7.9%)
Up to 1 hour	1(16.7%)	5(83.3%)	6(4.7%)
Longer	1(16.7%)	5(83.3%)	6(4.7%)
Don't know/No response	32(42.7%)	43(57.3%)	75(56.1%)
Can obtain condom every time needed	2(6.7%)	27(93.1%)	29(22.8%)

HIV Risk Perception

A total of 21(16%) reported having had sexual intercourse while under the influence of alcohol or drugs. Overall, 101 (20.5%) considered themselves to be at risk of contracting HIV. Compared to Somaliland (7%), more participants in Banadir/Gedo and Puntland considered themselves to be at greater risk of contracting HIV. Three main reasons cited for being at risk included: working as a healthcare worker; having multiple sexual partners; and, practicing unsafe sex.

Reasons cited by 387 (79%) respondents for not believing -themselves at risk of contracting HIV included: fear of Allah; abstaining from sex; and, being faithful to one partner.

HIV testing

Overall, 196 (39.8%) knew where they could get confidential results for a HIV test, while a majority of respondents were unaware. Similarly, 189 (38%) knew a place where

Table 14: HIV risk perceptions

	Females	Males	Total
Considers self at risk for contracting HIV			
No	192(49.9%)	195(50.4%)	387(78.7%)
Yes	35(34.6%)	66(65.3%)	101(20.5%)
Don't know	1(1.4%)	1(3.57%)	0(0%)
Reason for being at risk			
Many partners	4(38.5%)	18(81.8%)	22(20.9%)
Practice unsafe sex	8(28.6%)	20(71.4%)	28(26.7%)
Engage in risky behaviour-drugs	0	4(100%)	4(3.8%)
Blood transfusion	8(53.3%)	7(46.7%)	15(14.3%)
Health worker	7(31.8%)	15(68.2%)	22(20.9%)
Reason for not being at risk	n=387		
Abstain from sex	29(28.2%)	74(71.8%)	103(26.6%)
Faithful to partner	21(60%)	14(40%)	35(9.0%)
Always use condoms	1(12.5%)	7(87.5%)	8(2.1%)
Fear Allah	145(55.8%)	115(44.2%)	260(67.2%)
Don't share sharp objects	32(55.2%)	26(44.8%)	58(15%)
Never got blood transfusion	21(56.8%)	16(43.2%)	37(9.6%)

people in their area could go to receive HIV counselling whereas 303 (62%) did not. When stratified by site, more participants in Mogadishu and Puntland knew where they could get HIV counselling compared to those in Somaliland. Overall, 36 (7%) reported having been given condoms in outreaches through active campaigns. Only 16 (27%) participants reported having last tested for HIV more than a year ago and 25 (42%) less than one year ago. Of the 59 that ever tested for HIV, only 39 (66%) reported receiving counselling after being tested.

Exposure to HIV Programmes and Information

Asked their preferred source of HIV information, survey respondents indicated, three main sources -- health **facility, radio and peer educators.** Only 33% reported to have heard of any agencies/organizations addressing the HIV/AIDS needs of their community. In Banadir/Gedo and Puntland, health workers and friends were the most preferred sources for HIV information. In Somaliland, the choice was health worker and NGO worker. There were more respondents in Puntland than elsewhere who reported having heard of agencies/organizations addressing the HIV & AIDS needs of their community.

Overall, very few participants reported having obtained free condoms in the previous 12

Figure 4 VCT information by site

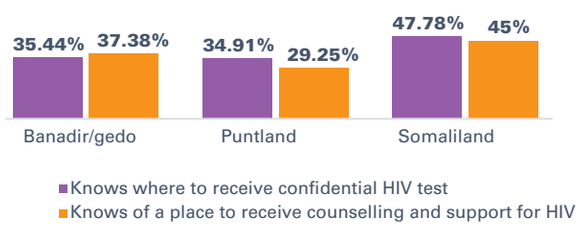


Table 15: HIV testing by site

	Females	Males	Total
Knows where to receive confidential HIV test	85(43.4%)	111(56.6%)	196(39.8%)
Knows of a place to receive counselling and support for HIV	80(42.3%)	109(57.7%)	189(38.4%)
HIV test was taken voluntarily	16(40%)	24(60%)	40(67.8%)
HIV test Required	7(43.7%)	9(56.2%)	16(27.1%)
Last test taken (n=59)			
<one year ago	17(45.9%)	20(54.1%)	37(62.7%)
>one year ago	7(43.7%)	9(56.3%)	16(27.1%)
Don't know/No response	0	6(100%)	6(10.2%)
Received counselling after last HIV test	14(35.9%)	25(64.1%)	39(66.1%)
Reason for not getting HIV test (n=433)			
Don't want to know	80(44.7%)	49(59.8%)	57(33.1%)
No risk behaviour	70(39.1%)	15(18.3%)	107(62.2%)
Not sexually active	3(1.7%)	16(19.5%)	17(9.9%)
No cure	6(3.3%)	6(7.3%)	3(1.7%)
No access to VCT	8(4.5%)	13(15.8%)	11(6.4%)
Lack of privacy and confidentiality	9(5.0%)	12(14.6%)	7(4.1%)

