

# REPUBLIC OF SOMALILAND

## NATIONAL POLICY

# HIV/AIDS AND STI PREVENTION AND CONTROL

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### ABBREVIATIONS

AIDs	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
GOS	The Government of Somaliland
HIV	Human Immunodeficiency Virus
ILO	International Labour Organisation
IMSC	HIV/AIDS Inter-Ministerial Steering Committee
KIIs	Key Informant Interviews
MOHL	Ministry of Health and Labour
MTCT	Mother to Child Transmission
NTC	HIV/AIDS National Technical Committee
OIs	Opportunistic Infections
PLHAs	People Living with HIV/AIDS
SACB	Somalia Aid Coordinating Body
STIs	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
TB	Tuberculosis
WHO	World Health Organisation
VCT	Voluntary Counselling and Testing

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## 1. INTRODUCTION

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1.1 The scale and impact of the global HIV/AIDS epidemic is devastating, constituting a formidable challenge to human life, dignity and the enjoyment of human rights, undermining social and economic development. The consequences of inaction and complacency in Somaliland can have equally devastating implications. Low prevalence rates of if left unchecked, rapidly transforms into high rates of infection with consequent social and economic costs. Through strong political, religious and community leadership, Somaliland must intervene early to prevent HIV/AIDS from totally taking off in the general population.

1.2 Worldwide, governments are in the frontline of the fight against HIV/AIDS and other STIs. International development partners are central in the provision of technical and financial support and civil society and the private sector play a vital role. However, the final responsibility for leading and coordinating national efforts to prevent and control HIV/AIDS and STIs and mitigating its impact rests with governments. HIV/AIDS and STIs is a political priority for the Government of Somaliland (GOS).

1.3 Under the auspices of the HIV/AIDS Inter-Ministrial Committee (IMC), the HIV/AIDS National Technical Committee (NTC) has developed the "National Policy on HIV/AIDS and STI Prevention and Control" with multi-sectoral participation to define the GOS's stance on various issues. The most important reasons why a policy is needed include:

- Coherence: To define the Government's position and elaborate guiding principles and a common core of what the Government and its partners should stand for
- Confidence: To clarify the range within which the Government and partners will operate
- Critical Judgement: To indicate a stance to guide decision on what the Government and partners will and will not do on sensitive issues

1.4 The National Policy is not a strategic framework as Somaliland already has one. The HIV/AIDS Action Plan for Somaliland 2004-2006 outlines goals, broad objectives, strategies and specific activities for the prevention and control of HIV/AIDS and other STIs, clarifying and operationalising the vision set out in the Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations 2003 – 2008. Various international development partners are currently leading the resource mobilisation process by translating the Strategic Framework and Action Plan into an application to the Global Fund for HIV/AIDS, TB and Malaria.

1.5 The purpose of the National Policy is to define broad guiding principles in support of the Action Plan, specifically resolving issues which have generated debate and division. Policy components include:

- HIV/AIDS and Human Rights
- Prevention of sexual transmission
- HIV testing
- Counselling
- Prevention of transmission through blood and blood products
- Standard universal precautions
- Prevention of mother to child transmission
- Prevention of transmission through injecting materials and skin piercing instruments
- Treatment, care and support and impact mitigation
- HIV/AIDS in the workplace

1.6 It is envisaged that once resources have been mobilised, the development of comprehensive technical protocols for HIV/AIDS and STI prevention and control service delivery will be conducted, further elaborating the broad guiding principles provided in this policy. To ensure implementation, the National Policy will require the various sectors to integrate HIV/AIDS into their sectoral policies.

## 2. THE CONTEXT

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### 2.1 Prevalence

Since the collapse of the health system in 1991, not much data has been collected about the HIV/AIDS situation in Somaliland and only limited data is available on sero-prevalence and epidemiological trends. In 1999, a community based survey on Knowledge, Attitudes, Beliefs and Practices (KABP) was carried out in Somaliland. The survey revealed a 0.9 percent HIV prevalence in the general population, 4.6 percent among tuberculosis patients and 47 percent HIV prevalence among a limited number of voluntary tested female sex workers. Among antenatal women, HIV and syphilis prevalence were 0.8 and 1.8 percent respectively. According to '*HIV Test Statistic Among Blood Donors in Somalia*' (2002), HIV prevalence is 0.8 percent. However, it is necessary to highlight that various vulnerability factors suggest that the prevalence of HIV/AIDS and other STIs in Somaliland are probably higher.

**Table 1**  
**Prevalence of HIV and other STIs in Somaliland**

<b>HIV prevalence</b>	<b>% Positive</b>
In the general population	0.9
Among tuberculosis patients	4.6
Among a limited number of voluntary tested female sex workers	47.0
Among antenatal women	0.8
*Among Blood donors	0.8 (Including Somalia)
<b>Syphilis prevalence among antenatal women</b>	<b>1.8</b>

[Sources: UNICEF, 1999 and \*HIV/AIDS among Blood Donors in Somalia, 2002]

### 2.2 Modes of HIV Transmission

Even with inadequate data it is reasonable to assume that adult HIV infection in Somaliland is primarily through heterosexual transmission. In children, infection appears to be acquired from the mother during pregnancy, delivery or in the postnatal stage through breastfeeding. Additionally, it can be assumed that a certain percentage of the population has acquired HIV through blood transfusion or through injury or injection with contaminated instruments.

### 2.3 Vulnerability factors for the spread of HIV/AIDS and other STIs

It has been suggested that the following direct and underlying vulnerability factors contribute to the spread of HIV/AIDS in Somaliland:

- Low awareness/lack of information/ denial
- High risk behaviour
- Prevalence of other STIs
- Migration and population mobility
- Conflict & displacement
- Poverty and unemployment
- Inadequate health resources and poor access to care
- Cultural and societal factors (remarriage/ 'dummaal', polygamy, FGM, gender inequality)

### 2.4 Impact of HIV/AIDS

The impact of HIV/AIDS in Somaliland is yet to be fully felt. Due to the low level of awareness, the majority of children and adults infected and affected by HIV/AIDS are ignorant of their situation and can not access the care and support needed. Stigma, fear and denial are the norm.

