

Somali HIV Legal Environmental Assessment (LEA) Report



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Final Draft

LIST OF ACRONYMS

ACHPR	African Charter on Human and People's Rights
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
FL	Federal Level
FSW	Female Sex Workers
GCHL	Global Commission on HIV and the Law
HIV	Human Immunodeficiency Virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
IOM	International Office of Migration
KP	Key Populations
LEA	Legal Environment Assessment
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
PAC	Puntland AIDS Commission
PL	Puntland
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SCAC	South Central AIDS Commission
SL	Somaliland
SOB	Sexual Offences Bill
SOLNAC	Somaliland National HIV/AIDS Commission
UDHR	Universal Declaration on Human Rights
UNAIDS	United Nations joint team on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Somali HIV Legal Environmental Assessment (LEA)

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Executive Summary

People living with HIV or AIDS (PLHIV) and Key Populations (KP) in Somalia experience considerable stigma and discrimination. From an extensive desk review and interviews carried out with HIV stakeholders (including with PLHIV and their Networks), it is evident that these marginalized groups face major stigma and discrimination, which affect their human rights on a daily basis.

Globally, it is widely accepted that a protective legal and regulatory framework can help reduce stigma and discrimination associated with HIV, in order to promote effective national responses to HIV and AIDS. Punitive laws and practices deter those most at risk of HIV from seeking the essential HIV services they need. To support this effort, UNDP in collaboration with the Ministry of Justice, Ministry of Health and the three AIDS Commissions, supported this HIV Legal Environmental Assessment (LEA). It reviews current laws and assesses the legal, regulatory and policy environments which support those living with, affected by and most vulnerable to HIV in Somalia/Somaliland.

The Provisional Constitution of Somalia (2012), the Constitution of Puntland State of Somalia (2012) and the Constitution of Somaliland (2000), the supreme laws of the land, are built upon global human rights principles. The Provisional Constitution states that the *'Human dignity is given by God to every human being, and this is the basis for all human rights'*. The Constitution also includes provisional articles that protect the dignity and rights of all Somalis and notes that *'all citizens, regardless of sex, religion, social or economic status, political opinion, clan, disability, occupation, birth or dialect shall have equal rights and duties before the law'*. Therefore, while the Constitutions do not explicitly mention HIV and AIDS, they do note that all Somali citizens should enjoy human rights and equal rights. To support this, Somalia and Somaliland have ratified several international conventions, declarations, covenants and treaties designed to support the rights of People Living with HIV (PLHIV) and Key Populations e.g. the Universal Declaration of Human Rights (1948) and the UN Political Declaration on Ending AIDS (2016), adopted by the United Nations General Assembly, which commits governments to protect and promote the human rights of people living with, at risk of, and affected by HIV.

Applying broad laws and rights to HIV and AIDS is possible, but it is argued that this leaves significant gaps, challenges and uncertainties in the current legal and regulatory framework. As a result, some countries have enacted specific laws to address HIV and AIDS. In this context Puntland and Somaliland developed a Draft HIV Law/Bill in 2009, a Draft HIV/AIDS Prevention, Control and Management Bill (2009) for Puntland and a Draft Somaliland HIV/AIDS Prevention and Control Law (2009), but neither of these have yet been finalized or officially endorsed.

This HIV Legal Environmental Assessment (LEA) identified numerous on-going challenges relating to HIV, the law and human rights in Somalia. Firstly, vulnerable and key populations in Somalia/Somaliland, including PLHIV and Key Populations (that include Female Sex Workers (FSW) and their clients), are at higher risk of HIV exposure and /or of vulnerability due to high levels of stigma and discrimination that continue to prevent these groups from accessing health services.

Secondly, although protective provisions exist in Somali law and policy, HIV-related stigma continues to fuel the spread of HIV in Somalia and exacerbate the negative impact of HIV. In addition, access to justice and law enforcement for human rights violations remains seriously limited. Key Populations are not fully aware of their rights, or of how to enforce these rights, with enforcement mechanisms and essential support being limited.

Thirdly, there are a number of punitive or coercive provisions in law, which are widely recognized as creating barriers to an effective HIV and AIDS response. E.g. the criminalization of sex work and homosexuality outlined in articles of the Somali Penal Code (1962) (which applies to Puntland and Somaliland), as well as the intentional transmission of HIV included in the Sexual Offences Act in Puntland (2016). Punitive laws and criminalization of these behaviours are globally seen to be counter-productive, as they deter those most vulnerable and at risk of HIV from seeking essential services. As a result, such laws effectively serve to fuel stigma, discrimination and the spread of HIV, rather than preventing them.

Fourthly, the LEA found that while there are various laws and policies which promote the health rights of all Somali citizens, including National HIV Policies, limited resources, low levels of knowledge and other constraints mean that the principles included in these policies are often not implemented or supported.

The **recommendations listed below** will help strengthen the HIV Legal Environment to support the rights of People Living with HIV (PLHIV) and Key Populations in Somalia/Somaliland. It is hoped that they will be incorporated into the next Somali HIV National Strategic Plan (2021-2024) and Somalia/Somaliland's next Concept Note and funding proposal to the Global Fund.

The majority of these recommendations are also cited in the Somalia HIV NSP 2018-2020, under Strategic Actions, Objective 4.1 (e.g. Finalize and endorse HIV Policy for FGS; Enact pending HIV/ AIDS bills to provide a legal framework for implementation of HIV/AIDS policies; Sensitize relevant stakeholders both in the civil society sector and the government institutions, on HIV Policies & legal framework; Scale up provision of legal aid to PLHIV; Strengthen links between Networks of PLHIV and PREP, PEP, GBV Help Desks; Create awareness on legal rights of PLHIV and Increase representation of PLHIV in decision making forums and processes).

1. Ensure that all human rights commitments outlined in the **Provisional Constitution (2012)** are guaranteed and enforced.
2. Ensure that Somalia/Somaliland **does not enact any law that explicitly criminalises HIV transmission**, exposure or non-disclosure of HIV status, which have widely proven to be counter-productive.
3. Somalia is encouraged to **ratify additional International Treaties to support Human Rights**, especially those that have a direct link to the national HIV response, including:
 - a. The Arab Convention for HIV Prevention and Protection of People Living with HIV, adopted by the Arab Parliament in 2012.
 - b. CEDAW, the Convention for the Elimination of Discrimination Against Women

4. Strengthen the legal and policy framework in Somalia to support the rights of PLHIV and KP

In order to strengthen the legal and policy framework in Somalia/Somalia, it is recommended that Somalia, Puntland and Somaliland review and repeal all punitive laws to outlaw all forms of discrimination. This will include reviewing and/or finalizing the following:

- i. Finalise FGS and Puntland HIV Policies
Somalia should ensure that the HIV Policy at the Federal Level and in Puntland are approved as soon as possible. It is recommended that the Ministry of Health take the lead at the Federal Level, noting challenges the AIDS Commission has faced trying to finalise this policy in the past. Once finalised, it will be important for the Ministry of Health, AIDS Commission, Network of PLHIV and CSOs to effectively disseminate and raise awareness about the HIV Policy. Key actors will also need to advocate, lobby for and actively support multiple efforts, at all levels, to ensure the effective implementation of these policies.
- ii. Sexual Offence Bill (2018): Review this bill to decriminalise private and consensual adult sexual behaviour, including voluntary sex work.
- iii. Sexual Offences Act in Puntland (2016): Review this act and decriminalise the 'intentional' spread of HIV
- iv. Sexual Offences Bill in Somaliland (2018): Review the bill to ensure it provides equal treatment for all citizens, regardless of their HIV status.
- v. Penal Code (1962): Review Article 409 to decriminalise private and consensual adult sexual behaviours, including same sex acts.
- vi. Review and finalise the Draft HIV Bill (2009): Ensure that the main issues of discrimination experienced by PLHIV that require policy and legal redress including: denial of healthcare services; loss of employment; discrimination in educational institutions; denial of access to public facilities; denial of property rights; abuse of the right to confidentiality of health information and domestic violence are addressed by the HIV Bills. In addition, any HIV Bill must ensure that it does not criminalise the 'intentional' spread of HIV. Finalising these Draft HIV Bills will demonstrate the government's commitment to ensuring that all its citizens are able to enjoy their human rights, in line with the Constitution.
- vii. Health Law: Ensure that any future Health Law developed for Somalia/Somaliland ensures the following:
 - Abolishes all mandatory HIV-related testing
 - Ensures Confidentiality
 - Guarantees Informed consent.
 - That having HIV does not mean being categorised as 'medically unfit' to work.

5. Access to Justice

- i. Sensitize relevant stakeholders in the civil society sector, government institutions and the private sector, on HIV Policies & legal framework;
- ii. Support HIV Training to sensitise the Judiciary, Lawyers and other legal practitioners about HIV, to ensure legal professionals are better prepared to support the rights of PLHIV and Key Populations in Somalia. This is important, as justice will only be assured when regulatory authorities, including the judiciary and law enforcement authorities, are sensitised and empowered to support the rights of PLHIV and KP, as outlined in Somali legislation.
- iii. Provide training on HIV Policies and Legal Frameworks for the police, noting that vulnerable women (FSW) in Somalia frequently face considerable physical and/ or sexual violence.
- iv. Make accessible and scale up the provision of Legal Aid, to facilitate access to justice and redress for PLHIV and KP. This will strengthen HIV-related legal services available to PLHIV and KP, in cases of HIV-related discrimination or other legal matters. These services should include access to legal information and referrals, legal advice and representation, alternative/community forms of dispute resolution, and engaging religious and/or traditional leaders/systems with a view to resolving disputes or changing traditional norms/processes (i.e. community norms). Considering that there are ongoing legal aid initiatives supported by UNDP and other partners, Networks of PLHIV should strengthen their partnerships with these service providers to ensure that their members have access to legal support when required.
- v. Legal Literacy: Raise awareness about the legal rights of PLHIV and KP through strengthening partnerships between Networks of PLHIV, AIDS Commissions, Legal Aid Clinics and other key actors. Mobilize funding for the same.
- vi. Recommended that the Networks of PLHIV and the AIDS Commissions, strengthen partnerships with Legal Aid Institutions e.g. OHPRD in Puntland and Human Rights Centre in Somaliland, so that they are better placed to refer and support individuals that require legal aid support. These Legal Aid providers are also well placed to document human rights abuses, and gather credible evidence to lobby for and support wider access to justice
- vii. Put in place effective Complaints Response Mechanisms (CRMs) to document and support the rights of PLHIV and KPs, as soon as possible. Experience shows that an effective CRM will help increase the uptake of HIV services and improve adherence to treatment.
- viii. Ensure effective support structures are put in place to address human rights abuses experienced by PLHIV and KP, including in healthcare, the security sector by police, courts and judges and other settings.
- ix. Scale up and support 'Knowing your Rights' programmes for PLHIV and KP. Ensure effective referral systems for subsequent, potentially life-saving support.
- x. Ensure that customary and religious laws promote that promote the rights of PLHIV and KPs are effectively capitalized on.
- xi. Strengthen links between Networks of PLHIV and PREP, PEP, GBV Help Desks and other relevant bodies.