Table 16: Sources of HIV information

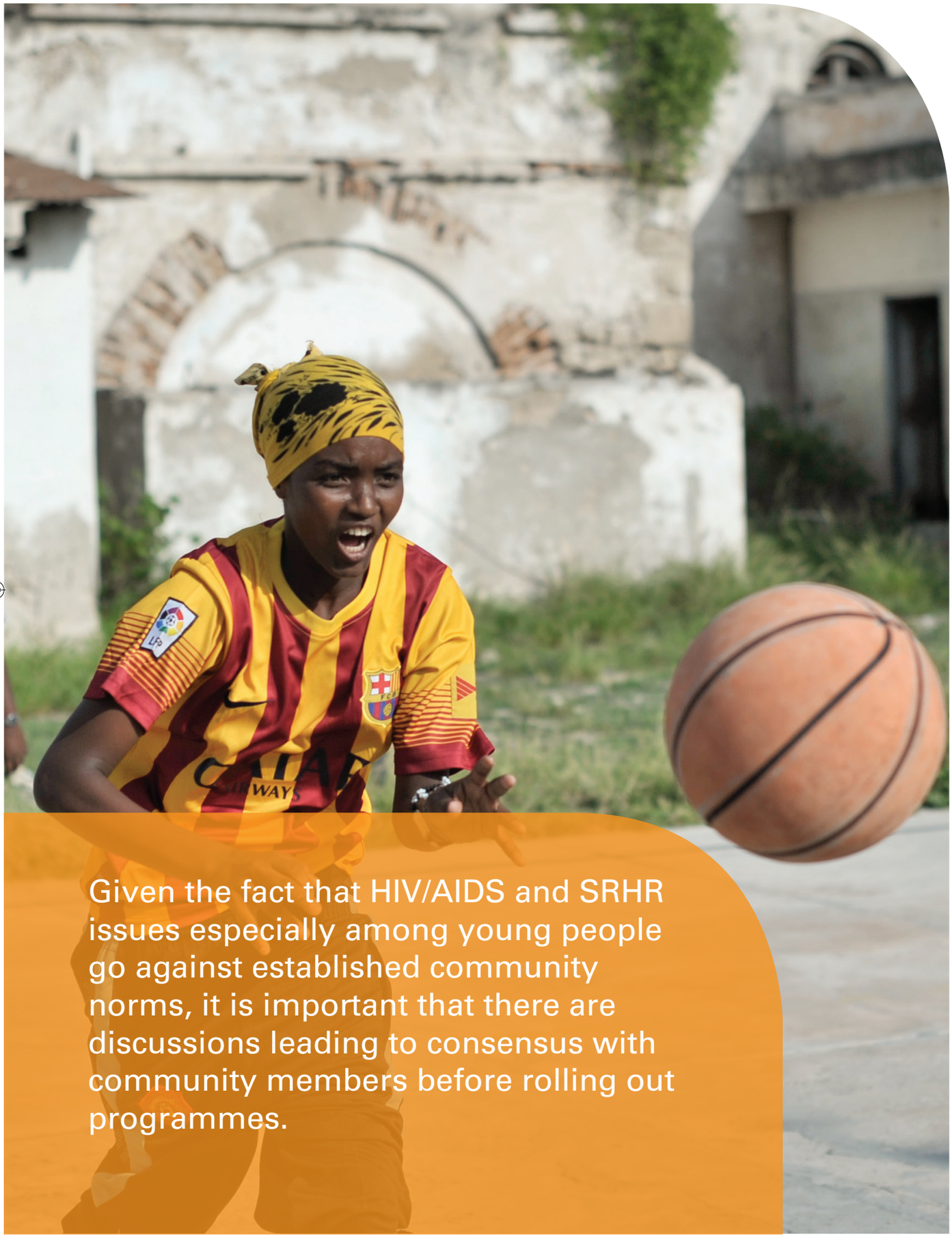
	Females	Males	Totals
Preferred source of HIV prevention information			
Clinic/Hospital	80(38.8%)	43(40.6%)	17(9.4%)
TV	109(57.1%)	82(42.9%)	191(38.8%)
Radio	94(44.5%)	117(55.4%)	211(42.9%)
Newspapers	23(41.8%)	32(58.2%)	55(11.2%)
Peer educators/outreach workers	19(52.8%)	17(47.2%)	36(7.3%)
Other	19(8.2%)	17(6.4%)	36(7.3%)
Type of person they would prefer to receive HIV information from			
Friend	68(48.6%)	72(51.4%)	140(28.5%)
Family member	32(65.3%)	17(34.7%)	49(10%)
Health workers	127(46.7%)	145(53.3%)	272(55.3%)
Elders	18(54.5%)	15(45.4%)	33(6.7%)
Religious leaders	43(53.1%)	38(46.9%)	81(16.5%)
NGO workers	56(60.9%)	36(39.1%)	92(18.7%)
Peer educators	13(52%)	12(48%)	25(5.1%)
Colleague	12(5.3%)	5(1.9%)	17(3.5%)
Heard of any agencies/organizations addressing the HIV/AIDS needs of the community (n=492)	81(39.3%)	57(53.8%)	61(33.9%)
During the last 12 months done the following:			
Attended a meeting or function about HIV/AIDS	36(46.4%)	222(53.6%)	414(15.8%)
Received information in the form of leaflets or booklets about HIV/AIDS	72(57.6%)	53(42.4%)	125(25.4%)
Received information from a teacher	88(53.3%)	77(46.7%)	165(33.5%)
Attended theatre show on HIV	18(40%)	27(60%)	45(9.1%)
Obtained free condoms	5(15.6%)	27(84.4%)	32(6.5%)
Talked with a peer educator/outreach worker	45(44.5%)	56(55.5%)	101(20.5%)
Talked with a peer educator from UN agency	32(43.8%)	41(56.2%)	73(14.8%)
During last 12 months taken HIV/AIDS more seriously as a result of			
Leaflets or booklets or posters	59(44.9%)	207(55.1%)	116(23.6%)
HIV/AIDS activities in the community	60(45.4%)	72(54.5%)	132(26.8%)
Knowing or talking to someone with HIV	33(37.1%)	56(62.9%)	89(18.1%)
Knowing someone who has died of AIDS	46(46.9%)	52(53.1%)	98(19.9%)
AIDS statistics	37(45.1%)	45(54.9%)	82(16.7%)
Talking to a health worker/nurse/doctor	53(49.5%)	54(50.5%)	107(21.7%)
Having a HIV test	25(45.4%)	30(54.6%)	55(11.2%)
Talking to friends	55(47.8%)	60(52.2%)	115(23.4%)
Talking to family members	40(46%)	47(54%)	87(17.7%)
Talking to a peer educator	33(44%)	42(56%)	75(15.2%)
Listening to a teacher	87(54.7%)	72(45.3%)	159(32.3%)
Listening to Friday sermons	19(32.2%)	40(67.8%)	59(12%)

months. Most (33%) participants reported having received HIV information from teachers while15.2% reported having talked to a peer educator in the previous 12 months. Interestingly, 14.8% reported talking to a peer educator from a UN agency in the preceding 12 months.