### 2.5 Somaliland's Response:

2.5.1 Since 1999, various international and local actors have worked to raise community and government awareness on the threat posed by HIV/AIDS and other STIs and mobilise support for action. However, much of these awareness raising efforts have been restricted to the major urban areas and there was limited action to address the issue.

2.5.2 The HIV/AIDS Working Group of the SACB, formed in September 1999, initiated, supported and implemented a number of activities in advocacy, research and integration of HIV/AIDS activities in other sectors, programmes targeting different social groups and training in counselling activities. Despite efforts promoting the participation of other sectors in the working group, health remains the primary sector working on HIV/AIDS. In response to the high STI prevalence in Somaliland, a collaborative pilot programme integrating Syndromic Management of STIs services into the existing referral system was launched as an

entry point to HIV/AIDS management. As part of this effort, STI kits were provided, information packages were translated into Somali and several health personnel were trained in syndromic management and counselling skills. Furthermore, blood safety control services have been established in major hospitals where screening of all blood donors is undertaken. Although test kits have been supplied and service providers have been trained, quality control and supervision require strengthening.

2.5.3 A major breakthrough was seen with the first public declaration of an HIV positive status in Somaliland by a veterinary doctor and his wife who have since passed away. Furthermore, a small anonymous self-help groups of PLHA was coming together. However, fear, stigma and discrimination have successfully precluded the visibility and the active participation of PLHA.

2.5.4 High political support presents a significant opportunity to prevent the HIV/AIDS epidemic from taking hold in Somaliland. The Vice President has publicly announced that HIV/AIDS is a problem in Somaliland. Furthermore the Vice President has formed two Multisectoral bodies under his auspices charged with leading and implementing the national response. The National HIV/AIDS Inter-Ministerial Steering Committee (IMSC), chaired by the vice president includes the Ministers of six key line ministries. The National HIV/AIDS Technical Committee (NTC), chaired by the Director General of the Ministry of Health includes technical representatives from the six key line ministries as well as civil society organisations and international development partners. Both the NSC and the NTC participated in the development of and fully endorsed the "Strategic Framework for the prevention and control of HIV/AIDS and STIs within Somali Populations 2003-2008" as well as the "Somaliland HIV/AIDS Action Plan (2004 – 2006)". The government is committed to financially supporting the national response and also requests for international cooperation in this regard.

2.5.5 The National HIV/AIDS policy will further contribute to the national response by addressing sensitive issues such as prevention of sexual transmission, the rights of PLHA as well as confidentiality.

### **3. GOALS, OBJECTIVES AND PRIORITY STRATEGIES**

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3.1 The National Policy adopts the goals, objectives and priority strategies outlined in the HIV/AIDS Action Plan for Somaliland 2004 – 2006, which clarifies and operationalises the vision set out in the Strategic Framework for the Prevention and Control of HIV/AIDS and STIs within Somali Populations 2003 – 2008.

3.2 The **overall vision or goals** of the Policy are:

1. To prevent the spread of HIV/AIDS in Somaliland (containment below epidemic levels).
2. To prevent and reduce the prevalence of other STIs in Somaliland

3.3 The **broad objectives** of the policy are:

1. To reduce the incidence of HIV infection and STIs in adults and children through strengthened support to preventive efforts.
2. To empower individuals, families and communities with knowledge and skills for HIV/AIDS prevention and community/home-based care.
3. To establish programme management structures for the coordination, monitoring and evaluation of the HIV/AIDS and STI response implementation.
4. To ensure that all people living with HIV and their families have access to services that are of high quality and affordable.
5. To ensure that people living with HIV/AIDS and their families are not subjected to discrimination
6. To ensure continuous support by both local and international communities in addressing the impacts of HIV/AIDS.

3.4 The National Policy principally aims to achieve the above goals and objectives through the following **priority strategies**:

1. Strengthening advocacy, resource mobilisation and policy formulation
2. Increased awareness and community mobilisation
3. Increased availability, quality and accessibility of safe services
4. Promotion of comprehensive prevention and treatment
5. Reduction and mitigation of negative impacts of HIV/AIDS epidemic
6. Improved knowledge-based response management and implementation

3.5 **Cross-cutting elements of the priority strategies**

1. Gender mainstreaming throughout the HIV/AIDS response
2. Capacity building for a multi-sectoral response

3. Involvement of people living with HIV/AIDS
4. Special target populations for behaviour change
5. Creating an enabling environment

#### 4. POLICY DEVELOPMENT AND IMPLEMENTATION

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4.1 Various qualitative research methods were utilised with 154 stakeholders including central and regional government officials from all sectors, education and health service providers, civil society organisations, religious and community leaders, young people, women and international development partners to develop a needs analysis and ensure participation, consensus building and support for the concept of a National Policy. The consultative process was very much an advocacy and awareness raising exercise as well as an extractive one. Stakeholders were given information, options and examples from other countries on how particular HIV/AIDS and STI issues can be dealt with.