6. Support Ethics and Stigma Reduction Training for Health Care workers

- i. Train and support healthcare workers to ensure that client friendly services are provided to PLHIV and KP, free from stigma and discrimination. To help ensure this, ensure that the necessary protective equipment is provided to all health care workers.
- ii. Disseminate information on anti-stigma policies to health facilities/health workers, including through visual posters/ resources visible at clinics and health facilities.
- iii. Develop and display HIV Service Charters, outlining available services and assuring customers that the services are free from stigma and discrimination. Support and monitor service providers, to ensure adherence to the same.
- iv. Provide capacity building to healthcare workers, including training on the necessary protective equipment (universal precautions), to prevent healthcare workers from contracting HIV during service provision.

7. Support HIV Stigma Reduction Programmes for Community and Influential Leaders. E.g. Religious, Customary, and Traditional Leaders

- i. Strengthen community knowledge and awareness about HIV modes of transmission, using a variety of audience-friendly approaches and mechanisms.
- ii. Support community HIV awareness campaigns on the legal rights of PLHIVs. Support community targeted anti-PLHIV stigma and discrimination campaigns in communities, through community conversations, suitable media and other channels.

- iii. Strengthen advocacy to reduce HIV Stigma and discrimination. This includes working with key government officers and religious leaders to identify Champions against stigma and discrimination. These Champions would be encouraged to act as role models within the community, to demonstrate that the rights of PLHIV and Key Populations should be respected at all times and that they should be treated in the same way as all other citizens.
 - iv. Increase community and PLHIV awareness on anti-stigma policies and laws to support their rights (Knowing your Rights).
 - v. Develop and disseminate IEC/ BCC materials to address HIV/AIDS stigma & discrimination.
8. **Support the Civil Service to put in place HIV Work Place Programmes.** This will help educate government staff about HIV. Priority Sectors where work place programmes should be rolled out should include the Health Sector (health workers), Law Enforcement Entities/Sectors (Ministers of the Interior and Justice, the police, security personnel, prosecutors, judges, lawyers) and others.

9. **Social Protection:**

- i. Develop a framework and advocate for PLHIV inclusion under broader government Social Protection programmes.
- ii. Ensure that all Somali legal frameworks:
 - provide social protection for all PLHIV and children living with and affected by HIV and AIDS.
 - reduce harmful gender norms and gender-based violence and increase women and girls' legal, social and economic empowerment.
 - offer the same standard of protection to migrants, visitors and non-citizen residents as that extended to citizens.

10. **Strengthen the capacity of the 3 Networks to support PLHIV in Somalia**

- i. Strengthen the capacity of the three Networks of PLHIV, so they can increase the representation of PLHIV in decision making forums and processes and strengthen their lobbying, advocacy capacity and effectiveness.
- ii. Support PLHIV Networks to work on multiple stigma reduction efforts in the community. E.g. by supporting the PLHIV Networks to lead Community Conversations to address stigma reduction in communities, working in collaboration with the AIDS Commission, Ministry of Health and influential leaders (Religious Leaders and Local Government Representatives), among others.
- iii. Ensure additional support is provided to allow Networks of PLHIV to expand and support more activities. This will enable Networks of PLHIV to decentralise and work more effectively with other CSOs, in order to effectively support more PLHIV in Somalia/Somaliland and strengthen their collective voice.

Introduction

Background to the HIV Legal Environment Assessment (LEA)

Stigma and discrimination towards People living with HIV (PLHIV) and Key Populations (KPs) in Somalia/Somaliland remain an obstacle to an effective National HIV response. These groups face challenges accessing, using and/or continuing their use of HIV-related health services due to stigma and discrimination widely experienced in healthcare and community settings. Stigma and discrimination prevent individuals from accessing basic health and legal services. They also fuel the spread of HIV, resulting in higher levels of new HIV infections.

In Somalia/ Somaliland, as elsewhere, the HIV Legal Environment Assessment (LEA) is an important follow up to the recommendations of the Global Commission on HIV and the Law, which issued its first report in 2012, followed by a supplement produced in 2018. The Global Commission report clearly stipulates that human rights are the foundation of enabling legal environments and are critical to strengthening national responses to HIV.

The overall purpose of the HIV Legal Environment Assessment is to see how the legal environment in Somalia/Somaliland can be strengthened to better protect and support the rights of all citizens (including People Living with HIV and Key Populations), in order to prevent the spread of HIV. An HIV LEA is an important step to better understand the important role that legislation can play in positively influencing HIV prevention, treatment and impact mitigation efforts. In this regard, HIV Legal Environmental Assessments are critical to strengthening a country's response to HIV.

An HIV Legal Environment Assessment involves assessing a country's national legal and policy framework. In a human rights context, the main aim of conducting a legal and policy assessment is to review HIV, health and other related laws, regulations, policies and practices, to identify those that have an impact on responses to HIV and make recommendations accordingly. A range of laws (not just health laws) need to be analysed, as HIV is not just a health or medical issue but a multi-sectoral one. This requires us to look into structural factors of inequality, power, personal and social dynamics, towards identifying effective responses.

The HIV Legal Environmental Assessment (LEA) is a government-led, participatory exercise that involves critical government entities, Networks of People Living with HIV (PLHIV), Key Populations, Civil Society Organizations and Human Rights bodies.

The HIV Legal Environmental Assessment for Somalia was prioritized as part of the UN Joint Team on AIDS work plan in 2018. It was decided that UNDP would lead the implementation of this activity, based on its technical expertise and UNDP's accumulated experience supporting HIV LEAs in more than 38 countries around the world. UNDP is providing technical support for the assessment, working closely with the Somalia/Somaliland AIDS Commissions, Ministry of Justice, Ministry of Health, and the three Networks of PLHIV.

Methodology

To develop this Somali HIV Legal Environmental Assessment (LEA), the consultant undertook an extensive desk review of key documents, laws and policies and conducted interviews with several Somali HIV stakeholders. This included interviews with representatives of People Living with HIV, representatives from the Ministries of Health and from the three National AIDS Commissions (NACs). A Draft HIV LEA report, highlighting the findings and recommendations of interviews and the desk review was subsequently presented and shared with key Somali stakeholders, at a National Dialogue meeting that took place in Djibouti from 24th – 26th November 2019. During this workshop the Draft HIV Report was presented and discussed by participants. Participants provided inputs to strengthen the report, and in groups, developed Action Plans to take forward recommendations participants thought most appropriate to support the rights of PLHIV and KP at the Federal Level, in Puntland and Somaliland. Please find attached Annex 1 for a list of Key Informant Interviews (KII) conducted to support this assignment. Annex 2 for a list of Participants that took place in the National Dialogue meeting in Djibouti (24th-26th November 2019) and Annex 3 for a copy of the Action Plans developed during the National Dialogue to take forward recommendations of the Somali HIV LEA at the Federal Level, Puntland and Somaliland.

The process of conducting an HIV Legal Environmental Assessment supports national stakeholders to build a comprehensive picture of a country's legal and policy framework, its strengths as well as its gaps and challenges, to make recommendations to create a more protective environment, in support of the national response to HIV. It is

expected that this HIV LEA will help generate evidence to sensitise a range of stakeholders on HIV-related legal and human rights issues, in order to strengthen the HIV legal environment in Somalia/Somaliland. It is also hoped that findings and recommendations of the HIV LEA will feed into the next Somali HIV National Strategic Plan (2021-2024), and Somalia's next application to the Global Fund.

Overview of HIV in Somalia/Somaliland

The HIV and AIDS epidemic has been categorized as geographically heterogeneous across Somalia: low prevalence at the Federal Level and in Puntland and generalized in Somaliland (MOH 2017). The Spectrum Report in 2016 reports HIV Prevalence at 0.38% and new infections at 1,797, with an incidence rate per 1000 population at 0.16. HIV prevalence in the general population aged 15-49 in 2014 was 0.78% in Somaliland, 0.59% in Puntland and 0.38% at the Federal Level. It has been suggested that the relatively higher HIV prevalence in Somaliland may be related to substantial trade-driven mobility and interaction with neighbouring countries with higher HIV prevalence rates such as Kenya, Ethiopia and Djibouti (MOH 2017).

However, significantly higher rates have been reported amongst key populations: namely Female Sex Workers (FSW) (also referred to as vulnerable women) and their clients, particularly in hotspots along trade and mobility corridors. Integrated Bio-Behavioural Surveillance Studies (IBBS) conducted in 2008 and 2014 indicated HIV prevalence to be 4.8 to 5.2% amongst FSW in Hargeisa. (a subsequent IBBS is currently underway which will provide updated data on prevalence rates and risk behaviours in additional sites across the country).

People Living with HIV

The estimated number of People Living with HIV (PLHIV) in Somalia in 2016 was estimated to be 23,936, of whom 51.2% were women and 48.8% men. The Federal Level had the highest number of people living with HIV (10,185) followed by Somaliland (5,809) and Puntland (2,612). Again, the Federal Level reported the highest number of new infections at 785, followed by Somaliland at 303 and Puntland at 255 (PLHIV Strategy, 2017).