As shown in table 17, half of the respondents reported changing their behaviour after taking HIV/AIDS more seriously. In Banadir/ Gedo (53.2%) and Somaliland (58%) slightly more than half of the respondents reported to have changed their behaviour after taking HIV/AIDS more seriously. Puntland had the least behaviour change prevalence. Some of the main behaviour changes made included abstinence, fidelity to partner and not sharing sharp objects.

Table 17: Behaviour Change Communication

	Females	Males	Total
Done anything to change behaviour since taking HIV/AIDS more seriously	65(43.6%)	84(44.4%)	149(50.3%)
Changes behaviour by			
Abstaining from sex (158)	21(32.8%)	43(67.2%)	64(40.5%)
Being faithful to partner (158)	19(46.3%)	22(53.7%)	41(26%)
Always use condoms	4(50%)	4(50%)	8(5.1%)
Not share sharp objects	21(60%)	14(40%)	35(22.1%)
Never getting blood transfusion	12(50%)	12(50%)	24(15.2%)
Other	10(71.4%)	4(28.6%)	14(8.9%)



Given the fact that HIV/AIDS and SRHR issues especially among young people go against established community norms, it is important that there are discussions leading to consensus with community members before rolling out programmes.

4

CONCLUSION

Since community, cultural and social norms strongly forbid premarital sex, unmarried adolescents are likely to shy away from seeking SRH services when in need.

4. Conclusion

While most of the participants **reported being knowledgeable about HIV/AID**S. a majority had a very basic knowledge, with only a few having an in-depth understanding. The study also noted that widespread misconceptions and misinformation about how HIV/AIDS is transmitted seemed to unduly influence youth perceptions and sexual behaviour and their response to PLWHIV in the community. The strong influence of religious and cultural beliefs in Somalia was observed to have taken prominence over the right of young people to seek care and access services including SRH services. Compared with other regions in Africa, public awareness of HIV/AIDS is relatively low in Somalia, and the available information on HIV prevalence and risk behaviour limited, leaving communities vulnerable to the virus due to lack of information. There is great need to educate community and religious leaders on HIV/AIDS.

The mean age sexual debut reported in the quantitative survey was 17 years. This is in line with what IOM found in 2012 [7]. The factors associated with early or delayed sexual debut were: in/out of school status, peer pressure, poverty and curiosity. Adolescents who have access to comprehensive age-appropriate sexuality education before they become sexually active are more likely to make informed decisions about their sexuality and approach relationships with more self-confidence [8]. Research has also shown that school-based, comprehensive age-appropriate sexuality education plays a critical role in delaying sexual activity and deterring risky sexual practices. It also encourages the use of condoms and other contraceptives, increases voluntary HIV testing, and reduces adolescent pregnancy (less sexual intercourse - fewer sexual partners) [9] [10]. Increased awareness is needed in order that CSE can support young people to make empowered decisions around their SRH. This is also confirmed by Wahba and Roudi-Fahimi, who emphasize the need for education and the better integration of comprehensive sexuality education in school curricula [11]. Also highlighted was the need to involve the community in fostering inter-generational communication in support of young people's SRHR and to counter social norms that hinder young people from accessing health services, especially SRH services.

7 http://publications.iom.int/system/files/pdf/somalia_youth_survey_final.pdf

8 Sidze E.M., Stillman M., Keogh S., Mulupi S., Egesa C.P, Leong E., Mutua M., Muga W., Bankole A. and C.O. Izugbara (2017). From Paper to Practice: Sexuality Education Policies and Their Implementation in Kenya.

9 Sidze E.M., Stillman M., Keogh S., Mulupi S., Egesa C.P, Leong E., Mutua M., Muga W., Bankole A. and C.O. Izugbara (2017). From Paper to Practice: Sexuality Education Policies and Their Implementation in Kenya.

10 Mbeba R, M., Mkuye, M, S., Magembe, G, E., Yotham, L, W., Mella, A, O., Mkuwa, S, B. (2012) Barriers to sexual reproductive health services and rights among young people in Mtwara district, Tanzania: a qualitative study. Pan African Medical Journal 2012; 13

11 Wahba, M. and F. Roudi-Fahimi (2012). The need for reproductive health education in schools in Egypt. Policy Brief: Inform, empower and advance. http://www.prb.org/pdf12/reproductivehealth-education-egypt.pdf

Risky sexual behaviour such as drug use while having sexual intercourse and, transactional sex while numerically low were nonetheless significant for a conservative community where HIV/AIDS and SRHR issues are frowned upon. In such circumstances, it is essential to provide young people with empowerment and negotiation skills to help them be responsible for their own wellbeing and to make safe decisions. Regardless of this, the challenge remains that if services are not available, young people find themselves with with no option other than to engage in unprotected sex.

It was repeatedly mentioned in qualitative discussions that **sexual abuse, assault and harassment were common in IDP camps**. Most cases went unreported or were dealt with among families, community and religious leaders. The high incidence of unreported cases could stem from a lack of knowledge about children's rights regarding sexual violence (even ignorance as to what constitutes violence). It could also be ascribed to, fear of being victimized in the community. Equally worrying as revealed by this study is the "solution" provided by community and religious leaders to resolve cases of sexual violence, whereby the **perpetrator is forced to marry the victim.** To address this gap, there is need to provide young people and the community at large with the information and skills to help them understand the impact of sexual violence on the affected girl or boy in order to acknowledge the non-acceptance of sexual violence through actions against perpetrators.

A majority of participants reported that their preferred source of HIV information was the health facility and radio. The majority also indicated preferring to receive HIV information from friends and health workers. This is not surprising, since peer influence plays an important role in development and socialization during adolescence. Studies have shown that peers can influence each other either positively or negatively. This study found that some participants who had interacted with peer educators got some HIV information. Studies on the effectiveness of peer education have shown that some interventions increased SRH knowledge and condom use, delayed sexual debut, promoted gender-equity and prevented STIs. However, varied results have been reported on peer-led programmes, with the young people who directly receive the peer training often benefitting the most [12].