**Table 1**  
**Participants of the Consultation Process**

Participants	Hargeisa	Berbera	Boroma	Burco
Inter-ministerial Steering Committee	1			
National Technical Committee	11			
Government Ministries	14	3	4	
Civil Society Organisations		17	13	3
Girls (under 18)	12			8
Boys (under 18)	12			7
Religious leaders		8		
Teachers	3			
Private Sector	0			
Healthcare Workers	8		1	
International Development Partners		18		
<b>Total</b>	<b>104</b>	<b>16</b>	<b>8</b>	<b>26</b>

**Table 2**  
**Age and Gender of Participants of the Consultation Process**

Gender	Male	Female	Total
Under 18	19	20	39
Over 18	76	39	115
<b>Total</b>	<b>95</b>	<b>56</b>	<b>154</b>

4.2 The NTC utilised the outcome of the consultative process together with the assessment of international normative guidelines and the national policies of other countries, especially other Muslim countries, to put together the first draft national policy. This draft was circulated widely to all stakeholders for feedback and a National Workshop was held to review the strengths and weaknesses of the proposed policy components for acceptability, technical soundness and feasibility and ensure consensus among stakeholders.

**Table 3**  
**Participants of the National Workshop**

*<TO BE INSERTED AFTER THE WORKSHOP IS HELD>*

4.3 As policy development and implementation is a dynamic process, the National Policy shall be:

- submitted to Parliament for endorsement;
- communicated to all stakeholders;
- integrated into all government sectoral policies;
- elaborated into comprehensive service delivery protocols and specific laws and policies once financial and technical resources have been mobilised.
- continually reviewed in the light of new sero-prevalence and epidemiological data;
- monitored for its successful implementation and evaluated for its effectiveness.

#### 5. POLICY COMPONENTS

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## 5.1 HIV/AIDS AND HUMAN RIGHTS

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### 5.1.1 Rationale

The wide spread abuse of human rights and fundamental freedoms associated with HIV/AIDS has emerged as a serious issue worldwide. Yet it has been recognised that when human rights are protected fewer people become infected and those living with HIV/AIDS and their families can better cope with HIV/AIDS. The Government of Somaliland recognises that the rights of people who are vulnerable, infected and affected by HIV/AIDS should be safeguarded and protected. People who are vulnerable, infected and affected by HIV/AIDS have the same rights as any other persons in the community.

### 5.1.1 Policy statements

To implement an effective human rights based response in line with international guidelines, the Government will:

- a. **Strengthen the national framework for its response to HIV/AIDS**, ensuring a coordinated, participatory, transparent and accountable approach, and integrating HIV/AIDS policy and programme responsibilities across all branches of government.
- a. **Sectoral policies to address discrimination**: Sector policy makers, including labour, corporate and social services sectors shall ensure that sectoral policies are put in place that effectively address discrimination on the basis of HIV/AIDS and take steps to effectively address discrimination in their institutions and in the implementation of their sectoral mandates.
- b. **Community consultation and participation**: Ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.
- c. **Review and reform public health laws** to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.
- d. **Review and reform criminal laws and correctional systems** to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against people living with HIV and other vulnerable groups.
- e. **Ensure that public health laws and systems represent a sound policy response to individual conduct that carries the risk of HIV transmission**, taking a graduated approach that employs coercive measures as a last resort and incorporating procedural safeguards to avoid the misuse of such powers in violation of human rights.
- f. **Enact anti-discrimination and other protective laws** that protect vulnerable groups, PLHA and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for speedy and effective administrative and civil remedies.
- g. **Enact legislation to provide for the regulation of HIV-related goods, services and information**, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information and services.
- h. **Rights education and provision of legal services**: Ensure support services that will educate people affected by HIV/AIDS about their rights, provide legal services to enforce these rights and develop expertise on HIV related legal issues.
- i. Collaborate with and work through communities, to **promote a supportive and enabling environment for women, children and other vulnerable groups** by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.
- j. Promote wide and ongoing distribution of creative education, training and media programmes explicitly designed to **change attitudes of discrimination and stigmatization** associated with HIV/AIDS to

understanding and acceptance.

- k. Ensure that the public, private and voluntary sectors develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into **codes of professional responsibility and practice**, with accompanying mechanisms to implement and enforce these codes.
- l. **Ensure monitoring and enforcement mechanisms** to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities.
- m. **Cooperate with international development partners to share knowledge and experience** concerning HIV-related human rights issues and will ensure effective mechanisms to protect human rights in the context of HIV/AIDS at international level.

## **5.2 PREVENTION OF SEXUAL TRANSMISSION**

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### **5.2.1 Rationale**

The primary mode of HIV transmission in Somaliland is through heterosexual transmission. The high prevalence of STIs in Somaliland is a cause for concern because the presence of STIs facilitate transmission of HIV infection. Other reinforcing vulnerability factors include low awareness, lack of information and denial; high risk behaviours; and lack of access to services among other factors. Worldwide a great deal has been learned regarding effective interventions for HIV/AIDS and STI prevention. People have the right to education on how to protect themselves against HIV transmission, including dispelling stigma and discrimination. However, providing people with information has proved to be insufficient in and of itself. People require enabling environments and services to reduce their vulnerability, and allow them to modify their behaviour based on their knowledge gained through information provision. Prevention efforts should be firmly placed in international best practice adapted to suit the religious and cultural contexts of Somaliland. The government and its partners will collaborate and work through communities to prevent the incidence of infection from HIV/AIDS and other STIs, whilst also reducing stigma and discrimination against people infected and affected by HIV/AIDS.

### **5.2.2 Policy Statements**

- a. **Key prevention messages:** Promote abstinence, especially among young people, and being faithful to a mutually faithful partner as effective means to prevent the transmission of HIV/AIDS and STIs, reinforcing religious and cultural values. In order to further increase the effectiveness of being faithful as a means of prevention, partners will be encouraged to be tested and pre-marital voluntary counselling and testing will be encouraged.
- b. **Condoms** of high quality are to be distributed to high risk groups through health facilities, especially attached to relevant services such as STI management, with proper counselling and guidance provided to clients. Other channels for distribution are to be agreed upon and authorised by the Inter-Ministerial Steering Committee. Education on condom use as a measure of HIV prevention, including culturally acceptable information packages, should be provided to high risk groups by healthcare professionals and adequately trained community-based counsellors.
- c. **Increase awareness and community mobilisation** and promote behavioural change through selective, targeted and comprehensive IEC/BCC campaigns for the whole population through relevant multi-sectoral channels.
- d. **Formal and non-formal education sectors:** Integrate life skills-based HIV/AIDS education and counselling in the formal and non-formal education sectors and for older pupils in Madrasses.
- e. **Out of school youth:** Promote HIV/AIDS education and counselling for out of school youth through peer counselling in the community.
- f. **Youth friendly services:** Integrate HIV/AIDS education and other prevention services into multi-purpose community centres offering youth friendly services.
- g. **STI control:** Top priority shall be attached to the prevention and control of STIs as a major strategy for controlling the spread of HIV/AIDS in the country. This includes increasing the availability, quality and accessibility of services for the diagnosis and treatment of STIs as well as HIV and other opportunistic infections in a phased manner.

