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HIV/AIDS... A New Threat in the Horn

It is a complex task to outline the issues involving HIV/AIDS in Somalia and Somaliland, and the role expected form the Somali Diaspora. It involves issues of prevention, cultural sensitivity and understanding the rights of the infected to participate on an equal basis. We all know that the routes of HIV transmission are, of course, the same worldwide. HIV is predominantly spread by unprotected sexual intercourse, by HIV-infected blood in transfusion or by the use of blood-contaminated injections or other skin-piercing equipment.

In a world where turmoil and conflict are widespread, at a time when more than 30 million people are estimated to be living with HIV, and nearly 12 million people in the world have lost their lives to the disease, an estimated 15 million refugees and an unknown number of displaced people have been forced from their homes. HIV continues to spread, especially in conditions of poverty, powerlessness, and social instability; conditions that generally prevail for refugees, internally displaced people and in countries facing social and economic upheavals. The increased mobility of people, across borders has undoubtedly contributed to the worldwide spread of disease, including HIV/AIDS. Somaliland is no exception, as the following figures will illustrate.

Of an original refugee population of some 700,000 North West Somalians, host government figures estimate that there are still 280,000 in Ethiopia, 22,000 in Djibouti and 10,000 in Yemen. UHHCR is currently engaged in a massive repatriation program from Ethiopia to North West Somalia with a target of 60,000 this year, but with the cessation of civil conflict in 1996-97, spontaneous repatriation movements are far outstripping this planned process. This spontaneous repatriation has made it very difficult to keep an accurate census of the refugee population, especially since the surrounding Somali population in Ethiopia is of the same ethnic origin. Furthermore, many families may repatriate some members of the family while others remain in the camps ready for any future eventuality.

The refugee camps have become focal points for cross-border population movements with much travel back and forth between the Ethiopian camps and North West Somalia. There are seven camps along this border, with an average size of 40,000 inhabitants. The camps of Teferiber and Darwanji, for example, are within 10 km of the border with NW Somalia, and there is frequent travel and trade across the border. The large camps of Hartisheikh, also in close proximity to the border, are serviced by a town that is an important regional trade destination and transportation hub with buses and trucks travelling to and from Hargeisa and the rest of the country.

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While there is no official data on the prevalence or incidence of HIV/AIDS in North West Somalia (Somaliland), and no standardized reporting system, Hargeisa Hospital has reported very high rates of HIV seropositivity among volunteer blood donors. Also, numerous AIDS cases have been confirmed serologically in people suspected to be positive on clinical grounds. Cases have been reported from the towns of Berbera and Borama as well.

At present there is no national AIDS program or coordinated STD (sexually transmitted diseases) prevention strategy, no surveillance, no education campaign, and an atmosphere of denial in large segments of the community. It has been estimated by the United Nations Program for AIDS that the region has HIV seroprevalence rates in the adult population of

approximately 1% and is surrounded by high seroprevalence countries with which it currently has a great deal of contact, particularly through trade and the movement of refugees.

Numerous international and local NGOs have expressed their concern at the *complete* lack absence of a coordinated HIV strategy both in the refugee camps, particularly in Eastern Ethiopia, and in North West Somalia. It would indeed appear likely that given the very rudimentary state of the health infrastructure, the stigma associated with a positive HIV diagnosis and the reportedly high rates of STD and TB (tuberculosis), as well as the population mobility across surrounding areas with high HIV prevalence, that HIV/AIDS does and will represent a significant public health problem for the region seeking to recover from a decade of civil war.

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Studies in rural areas of East Africa (Kenya and Tanzania) confirm that a huge proportion of adult deaths can be laid at the door of HIV. Where 4% of adults are infected with HIV, the virus accounts for 35% of all deaths. At HIV level of 10%, prevalence rates observed in many parts of East Africa - Djibouti, Kenya and Ethiopia - the presence of the virus in a population more than doubles the probability of dying at working age. It is for these reasons that Somalia with its mobile population is a high-risk area for the epidemic to anchor. Time is running out, and we should act now.

The development of a coordinated HIV/AIDS program must be and should be a priority for both the administration of North West Somalia and for the UN agencies involved in the repatriation/reintegration process, among which UNHCR is the lead agency.

What needs to be done?

The development of an HIV/AIDS program must be integrated with other health programs as this will improve its acceptability to the community concerned (locals and returnees) and insure that any financial and technical assistance that is given will have benefits in other areas for the currently under-resourced health care system. While interventions need to be community based, they must also strengthen the very weak central ministry of health, which may otherwise be in danger of collapsing. Any program should take the form initially of an extensive public awareness campaign and improved STD control using the WHO syndromic management principles. Training of local health workers, provision of essential medical supplies and technical assistance to the local regional authorities are the priority interventions that have to be implemented.

1. Multi-Sectoral approach: Any prevention program should ensure a multi-sectoral approach strategy that involves other institutions such as the education sector, the mass media, local/traditional elders, etc
2. Sustainability: The strategy should be to build a sustainable program primarily through capacity building, participation and the ownership of the local population. It should link the HIV/AIDS program into other health programs implemented and carried out by UN agencies and international NGOs.

Specific and immediate actions

a. To strengthen the capacity of the central ministry of health at an important time in its development. Although any program for that aspect will concentrate on STD and HIV prevention and control, it is anticipated that improvements in disease surveillance, health information systems, planning and health worker education will have flow-on effects in other areas of the health sector.
b. To increase the community awareness of the problem of HIV/AIDS in the region and to dispel some of the myths surrounding the disease.

c. To develop a coordinated STD and HIV/AIDS prevention and control program that is multi-sectoral and sensitive to the culture and traditions of the population concerned.
d. Any HIV/AIDS program should aim at equipping and providing essential supplies to referral laboratories in regional towns and strengthening Blood Banks.

The cooperation of national authorities, the Somalis in the diaspora, health professionals, and communities are essential to implement effective prevention programs. Further, governments and civil society are instrumental in the formulation of policy, the resourcing and implementation of programs and as provider of information. I believe the role of the Somalis in the diaspora is needed more than ever, and time is running out. It is now we must act.

Each of us needs to realize that our participation, both individual and jointly, is vital. Our commitment to controlling the epidemic relies on our capability to change, our responsibility to act and the knowledge that HIV/AIDS affects all of us... our brothers and sisters. Our task is for each of us to respond to the HIV/AIDS epidemic to the best of our ability in our respective fields, keeping in mind that prevention requires a holistic approach, which includes making difficult decisions. HIV/AIDS knows no borders, no tribes, and has no affiliation with any politician. The disintegration of community and family life means the breakup of stable relationships and the loss of mutual support, as well as the loosening of cultural and familial controls on behaviour.

In terms of increased risk of infection, people are able to avoid infection to the degree that they have access to HIV/AIDS prevention information, education and health (STD and reproductive) services and means of prevention (condoms), and are able to use these to avoid infection. This is not the case in our land. In addition, the use of illicit drugs and khat perpetuate the spread of the disease.

Finally, my message to everyone is that the situation at home vis-à-vis HIV/AIDS is serious, and we should mobilize our brains and efforts to confront this scourge.