In as much as the youth also preferred receiving HIV information from health workers, access to services was limited and facilities were not youth-friendly characterized by a lack of privacy, and negative attitudes among health workers. This resulted in stigma and discrimination and lack of confidentiality. Studies have shown that confidentiality is a major factor when it comes to determining the use of SRH services by young people, there is need to train healthcare providers on the principles of confidentiality and privacy. This study has shown that a good number of facilities providing SRH services are adult-centric. Previous research has indicated the need to integrate youth-friendly services into health facilities, to reconsider the criteria that help determine the allocation of available resources in the localities, and to help young people feel free to disclose sensitive SRH matters to health providers

12 Villa-Torres L. et al. J. (2015). Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs. Journal of adolescent health.

13. Some respondents indicated that they have not accessed SRH services because they do not know where to go or where to find such services. This goes to prove that it is not sufficient to simply ensure the availability of such services14. Additionally, youth-friendly centres lack adequate supplies of family planning commodities as well as skilled personnel with the right empowering attitude to win the confidence of young people. Study participants suggested that a truly youth-friendly centre should provide the following: commodities; trained, skilled and supportive staff; equipment (both clinical and recreational); and information, education and communication materials. Moreover, the premises should be clean, safe and comfortable.

Since community, **cultural and social norms strongly forbid premarital sex**,unmarried adolescents are likely to shy away from seeking SRH services when in need. They are more likely to try to deal with the situation on their own or seek help from friends whom they can trust to keep their secrets.

Recommendations

- There is need for an age-appropriate curriculum that incorporates important life skills in schools and out of school. This has relevance for young people who are engaged in (transactional) sexual relationships. Also, more insights are needed about the quality of SRHR information and education currently being provided.
- There is need to increase the level of involvement and participation by young people in youth programmes on a sustainable basis -- e.g. improving youth health and lobbying for their representation in local and national health and development programmes.
- There is need for resource mobilization for HIV & AIDS prevention programmes among the youth to avoid negative impact in the future. These resources can be used to develop and maintain youth-friendly centres/clinics and to develop programmes and provide commodities for young people in the communities.
- There is need to engage in public education efforts so that community members can learn about HIV/AIDS and youth SRH issues in culturally sensitive ways, thereby increasing prospects for attitude change within their community.
- Increase health worker training especially on stigmatization, privacy and confidentiality because they are the main barrier to young people's access to health services.
- Increase coverage and introduction of the youth-friendly services concept in health facilities to increase availability, accessibility and utilization of SRH services. This can be achieved by developing standards and guidelines of the services offered.

13 Mehra et al. (2013). Doctor-Patient Gender and Interactions in a medically underserved population. Journal of Academy of Taiwan Business Management Review, 9, 2, 1-9.

14 Erulkar, A. S., Onoka, C, J. and A. Phiri (2005). What is Youth-Friendly? Adolescents' Preferences for Reproductive Health Services in Kenya and Zimbabwe. African Journal Health; 9(3): 51-58

- Promote greater tolerance and understanding among religious leaders about HIV prevention programming and, by extension, SRH services

- There is need to conduct analysis of social marketing opportunities for condom as well as other contraceptive methods to increase uptake and better utilization of these HIV prevention commodities

- Need to emphasize strengthening community engagement programmes to increase knowledge and attitudes towards better HIV prevention activities in general, especially among adolescents, as well as to increase access to SRH services

- There is need for creating champions among religious leaders to support HIV preventive activities that go beyond abstinence. The Government can offer religious leaders education tours to learn from other Muslim majority countries on how they have managed the spread of HIV over the years

- There is need to increase availability and utilization of quality data and information for planning, monitoring and evaluating HIV & AIDS programmes at all levels

5. Appendix:

Questionaire

1. Socio-demographic Questions

This survey only interviews youth aged 15-24 regardless of marital status. If the respondent is younger than 15 or older than 24, do not interview this person

100	What is the name of this area	1.Dullow 2. Hargesia 3. Garowe 4.Mogadishu 5. Wajale 6. Bossaso	
101	Sex of respondent	Male 1 Female 2	
102	In what month and year were you born?	Month [_____] Don't know 98 No response Year [_____] Don't know 98 No response99	
103	How old are you?	Age [_____] Don't know 98 No response	
104	Have you ever been married?	Yes No	
105	What is your current marital status?	Single Married Separated/Divorced Widowed	
106	Do you have a child(ren)?	Yes No	If No skip to Q108
107	How many children do you have?	Number ————	
108	Have you ever attended school?	Yes 1 No 2 No response 99	
109	What is the highest level of schooling you have completed?	None 1 Madrassa 2 Primary 3 Secondary 4 College 5 University 6 Other tertiary 7	
110	Have you ever dropped out of school?	Yes 1 No 2	If No go to 112

111	What is the MAIN reason for taking a break from your schooling?	1. Financial challenges 2. Got married 3. Got pregnant 4. Parents got sick/died 5.Got bored with school 6. Difficulty in understanding at school 7.School closure. 8.Bullying 9. Other reason……..	
112	Are you currently in school?	Yes 1 No 2	If No Skip to Q114
113	What level are you?	Primary 1 Secondary 2 College 3 University 4 Other specify	
114	Do you work to earn money for yourself?	Yes 1 No 2 No response 99	
115	What do you do to earn money?	Truck driver 1 Port worker2 Khat trader 3 Tea seller 4 Trader 5 Farming 6 Casual labourer 7 Family support 8 Other [specify]_____	
116	What do you do with most of this money?	Keep for self 1 Family 2 Other [specify]_____ Don't know 98 No response 99	
117	How often do you listen to the radio?	Never 1 At least once a week 2 At least 2 -6 day a week 3 Daily 4	
118	How often do you watch television?	Never 1 At least once a week 2 At least 2 -6 day a week 3 Daily 4	
119	How often do you read a newspaper / magazine?	Never 1 At least once a week 3 At least 2 -6 day a week 4 Daily 2	