- h. **Sharing knowledge and experience with other Muslim countries:** The government will collaborate with HIV/AIDS Programmes of other Muslim countries to share knowledge and experiences on Islam and the prevention of HIV/AIDS and other STIs to further strengthen its prevention policy based on the ABC approach.

### 5.3 HIV TESTING

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#### 5.3.1 Rationale

Due to the fear, ignorance and stigma attached to HIV/AIDS, the community is divided on the issue of mandatory testing. The Government prohibits mandatory testing and recognises that violations of the principles of voluntary testing including informed consent and confidentiality is a violation of human rights. Indeed there is no evidence that mandatory testing will achieve the goal of preventing the spread of HIV/AIDS in Somaliland. On the contrary, such an approach will be counter-productive and wasteful of resources as it will create fear, drive high risk groups underground and prevent access to diagnostic and care services. Furthermore, such initiatives create a false sense of security among the general population that all HIV infected persons are known and that there is no need to take necessary precautions.

The WHO recommends that HIV testing should only be carried out for the following purposes:

- Early diagnosis of HIV infection among asymptomatic persons who would like to know their HIV status
- Screening of blood and blood products
- Epidemiological surveillance, particularly HIV sentinel surveillance using unlinked anonymous HIV testing methodology
- Diagnosis of symptomatic infection among those clinically suspected of having AIDS.

HIV testing carried out on a voluntary basis with appropriate pre-test and post-test counselling is considered to be a better policy. Voluntary counselling and testing (VCT) provides an effective means of preventing HIV transmission because it can motivate individuals to initiate and maintain safer sexual relations. VCT also provides an important entry point for improved health status through good nutritional advice and early access to care and treatment for HIV-related illness, psychosocial support and prevention of mother-to-child transmission. Other benefits include safer blood donations.

#### 5.3.2 Policy Statements

##### 5.3.2.1 General principles

- a. **No individual should be made to undergo a mandatory test for HIV.** No mandatory HIV testing should be imposed as a precondition for employment or for providing healthcare facilities during employment, except as may be provided in this policy.
- b. **Informed consent:** Informed consent following adequate counselling shall be obtained from individuals before HIV testing can be done, except as may be provided in this policy.
- c. **Pre-test and post test counselling and follow up counselling:** HIV testing shall be accompanied by pre-test and post-test counselling and follow up counselling if necessary, except as may be provided in this policy.
- d. **Confidentiality:** All HIV testing shall be strictly confidential. The results of an HIV test, including the fact that a test was performed, shall not be disclosed to a third party without the consent of the individual tested, except as may be provided in this policy.
- e. **Voluntary disclosure to partner(s) and family members:** Counselling shall promote voluntary disclosure, emphasising the duty to inform partners to prevent HIV transmission and to inform family members to ensure proper home based care and support. Healthcare professionals shall be trained on how to recommend and assist PLHAs to disclose their HIV status to partners(s) and family members. With the consent of the individual, notification of partner(s) and if necessary, family members can be done by the attending healthcare professional with proper counselling.
- f. **Beneficial disclosure:** In exceptional cases, public health laws shall be made to authorise healthcare workers – including professional and community counsellors - to decide on the basis of each individual case and ethical considerations, to inform partner(s) of the HIV status of their patients if counselling of the HIV positive individual has failed to achieve appropriate behavioural changes and if there is a real risk of HIV transmission to partner(s). Beneficial disclosure shall be subject to explicit guidelines to be developed by government in accordance with International Guidelines on HIV and Human Rights.

- g. **HIV testing for couples:** HIV testing and counselling for couples is effective, and their voluntary participation should be encouraged. Couples will be encouraged to undertake VCT together.
- h. **HIV testing during pregnancy:** VCT shall be promoted and made available to pregnant women attending antenatal clinics and if possible to their partners, to enable the couple to make informed decisions about the prevention of mother-to-child transmission and family planning.
- i. **Pre-marital testing:** Pre-marital VCT will be encouraged and made accessible.
- j. **Development of comprehensive VCT service delivery guidelines:** The Government will develop comprehensive HIV testing guidelines and adopt legislative and other measure to ensure that facilities in the public, private and voluntary sectors alike adhere to them.

#### **5.3.2.2 Voluntary Counselling and Testing (VCT)**

- a. VCT can be ordered by the medical officer approached by the person interested in being tested.
- b. Informed consent of the individual must be obtained and pre-test and post-test counselling and follow up counselling must be carried out.
- c. Test results must be kept strictly confidential with only the following having the right to know the results: the person requesting the test; the counsellor responsible for post-test and follow-up counselling; and, partner(s) and family members only with the informed consent of the individual, although this will be strongly encouraged through counselling.
- d. Good quality, accessible, affordable and confidential VCT services shall be made available throughout the country in a phased manner. All persons of reproductive age and above who want to have a HIV test should have access to the necessary facilities irrespective of their gender, age or marital status. VCT services shall be provided in a non-stigmatised environment and shall give special consideration to increasing women's and young people's voluntary access.