Key Populations and the HIV and AIDS Context in Somalia

Higher levels of HIV prevalence have been found to exist in specific key and vulnerable populations. These key populations, such as FSW and their clients, share characteristics and engage in behaviours that increase their risk of contracting HIV and limit their access to HIV services. Strong religious and cultural beliefs and practices regarding sexual relations outside marriage have limited HIV transmission in Somalia but have also forced those who engage in these behaviours, such as sex with multiple partners, sex work or male-to-male sexual activity, to remain hidden for fear of losing their livelihood, being subjected to violence and abuse or imprisonment (MOH 2014). This also results in their avoidance of programmes and services geared towards reducing their risk of HIV infection and treating those who are HIV positive. Members of key populations may be involved in several simultaneous sexual relationships, which can result in HIV transmission to the general population. WHO recommends that countries prioritise HIV responses to focus on these key populations which are the most vulnerable; experience the greatest burden of HIV; and are currently underserved (WHO 2016).

Definition of Key Populations

Globally key populations are defined as groups who, due to specific higher-risk behaviours with related legal and social implications, are at increased risk of HIV regardless of epidemic type or local context (WHO 2016). These include 1) sex workers 2) people who inject drugs, 3) people in prisons and other closed settings, 4) men who have sex with men and 5) transgender people. These key populations are important to the dynamic of HIV prevention and are also essential partners in an effective response. Additionally, vulnerable populations are groups of people who are particularly vulnerable to HIV in certain situations or contexts, such as mobile workers, but are not uniformly affected by HIV across all country epidemics.

Key Populations and Vulnerable Groups in Somalia

In the Somali context, women who sell sex and their clients have been identified as the key populations. Despite the lack of a Modes of Transmission study, it has been suggested that heterosexual transmission accounts for the majority of HIV transmission, followed by perinatal transmission (MOH 2017). Female sex workers (FSW), defined as women who have engaged in sexual activity with men in exchange for money or goods, have been identified as a high risk group by the IBBS in Hargeisa, Somaliland reporting prevalence rates of 5.2% in 2008 and 4.8% in 2014 (with an additional IBBS currently underway in Hargeisa and additional sites across the country). A mapping and size estimation of sex worker numbers in three hotspots in Somalia found that there were 963 FSW in Mogadishu, 1,126 in Hargeisa and 911 in Bossaso (IOM 2016). In Somalia, where sex work activity is criminalized and mostly undertaken in a

clandestine manner, many women do not identify as sex workers and may engage in sex work regularly or occasionally to supplement income from other sources.

Of the other key population groups there has been little research undertaken thus far. The role of injecting drug use is unclear as there have been no IBBS undertaken, although a rapid assessment among key and vulnerable populations in Mogadishu indicated some use of injecting drugs amongst key populations (HIV Rapid Assessment Amongst Key Populations in Mogadishu, Somalia. Final report. IOM Somalia, October 2014). There have also not been any studies on HIV in prison settings although globally these are settings that are very high risk for HIV transmission due to risky behaviours such as injecting drug use and limited access to prevention and treatment. Similarly, no IBBS have taken place with men who have sex with men or transgenders, who experience very high levels of social stigmatization and discrimination including imprisonment, violence and death.

Aside from these globally-defined key populations, clients of sex workers, defined as men who pay money or provide goods in exchange for sexual services with FSW, have been identified as an additional key population in the Somali context. Clients have been identified through several studies, including the recent *Risk Assessment of Key Populations Accessing HIV Services*, as truckers, fishermen, port workers, seafarers, military and police personnel, tea clients, and khat clients (UNDP 2017). The IOM mapping and size estimation study found that there was an estimated total of 2,202-2,599 clients of FSW in Mogadishu; 1,559 – 1,827 in Hargeisa; and 3,467-3,530 in Bossaso (IOM, 2016). Mobile men, such as truckers, seafarers and uniformed personnel that spend long periods away from their families and may have limited access to health and HIV services while away are considered to be particularly at risk.

HIV Vulnerability of Key Populations

Key populations, particularly FSW and their clients, have long been identified as being at higher risk of HIV in Somalia due to higher number of sexual partners and low knowledge of HIV (IOM 2016). They are also vulnerable due to low levels of literacy, lack of information on condom use and weak policy frameworks. Sex work remains criminalized across Somalia, exacerbating the spread of HIV due to high levels of stigma; lack of legal protections for FSW and clients; high levels of violence against FSW and limited capacity to negotiate the terms of paid sex; and limited access to health services, including for HIV. Although globally men who have sex with men have also been identified as a key population, there is currently no strategic information on the number or HIV prevalence rates in this population in Somalia.

The vulnerability of FSW is further compounded by the greater risk of HIV faced by women in Somalia due to harmful sociocultural norms which increase the likelihood of HIV transmission such as Sexual and Gender-Based Violence (SGBV) including rape, child marriage, forced marriage and female genital mutilation. These gender discriminatory social norms increase women's physical risk of infection but also contribute to women's inability to negotiate the terms of sex, particularly when combined with other vulnerabilities faced by women such as dowry, inheritance and lack of financial independence. This can result in women's limited decision making with regards to their sexual relationships such as choice of partner, knowing the status of their partners, being able to negotiate condom use and type of sexual acts. Where laws and policies exist to protect women and girls, they remain unenforced for the most part, with women and girls lacking access to legal support or knowledge of their rights.

IOM defines hotspots as areas where transactional sex is openly or covertly available and where migrants and mobile populations live or pass through, as spaces of vulnerability such as land border posts, ports, truck stops or hotspots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant sending sites, detention centres and emergency settlements (UNDP 2011). Clients of sex workers include mobile men, such as truck drivers, seafarers, uniformed services and pastoralists, who are often young, sexually active, away from their families and partners for long periods with low levels of literacy and HIV awareness (UNDP 2011). Use of khat is also linked to greater incidence of paid and high risk sex and levels of sexual violence, with khat and tea shops categorized as hotspots for FSW and clients. Clients of sex workers act as a critical bridging population with HIV transmitted to their wives and/or girlfriends, who would otherwise be at low risk of HIV, via unsafe paid sex with FSW.

Findings from studies with key populations in Somalia

Integrated Bio-behavioural Surveillance (IBBS) studies

IBBS studies by IOM in 2008 and 2014 amongst FSW in Hargeisa and Berbera identified concentrated prevalence of HIV amongst FSW (5.2% and 4.8% respectively), compared to less than 1% prevalence in the general population according to ANC surveillance. These studies also indicate high levels of risky behaviours with less than a quarter of

FSW reportedly using a condom with their last client and 4.3% consistently using condoms (IOM 2008); less than 6% know where to go to receive an HIV test and only 21% received a test in the last 12 months (IOM 2014). Strong religious and cultural bias towards use of condoms greatly reduces their availability and use-only 59.4% of FSW had heard of a condom and only 34.6% reported having used one in their last sex act (IOM 2014). Another IBBS is underway in 2017, which will provide updated information on HIV prevalence and risk behaviours in key populations across Somalia, as well as Somaliland.

Access and Availability of HIV Prevention and Treatment Services

Good progress has been made towards improving ART coverage in Somalia, with the total number of facilities providing ART increasing from 11 in 2014 to 17 by the end of 2016 (UNICEF, 2017). WHO Cohort Analysis (2016) also indicates progress in the number of people living with HIV, still alive after 12 months of starting treatment, increasing from 77.3% to 82.6% in 2015. However, while the number of PLHIV on ART was estimated to be 2,671 by the end of 2016 (UNICEF, 2017), the Spectrum Report (2016) estimated the number of people in need of ART was 19,440. Low uptake has been linked to low uptake of HIV testing and counselling services, with the majority of people not knowing their HIV status. In addition, the Service Availability and Readiness Assessment (SARA) from 2016 indicates that only 5% of surveyed health facilities were providing HIV care and support and only 3% were offering ART.

Stigma and Discrimination

Like elsewhere, stigma and discrimination have emerged as a critical issue that constrains and drives Key Populations and People Living with HIV away from accessing HIV prevention, care and treatment services in Somalia. PLHIV and Key Populations commonly face considerable stigma and discrimination at a variety of levels, including family, household and community levels. This affects their access to healthcare, employment opportunities as well as access to family and community assets. As a result, PLHIV and Key Populations are inclined to avoid disclosing their HIV status to their families, friends and health care providers. This is reflected in the first Somali HIV Stigma Index (2017), which reported stigma at 61.8 (UNICEF, 2017). This index is computed based on a scale of 0-100, where 0 represents zero stigma and 100 the highest manifestation of stigma. Broken down further, the Stigma Index was 65 for Somaliland and 58.8 at the Federal Level and in Puntland.

The statistics and quotes below highlight stigma experienced at the family level, in communities and experienced by PLHIV and Key Populations when accessing health services. This adversely affects their access to healthcare, to employment opportunities and to family and community assets (PLHIV Strategy 2017).

At the family level, PLHIV are often disowned by family members including parents, siblings and children. Cases of divorce and separation are very common not only among discordant couples but also among concordant couples, as highlighted by the HIV Stigma Index (2017):

- i. 42.7% of the PLHIVs had been abandoned by their spouses and 56.0% isolated in their households.
- ii. 47.5 % had been abandoned by family or sent away from the village;
- iii. 34.5 % were not be touched by their spouses after they tested HIV positive or after disclosing their status;
- iv. 45.7 % had their partners leave after they tested positive or after disclosing their HIV status.
- v. 59.2 % said they were no longer visited or less visited by family and friends, after they tested positive for HIV

In addition, **violence against PLHIV is common**, resulting in many PLHIVs being thrown out of their homes, denied the right to inherit property and/ or denied access to other family resources:

- i. 51.1 % of PLHIV reported that they had been threatened with violence
- ii. 25.5% of PLHIV said they had been physically assaulted
- iii. 28.3 % of PLHIV indicated that they had their property taken away
- iv. 57.3 % of the PLHIVs had either lost housing or had not been able to rent housing as a result of their HIV status.