2. Migration and Mobility Questions

200	What is your nationality?	Somali 1 Ethiopian 2 Yemeni 3 Djiboutian 4 Other [specify]_____	
201	How long have you lived here?	Less than one year 1 Between 1 and 3 years 2 Between 4 and 10 years 3 Between 11 and 15 years 4 All my life (Born here) 5	If 5 skip to Q203
202	Why did you move here?	Resident 1 To find work 2 To study 3 Returnee to Somalia 4 Refugee 5 Asylum seeker 6 Forced/trafficked 7 IDP 8 Other [specify]_____	
203	Who do you live with?	Alone 1 With Parents 2 With family (extended) 3 With employer 4 With peers / friends/ co-workers/ students 5 Other [specify]_____ No response 99	

3. Knowledge about HIV and AIDS

Now, I would like to ask you questions regarding your knowledge and perceptions about HIV/AIDS

301	Have you ever heard of HIV or AIDS?	Yes 1 No 2 Don't know 98 No response99	If no or no response skip to Q501
302	How did you hear about HIV/AIDS?	TV 1 Radio 2 Friends 3 Husband/ Wife 4 Health workers 5 Religious leaders 6 Agencies / NGO 7 Posters 8 Print material 9 Other [specify]_____	
303	Do you know of anybody who is infected with HIV or who has died of AIDS?	Yes 1 No 2 Don't know 98 No response 99	
304	Can a pregnant woman infected with HIV or AIDS transmit the virus to her unborn child?	Yes 1 No 2 Don't know 98	

305	What can a pregnant woman do to reduce the risk of transmission to her unborn child?	Take medication 1 Exclusive Breastfeeding 2 Don't breastfeed 3 Other [specify]_____ Don't know 98 No response 99

306	Please tell me whether you agree or disagree with the following statements:	Yes	No	Don't know / No response
a)	Can having sex with only one faithful, uninfected partner who has no other partner reduce the risk of HIV transmission?	O	O	O
b)	Can people protect themselves from HIV infection by using a condom correctly every time they have sex?	O	O	O
c)	Can people get infected with HIV through a mosquito bite?	O	O	O
d)	Can people get infected with HIV by sharing food with someone who is infected	O	O	O
f)	Is it possible for a healthy-looking person to have HIV?	O	O	O
	Can people protect themselves from HIV infection by abstaining from sex?	O	O	O
g)	Can a mother pass HIV on to her baby through breastfeeding	O	O	O
h)	Can a person get HIV by sharing cutlery, plates and cups with someone who is infected?	O	O	O
I)	Can a person get HIV by getting injections with a needle that was already used by someone else?	O	O	O
	Can circumcising girls reduce the transmission of HIV?	O	O	O
j)	Can male circumcision reduce the transmission of HIV?	O	O	O
	Can a traditional healer cure HIV?	O	O	O
k)	Can people get the AIDS virus because of witchcraft or other supernatural means?	O	O	O
	Can reusing circumcision tools transmit HIV?	O	O	O
		O	O	O
		O	O	O

4. Stigma and Discrimination:

401	What groups of people do you think are responsible for spreading HIV/AIDS? (multiple responses)	Sex workers O Men O Women O Unmarried youth O Military / uniformed services O Married people O Truck drivers O Foreigners O Khat sellers O Drug users O Other [specify]_____

402	**Please tell me whether you agree or disagree with the following statements:**	**Agree**	**Disagree**	**Don't know /No response**
a)	HIV is a punishment from God	O	O	O
b)	I would be willing to share a meal with a person who has HIV/AIDS	O	O	O
c)	If a male or female relative became ill with HIVI would be willing to care for them in my household	O	O	O
d)	If a member of my family became ill with HIVI would want to keep it a secret	O	O	O
e)	If a student has HIV but is not sick he or she should be allowed to continue attending school	O	O	O
f)	If I knew a shopkeeper or food vendor had HIV/AIDS I would continue to buy food from them	O	O	O
g)	If a teacher has HIV but is not sick he or she should be allowed to continue	O	O	O
h)	teaching in school	O	O	O
I)	If a work colleague or fellow student told me that he /she had HIV I would			
j)	support them.			
	If a mother has HIV she should breastfeed.			

5. Sexual behaviour

Now I would like to ask you some personal questions. Some of the topics we'll be discussing are sensitive. You are free not to answer any question that you feel uncomfortable with. I would like to remind you that everything we discuss is confidential.

501	Have you ever had sexual intercourse? (UNGASS) [For the purposes of this survey, 'sexual intercourse' is defined as vaginal or anal sex'.	Yes 1 No 2 No response 99	If No skip to 701
502	How old were you when you had sexual intercourse for the first time? (UNGASS) At what age did you first have sex ?	Age in years [_____] Don't know 98 No response 99	
503	Was a condom used during this first time you had sexual intercourse?	Yes 1 No 2 No response 99	
504	Did you use any other protection during the first time you had sex.	Yes 1 No 2	If yes specify
504b	If Yes in 504 specify other form of protection		
505	What was the age of the person with whom you first had sexual intercourse?	Age in years [_____] Don't know 98 No response 99	
506	Have you had sexual intercourse in the last 12 months? (UNGASS)	Yes 1 No 2 No response 99	If no skip to 511
507	In the last 12 months, how many different people have you had sexual intercourse with? (UNGASS)	No of partners [_____] Don't know 98 No response 99	If 0 skip to 512
508	Did you or your partner use a condom the last time you had sexual intercourse? (UNGASS)	Yes 1 No 2 No response 99	If Yes skip to 510
509	Why didn't you and your partner use a condom the last time you had sexual intercourse?	Not available 1 Too expensive 2 Partner objected 3 Embarrassed to buy 4 Don't like them 5 Used other contraceptive 6 Didn't think it was necessary 7 Other [specify]_____ Don't know 98 No response 99	ALL Skip to 511
510	Who suggested condom use the last time you had sexual intercourse?	Myself 1 Partner 2 Joint decision 3 Don't know 98 No response 99	