#### **5.3.2.3 HIV Testing of Blood Donors**

- a. All blood and blood products donated shall be routinely screened for the presence of HIV antibodies and other infectious agents.
- b. Such screening shall not require informed consent but will adhere to principles of confidentiality and anonymity.
- c. For donors who wish to know their test results, provision shall be made for follow up VCT, care and support.
- d. Test results must be kept strictly confidential with only the following having the right to know the results: the donor; the Blood Transfusion Service; the counsellor responsible for post-test and follow-up counselling; and, partner(s) and family members only with the informed consent of the donor, although this will be strongly encouraged through counselling.

#### **5.3.2.4 Sentinel Surveillance and epidemiological surveys:**

- e. Testing as part of sentinel surveillance and epidemiological surveys will be anonymous and unlinked and will therefore not require individual consent, pre-test or post-test counselling.
- f. All research protocols and proposals involving HIV testing of subjects or patients must conform with these guidelines, the International Guidelines on Ethics and Research and be approved by the MOH&L and the NTC.

#### **5.3.2.5 Diagnostic testing**

- a. Diagnostic testing for clinical management can be ordered by the medial officer responsible for the care of the patient.
- b. Diagnostic testing will be carried out with the informed consent of the individual, with proper pre-test and post-test counselling and with proper follow up.
- c. If a patient is unable to give informed consent because he or she is unconscious or deemed to be of unsound mind, counselling shall involve the next of kin in order to obtain informed consent before proceeding with diagnostic testing, treatment and clinical care. Public health law shall authorise healthcare professionals to test without consent for diagnosis of an unconscious patient in the absence of the next of kin.
- d. If the patient is a child, it is recommended that mother and child be tested together. Informed consent and pre-test and post test counselling of the mother or principle guardian of the child must be carried out as well as proper follow up.
- e. Test results must be kept strictly confidential with only the following having the right to know the results:
  - the patient (mother or principle guardian if the patient is a child)
  - the healthcare workers directly responsible for the care of the patient

- the counsellor responsible for post-test and follow up counselling.
- in the case of adult patients, partner(s) and family members, only with the informed consent of the patient, although this will be strongly encouraged through counselling
- in the case of child patients, the mother is to decide who else to inform about the results, including giving permission for the result to be communicated to the father.

#### **5.3.2.6 HIV Screening in the armed forces**

- f. The Armed Forces shall be permitted to carry out confidential HIV screening, with pre-test and post-test counselling and proper follow up, as part of their pre-recruitment and periodic general medical assessments for fitness.
- g. HIV testing within the armed forces will be part of a comprehensive HIV/AIDS prevention and control programme for the armed forces to be developed by the government.

## **5.4 COUNSELLING**

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### **5.4.1 Rationale**

Worldwide it has been proved that good HIV counselling - including counselling for behavioural change, pre-test and post-test counselling as part of VCT and ongoing counselling - is effective for HIV prevention and care. HIV counselling assists people to make informed decisions such as whether to have an HIV test; helps people living with HIV or AIDS to accept and cope better with their condition and lead more positive lives; encourages acceptance from families and communities; and helps prevent transmission. Furthermore, the availability of HIV counselling, even without HIV testing, may augment AIDS education in promoting behavioural change.

### **5.4.2 Policy Statements**

- a. **Availability and accessibility of HIV counselling services:** Good quality clinical-based HIV counselling provided by trained healthcare professionals and community-based HIV counselling provided by community members trained in counselling shall be made available throughout the country in a phased manner. This will include counselling for behavioural change, pre-test, post-test and ongoing counselling. HIV counselling shall be made available to PLHA, vulnerable and affected people and all those who need it irrespective of their age, gender or marital status.
- b. **Confidentiality:** HIV counselling shall be voluntary and confidential between a client and a counsellor and discussions shall not be disclosed to a third party without the consent of the individual being counselled, except as may be provided in this policy.
- c. **Couple counselling and family-level counselling** will be encouraged with the consent of the client and based on the concept of shared confidentiality.
- d. **Group counselling among PLHA** has proved to be very effective and will be encouraged.
- e. **Role of religious leaders:** As spiritual care is a component of holistic care, the collaboration of religious leaders in providing spiritual care for PLHA will be encouraged.
- f. **Development of infrastructure and training of counsellors:** The government shall extend all necessary help to create necessary infrastructure for the establishment of clinical and community-based counselling centres and in training counsellors.

## **5.5 PREVENTION OF TRANSMISSION THROUGH BLOOD AND BLOOD PRODUCTS**

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### **5.5.1 Rationale**

Blood transfusion is the most efficient mode of transmission of infectious agents such as HIV, hepatitis B and C, syphilis and Malaria. Infectious agents can also be transmitted through tissue and other blood products. However, transmission-transmitted infections are also the most easily preventable and can be substantially reduced. Nevertheless, existing blood transfusion services in Somaliland face many constraints due to lack of an adequate infrastructure. Phased measures should be taken by the government and its partners to ensure safe and adequate supply of blood and blood products.

### **5.5.2 Policy Statements**

- a. **Blood Transfusion Service:** An efficient and effective blood transfusion service which includes safe and reliable blood banking and transfusion, blood and tissue safety supplies and adequate numbers of trained personnel will be established in a phased manner.
- b. **Motivation, recruitment and retention of blood donors:** Donations which are voluntary, non-remunerated and obtained from low-risk and regular donors will be encouraged. The procedure of blood collection should be made completely safe by using disposable materials to instil confidence in the donors about their own safety. HIV test results should be kept strictly confidential and donors who wish to know their test results should be provided with follow up VCT.
- c. **Screening of blood and blood products:** Screening of blood and blood products for the presence of HIV and other infectious agents shall be mandatory in addition to screening of blood grouping and compatibility of the donor and the recipient.
- d. **Promoting and practising rational use of blood:** Measures will be taken to ensure the rational use of blood – providing the right blood product, in the right quantity, for the right patient – to bridge the gap between demand and supply and prevent exposure of a patient to the risk of disease transmission.
- e. **National Blood Policy and guidelines:** A comprehensive National Blood Policy will be developed, including technical guidelines and standard operating procedures encompassing all aspects of the operation of blood banks and appropriate clinical use of blood and blood products based on WHO guidelines.