At **community levels**, despite the work done to raise awareness about HIV, high levels of stigma and discrimination persist. For example, 55.9% of PLHIV interviewed for the Stigma Index reported having been excluded from social gatherings as a result of their HIV status. The community also tend to keep away from PLHIV and their children, as illustrated in the quotes below:

"Honestly, I am scared [away] from PLHIV. I am not willing to interact with or support them."
(FGD Participant- General Population)

“When a female PLHIV is known in the community, all her children are associated with the virus and the other children do not want to play together with such children while in school. They are isolated and stigmatized by their peers. Parents of the other children then begin to pull out their children from that school and transfer them to other schools (Stigma Index)

Stigma and discrimination also negatively affect the livelihoods of PLHIV, as the 2017 HIV Stigma Index found: *52.3 % of the PLHIVs indicated that people would refuse to buy food from them in a market place if they showed any signs of HIV.*

Stigma and Discrimination in health care settings

Incidents of stigma and discrimination in Somali **healthcare settings** are all too common, as evidenced in the *Somali HIV Stigma Index (2017)* and the *Risk Assessment of Key Populations Accessing health services (UNDP, 2017)*. These two reports highlight a significant number of cases where PLHIV were stigmatized by healthcare providers. For example, *37.6% of PLHIVs interviewed reported being given poorer quality of health services as a result of their HIV status, and 36.4% of PLHIVs said that this caused a delay with them accessing health services (Stigma Index, 2017).*

As highlighted by the HIV NSP 2018-2020, Key Populations often operate in hidden ways and **avoid utilizing HIV prevention, care and treatment services** in the country, for fear of losing their livelihood and being imprisoned (Somali NSP, 2014).

Experiences shared by Networks of People Living with HIV below illustrate examples of stigma and discrimination faced by PLHIV when accessing health care services in Somalia/Somaliland (Stigma Index 2017):

‘In 2017 an HIV positive women who was terminally ill was taken to the emergency room. However, she was abandoned by staff for three days and died on the fourth day.’

Networks of PLHIV also shared the following in relation to the lack of **confidentiality at health care facilities**:

‘Somali people talk a lot. There is no secret to be kept. Once you are found to be HIV positive, the first person to spread it is the nurse.’

Networks of People Living with HIV (PLHIV)

To support the rights of PLHIV, three PLHIV Networks have been set up – **SCPLHIV Network at the Federal Level (FL), Daryel Network in Puntland and Talawadag Network of PLHIV in Somaliland**. The Networks have demonstrated significant commitment in trying to support the plight of PLHIV, working closely with the AIDS Commissions, the Ministry of Health (MOH) and other NGOs. Their achievements include advocating for the rights of PLHIV, setting up support groups, providing counselling services, delivering ARVs to members in rural settings, providing livelihood support through the provision of food support and providing school fees for children. The Networks have also provided shelter to members thrown out of their homes, and built the confidence of their members, as the quote below demonstrates.

In 2014, Asha was disowned by her family. But Asha remarks that after learning about the PLHIV network she became a member of the Network and found comfort in it after going through peer counselling, that helped her regain her confidence. ‘I had lost hope after all the stigma that I faced. I lost over thirty kilograms in few months due to stigma. I am glad I joined the network as I have since gained back my weight, from fifty-two kilograms when I joined to eighty kilograms now.’

PLHIV, Stigma Index 2017

PLHIV Networks provide a platform that support PLHIV to **participate in policy processes and to strengthen the national response to HIV response in Somalia/Somaliland**. This supports Best Practise guidelines of UNAIDS, which advocate for all HIV responses to include the Greater Involvement of People Living with HIV (GIPA Principle) as much as possible. For example, the PLHIV Networks actively participated in the preparation of the HIV NSP 2018-2020, as well as in country dialogue meetings undertaken to support the development of the HIV funding request to the Global

Fund (submitted in May 2017). In addition, the Networks have played an active role in drafting Somali HIV policies and provided a platform for the government and other stakeholders to channel their support to PLHIV. For example, UNICEF and UNDP have provided support for PLHIV through these networks.

The situation remains far from optimal, however. All three Networks continue to **face challenges** that include significant financial and capacity constraints (technical; management; operational; coordination; and staff capacity among others). In addition, the Networks are centralised in urban settings, with limited presence at a district level. The scope of activities implemented by each Network remains limited due to the quality and quantity of human resources available at each of the Networks. In addition, PLHIV Networks have not been able to effectively provide services to all PLHIV, or to effectively represent members when their rights have been abused. Against this backdrop, there is an urgent and critical need to further develop and strengthen the three Networks of PLHIV. This is accompanied by the need to identify and strengthen capacity gaps in order to improve PLHIV representation, participation and advocacy.

Gender and HIV

The Somalia/ Somaliland 2014 Gender Assessment Report highlights significant gender related challenges and barriers frequently faced in the Somali context. Somali women and girls are disproportionately impacted negatively by several factors that affect women's access to HIV prevention, care and treatment services, including:

- Lower socio-economic status, including lower levels of education and workforce participation;
- Conflict and livelihood driven mobility;
- Harmful cultural practices including limited participation and empowerment, and Female Genital Mutilation;
- Limited powers over their own reproductive health and well-being;
- Pervasive Gender Based Violence (GBV), including sexual assault;
- Limited political representation.

Findings from the Gender Assessment (2014) further indicate that women living with HIV are often treated differently to and worse than their male counterparts. As women are often the first to know about their HIV status through testing when they are pregnant, women are typically blamed for 'infecting' their husbands with HIV. This often leads to physical violence and/ or separation (UNAIDS, 2014). Women are also usually the ones who care for sick relatives, often leaving no one to care for them when necessary.

In Puntland a Network of PLHIV representative commented that ...

'Most of our members are women. I would say 75%. In some situations, if the woman is the one infected she will just have to leave home, even if the husband has not tested. She will then become isolated from the family and community. Polygamy, divorce and remarriage do not help in the response. FGM is also a problem. Women suffer a lot (KII Daryel Network of PLHIV, Puntland)

The HIV National Strategic Plan 2018-2020

Given the above context and the sensitive challenges raised, the HIV National Strategic Plan 2018 - 2020 focuses on achieving two primary goals:

Goal 1: Reduce the rate of new infections by 2020

Goal 2: Reduce HIV related mortality and morbidity for Somali women, men and children by 2020.

To achieve these goals, three key objectives have been agreed:

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

Overview of Laws affecting PLHIV and KP at risk of HIV in Somalia/Somaliland

1. International Laws that Somalia has ratified

This section provides an overview of the laws, regulations and policies that protect and challenge the rights of People Living with HIV (PLHIV) and Key Populations in Somalia. It includes looking at **International Human Rights Conventions** that Somalia has ratified, as well as the **Provisional Constitution of Somalia (2012)**, the **Penal Code (1962)**, and **Sexual Offences Bills** developed at the Federal Level, in Puntland (2016) and Somaliland (2018). It also outlines the HIV Policies developed by the three AIDS Commissions to date.

Somalia is a member of the **United Nations** and has ratified several **UN Human Rights Conventions**. In signing these conventions, Somalia has made binding commitments to adhere to the standards laid down in these universal human rights documents. The Human Rights Conventions that Somalia has ratified include:

1. **Universal Declaration of Human Rights (1948)**: This highlights that ‘*all human beings are born free and equal in dignity and rights*’. The Human Rights Declaration stipulates that everyone has the right to dignity, to health and medical care and non-discrimination, as seen in the below excerpt:

*‘Everyone has the right to a standard of living **adequate for the health and well-being** of himself and of his family, including food, clothing, housing and medical care and necessary social services’.* The right to life also includes the **right to health**, that is, the right to medical care, support and treatment.

2. **International Covenant on Economic, Social and Cultural Rights**: Somalia ratified the ICESCR Covenant in 1990 which protects the right to work (Articles 6 and 7), the right to Health (Article 12) and the right to education (Article 13).
3. **International Covenant on Civil and Political Rights (ICCPR)**: Somalia has also ratified the ICCPR (1990), which states that ‘*No one be subjected to unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour or Reputation*’. This right to privacy means that individuals are entitled to keep their HIV status private and cannot be forced by any means to have an HIV test without their consent.
4. Somalia is party to the following international treaties which support **Gender Equality** and prohibit non-discrimination on the basis of sex:
 - a. United Nations Charter, Articles 1 (3), 55 and 56;
 - b. Universal Declaration of Human Rights, 1948, Articles 1 and 2;
 - c. The International Covenant on Civil and Political Rights (ICCPR), 1966, Articles 2, 3 and 26;
 - d. The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966, Articles 2
5. **Convention on the Rights of the Child (CRC)**: The CRC, **ratified by Somalia in 2015**, is a universally agreed set of non-negotiable standards and obligations which provide protection and support for the rights of children. This includes protecting children from trafficking, prostitution and child pornography.
6. **More specifically in relation to HIV, Somalia has endorsed the following Political Declarations:**
 - i. **UN Political Declaration on Universal Health Coverage (UHC)**: In September 2019, the UN Political Declaration on Universal Health Coverage was adopted by Heads of States including Somalia. The Declaration states that Health Services must respect human rights’ principles (including privacy and confidentiality) and that health facilities need to be accessible to everyone, with no risk of discrimination. To ensure this, Governments are required to provide health workers with relevant training, to support medical ethics and the rights of PLHIV and Key Populations. In relation to HIV, this means having access to quality HIV treatment and services, e.g. ARV drugs and drugs for HIV related illnesses. It also means that individuals cannot be examined, tested, treated or given medicines without their prior consent (or until they have given their explicit permission for the same).
 - ii. **Political Declaration on Ending AIDS (2016)**: This UNAIDS Declaration was unanimously adopted by the United Nations General Assembly in 2016. It commits governments to protect and promote the human rights of people living with, at risk of, and affected by HIV. In addition, Somalia had previously ratified the UN Political Declaration on HIV and AIDS (2011), as outlined below.

- iii. **The UNGASS Political Declaration on HIV/AIDS (2011)** further commits countries to develop HIV strategies that promote and protect human rights, eliminate gender inequalities and review appropriate laws to address the specific needs of People Living with HIV (PLHIV).
- iv. **UNAIDS International Guidelines on HIV/AIDS and Human Rights (2006)** Although non-binding, support human rights' issues associated with HIV. For example, Guideline 4 recommends that states take appropriate measures to review their criminal laws, to ensure they do not unfairly discriminate against Key Populations accessing healthcare services. Guideline 5 recommends that states enact and/or strengthen anti-discrimination and other laws which protect vulnerable groups, PLHIV and people with disabilities from discrimination in both the public and private sectors.

At a **National Level**, Somalia/Somaliland have put in place the following legislation to support the rights of all its' citizens, which include those infected, affected and most vulnerable to HIV infection. Below is an outline of the legislation in place to support the rights of all Somalis to equality, non-discrimination, health, education, the right to work, and other social rights, such as the right to own property.