511	With what frequency did you and all of your partner(s) use a condom during the past one month?	Every time 1 Almost every time 2 Sometimes 3 Never 4 Don't know 98 No response 99	
512	Which places or persons do you know where you can obtain condoms?	Shop 1 Pharmacy/drug store 2 Market 3 Clinic 4 Health centre /hospital 5 Community Health Worker 6 Friends 7 Guest house / hotel 8 Other [specify]---------- Don't know 98 No response 99	
513	How long would it take you to obtain a condom close to your house or to where you work?	10 minutes 1 Under 30 minutes 2 Up to one hour 3 Longer 4 Don't know 98 No response 99	
514	Can you obtain a condom every time you need one?	Yes 1 No 2 Don't know 98 No response 99	
515	In the past month have you had sexual intercourse while you were drunk or after using any other substances such as khat, drugs?	Yes 1 No 2 Don't know 98 No response 99	If no skip to 517
516	What substances did you use while having sexual intercourse? (multiple responses possible)	Substances used Alcohol Khat Hashish Injecting drugs (LIST OTHER APP CATEGORIES Other [specify]_____	Yes / No O O O O O O O O O O

Transactional Sex:

All the questions in this section are about transactional sex only – that is sex where you gave or received a gift, money or a favour to someone in exchange for sex. Examples of gifts include food, khat etc.

517	Have you ever given or received money, gifts or other favours in exchange for sex?	Yes 1 No 2 Don't know 98 No response 99	If no skip to 522
518	On average, how often do you exchange sex, for money, gifts or favours, per month?	No of times [_____] Once 97 Don't Know 98 No response 99	
519	On average, how many different partners do you exchange sex for money, gifts, favours with, per month?	No of partners [_____] Don't know 98 No response 99	
520	Did you or your most recent partner with whom you exchanged sex for money, gifts, favours use a condom the last time you had sexual intercourse?	Yes 1 No 2 No response 99	
521	During the last 12 months did you ever have sexual intercourse without using a condom with any partner with whom who exchange sex for money, gifts, favours?	Yes 1 No 2 No response 99	

Social Norms:

522	Do you agree or disagree with the following statements?	Not applicable	Agree Strongly	Agree	Unsure	Disagree	Disagree strongly
a)	I believe that my most recent sexual partner has had other sexual partners in the past month	O	O	O	O	O	O
b)	I sometimes give/receive money or gifts in exchange for sex	O	O	O	O	O	O
	Many of my friends currently have more than one sexual partner	O	O	O	O	O	O
c)	It's okay for men to have more than one sexual partner (outside of marriage)	O	O	0	O	O	O

6. STI Symptoms and Treatment Seeking Behaviour:

601	In the past THREE MONTHS, have you experienced any of these symptoms? (multiple responses possible)	Symptoms	Yes	No	
		Sore on genitals	O	O	If no to
		Unusual discharge from genitals	O	O	all skip
		Painful urination	O	O	to
		Swelling in groin area	O	O	701
602	Did you seek treatment for these symptoms?	Yes 1 No 2 No response 99	If yes Skip to 604		
603	Why did you not seek treatment?	Embarrassed 1 Expensive 2 Health worker unfriendly 3 Treatment not available 4 Treatment too far 5 Self-treated 6 Other [specify]_____ Don't know 98 No response 99	ALL SKIP TO 701		
604	The last time you had genital discharge AND/OR a genital ulcer did you do any of the following? (READ OUT OPTIONS, MORE THAN ONE ANSWER IS POSSIBLE)	Yes	No	DK	
	Sought advice/medicine from a general hospital	O	O	O	
	Sought advice/medicine from a maternal and child health clinic?	O	O	O	
	Sought advice/medicine from a private clinic or hospital?	O	O	O	
	Sought advice/medicine from a private pharmacy?	O	O	O	
	Sought advice/medicine from a traditional healer?	O	O	O	
	Took medicine you had at home?	O	O	O	
	Told your sexual partner about the discharge/ulcer	O	O	O	
	Stopped having sexual intercourse when you had the symptoms?	O	O	O	
	Used a condom when having sexual intercourse during the time you had the symptoms?	O	O	O	

7. HIV Risk Perception, Access to and Use of HIV Services:

701	Do you consider yourself at risk of contracting HIV?	Yes 1 No 2 No response 99	If no skip to 703
702	Why do you consider yourself at risk?	Many partners 1 Practise unsafe sex2 Engage in risky behaviour - drugs 3 Blood transfusion 4 Health worker 5 Other [specify] _____ No response 99	Skip to 704
703	Why do you not consider yourself at risk?	Abstain from sex 1 Faithful to partner 2 Always use condoms 3 Fear Allah 4 Don't share sharp objects 5 Never got blood transfusion 6 Others [specify]_____ No response 99	
704	Do you know where you can go to receive a confidential HIV test?	Yes 1 No 2 Not sure 98	
705	Do you know of a place where people in this area can go to receive counselling and support for HIV?	Yes 1 No 2 Not sure 98	
706	In the last 12 months, have you been given condoms (e.g. through an outreach service or clinic)?	Yes 1 No 2	
707	I don't want to know the result, but have you ever been tested for HIV in the last 12 months? (UNGASS)	Yes 1 No 2 Don't know 98 No response 99	If yes skip to 709
708	Why have you not had a HIV test?	Don't want to know 1 No risk behaviour 2 Not sexually active 3 No cure 4 No access to VCT 5 Fear of losing husband /wife 6 Lack of privacy and confidentiality 7 Other [specify]_____	Skip to 713
709	Did you voluntarily have the HIV test, or were you required to take it?	Voluntary 1 Required 2 Other [specify]_____ No response 99	
710	Please do not tell me the result, but did you find out the result of the test? (UNGASS)	Yes 1 No 2 No response 99	

711	When did you have your most recent HIV test?	Less than one month 1 1-3 months 2 3-6 months 3 6-12 months 4 More than 12 months 5 Don't know 98 No response 99
712	After you were tested did you receive any counselling?	Yes 1 No 2 No response 99
713	If you discovered you were HIV positive where would you seek treatment?	Traditional Healer 1 Government Clinic 2 Private Doctor 3 Herbalist 4 Home-based Caregiver 5 Couldn't seek treatment 6 Other (specify).....
714	Why would you seek treatment at this place?	Cheap 1 Close to home / work 2 Provide confidential services 3 Effective 4 Other [specify]_____
715	What services are available for people living with HIV?	1. ARV distribution 2. Counselling 3. Empowerment 4. Nutrition support 5. Don't Know 6. Others specify.....