## **5.6 UNIVERSAL PRECAUTIONS**

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### **5.6.1 Rationale**

Failure to observe universal precautions for infection control, including the use of gloves and appropriate cleaning techniques when dealing with open wounds and blood spills and the safe disposal of needles and medical waste can increase the risk of accidental exposure to HIV and other blood borne infections. There is always the risk of accidental exposure to HIV infection through needlestick injuries and other contact with blood and blood products in healthcare, workplace and other settings.

### **5.6.2 Policy statements**

- a. **Development of guidelines:** Guidelines for infection control standardised universal precautions shall be adapted.
- b. **Training, information and equipment:** Adherence to universal precautions to reduce the risk of HIV infection through accidental exposure shall be widely promoted. Appropriate training, information and equipment for the application of universal precautions shall be made available to healthcare providers, community and home-based care providers, traditional healers and traditional birth attendants.

## 5.7 PREVENTION OF MOTHER TO CHILD TRANSMISSION

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### 5.7.1 Rationale

HIV can be transmitted from mother to her child during pregnancy, labour and delivery and through breast milk. The desire of couples living with HIV/AIDS to have a child must thus be balanced with the possibility of having an HIV infected baby who has a high risk of dying in early childhood. Reducing mother-to-child transmission (MTCT) involves preventing HIV infection among women of childbearing age; unwanted pregnancy among HIV positive women; and transmission during pregnancy, labour and delivery and breastfeeding. In addition, the death of a parent, especially the mother, drastically reduced the baby's chances of survival. Interventions should therefore also address treatment, care and support for parents so as to minimize orphanhood and improve the chances of child survival.

### 5.7.2 Policy Statements

- a. **Sexual and reproductive rights:** HIV positive women have complete choice in making decisions regarding pregnancy and childbirth. There should be no forcible abortion or sterilisation on the ground of HIV status of women. Proper counselling shall be given to pregnant women to enable them to make appropriate decisions and access prevention, treatment, care and support services.
- b. **Mother and child health services:** Improvement in the availability, accessibility, quality and utilisation of maternal and child health (MCH) services shall be prioritised and ensured in a phased manner as the foundation for intervention to prevent MTCT. Infrastructure, staff skills, supplies and the proper management of services shall be progressively ensured and community based efforts to improve health-seeking behaviour and increase the use of MCH services shall be implemented.
- c. **Promotion of VCT and antenatal care:** VCT for couples planning to have a child and early couple attendance of antenatal care shall be vigorously promoted as an important entry point to prevention and care services and a critical component of MTCT interventions. Every pregnant women attending antenatal clinic, in sites where there is prevention of MTCT services, shall be given the option for an HIV test for the purpose of preventing MTCT.
- d. **The progressive provision of Antiretroviral treatment (ART):** The capacity of the healthcare system for the administration of ART during pregnancy and the time around delivery to reduce the risk of MTCT shall be assessed and efforts will be extended to progressively prepare the necessary infrastructure and train personnel.
- e. **Infant feeding options:** Accurate and accessible information on breast feeding options shall be provided to all pregnant women and their partners.
- f. **Treatment, care and support:** Referral systems shall be identified and strengthened to meet the long term prevention, treatment, care and support needs of mothers and children living with HIV/AIDS.
- g. **Prevention programmes:** Programmes that prevent HIV infection and unwanted pregnancy especially among young women of reproductive age shall be promoted and strengthened. Information and education on prevention of MTCT transmission shall be provided to all pregnant women, their partners and the population at large.
- h. **An enabling environment for women and girls** of reproductive age to participate in the prevention of MTCT and other preventative, care or support programmes without the consent of partners or family shall be provided.

## **5.8 PREVENTION OF TRANSMISSION THROUGH SKIN-PIERCING AND SURGICAL INSTRUMENTS**

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### **5.8.1 Rationale**

Even with inadequate data, it is reasonable to deduce that a certain percentage of people in Somaliland have or will acquire HIV through injury, injection or surgery with contaminated instruments. The use of unsterilised instruments in healthcare facilities including dental surgeries pose a risk of HIV transmission. The use of disposable materials and proper sterilisation of reusable materials can therefore reduce the risk of HIV infection. A similar risk is posed by the use of unsterilised skin piercing and surgical instruments by traditional healers and TBAs as they are often the most accessible or preferred choice of health-related service provision, especially among rural and nomadic populations. Furthermore, there is increased concern about the risk posed by use of unsterilised cosmetic instruments for hair dressing and skin piercing. While it is estimated that approximately 99 percent of all girls and women in Somaliland have undergone the practise of FGM (WHO, 1999a) with many immediate and long-term health consequences, there is increased concern about the link between FGM and HIV infection, especially in the context of use of unsterilised instruments in multiple procedures. While discouraging medicalisation, the eradication of FGM and other harmful traditional practices can reduce the risk of HIV infection.

### **5.8.2 Policy statement**

- a. ***In healthcare facilities:*** Adequate disposable materials and adequate facilities for the disposal and removal of used disposable materials shall be provided at all health facilities. Sterilising equipment for non-disposable materials shall also be provided at all health facilities. Appropriate information on the dangers associated with the use of unsterilised materials and guidelines for the use of disposable materials and the sterilisation of non-disposable materials shall be developed, regularly updated and communicated to all staff in healthcare facilities.
- b. ***Eradication of Harmful Traditional Practises:*** Government and partners will collaborate with and work through communities, to eradicate harmful traditional practises prejudicial to the health and development of children, women and men, including FGM and harmful traditional operations and remedies.
- c. ***Traditional healers and TBAs:*** Appropriate information on the dangers associated with the use of unsterilised skin piercing and surgical instruments will be disseminated to traditional healers and TBAs.
- d. ***Awareness raising and community mobilisation:*** Public education will highlight the dangers associated with the use of skin piercing and surgical instruments with the aim of ensuring that consumers of healthcare services demand sterile materials and instruments. Particular attention will be paid to public education on harmful traditional practices as potential modes of HIV transmission.