2. National Legislation to support Equality and Non-discrimination

To complement International Human Rights Treaties outlined above, the **right to equality and non-discrimination** is articulated in the three Somali Constitutions as well as by several Somali laws and policies, as outlined below. As highlighted by the three Somali Constitutions, this includes for women to be treated as equal citizens and to enjoy the same rights as their male counterparts.

For example, the **Provisional Constitution** of Somalia (2012), the supreme law in the country, outlines fundamental rights and duties for all its citizens. These include the right to dignity, equality, and to non-discrimination, as detailed below.

Article 10. Human Dignity

1. *Human dignity is given by God to **every human being**, and this is the basis for all human rights.*
2. *Human dignity is inviolable and must be protected by all.*
3. *State power must not be exercised in a manner that violates human dignity.*

Article 11. Equality

1. *All citizens, regardless of **sex**, religion, social or economic status, political opinion, clan, disability, occupation, birth or dialect shall have **equal rights** and duties before the law.*
2. *Discrimination is deemed to occur if the effect of an action impairs or restricts a person's rights, even if the actor did not intend this effect.*
3. *The State **must not discriminate against any person** on the basis of age, race, colour, tribe, ethnicity, culture, dialect, gender, birth, disability, religion, political opinion, occupation, or wealth.*
4. *All State programs, such as laws, or political and administrative actions that are designed to achieve **full equality for individuals** or groups who are disadvantaged, or who have suffered from discrimination in the past, shall be deemed to be not discriminatory.*

Similarly, the **Constitution of Regional Puntland State of Somalia**, adopted in 2012, outlines the duties of the state and the rights of all citizens. It notes:

Article 11 Equality of Citizens

1. *All persons are equal before the Law.*
2. *The constitution safeguards and respects the rights of the minorities.*

Article 12

1, No person shall suffer **any form of discrimination** based on colour, religion, birth, nationality, property, beliefs, political affiliation, language or race.'

Article 17 The Right to Life and the protection of the body

1. Every person has a right to his/her life; save for capital punishment imposed in accordance with the Law.
2. Every person shall have a right to protection of his/her body and self esteem

The **Constitution of Somaliland** (2000) similarly supports the human rights of all its citizens, including the right to equality, to non-discrimination (Article 8), and the right to life (Article 24), as outlined below:

Article 8: Equality of Citizens

1. All citizens of Somaliland shall enjoy **equal rights** and obligations before the law, and shall not be accorded precedence on grounds of colour, clan, birth, language, gender, property, status, opinion etc.
2. Precedence and **discrimination** on grounds of ethnicity, clan affiliation, birth and residence is prohibited; and at the same time programmes aimed at eradicating long lasting bad practices shall be a national obligation.

Article 24: The Right to Life, Security of the Person, Respect for Reputation and Crimes against Human Rights

1. Human life is the gift of Allah and is beyond price. Every person has the **right to life**, and shall only be deprived of life if convicted in a court of an offence in which the sentence laid down by law is death.
2. Every person shall have the **right to have his dignity**, reputation and private life respected.

HIV Policies

Specific **HIV Policies** have also been developed at the Federal Level, in Puntland and Somaliland. However, it is only in Somaliland that the HIV Policy has been endorsed by the government (2009). Nevertheless, all three HIV Policies recognise that people who are vulnerable, infected and affected by HIV/AIDS need their rights safeguarded and protected at all times. The HIV Policy for Somaliland further states that people who are vulnerable, infected and affected by HIV should have the same rights as any other persons in the community. This includes ensuring that people living with HIV/AIDS and their families are **not subjected to discrimination**. Furthermore, the HIV Policy for Somaliland encourages the government to enact anti-discrimination and other laws that protect vulnerable groups, PLHIV and people with disabilities from discrimination in both the public and private sectors.

To complement the above, one of the main principles underlying the *Somali HIV National Strategic Plan 2018-2020*, is to promote and protect human rights, in alignment with the provisional Somali constitutions.

However, there is a lot of evidence and research that highlights that People Living with HIV (PLHIV) and Key Populations still face considerable stigma and discrimination at a family and community level, as noted by the case study below:

'Asha (not real name) was diagnosed with HIV in 2013. When she disclosed her HIV status to the family, her father disowned her and none of the families wanted to be associated with her. She was locked in a room for several days before a well-wisher requested the family to allow Asha into her custody. The father 'donated' her and instructed the new keeper that he did not want to see her again.

Asha (Stigma Index, 2017)

3. The Right to Health

The right to health is one of the most fundamental human rights and is pertinent to the realization of all other human rights and freedoms. In this regard, the **Constitution of Somalia** spells out the right to healthcare in Article 27 (2) and states '*all citizens have the right to healthcare and no one may be denied emergency care for any reason, including lack of economic capability*'.

Similarly, the **Constitution of Puntland** (2012) outlines the duties of the state and the rights of all citizens. Article 32 states that '*it is the Government's responsibility to **provide public health**, both preventive and curative, to all the inhabitants, but special care must be taken for the health condition of women and children*'.

The Constitution further states that '*For the disabled or any other persons that cannot sustain himself/herself and has nobody to sustain him/her, it shall be the responsibility of the Government to sustain him/her*' and that '*The Government should encourage and establish organizations that support persons referred to in this article.*' **Article 33**
Physically and Mentally Disabled

The **Constitution of Somaliland** (2000) likewise supports the right to health for of all its citizens. Article 17 states that '*in order to fulfil a policy of promoting public health, the state shall have the duty to meet the country's needs for equipment to combat communicable diseases, the provision of free medicine, and the care of the public welfare*'

Health Law

Somalia and Somaliland do not currently have a **Health Act or Law**. However, in 2016 the WHO, in consultation with Somali Health Authorities, developed a Discussion Paper to discuss the issue, emphasizing how a Public Health Law could support and strengthen the Somali Health Sector. The Public Health law drafted currently focuses on developing an effective tool to strengthen the country's national health systems, regulate and deliver essential public health functions, and support the government to achieve its public health policies and priority health programmes (See **Annexes 6** for further information). Related to this, a Draft Health Professionals Act is also being developed, to support a National Health Professionals Council (NHPC). The NHPC will be an autonomous professional regulatory body whose main mandate will be to protect society from abuse of medical practice and promote ethical standards amongst health professionals in Somalia (**Annex 7**).

UNAIDS Guidelines recommend that in order to strengthen the legal environment to support the right to health, the Health Law being developed should include articles to support the right to a range of HIV prevention, treatment, care and support services for key and vulnerable people at high risk of HIV infection. This would align with key principles outlined in the HIV Policies developed by the three AIDS Commissions, as below.

Somali HIV Policies

To support the **health rights of People Living with HIV (PLHIV) and Key Populations**, the *National Policy on HIV/AIDS and Sexually Transmitted Infections Prevention and Control* developed by the Somaliland AIDS Commission (SOLNAC) in 2009, states that:

- **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.
- **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.
- **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.
- **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.
- **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.
- **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.

Draft HIV Policies developed at the Federal Level and in Puntland, still await final approval. However, they include similar provisions to support the rights of PLHIV and Key Populations.

Nevertheless, PLHIV & KPs continue to face huge risks when trying to **health services** in Somalia, due to stigma associated with HIV and the sensitivity of the issue, as highlighted by the quotes below:

'A pregnant woman was diagnosed with HIV during her routine antenatal care visits. None of the healthcare workers at the health facility wanted to attend to her. She visited three other health facilities before having a still birth due to delayed attendance'.

(PLHIV Network)

‘Medical personnel are the ones to stigmatise PLHIV. Even in private hospitals stigma is present/ There was a situation where an HIV positive man needed an amputation. And despite having the means to pay for the operation, one his HIV positive status was known, he was not helped and he was asked to leave the private hospital.
(MOH, HIV Programme Manager)

Somali people talk a lot. There is no secret to be kept. Once you are found to be HIV positive, the first person to spread it is the nurse’
(PLHIV Network)

4. The Right to Work

The right to work is a fundamental human right enshrined in the Universal Declaration for Human Rights (Article 23). To support the right to work in Somalia, the **Provisional Constitution of the Federal Republic of Somalia (2012)**, Article 23, states that ‘Every citizen has the right to choose their trade, occupation or profession freely.’ Article 24 further notes that ‘All workers, particularly women, have a special right of protection from sexual abuse, segregation and discrimination in the work place’.

Similarly, the **Constitution of Puntland (2012)** highlights that ‘each worker has a right to select the employer of his/her choice’ (Article 35) and the **Constitution of Somaliland (2000)** states that ‘all able citizens have a right and a duty to work’ (Article 20)

HIV Policy

To support the right to fair working conditions, free from discrimination, the **HIV Policy for Somaliland** further states that: ‘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’. (Section 5.3.2.1). The only exception to this is HIV Screening in the armed forces (5.3.2.6), where confidential HIV screening, accompanied by pre-test and post-test counselling, is permitted.

In order to protect the right to work in the context of HIV and AIDS, the **International Labour Organisation (ILO)** recommends the enactment of **workplace laws**, regulations and agreements to guarantee that the workplace is free from stigma and discrimination, pre-employment testing, unfair dismissal and to ensure that the privacy of all workers is respected (ILO, HIV and the World of Work (2010)).

However, it is clear from interviews with Networks of PLHIV in Somalia/Somaliland that pre-employment HIV screening and breaches of confidentiality often take place:

‘pre-employment screening happens, but there are no means to prove it’
(PLHIV Network)

5. The Right to Education

The right to education is recognized as a human right in a number of international conventions including the Universal Declaration of Human Rights (Article 26) and the Convention on the Rights of the Child, ratified by Somalia in 2015. This recognizes the right to free, compulsory primary and secondary education for all, irrespective of their actual or perceived HIV status.

To support this the **Provisional Constitution of Somalia (2012)** notes that ‘education is a basic right for all Somali citizens’ (Article 30).

Similarly, the **Constitution of Puntland (2012)** states that ‘each and every person has a right to education’ (Article 31) and that ‘the promotion and expansion of education shall be the duty of the Puntland State’.