8. Exposure to HIV Programmes and Information:

801	How would you prefer to hear about HIV and how to prevent it?	Clinic / Hospital 1 TV 2 Radio 3 Newspapers 4 Leaflets 5 Peer educators / outreach workers 6 Counselling as part of HIV/STI testing 7 Mosque sermons 8 Drama/music/circus shows 9 School-based health education 10
802	What sort of person would you prefer to receive information from about HIV?	Friend 1 Family member 2 Health workers 3 Elders 4 Religious leaders 5 NGO workers 6 Peer educators 7 Colleague / someone I work with 8 Other [specify]_____

803	Have you heard of any agencies / organizations addressing the needs of the community in this area in relation to HIV/AIDS?	Yes 1 No 2 Don't know 98

804	During the PAST 12 MONTHS, which of the following apply to you?	Yes	No
a)	I have attended a meeting or function about HIV/AIDS	O	O
b)	I have received information in the form of leaflets or booklets about HIV/AIDS I have received HIV information from a teacher.	O	O
c)	I have attended a theatre show on HIV	O	O
d)	I have obtained free condoms	O	O
e)	I have talked with a peer educatoroutreach worker I have talked with a peer educator from UN agency	O	O

805	In the PAST 12 MONTHS have any of the following made you take the issue of HIV and AIDS more seriously?	Yes	No
a)	Leaflets or booklets or posters	O	O
b)	HIV/AIDS activities in the community	O	O
c)	Knowing or talking to someone with HIV	O	O
d)	Knowing someone who has died of AIDS	O	O
e)	AIDS statistics	O	O
f)	Talking to a health worker	O	O
g)	Having an HIV test	O	O
h)	Talking to friends	O	O
i)	Talking to family members	O	O
j)	Talking to a peer educator from UN/NGOs Listening to a teacher Listening to Friday sermons Watching a theatre show on HIV	O	O

If respondent answers YES to any items in Q 805 ask the following questions. If NOT, end the interview.

806	**Have you done anything to change to your behaviour since taking HIV/AIDS more seriously?**	Yes 1 No 2 No response	If No end interview
807	**What have you done to change your behaviour ?**	Abstain from sex 1 Faithful to partner 2 Always use condoms 3 Don't share sharp objects 4 Never got blood transfusion 5 Others [specify]_____ No response 99	

THANK YOU FOR PARTICIPATING IN THIS SURVEY

Somali Federal Republic
Ministry of Health & Human Services

RESEARCH & ETHICS REVIEW COMMITTEE

ETHICAL APPROVAL

This is to certify that the proposal submitted by:

Principal investigator: Dr. Tabither Muthoni Gitua

Co-Investigator: Fatuma Muhumed

Reference No:

MOH&HS/DGO/1552/Sep/2018

Full project Title:
HIV Youth behavioral Survey

To be undertaken in

Mogadishu and Dolow , Somalia

For the proposed period of research

Has been approved by the Research & ethics committee at the Ministry of Health

On the 22 September 2018

Chairman

Secretary

Ministry of health, Somalia Tell: +252612375800 Email: dg@moh.gov.so/P.O BOX 22

Somaliland National AIDs Commission

Date: 15/09/2018

RE: RESEARCH PROTOCOL: HIV YOUTH BEHAVIOURAL SURVEY

Thank for submitting your research protocol to Somaliland National AIDS Commission (SOLNAC), I am pleased to inform you that the Executive Director has approved your protocol. The approval period is from 13th September 2018 to 30th of January 2019 and is subject to compliance with the following requirements:

a) Only approved documents (informed consents and, study instruments) will be used.
b) All changes (Amendments, deviations, violations etc.) are submitted for review and approval to Executive Director of SOLNAC.
c) SOLNAC will be fully involved in the implementation of the survey and will supervise.
d) Any unexpected adverse events should be reported to SOLNAC.
e) You will be expected to provide progress every three months.
f) Submission of the report within 90 days of completion.

Please do not hesitate to contact SOLNAC office or through email (sl_nac@yahoo.com) for any clarification or query.

Yours sincerely

Nasir A. Farah
Executive Director
Somaliland National Aids Commission

ETHICAL APPROVAL: HIV YOUTH BEHAVIOURAL SURVEY

I am pleased to inform you that the executive director of Puntland AIDS commission(PAC) has received the submission of UNFPA youth behavioral survey draft protocol, questionnaires, focused group discussion and key informant interview guide to the secretariat office you're your review, analysis and approval.

We are pleased to inform you that the study is approved.

The approval period is valid from 2nd October 2018 to 02 October 2019 and is subject to compliance with the following requirements;

a) Only approved documents (informed consents and study instruments) will be used.

b) Any unexpected adverse events should be reported to PAC.

c) Submission of the report within 90 days of completion.

Please do not hesitate to contact PAC burburshe22@gmail.com for any clarification or query.