## **5.9 TREATMENT, CARE AND SUPPORT AND IMPACT MITIGATION**

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### **5.9.1 Rationale**

Prevention, treatment, care, support and impact mitigation are all mutually reinforcing elements of a continuum of an effective response to HIV/AIDS. HIV infection results in serious medical, emotional, psychological, social and economic consequences for the affected individual and family. Although there is no known cure to-date for HIV/AIDS, infection can not be equated with imminent death. Advances in the management of opportunistic infections (OIs) and the development of effective antiretroviral therapies (ART) mean that illness associated with HIV infection can be treated, improving the quality of life of PLHA. Although affordable drugs are available for the prevention and treatment of OIs, many developing country governments are struggling to support the provision of ART due to their prohibitive costs on account of indefinite period of treatment and other supportive investigations required for monitoring the progress of the disease. Proper nutrition and psycho-social support including support counselling, as well as community home-based care can also help to improve the quality of life for PLHA.

Although several treatment, care and support options are available, the capacity of Somaliland's healthcare system including the quality and effectiveness of existing mainstream services are still weak, providing minimal infrastructure for the establishment of essential HIV/AIDS and STI related services. Furthermore, treatment, care and support to PLHA can only be provided if they voluntarily disclose their status. There are currently few known cases of PLHA in Somaliland due to the low prevalence rate, the lack of testing facilities and VCT guidelines and the prevailing discrimination and stigma which discourages PLHA from disclosing their status and seeking services. Particular attention must be paid to vulnerable populations such as women, youth, disabled people, orphans and vulnerable children as well as high risk groups. Vulnerable populations are underprivileged socially, culturally, economically and politically, are less able to enforce HIV prevention

options and access treatment, care and support information and services. They are therefore more vulnerable to the risk of HIV infection and suffer disproportionately from its impact.

### **5.9.2 Policy statements**

- a. ***Protection of human rights and dignity:*** A conducive legal, political, economic, social and cultural environment shall be ensured in which the rights and dignity of people living with and affected by HIV/AIDS - both adults and children alike - shall be respected, protected and fulfilled.
- b. ***Participation:*** The effective participation of people living with and affected by HIV/AIDS in all decision making in relation to the design, implementation, monitoring and evaluation of HIV/AIDS policies and programmes will be ensured.
- c. ***Access to social services and employment:*** People living with and affected by HIV/AIDS shall be guaranteed equal rights to healthcare, education and employment and other fundamental freedoms as other members of society. Privacy and confidentiality will be strictly upheld.
- d. ***Response to violation of rights:*** People living with or affected by HIV/AIDS shall have access to independent, speedy and effective legal and/or administrative procedures for seeking redress if their rights are violated.
- e. ***Protection for HIV status disclosure:*** The Government and partners shall establish mechanisms and services to protect those who choose to disclose their HIV status at family, community or national levels, as well as their families and communities.
- f. ***Protection of orphans and vulnerable children:*** HIV positive children and children who have been orphaned or made vulnerable due to HIV/AIDS shall not be discriminated against in access to healthcare, education, family and alternative care. The protection of HIV positive children and children orphaned or made vulnerable due to HIV/AIDS shall be integrated into existing and on-going initiatives, particularly in the health, education and child protection sectors. Emergency educational supplies and fees, medical supplies, clothing, bedding and food for orphans and vulnerable children shall be supplied through orphan support and child protection centres.
- g. ***The capacity of the healthcare system*** including existing mainstream services will be strengthened in order to have the necessary infrastructure for the delivery of quality, accessible and safe HIV/AIDS and STI services.
- h. ***Voluntary Counselling and Testing:*** Good quality, accessible, affordable and confidential VCT services shall be made available throughout the country in a phased manner to enable people to know their status and access treatment, care and support.
- i. ***Integrated services:*** Health facilities shall be upgraded to provide gender sensitive and youth friendly integrated services including care for opportunistic infections and diagnosis and rational treatment & follow up of STIs. This will include assessment of the capacity of health facilities, training of healthcare professionals and procurement of the necessary drugs for the treatment of opportunistic infections, STIs diagnostics kits and other logistics.
- j. ***Adherence to universal safety guidelines:*** The clinical management of HIV/AIDS should adhere to strict enforcement of biosafety and infection control measures in health facilities as per the universal safety precaution guidelines to be developed.
- k. ***Counselling and information:*** PLHA shall have access to counselling and information on how to live positively with HIV/AIDS while protecting themselves and other from further transmission.
- l. ***Community and home-based care:*** Care and support for PLHA will be provided through a community and home-based care programme including targeted care for opportunistic infections, palliative care, education about improved nutrition and provision of nutritional supplies.
- m. ***Spiritual care:*** The Collaboration of religious leaders in providing spiritual and material support for PLHAs should be encouraged as spiritual care is a component of holistic care.
- n. ***Self-help groups for PLHA:*** The formation of self-help groups, CBOs and NGOs among PLHA for social

action, group counselling, community and home-based care and support for their members and families will be encouraged and supported.