The **Constitution of Somaliland (2000)** states that ‘the state shall pay particular attention to the advancement, extension and dissemination of knowledge and education as it recognises that education is the most appropriate investment that can play a major role in political, economic and social development’ (Article 15).

HIV Policy

To support the right to education, all three Somali **HIV Policies** recommend ‘empowering individuals, families and communities with knowledge and skills for HIV/AIDS prevention and community/home-based care’. They also support

'Rights education and the provision of legal services to 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' (HIV Policy, Somaliland).

However, as highlighted below, Somali children living with HIV continue to be deprived of a decent education, due to the stigma associated with HIV:

*'When a female PLHIV is known in the community, all of her children are associated with the virus and other children do not want to play together with such children while in school. They are isolated and stigmatised by their peers'.
(PLHIV Network)*

6. Other Social Rights

Other fundamental rights and freedoms of all Somali citizens, such as the right to freedom of movement, the right to own property and ensure security of all citizens homes, are also protected by the three Constitutions. These three issues have close links to HIV, as people living with HIV are often forced out of their homes, restricting their freedom of movement and to live in a place of their choosing.

For example, the **Provisional Constitution of Somalia (2012)** supports **Freedom of Movement and Residence** 'every person lawfully residing within the territory of the Federal Republic of Somalia has the right to freedom of movement, freedom to choose their residence, and freedom to leave the country' (Article 21).

Article 26 of the Constitution that focuses of **Property**, further states, 'Every person has the right to own, use, enjoy, sell, and transfer property.

Similarly, **Puntland Constitution** (2012) supports social rights, such as freedom of movement, the right to own property and security of homes as outlined below:

The right to **Freedom of Movement** states, 'Any person shall be free to travel or settle wherever he/she wishes and also to travel out of the Puntland State and back whenever he/she wishes (Article 15)'.

Article 16 supports the right of all citizens to **own property**, 'every person shall have the right to own, administer and dispose of property by lawful means.' While Article 20, focuses on the Security of Homes and notes, 'homes and other residential areas shall be respected' and 'inspection of, spying on, and forceful entrance into a person's house is prohibited without a court warrant or other judicial directives'.

The **Constitution of Somaliland (2000)** similarly supports Freedom of Movement and Association, 'every person who is a citizen or lawfully resident in the country shall be free to move to or settle at any place of his choice, or leave or return to the country at will'. (Article 23)

Article 31, further states, that 'Every person shall have the right to own private property, provided that it is acquired lawfully'.

7. Sexual Offences Bills (SOB)

On the 30th May 2018, the Cabinet of the Federal Government of Somalia unanimously approved a **Sexual Offences Bill (SOB)**, which was seen as a **landmark Bill to protect women's rights**. The main aim of the Bill is to protect women and children against **sexual assault, rape, sexual harassment, child rape, child marriage and abuse of trust or authority**. The SOB is highly relevant for PLWHIV in Somalia, as a large percentage of Female Sex Workers (FSW) face the risk of constant physical or sexual violence.

Please see below specific Articles of the Sexual Offences Bill (2018) that protect the rights of women, including vulnerable women at risk of HIV infection.

1. **Sexual Assault:** The SOB protects people from Sexual Assault, stating that 'a person commits an offence of causing a person to engage in a sexual activity if he or she intentionally causes a person to engage in a sexual activity without the other person's consent'. A person guilty of an offence under this article is liable to conviction, to a term of imprisonment of between two and seven years. In addition, a person who attempts to commit an offence under this article is liable, on conviction, to a term of imprisonment for between one and five years.

2. **Rape:** The SOB supports **rape victims** by defining rape as '*a person commits an offence of rape if he or she intentionally penetrates to any extent whatsoever, however slight, any body orifice of another person with their genital organ; and the other person does not consent to the penetration.*' A person guilty of an offence of rape is liable, on conviction, to a minimum term of imprisonment of not less than ten years and not exceeding twenty-five years (SOB, Part 2, Article 4).
3. **Sexual harassment:** '*A person commits an offence of sexual harassment if he or she intentionally makes unwanted sexual demands whether by words or actions against another person.*' A person guilty of an offence under this article is liable on conviction to a term of imprisonment not less than six months and not exceeding two years (SOB, Article 13).
4. **Child rape:** '*A person commits an offence of child rape, if he or she intentionally penetrates to any extent whatsoever, however slight, any body orifice of a child with their genital organ.*' (Article 18, SOB)
5. **Forced marriage:** '*A person commits the offence of forced marriage if he or she intentionally facilitates, organises or arranges a marriage without the consent of one or all of the parties.*' A person guilty of an offence under this article is liable, on conviction, to imprisonment for a term not less than five years and not exceeding seven years. According to the SOB '**Marriageable age**' is now 18 years old or above, which helps protect against child marriage.
6. The SOB also includes a clause to protect against the '**Abuse of trust or authority**', and states that '*A person commits an offence abuse of trust if he or she intentionally engages in an unlawful sexual act with a person; and is in a position of authority, power or trust.*' A person guilty of an offence under this article is liable, on conviction, to a term of imprisonment not less than five years and not exceeding seven years, which helps protect the rights of vulnerable women.

Furthermore, the SOB notes that as far as it is possible, the Federal Government of Somalia shall endeavor to provide the accused with **free and impartial legal aid**, in the event the accused does not have the means to pay for defence lawyers' services, and provides the following guidelines for **Handling a complaint**: '*For the purpose of implementing the provisions of this Law, any police station may establish a specialised unit to investigate sexual offences. The specialised unit may be staffed with desk officers, responding police officers and investigative officers.*'

The Sexual Offences Bill (SOB) replaces Articles 405 of the Penal Code and **criminalises prostitution** under the term of 'sex tourism', noting that a person is guilty of sex tourism if he or she engages in a commercial sex act. A commercial sex act is defined as 'any sexual act on account of which anything of value is given to or received by any person' (SOB, Article, 10). It further elaborates that '*a person guilty of an offence under this article is liable, on conviction, to a term of imprisonment not less than five years and not exceeding seven years.*'

The **criminalisation of sex work** makes Female Sex Workers (FSW) in Somalia more vulnerable to HIV infection, as most FSW do **not feel comfortable reporting to the police** in cases where they are physically or sexually abused (Stigma Index). This highlights the need for HIV stakeholders to sensitise and work with the police, to help protect key populations from HIV infection.

At the same time, a few FSW said they would report cases to the police 'in disguise'. As one FSW in Bosaso remarked:

'I say that he beats me up while eating at the restaurant, or buying khat. I never mention that he beats me during sex. I disguise it'. (Stigma Index, 2017)

Sexual Offences Act in Puntland (2016)

A similar sexual offences bill, the Sexual Offence Act, was endorsed in Puntland in 2016. Like the SOB approved at the Federal Level, the Puntland Rape Act protects women and children against rape, sexual assault, sexual harassment, exploitation and abuse. However, under the section on Sentencing for Sexual Offences, the Puntland SOB states that where '*the offender has intentionally infected HIV/AIDS to the victim*', *the penalty for this offence will be imprisonment for life*' (SOB, p.25). This is a matter of concern as evidence from across the world demonstrates that laws that criminalise the '*intentional*' spread of HIV actually serve to undermine the response to HIV. Such laws prevent people from finding out their HIV status, and push groups most affected away from vital HIV health services.

It is worth noting that a draft of the Federal Government SOB initially included a similar clause that criminalised the deliberate transmission of HIV, but it was removed before the SOB was approved by the Federal Government in 2018.

Sexual Offences Bill (Somaliland, 2018)

A SOB was also endorsed in Somaliland in 2018. As above, the main intention is to protect women and children against rape, sexual assault and abuse. The Somaliland SOB does not criminalise the 'intentional' spread of HIV. However, it states that in rape and gang rape cases, where 'the **injured party contracted HIV as the direct result of the rape**', the punishment shall be life imprisonment (SL, SOB, Article 4 and 5). As in Puntland this is a matter of concern, with evidence showing that the criminalization of HIV serves to undermine the response to HIV.

The SOB for Somaliland also notes that under **Article 29: Right to Legal Aid**, the victim of any of the above offences shall have '*the right to access lawyer for his/her legal aid needs, where the victim cannot afford to hire a lawyer, it is the duty of the State to give free legal assistance to the victim.*'

Despite the above legislation, however, a variety of **cultural and gender norms** still make Somali women and young girls particularly vulnerable to HIV. This includes cultural practices such as Female Genital Mutilation (FGM) and the inferior position of women in marriage and divorce.

8. Somalia's Penal Code (1962)

The Penal Code (1962) for Somalia **criminalises sex work and homosexuality**, and applies to all Somalis (Federal Level, as well as Puntland and Somaliland). Article 405 states that '*whoever practices prostitution in any form, shall be punished with imprisonment from two months to two years and with fine*'. As noted above, the Sexual Offence Bill (2018) has since replaced Article 405 of the Penal Code. However, the Penal Code also **criminalises homosexuality** and states that '*whoever has carnal intercourse with a person of the same sex shall be punished, where the act does not constitute a more serious crime, with imprisonment from three months to three years*' (Penal Code, Article 409, Homosexuality).

The Lancet highlights the negative impacts of criminalizing homosexuality, in an article titled 'Criminalising homosexuality threatens the fight against HIV/AIDS'. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60403-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60403-7/fulltext) (2014).

9. HIV Bill (Draft)

In 2009 Puntland and Somaliland developed Draft **HIV Bills**, referred to as the 'HIV/AIDS Prevention, Control and Management Bill' in Puntland (Draft 2009), and the HIV/AIDS Prevention and Control Law (Draft 2009) in Somaliland. However neither of these HIV Bills have been finalised or officially endorsed. One reason given for this is due to the high levels of stigma associated with HIV in Somalia, and the fact that most legal professionals have not been sensitised on HIV. As a result, pushing for an HIV Bill to be passed might be counter-productive as it risks legislators criminalising the 'intentional' spread of HIV. As noted above, evidence shows that if HIV is criminalised in any shape or form, this discourages people from going to find out their HIV status, and ultimately weakens HIV responses. Others have also expressed their scepticism, e.g. the Daryel Network of PLHIV in Puntland commented. It is therefore recommended that before pushing for the HIV Draft Bills to be finalised, greater efforts should be made and supported to sensitise legal practitioners about HIV.