Yours sincerely

PUNTLAND AIDS COMMISSION PAC EXECUTIVE DIRECTOR

Abdukadir Mohamed Ahmed

Executive director PAC

Puntland Aids Commission, Garowe, Email: pac_sec_aids@hotmail.com, **Mobile: +252907790453**

Survey findings	Expected outcome	Lead activities	Sub-activities	Responsible party
Knowledge and advocacy Low HIV testing & counselling Very low HIV/AIDS awareness among community (youth) Lack of involvement of young people in awareness creation Low knowledge about HIV in terms of transmission	Increased level of HIV knowledge among young people. Increased demand for HIV services Improved access to information and education for young people on HIV & AIDS Increased knowledge and awareness on myths, risky behaviour, services available of HIV	Develop comprehensive BCC strategy & implement throughout the country Creation of communities' awareness through, community engagement & Government engagement Capacity building of health professionals and youth led CSOs Drama performance, mobile theatre performance that promote safe sex awareness on social media. Develop a National Policy against Stigma Train in HIV test, prevention and management Increase number of HFs and multipurpose YFCs and promote free testing and counseling services Include HIV knowledge in the national curriculum. Enhance PE's activities through provision of incentives	Promote radio talks and TV drama and use of public billboards on HIV-related issues. CHWs to conduct home-to-home visits to create awareness. Create awareness in social media, public billboards & increase peer educators, (Sheikhs, PLHIV,) Organize quarterly meetings for health workers to promote community sensitization and increase consumption of HIV prevention commodities Parliament should pass article against stigma with the aim of achieving zero tolerance of stigma Conduct training in information packaging and dissemination of HIV information to youth. Develop and disseminate appropriate materials for HIV prevention and management Promote formation of youth clubs in schools and communities Develop and support mechanisms for sustained behaviour change. Make documentary film on HIV -- include HIV in school curriculum	Government institutions (PAC, MOH, OPHRD/OTHER LINE MINISTERIES) UN AGENCIES, INGOs /LNGOs and COSs
Access to HIV services Lack of youth-friendly HIV services in health facilities Stigma and discrimination in health care facilities youth PE and youth-friendly services are not integrated in HIV health services so hence youth don't use HIV services Fear of contamination by health providers Lack of knowledge about HIV transmission by the youth, barriers of access Reduced funding of HIV services by the Global Fund Incomplete policies, legislations to protect youths at risk of HIV inadequate livelihood and nutritional support for youth and other adults living with HIV Inadequate livelihood and nutritional support for youth and other adults living with HIV	Increase use of ART services by youth in the country Increased access and utilization of treatment, prevention, care and support services for the youth Zero tolerance of stigma towards PLHIV in health care settings especially by health care workers. Improved utilization of HIV services by youth -- youth engaged in service provision of HIV services Zero tolerance of stigma towards PLHIV in health care settings especially by health care workers Improved IC practices in health facilities and improved attitudes, knowledge and practices of health workers. More funds secured for HIV services for youth and other adults Ensure HIV policies, legislations and other strategies are developed and enforced Provide good nutrition for PLWHIV Increased access to the facility service demand. Enhanced capacity of key national coordinating agencies to manage the HIV & AIDS programme effectively	Rehabilitate ART health facilities so that they can provide youth-friendly ART services Increase number of ART centres Enhance quality of ART services by availing job assistants tools and other treatment guidelines in the IRT centres Increase number of health staffs in the ART centres by including more youth peer educators Train health workers in the ART and other hospital department staff on stigma and discrimination of PLHIV Improve infection control & PEP services and provide IC equipment and supplies to hospitals and improve patient safety Engage private sector providers to provide HIV services to youths who prefer to visit private facilities HIV integration with all services including private sectors. Conduct more operational research studies on youth at risk of HIV Establish school health youth-friendly services including HIV and SRH services and linkage of HIV positive youth to ART centers. Increase incentives of the staff and training to improve staff retention. Complete HIV/AIDS policies and legislation for youth Provide nutritional support of the client to increase numbers of the patient taking treatment. Start and improve HIV income-generating activities for youth living with HIV and youth at risk of HIV to reduce their vulnerability Develop a resource mobilization strategy.	Rehabilitation, training of staff on youth-friendly HIV services, supplies, equipment, Identify new hospitals to provide ART centre. Train staff on youth-friendly HIV/ART services. Provide supplies & training of staff on stigma reduction in health facilities. Improve quality of ART services, develop and provide updated job assistants, guidelines and SOPs to enhance the services. Identify and train youth peer educators and connect them to HIV facilities. Train health workers on Infection control and PEP services for all staff in the hospitals and PHC facilities and other selected private facilities so that stigma is reduced and youths and other patients receive ART services as their rights. Develop and write more proposals for youth HIV services, advocate for more resources and use the survey findings as evidence Develop and complete current policies and legislation. Mobilize resources for nutritional support & resources to start income-generating activities for youths with HIV and youth at risk of HIV Training of nurses and doctors on ART guidelines Training of counselors and nurses on VCT & PMTCT guidelines Strengthening PLWHIV Network by integrating their budget. Strengthen hotline services for PLWHIV Conduct donor and NGO mapping to determine areas of operation, activities and funding levels.	Government institutions (PAC, MOH, OPHRD/OTHER LINE MINISTERIES) UN AGENCIES, INGOs /LNGOs and COSs

Stigma and discrimination Low awareness and misconception among communities Limited awareness and negative attitude among health workers on HIV/AIDS and SRH services Poor acceptance among the youth for specific HIV Prevention Services-Condom and testing High level of self-stigma and stigma from the community including their perception towards PLWHIV populations. Low uptake of HTC and delayed disclosure of HIV status.	Increase awareness among communities Improve the awareness among health care providers Increase acceptance by engaging the private sector. Enhanced reduction of stigma and discrimination among PLWHIV Increased numbers of disclosure and timely initiation to ARVS	Develop action plan implement action plan Conduct sensitization workshops for health care workers. Establish working group for HIV and SRH To conduct sensitization workshop on HIV prevention provide supplies for the private sectors Awareness-raising programmes. Psycho-social and spiritual counselling activities. Civic education Programmes. PEER education on HIV & AIDS Income-generation activities	To conduct sensitization workshop on HIV prevention & provide supplies for the private sectors Persistent awareness campaign though local and national media Establishment of working group for advocacy initiatives, which include members of legislative and executive branches, known personalities. Creation of HIV Committees which includes community elders, religious leaders, women and youth groups. Radio talk show TV debates and flash messages on TV IEC materials Large billboards Engagement of influential sheikhs and cultural leaders Schools curricula integration Cross-cutting peer-to-peer training on youth-related HIV & AIDS	Government institutions (PAC, MOH, OPHRD/OTHER LINE MINISTERIES) UN AGENCIES, INGOs /LNGOs and COSs

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