- o. **Referral System:** An efficient referral system shall be established starting from VCT centres and counselling sites to hospitals or clinics, community and home-based care.
- p. **The progressive provision of Antiretroviral Therapy:** PLHAs have the right to access affordable Antiretroviral Therapy (ART) to prolong and improve quality of life. The capacity of the healthcare system for the provision and monitoring of ART - including its application for the prevention of mother-to-child transmission (PMTCT) and post-exposure prophylaxis for persons who have experienced occupational exposure to HIV and rape survivors - will be assessed and efforts will be extended to progressively prepare the necessary infrastructure and train personnel.
- q. **Universal access plan and ART service delivery guidelines:** A national plan for the progressive realisation of universal access to treatment and comprehensive ART service delivery guidelines will be developed and implemented.
- r. **Public awareness on treatment, care and support options:** The general population shall have access to accurate information on treatment options and where and how to access VCT, treatment, care and support.

## 5.10 HIV/AIDS AND THE WORLD OF WORK

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### 5.10.1 Rationale

The public, private and voluntary sectors alike are divided on whether HIV/AIDS is a workplace issue due to perceptions of low prevalence rates and negligible impact on workers, employers and enterprise. Furthermore, it is argued that there are more immediate and pressing issues to be dealt with in the world of work such as: revision of labour laws; the development and implementation of basic sectoral policies or business plans; resource mobilisation, and; staff development. In higher prevalence countries, the impact of HIV/AIDS on the workplace has been devastating in terms of loss of experienced personnel, absenteeism, increased recruitment and training costs, increased labour turnover, lower productivity of new recruits and increased healthcare costs. The consequences of inaction and complacency in Somaliland can have equally devastating implications. Low prevalence rates of if left unchecked, rapidly transforms into high rates of infection with consequent social and economic costs. Early investment such as education and prevention campaigns and healthcare provision, while initially costly, have long-term cost benefits. Not responding may result in related costs increasing exponentially in association with rising HIV/AIDS rates, through rising production costs and declining productivity.

### 5.10.2 Policy Statements

- a. **Recognition of HIV/AIDS as a workplace issue:** The Government recognises that HIV/AIDS is a workplace issue because it has the potential of affecting workers and enterprise, increasing labour costs and reducing productivity. The management of HIV/AIDS at the workplace shall be prioritised because employers – in the private, public and voluntary sectors alike – can play a key role in preventing the transmission of HIV and in caring for and supporting those affected.
- b. **National legal and policy framework:** A national legal and policy framework shall be developed including reform of labour laws and the development of a National Code on HIV/AIDS and the world of work that protects the rights and dignity of persons living with and affected by HIV/AIDS and those at the greatest risk of HIV/AIDS, in consultation with representatives of employers and workers, taking account of established international guidelines on HIV/AIDS in the workplace,
- c. **Development and implementation of work place policies:** All public, private and voluntary sector workplaces shall progressively develop and implement an HIV/AIDS workplace policy and an HIV prevention, treatment, care, support and impact mitigation programme. Social dialogue will be initiated to educate and build trust between the public, private and voluntary sectors of the importance of HIV/AIDS as a workplace issue and the necessity of early intervention.
- d. **Guiding principles for legislation and policy formulation:** The national legal and policy framework and all public, private and voluntary sector workplace policies shall adhere to the following guiding principles:
- e. **Non-discrimination:** There should be no discrimination against workers on the basis of real or perceived HIV status. The principle of non-discrimination extends to job status, promotion and transfer; recognised

dependants; all occupational insurance and benefits schemes including healthcare facilities/insurance and pension funds; and, all employment policies and practices. The same ethical principles that govern all health or medical conditions in the employment context should be equally applied to HIV/AIDS.

- f. **Gender equality:** Women and girls are more likely to be infected and adversely affected by HIV/AIDS than men due to biological, socio-cultural and economic factors. Women are also more likely to be involved in caring for HIV positive family members and caring for orphans. Work place policies and programmes must respond to the circumstances and needs of men and women separately as well as together – both in terms of prevention and social protection to mitigate the impact of the epidemic.
- g. **Healthy work environment:** The work environment should be healthy and safe for all concerned parties, providing protection from HIV transmission. This includes providing protection from HIV transmission by instituting universal precautions when relevant; providing information and education on HIV transmission including education on the fact that casual contact at the workplace presents no risk of HIV transmission; providing appropriate first aid provisions in the event of an accident; and, creating a stigma free environment for workers infected or affected by HIV/AIDS.
- h. **No screening for purposes of exclusion from employment or work processes:** No employer shall require, whether directly or indirectly, any person to undergo testing for HIV as a precondition for employment or for continuation of employment. There should be no compulsory HIV testing for training. HIV testing for training should be governed by the principle of non-discrimination, between individuals with HIV infection and those without, and between HIV/AIDS, and other comparable health or medical conditions. No mandatory HIV testing should be imposed as a precondition for providing healthcare facilities during employment.
- i. **Confidentiality:** PLHAs should have the legal right to confidentiality about their HIV status in any aspect of their employment. Job applicants and workers are under no obligation to disclose their HIV status to their employer or co-workers. No co-workers shall be obliged to reveal such personal information about fellow workers. Where an employee chooses to voluntarily disclose his or her HIV status to the employer or to a co-worker, such information shall not be disclosed to others without that worker's expressed written consent.
- j. **Continuation of employment relationship:** No employer shall terminate the employment of a worker solely on the grounds of HIV status or family responsibilities relating to HIV/AIDS. HIV infection itself usually takes years to produce illness, and merely being HIV positive does not entail any limitations in fitness to work. HIV positive workers shall continue to work under normal conditions in their current employment for as long as they are medically fit to do so. When on medical grounds they can not continue with normal employment arrangement, reasonable accommodation to help workers continue in employment can include rearrangement of working time, special equipment, opportunities for rest breaks, time off for medical appointments, flexible sick leave, part-time work and return-to-work arrangements. If and when a worker becomes too ill to perform his/her agreed functions, standard procedures for termination of services for comparable life-threatening conditions should apply without discrimination or prejudice to his/her benefits.