*'There might be a need for legislation on HIV, but how effective this will be is questionable. Awareness raising so far has been the best avenue to reduce the spread of HIV
(Daryel Network, Puntland)*

10. Access to Justice

To ensure and protect the above rights of all Somali citizens, the three Constitutions note that all Somalis are **equal before the law** and are entitled to **access to justice** when necessary to help protect their rights.

For example, the **Provisional Constitution (2012)** provides access to Legal Defense and supports the rights of the accused as outlined below:

Article 34. Access to Courts and Legal Defence

1. Every person is entitled to file a legal case before a competent court.
2. Every person has the right to a fair public hearing by an independent and impartial court or tribunal, to be held within a reasonable time,
3. Every person is entitled to defend him or herself from the case he or she is party to, whatever the level or stage of the proceedings may be.

4. *The state shall provide free legal defence to the people who do not have the means of doing so themselves.*
5. *The state shall provide free legal defence to individuals or communities if they are legally pursuing the public interest.*

Article 35. The Rights of the Accused

1. *The accused is presumed innocent until proven guilty in a final manner by a court of law.*
2. *Every person arrested or detained has the right to be informed promptly of the reason for their arrest or detention in a language that the person understands.*

The **Puntland Constitution (2012)** similarly states that '*all persons are **equal before the law***' (Article 12) and '*the Law is above every one.*' (Article 2). The Constitution further states that '*no person shall be deprived of his/her personal liberty*' (Article 18) and that any restriction by the public authorities to this right must be explicitly established by the Law. The only caveat is that all personal liberties should not contradict/contravene Islamic Sharia Laws.

Puntland Constitution further states that '*every person shall have the right to institute legal proceedings in a competent court*' and that '*every person shall have the right to self defence in front of court*', and '*The Puntland State shall appoint a lawyer for any person unable to defend himself/herself, or devoid of means to procure one.*' (Article 24)

Articles 26 and 27 of the Puntland Constitution, further highlight the rights of **accused individuals**, '*the accused shall have the right to protection, security and human dignity*', in addition, '*the accused shall have the right to be visited by his/her relatives, Lawyer, doctor, and friends; he/she shall also have the right to be released on bail if permitted by the Law*' and '*the accused shall have the right to engage the services of a Lawyer to defend him/her; the government shall guarantee free legal services for the accused if he/she cannot afford it.*

Similarly, Article 27 focuses on the **rights of convicted individuals and states**, '*any person sentenced by a court of Law shall have the right to protection, security and dignity as a human being*', '*every prisoner shall have the right to be visited by his/her relatives, Lawyer, doctor and friends*' and '*every prisoner shall be entitled to medical attention, food and education*', and '*be entitled to the universal rights granted to prisoners worldwide*'.

Analysis of factors limiting the human rights of PLHIV and Key Populations in Somalia/Somaliland

Based on the above analysis, below the main challenges Somalia and Somaliland face in strengthening their legal and policy environments to support the rights of PLHIV and Key Populations.

1. Incorporating International Laws and Treaties into the National Legal Framework:

Somalia/Somaliland have ratified a number of International Covenants and Treaties that support the rights of PLHIV and KP. To some extent domestic laws have been put in place to support these treaties and rights (outlined above), however the challenge of incorporating all these rights into the national legal framework in Somalia/Somaliland, and ensuring that mechanisms are put in place to support these rights at national level remain.

2. Widespread Stigma and Discrimination

Experiences of People Living with HIV (PLHIV) and Key Populations (KP) demonstrate that stigma towards PLHIV and KP is widespread at the family level and in communities, as well as widespread among health care professionals and law enforcement officers. For example, it is reported that often due to myths and misconceptions associated with HIV, health care workers are not familiar with the facts about HIV and AIDS and fear of contracting the disease. As a result, health workers are often not prepared or willing to provide health care services to PLHIV and KP, as outlined above.

3. People Living with HIV and KP are not aware of their rights

The desk review demonstrates that PLHIV & KP in Somalia/Somaliland have minimal knowledge about human rights and protective laws that concern them and could help protect them. The three Networks of PLHIV (Talawadag, Daryel and SCPLHIV Network) have all supported training on human rights for PLHIV, but there is a need to continue and to expand this training to reach as many PLHIV and KP as possible, as due to high levels of stigma and a lack of trust in the legal system, PLHIV & KP are still often prevented from knowing about and from claiming their rights.

4. The problematic application of Laws in Somalia/Somaliland

Somalia/Somaliland's legislative framework, ranging from the Provisional Constitution (2012) to other laws, generally support the rights of PLHIV and KP (in terms of their right to live a dignified life, be treated equally and have access to quality health services). It is how the law is interpreted and implemented that remains problematic. As a result, abuses are regularly reported.

'There are no protective laws and even if there are laws they are not implemented'.

5. Lack of a clear Legal Pathway for Legal Complaints and mechanisms to resolve them

Even where there are laws to protect rights of PLHIV & KP in Somalia/Somaliland, laws are rarely implemented by service providers. This combined with the lack of a clear legal pathway and legal complaints mechanism, make it almost impossible to estimate or to know the scale and impact of HIV related stigma and discrimination experienced in Somalia (the numbers involved and how relevant laws are interpreted by different groups).

However, to support Access to Justice, there are several Legal Aid organisations that are well placed to provide legal services to support marginalized groups in Puntland (Office of Puntland Human Rights Defenders, (OPHRD)) and in Somaliland (Human Rights Concern), as elaborated on below.

Office of Puntland Human Rights Defenders (OPHRD)

The Office of Puntland Human Rights Defenders (OPHRD) was established in 2014, pursuant to the Puntland State Constitution, the Human Rights Defender Act (2011) and UN recommendations to establish national human rights institutions. OPHRD is an independent state institution entrusted to support Human Rights Issues in Puntland. The mandate of the Office of Puntland Human Rights Defender is to influence human rights policy, research and monitor national human rights compliance, advocate for and educate Puntland citizens on their rights and engage various stakeholders at local and international level to ensure the state adheres to human rights. For more information, please see their website www.ophrd.org

Human Rights Centre (HRC)

The Human Rights Centre (HRC) is a non-profit organization, established in January 2013 to protect and promote human rights in Somaliland. HRC was founded by lawyers, inspired by the Bill of Rights in the Somaliland Constitution and the Universal Declaration of Human Rights. It is registered with the Somaliland government as a non-profit-making and NGO.

It appears however that Networks of PLHIV, AIDS Commissions and other marginalized individuals (that could benefit from this support), are in most cases not aware that these services exist. It is therefore recommended that the Networks of PLHIV and the AIDS Commissions, strengthen partnerships with these institutions, so that they are better placed to refer and support individuals that require legal aid support. These Legal Aid providers are also well placed to document human rights abuses, and gather credible evidence to lobby for and support wider access to justice

6. Weak coordination and lack of HIV awareness among Senior Leaders of Law enforcement entities

This assessment highlights the importance of offering and actively supporting HIV awareness-raising sessions with law enforcement entities as well as security forces (police) and their leadership, to ensure the legal protection of PLHIV and KP. It further recommends that HIV Work Place Programmes be put in place, both to raise awareness about HIV and in order to sensitise Law Enforcement personnel about relevant issues and challenges associated with HIV.

7. Weak Capacity of PLHIV Networks

Capacity constraints experienced by the three Networks of PLHIV significantly limit the amount of support they are able to offer and provide to their members, as well as their lobbying and advocacy power in this highly sensitive field.

8. HIV Legal Framework

In summary, it is clear that PLHIV and KP continue to experience multiple human rights abuses in Somalia/Somaliland, with a worrying gap evident between legislation and on the ground realities (practice). This will remain the norm until related policy, legal and institutional governance systems are strengthened, more informed and better prepared to secure and protect the rights of PLHIV and Key Populations.

Recommendations to strengthen the Legal Environment to support the rights of PLHIV and Key Populations in Somalia

People Living with HIV (PLHIV) and Key Populations (KPs) are amongst the most marginalised groups in Somalia. They face stigma and discrimination on a daily basis, at family and community levels, as well as at health facilities. All this seriously undermines their quality of life.

To help ensure that PLHIV and KP can fully enjoy their rights, as outlined in the Constitution of Somalia, Puntland and Somaliland, the recommendations outlined below will help strengthen the legal and policy environment, to prevent the further spread of HIV in Somalia/Somaliland.

The majority of these recommendations are also cited in the Somalia HIV NSP 2018-2020, under **Strategic Actions under objective 4.1** (e.g. Finalize and endorse HIV Policy for FGS; Enact pending HIV/ AIDS bills to provide a legal framework for implementation of HIV/AIDS policies; Sensitize relevant stakeholders both in the civil society sector and the government institutions, on HIV Policies & legal framework; Scale up provision of legal aid to PLHIV; Strengthen links between Networks of PLHIV and PREP, PEP, GBV Help Desks; Create awareness on legal rights of PLHIV and Increase representation of PLHIV in decision making forums and processes).

It is hoped that these recommendations will be incorporated into the next Somali HIV National Strategic Plan 2021-2024, as well as Somalia's next Concept Note and proposal to the Global Fund.

1. Ensure that **all human rights commitments** outlined in the **Provisional Constitution (2012)** are guaranteed and enforced.
2. Ensure that Somalia/Somaliland **does not enact any law that explicitly criminalises HIV transmission**, exposure or non-disclosure of HIV status, which have widely proven to be counter-productive.
3. Somalia is encouraged to ratify additional **International Treaties** to support Human Rights, especially those that have a direct link to the national HIV response, including:
 - a. The Arab Convention for HIV Prevention and Protection of People Living with HIV, adopted by the Arab Parliament in 2012.
 - b. CEDAW, the Convention for the Elimination of Discrimination Against Women

4. Strengthen the legal and policy framework in Somalia to support the rights of PLHIV and KP

In order to strengthen the legal and policy framework in Somalia/Somalia, it is recommended that Somalia, Puntland and Somaliland review and repeal all punitive laws to outlaw all forms of discrimination. This will include reviewing and/or finalizing the following:

- i. Finalise FGS and Puntland HIV Policies
- ii. The Federal Government and Puntland should ensure that the Draft **HIV Policies developed, are finalised** and approved as soon as possible. At the Federal Level, it is recommended that the Ministry of Health take the lead to ensure that the Draft HIV Policy is finalised and endorsed by Parliament, noting challenges the AIDS Commission has faced trying to finalise this policy in the past. Once finalised, it is recommended all HIV Policies are translated into Somali, and that the Ministry of Health, AIDS Commission, Network of PLHIV and relevant CSOs effectively disseminate and raise awareness about the HIV Policy. Key actors will also need to advocate, lobby for and actively support multiple efforts, at all levels, to ensure the effective implementation of these policies.
- iii. Sexual Offence Bill (2018), review this bill to decriminalise private and consensual adult sexual behaviour, including voluntary sex work.
- iv. Sexual Offences Act in Puntland (2016), review this act and decriminalise the 'intentional' spread of HIV
- v. Sexual Offences Bill in Somaliland (2018) - review the bill to ensure it provides equal treatment for all citizens, regardless of their HIV status.
- vi. Penal Code (1962), review Article 409 to decriminalise private and consensual adult sexual behaviours, including same sex acts.
- vii. Review and finalise the Draft HIV Bill (2009): Ensure that the main issues of discrimination experienced by PLHIV that require policy and legal redress including: denial of healthcare services; loss of employment; discrimination in educational institutions; denial of access to public facilities; denial of property rights; abuse

of the right to confidentiality of health information and domestic violence are addressed by the HIV Bills. In addition, any HIV Bill must ensure that it does not criminalise the 'intentional' spread of HIV. Finalising these Draft HIV Bills will demonstrate the government's commitment to ensuring that all its citizens are able to enjoy their human rights, in line with the Constitution.

- viii. Health Law/Act: Ensure that any future Health Law/Act developed for Somalia/Somaliland ensures the following:
- Abolishes all mandatory HIV-related testing
 - Ensures Confidentiality
 - Guarantees Informed consent.
 - That having HIV does not mean being categorised as 'medically unfit' to work.

5. Access to Justice

- i. Sensitize relevant stakeholders in the civil society sector, government institutions and the private sector, on HIV Policies & legal framework;
- ii. **Support HIV Training to sensitise the Judiciary, Lawyers and other legal practitioners about HIV:** To ensure that Somali legal professionals are well prepared to support the rights of PLHIV and Key Populations, it is recommended that legal professionals are provided with training on the basic facts about HIV, Somali HIV Policies, stigma associated with HIV and other relevant legal documents. This is important, as justice will only be assured when regulatory authorities, including the judiciary and law enforcement authorities, are sensitised and empowered to support the rights of PLHIV and KP, as outlined in Somali legislation.
- iii. **Provide training on HIV Policies and Legal Frameworks for the police**, noting that vulnerable women (FSW) in Somalia frequently face considerable physical and/ or sexual violence.
- iv. **Make accessible and scale up the provision of Legal Aid**, to facilitate access to justice and redress for PLHIV and KP. This will strengthen HIV-related legal services available to PLHIV and KP, in cases of HIV-related discrimination or other legal matters. These services should include access to legal information and referrals, legal advice and representation, alternative/community forms of dispute resolution, and engaging religious and/or traditional leaders/systems with a view to resolving disputes or changing traditional norms/processes (i.e. community norms). Considering that there are ongoing legal aid initiatives supported by UNDP and other partners, Networks of PLHIV should try to strengthen their partnership with these service providers to ensure that their members have access to legal support when required.
- v. **Legal Literacy:** Raise awareness about the **legal rights of PLHIV and KP** through strengthening partnerships between Networks of PLHIV, AIDS Commissions, Legal Aid Clinics and other key actors. Mobilize funding for the same.
- vi. Recommended that the Networks of PLHIV and the AIDS Commissions, **strengthen partnerships with Legal Aid Institutions** e.g. OHPRD in Puntland and Human Rights Centre in Somaliland, so that they are better placed to refer and support individuals that require legal aid support. These Legal Aid providers are also well placed to document human rights abuses, and gather credible evidence to lobby for and support wider access to justice
- vii. Put in place effective **Complaints Response Mechanisms (CRMs)** to document and support the rights of PLHIV and KPs, as soon as possible. Experience shows that an effective CRM will help increase the uptake of HIV services and improve adherence to treatment.
- viii. Ensure effective support structures are put in place to address human rights abuses experienced by PLHIV and KP, including in healthcare, the security sector by police, courts and judges and other settings.
- ix. Scale up and support **'Knowing your Rights'** programmes for PLHIV and KP. Ensure effective referral systems for subsequent, potentially life-saving support.
- x. Ensure that customary and religious laws which could help promote traditional and religious practices that promote the rights of PLHIV and KPs are effectively capitalized on.
- xi. Strengthen links between Networks of PLHIV and PREP, PEP, GBV Help Desks and other relevant bodies.

6. Support Ethics and Stigma Reduction Training for Health Care workers

- i. Train and support healthcare workers to ensure that client friendly services are provided to PLHIV and KP, free from stigma and discrimination. To help ensure this, ensure that the necessary protective equipment is provided to all health care workers.
- ii. Disseminate information on anti-stigma policies to health facilities/health workers, including through visual posters/ resources visible at clinics and health facilities.

- iii. Develop and display HIV Service Charters, outlining available services and assuring customers that the services are free from stigma and discrimination. Support and monitor service providers, to ensure adherence to the same.
 - iv. Provide capacity building to healthcare workers, including training on the necessary protective equipment (universal precautions), to prevent healthcare workers from contracting HIV during service provision.
7. **Support HIV Stigma Reduction Programmes for Community and Influential Leaders.** E.g. Religious, Customary, and Traditional Leaders
- i. Strengthen community knowledge and awareness about HIV modes of transmission, using a variety of audience-friendly approaches and mechanisms.
 - ii. Support community HIV awareness campaigns on the legal rights of PLHIVs. Support community targeted anti-PLHIV stigma and discrimination campaigns in communities, through community conversations, suitable media and other channels.
 - iii. Strengthen advocacy to reduce HIV Stigma and discrimination. This might include working with key government officers and religious leaders to identify Champions against stigma and discrimination. These Champions would be supported to act as role models within the community, to demonstrate that the rights of PLHIV should be respected at all times and that they should be treated in the same way as other citizens.
 - iv. Increase community and PLHIV awareness on anti-stigma policies and laws to support their rights (Knowing your Rights).
 - v. Develop and disseminate IEC/ BCC materials to address HIV/AIDS stigma & discrimination.
 - vi. Work with Influential Leaders, such as Religious Leaders and government officials, to support anti-stigma and discrimination campaigns.
8. Support the **Civil Service to put in place HIV Work Place Programmes.** This will help educate government staff about HIV. Priority Sectors where work place programmes should be rolled out should include the Health Sector (health workers), Law Enforcement Entities/Sectors (Ministers of the Interior and Justice, the police, security personnel, prosecutors, judges, lawyers) and others.
9. **Social Protection:**
- i. Develop a framework and advocate for PLHIV inclusion under broader government Social Protection programmes.
 - ii. Ensure that all Somali legal frameworks:
 - provide social protection for all PLHIV and children living with and affected by HIV and AIDS.
 - reduce harmful gender norms and gender-based violence and increase women and girls' legal, social and economic empowerment.
 - offer the same standard of protection to migrants, visitors and non-citizen residents as that extended to citizens.
10. **Strengthen the capacity of the 3 Networks to support PLHIV in Somalia**
- i. Strengthen the capacity of the three Networks of PLHIV, so they can increase the representation of PLHIV in decision making forums and processes and strengthen their lobbying, advocacy capacity and effectiveness.
 - ii. Support PLHIV Networks to work on multiple **stigma reduction efforts in the community.** E.g. by supporting the PLHIV Networks to lead Community Conversations to address stigma reduction in communities, working in collaboration with the AIDS Commission, Ministry of Health and influential leaders (Religious Leaders and Local Government Representatives), among others.
 - iii. Ensure additional support is provided to allow Networks of PLHIV to expand and support more activities. This will enable Networks of PLHIV to decentralise and work more effectively with other CSOs, in order to effectively support more PLHIV in Somalia/Somaliland and strengthen their collective voice.

Conclusion

When human rights are recognized and protected by laws that are effectively implemented, people are free to live healthier, happier and more fulfilling lives. In addition, as outlined by UNAIDS, the realization of human rights for everyone is essential to stop the spread of HIV and AIDS (UNAIDS Fast-Track the HIV response).

In Somalia, human rights violations in the context of HIV remain all too common. They include stigma and discrimination experienced at family and community levels, as well as when trying to access healthcare services and in the workplace. Violence, negative social attitudes and other abuse commonly limit access to HIV prevention, testing, treatment and care services. The criminalisation and enactment of punitive laws that unfairly target people living with and those most affected by HIV, urgently need addressing.

Personal testimonies and daily experiences commonly shared by PLHIV and KP demonstrate that much remains to be done, to ensure that the human and legal rights of PLHIV and KP in Somalia are respected and effectively protected.

To ensure that the rights of PLHIV and KP as outlined in the Constitution (2012) are supported, it is critical for governments to put in place effective mechanisms to safeguard the rights of all their citizens, including PLHIV and Key Populations. Much more remains to be done to close the significant gap between official policy and common practice, at every level and across sectors. With effective oversight, such measures would significantly lessen the multiple vulnerabilities constantly faced by PLHIV and KP, and give these vulnerable groups hope and optimism moving forward in Somalia.

Lastly, it is recommended that in order to secure and mobilise resources to implement the recommendations stemming from this Somali HIV LEA, the recommendations from this report be included in the next Somali HIV National Strategic Plan, 2021-2023, as well as incorporated into Somalia's next funding proposal to the Global Fund.

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Annexes

Annex 1: List of Key Informant Interviews

Annex 2: Participants List, National Dialogue, Djibouti 24th – 26th November 2019

Annex 3: HIV Legal Environment Assessment (LEA) Action Plans:

- i. Federal Level
- ii. Puntland
- iii. Somaliland

Annex 4: Agenda, National Dialogue meeting, 24th – 26th November 2019, Djibouti

Annex 5: National Dialogue Invitation Letter, 24th – 26th November 2019, Djibouti

Annex 6: Discussion Paper; Draft Model Health Administration Law; and Table of Health Law Building Blocks

Annex 7: Draft, Health Professionals Act. National Health Professionals Council